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BEHAVIORAL HEALTH, SECOND AMENDMENT AND GUN VIOLENCE

SUBMITTED BY

THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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Good morning, my name is Dr. David Rogers and I am a past president of the Pennsylvania Psychological Association. I would like to first thank Senator Baker and Senator Farnese along with the other members of the Senate Judiciary Committee for allowing the Pennsylvania Psychological Association to provide written testimony on this important topic, behavioral health, the second amendment and gun violence.

Gun violence is an urgent, complex, and multifaceted problem that requires evidenced-based solutions. (Association, 2013) Nationally, 39,773 people died from gun-related injuries in the U.S., according to the CDC. (Statistics, 2018) In 2017 (alone), One Thousand Six Hundred and Thirty- Six (1,636) people died by firearms in Pennsylvania and (with) Seven Hundred and Ninety One (791) were (being) homicides. (Statistics, 2018) In addition, Twenty Three Thousand Eight Hundred and Fifty Four (23,854) people died due to firearm suicide. (Statistics C. N., 2017)

Psychology, and psychologists, can provide public health insights and information to help assist in the creation of policies that will aid in the prevention of gun violence. No single profile can reliably predict who will perpetrate gun violence (Association, 2013). Instead, one must consider a variety of factors including, but not limited to, the individual profile, family situations, the school setting, peer relationships, and community and sociocultural risk factors that interact over time during childhood and adolescence. (Association, 2013) Notwithstanding this, the most consistent and powerful predictor of future violence is a history of violent behavior. (Association, 2013).

In our testimony we will describe the relationship between mental health and violence, the emergency psychiatric hospitalization process in Pennsylvania, steps that mental health

professionals can take to reduce violence, and policy initiatives that may further the goal of public protection.

Mental Health and Gun Violence

Although many highly publicized shootings have involved persons with serious mental illness, it must be recognized that these shootings constitute only a small proportion of firearm-related homicides; as such, the problem of gun violence cannot be resolved simply, or solely, through efforts focused on serious mental illness (Webster & Vernick, 2013). In addition, inasmuch as the overwhelming majority of people with serious mental illness do not engage in gun violence, it is essential that they are not stereotyped as dangerous (Sirotich, 2008).

For the small proportion of individuals (for whom there may be some connection or predisposition with a serious mental illness and gun violence), their situations are often complicated due the many, significant, societal barriers to treatment. For example, one solution, psychiatric hospitalization can be helpful, but treatment can be expensive, and there may not be appropriate follow-up services in the community.

We note that a few forms of mental disorders that do not rise to the level of serious mental illness also are associated with gun violence. For example, conduct disorder and antisocial personality disorder are associated with increased risk for violence. (This connection is not surprising because violent behavior is counted as one of the symptoms that helps qualify someone for the diagnosis.) However, unlike those with serious mental illness, there are more well-established, scientifically validated mental health treatment programs for individuals with these disorders, such as multisystemic therapy, can reduce violent recidivism (Henggeler, 2011) if they are implemented with integrity. Similarly, substance abuse misuse also compounds the

risk for violence among persons with serious mental illness (Van Dorn, Volavka, & Johnson, 2012).

Suicide by Firearms

According to the National Institute of Mental Health website and the Centers for Disease Control and prevention leading causes of death reports in 2017, suicide was the 10th leading cause of death overall in the United States, claiming the lives of over 47,000 people. There were more than twice as many suicides 47,173, in the United States as there were homicides 19,510. In 2017, the number of deaths from firearm suicide (23,854) which represents nearly 50% of all suicide deaths in the United States. In 2017, firearms were the most common method used in suicide deaths in the United States, accounting for almost half of all suicide deaths. There were more than twice as many deaths by suicide than by homicide in 2016. 1.3 million adults attempted suicide within the past year in 2016.

Those most affected by suicide include males, who use firearms as the most common method (56%), veterans, who are more than 1.5 times as likely to attempt suicide, older adults, where the highest suicide rate was among males age 65 and older with 32.3 deaths per 100,000, followed by males age 45 to 54, with 29.2 deaths per 100,000.

Suicide is a public health issue. Between 2001 through 2017 for the total United States population suicide rate increased 31% from 10.7 to 14.0 per 100,000. The suicide rate among males remained nearly 4 times higher 22.4 per 100,000 in 2017 than among females 6.1 for 100,000 in 2017.

Suicide assessments should be conducted by providers. For example, the Colombia Suicide Severity Rating Scale (CSSRS) can be utilized for free, not only by psychologists and

other mental health practitioners, but also by primary care doctors, police, pediatricians, teachers, clergy, parents, and the community at large. Current Pennsylvania Law requires teachers and school staff to receive suicide prevention training. Pennsylvania legislators should consider the requirement of all Pennsylvania students entering the 9th grade, where the transition into high school can be most challenging, to have suicide prevention training in schools, such as through Mental Health First Aide or Question, Persuade, Refer (QPR).

We commend Governor Wolf's recent establishment of a state- wide Suicide Prevention Task Force and we recommend that one of the goals of this task force be research in the area of gun violence and suicide. We also commend Attorney General Josh Shapiro for establishing Safe to Say Something School Safety Program.

Current Emergency Psychiatric Hospitalization (302) Procedure in Pennsylvania

The involuntary civil commitment of mentally ill persons is regulated by the Mental Health Procedures Act of 1976 (50 Pa. C.S.A. § 7101 et. seq.). This Act outlines the standards which must be met to effectuate an involuntary commitment, and the due process regulations which must be followed during an involuntary commitment proceeding. Under the Act, persons are subject to involuntary commitment if they are severely mentally disabled, in need of treatment and, as a result of mental illness, pose a clear and present danger of harm to themselves or others. Clear and present danger is established by showing that within the past 30 days, the person has inflicted or has attempted to inflict serious bodily injury to himself or others, and that there is a reasonable probability that such conduct will be repeated. Harm to self also can be established showing that, without adequate intervention, there is a reasonable

probability that death, serious bodily injury, or serious physical debilitation will ensue within the next 30 days.

Section 7302 of the Act authorizes involuntary emergency examination, treatment and detention for a period not to exceed 120 hours. A 302 commitment requires that a person, referred to as the petitioner, state in writing the facts constituting the grounds by which the petitioner believes the person is severely mentally disabled and in need of treatment. If warranted, the county mental health delegate can order the transportation of the individual to an approved facility for examination by a physician. If the examining physician finds that the individual needs emergency treatment, then the facility can hold that individual for up to 120 hours. Limited due process protections are attached during the course of this 302 emergency examination. That is, during this 120-hour period, there is no right to counsel, no right to an immediate hearing and no right to confront witnesses.

Under Pennsylvania law, and the laws of most other states, a person who has been the subject of a 302 commitment may not own, possess, use or transfer firearms. The law does provide an avenue to have those rights reinstated if the individual can prove that they can possess a firearm with no risk to themselves or others. Once rights are lost, the only option is to have a full hearing before a judge. In order to reinstate these rights, the judge must find that the commitment pursuant to Section 302 should never have happened in the first place.

Often the involuntary hospitalization system in Pennsylvania works well. Sometimes it does not and one common problem that occurs is that is often a shortage of available beds for inpatient services.

Strategies to Address the Immediate Risk of Gun Violence

When addressing this problem from an individual level, strategies to prevent gun violence should be tailored to different kinds of violence, be they impulsive or predatory violence. Impulsive violence occurs when violence is carried out in the heat of the moment such as when an argument escalates into an assault. (Association, 2013). In contrast, targeted or predatory violent acts are planned and are directed toward an identified target. (Association, 2013) It is important to differentiate which type of violence is occurring as there are different risk factors for each and they require different interventions.

Researchers have developed models that can assess a person to determine whether a person is more likely to engage in impulsive violence. However, these models cannot predict whether or when any individual person will engage in violence. These models known as violence risk assessment or clinical assessment of dangerousness are administered by mental health professionals who have specific training in this area. There must be a vigorous and coordinated response to persons whose histories include acts of violence, threatened or actual use of weapons, and substance abuse, particularly if they have access to a gun. This response should include a violence risk assessment by well-trained mental health professionals and referral for any indicated mental health treatment, counseling and mediation services, or other forms of intervention that can reduce the risk of violence. (Association, 2013)

It is harder to identify individuals who are going to commit targeted or predatory act of violence. Therefore, mental health practitioners use behavioral health assessment to try to identify individuals who are threatening, planning or preparing to commit targeted or predatory violence. (Association, 2013). Behavioral threat assessment also emphasizes the need for

interventions to prevent violence or harm when a threat has been identified, so it represents a more comprehensive approach to violence prevention. The behavioral threat assessment model is an empirically based approach developed largely by the U.S. Secret Service to evaluate threats to the president and other public figures and has since been adapted by the U.S. Secret Service and U.S. Department of Education (Fein et al., 2002; Vossekuil et al., 2002) and others (Cornell, Allen, & Fan, 2012) for use in schools, colleges and universities, workplaces, and the U.S. military. Threat assessment teams are typically multidisciplinary teams that are trained to identify potentially threatening persons and situations. They gather and analyze additional information, make an informed assessment of whether the person is on a pathway to violence — that is, determine whether the person poses a threat of interpersonal violence or self-harm — and if so, take steps to intervene, address any underlying problem or treatment need, and reduce the risk for violence. Behavioral threat assessment is seen as the emerging standard of care for preventing targeted violence in schools, colleges, and workplaces, as well as against government officials and other public figures. (Association, 2013)

Many violent attacks are carried out by individuals motivated by personal problems who were at a point of desperation. In their troubled state of mind, these individuals saw no viable solution to their problems and could envision no future. The behavioral threat assessment model can also be used to identify personal or situational problems that could be addressed to alleviate desperation and restore hope. In many cases, this includes referring the person to mental health services and other sources of support. In some of these cases, psychiatric hospitalization may be needed to address despondence or suicidality, if present. Nonpsychiatric resources also can help alleviate the individual's problems or concerns. Resources such as

conflict resolution, credit counseling, job placement assistance, academic accommodations, veterans' services, pastoral counseling, and disability services all can help address personal problems and reduce desperation. When the underlying personal problems are alleviated, people who may have posed a threat of violence to others no longer see violence as their best or only option.

In addition to looking at this problem from an individual perspective it is also important to address it from a community perspective. Within the larger community, many stakeholders including community, schools, workplaces, neighborhoods and faith-based groups, are affected by gun violence that results in a homicide, suicide, or mass shooting. When it comes to perpetrating gun violence, however, a common thread that exists across community groups is the recognition that someone, or possibly several people, may have heard something about an individual's thoughts and/or plans to use a gun. Where do they go with that information? How do they report it so that innocent people are not targeted or labeled unfairly — and how can their information initiate a comprehensive and effective crisis response that prevents harm to the individual of concern and the community?

There is a need to develop a new model that would bring community stakeholders together in a collaborative, problem-solving mode, with a goal of preventing individuals from engaging in gun violence, whether directed at others or self-inflicted. This model would go beyond a single activity and would blend several strategies as building blocks to form a workable systemic approach. It would require that community service systems break their tendencies to operate in silos and take advantage of the different skill sets already available in the community — for example:

- Police are trained in crisis intervention skills with a primary focus on responding to special populations such as those with mental illness.
- Community members are trained in skilled interventions such as Emotional CPR and Mental Health First Aid — consumer-based initiatives that use neighbor-to-neighbor approaches that direct people in need of care to appropriate mental health treatment.
- School resource officers are trained to show a proactive presence in schools.

  This approach would allow for earlier identification of those individuals that may carry out a violent act.

Policy Strategies to Address Mental Health Problems

Several strategies can be adopted to reduce gun violence. First by providing more access to mental health care, those who are feeling desperation can get the help they need. Currently, SR 168, in the Senate Health and Human Services Committee would require the Joint State Commission to identify workforce shortages in our mental health system within the Commonwealth. This study is important because it will identify the areas in which our mental health system needs the most improvement.

One way that we can improve are mental health system is to provide more access to services through new modes of delivery. Two ways in which this can be achieved is through telemedicine and increasing the use of integrated care (providing mental health services within the physicians' offices). Telemedicine would allow access to mental health services in rural areas or other areas of provider shortage. Integrated Care practices can take many forms, but generally they allow for greater coordination between medical and behavioral health providers, typically by locating the behavioral health providers in the offices of physicians or other medical

personnel. Fortuitously, this integration of medical and behavioral health in the same facility helps reduce the stigma because the behavioral health is viewed as a common and necessarily part of complete health care.

Other ways to increase access to mental health services is by integrating more school psychologists in the schools to provide services to students and by making sure that state hospitals and prisons have enough staff and have funding to provide services. Since the state hospitals have closed that majority of the people with serious mental illness are now housed in our state prison system. The Department of Corrections has taken aggressive action to increase access of prisoners to mental health services, but much more needs to be done to strengthen these efforts. In addition to being a humane action to be taken, research suggests that prisoners who receive mental health services in prison have a significantly lower rate of criminal recidivism.

In addition, for those individuals that are currently suffering from a crisis, there is a bill in the Senate and the House (SB 90 and HB 1075) that would allow for Extreme Risk Protective Orders which temporarily disarms people in crisis while providing for due process for them to get their guns back once there are no longer in crisis. This bill respects a person's right to bear arms while recognizing that if they are suffering from a crisis it temporarily takes away a means of hurting themselves or others during this time.

Building community coalitions and funding research to come up with strategies to address this situation would also be valuable. Public policy is missing and overlooking the opportunity to save lives by focusing on prevention and treatment strategies that target the root psychological motivation for killing. In doing so, we are repeating the same mistake that

doomed the failed war on drugs, which focused only on criminalizing the drugs of choice without also focusing on addiction prevention and treatment strategies. This research could include developing a statewide public awareness campaign about the dangers of revenge cravings and ways to get help, and training of mental health professionals in the motive control intervention for individuals identified as at risk for retaliatory violence.

In our testimony we have noted that those with mental illness contribute to only a small portion of the violence within our society. We described the emergency psychiatric hospitalization (302) process in Pennsylvania but noted that the shortage of psychiatric beds can sometimes make its implementation difficult. Furthermore, our testimony described in general terms the procedures that professionals can use to identify and circumvent violence. Mental health treatment, combined with other social supports, can often prevent needless violence. Finally, we identified policy initiatives that could expand mental health services including the proposed bill on Extreme Risk Protection Orders which would be used selectively in situations of immediate need to reduce the risk of violence.

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