Implementing Extreme Risk Protection Orders to Prevent Gun Violence and Suicide

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Abstract

More than 130 people lose their lives every day to firearm violence in the United States. Firearms account for a significant share of the increase in deaths by suicide in the past 20 years, and gun violence toward others is also rising. Though suicide can be linked to mental illness, gun violence toward others is typically associated with a wide variety of factors unrelated to mental illness. Regardless of etiology, when danger seems imminent, risk mitigation is important for community safety. Extreme risk protection orders (ERPOs), a legal mechanism to temporarily remove firearms from individuals behaving dangerously, can be an important tool for gun violence prevention. This report describes the public health context of gun violence in the United States, the logic and legal design of ERPOs and the evidence for their effectiveness. Implementation of ERPOs, including the role of clinicians and risk assessment for people with and without mental illness who present in clinical settings, is also discussed. As behavioral health crisis services evolve to serve all who need them, leaders in the behavioral health field should join with leaders in public health and public safety, along with other community members, to examine the causes of gun violence in their communities and implement solutions to address it, including the use of ERPOs as one gun violence prevention tool.

Highlights

- Firearms are the most common mechanism for death by suicide and have driven increases in suicide rates among Veterans, young people, older adults, and Black Americans.
- Serious mental illness may be a contributing risk factor for death by suicide but contributes relatively little to the overall risk of interpersonal violence in the population.
- An evidence-based public health approach to preventing gun violence and suicide should promote safe storage of firearms and lethal means counseling.
- ERPO laws authorize law enforcement, with a judge's civil court order, to temporarily remove firearms from a person found to be at risk of dangerous behavior directed toward themselves or others and prohibit the person from purchasing or possessing firearms for the order's duration. Research suggests that ERPO laws are a promising strategy for preventing firearm suicide.
- As of December 2024, 21 states and the District of Columbia have ERPO laws; 6 of those states and D.C. allow clinicians to serve as authorized petitioners for ERPOs, and almost all allow for clinician input to the court. In all 21 states and D.C., law enforcement are authorized petitioners, and most states also allow family or household members to petition for an ERPO.

Recommendations

Taking a public health approach to address gun violence includes incorporating evidence-driven practices as outlined in this paper. The following recommendations can guide behavioral health, public health, public safety, and community leaders on using ERPOs to address gun violence.

1. As a strategy to prevent gun violence and suicide, ERPOs should be used when someone is presenting as dangerous toward themselves or others for whatever reason, for example, ranging from impulsive anger and hostility to substance intoxication to feelings of despair in a mental health crisis.
2. Public mental health systems should be knowledgeable about ERPO laws and their use.
3. Communities can enhance cross-sector collaboration for effective ERPO implementation.
4. Data collection and research can be prioritized to ensure that ERPO laws and programs achieve the desired goals and inform best practices.

Introduction

Gun violence is an increasingly serious public health crisis in the United States in need of evidence-based public health policy solutions. It is now measured in a daily toll of more than 130 lives lost[1] in firearm-involved crime, domestic assaults, multiple-casualty shootings, and suicides, and was declared a public health crisis by the U.S. Surgeon General in 2024.[2] Whereas some point to "mental illness" as the source of gun violence, studies have demonstrated only a weak and nonspecific link between serious mental illness (SMI) and violent behavior towards others.[3] Rather, violence risk is mostly attributed to other risk factors such as substance use and social-environmental stressors in someone's life.[4] Suicide, however, accounts for more than half of gun deaths in the United States, and mental illness is a strong contributing risk factor.[5]

2022 FIREARM DEATHS IN THE UNITED STATES

48,204 deaths from firearms

- **27,032** suicide
- **19,651** homicide
- **1,521** unintentional, undetermined, or due to legal intervention

Source: Centers for Disease Control and Prevention. (2024). 2022 firearm deaths in the US. Underlying cause of death, 2018-2022, single race request.

This technical assistance paper focuses on firearm injury and mortality and describes the ways in which leaders from behavioral health, public health, and public safety can join with a variety of community and state partners to address the causes of gun violence to save lives and support communities. The transition to 988 Suicide & Crisis Lifeline makes it all the more important for mental health leaders, crisis workers, and other community partners to be aware of the latest relevant research evidence and innovations in gun violence prevention policy and practice—including ERPOs—in order to improve crisis response, reduce harm, and mitigate risk.

In June 2022, Congress passed and President Biden signed the Bipartisan Safer Communities Act into law, which among other community safety initiatives, expanded the Department of Justice Byrne grant program to support the implementation of ERPOs, dedicating $750 million for state crisis intervention programs, including ERPO. President Biden then announced an executive order in March 2023 that set a goal of reducing gun violence and improving community safety through a broad array of strategies, including increasing the effective use of "red flag" laws.[6] These laws, known more specifically as extreme risk protection orders, or "ERPO" laws, authorize law enforcement officers (or, in some states, other community members such as family members and clinicians) to petition a court for a type of civil restraining order to temporarily remove firearms from an individual determined to be dangerous. The executive order spotlighted the need for greater public education, cross-system partnerships, and infrastructure to make these laws as effective as possible.

Behavioral health, public health, and public safety leaders face important challenges as they seek to improve crisis response and promote community safety and wellbeing while respecting individuals' rights. To help them achieve these goals, it is important that they be knowledgeable about ERPOs as an effective intervention.

Part I of this report provides the public health context surrounding gun violence and ERPOs, with a focus on components related to behavioral health care. **Part II** describes public health strategies for gun safety that create time and space between a person in crisis and firearms, such as safe storage and lethal means counseling. **Part III** describes the logic and legal design of ERPOs, evidence for their effectiveness, and the state of their implementation. **Part IV** describes clinicians' role in the utilization of ERPOs and summarizes the key barriers to their use. **Part V** offers recommendations for implementation.

Part I. Suicide, interpersonal violence, and mental illness

Suicide, mental illness, and firearms

A total of 49,476 people died by suicide in the United States in 2022. Suicide was the second leading cause of death among those under age 35. From 2001 through 2021, suicide rates increased most years in males and females. The total age-adjusted suicide rate increased from 10.7 deaths per 100,000 population in 2001 to a recent peak of 14.23 in 2018. The age-adjusted suicide rate in 2022 was 14.21 per 100,000 population.[7,8] Suicide rates are disproportionally higher among Indigenous populations, [9] Veterans,[10] LGBTQI+ populations,[11] people living in rural areas,[12] White males, and people ages 85 and older.[13,14,15] With regard to age, suicide mortality has a first peak among young adults and a second peak (of greater magnitude overall) among older adults. The suicide rate for persons ages 25–34 in 2022 was 19.5 per 100,000, which is similar to the rates for persons ages 75–84 and higher than the rates for other age groups under age 75.[16] Other important risk factors for suicide include certain mental health conditions,[17] substance use,[18] a personal or family history of suicide attempts,[19] isolation,[20] poverty,[21] chronic pain,[22] and easy access to firearms.[23]

Many who die by suicide have a mental illness that is a predisposing or precipitating factor.[24] Certain mental illnesses markedly increase an individual's lifetime risk for suicide, including major depressive disorder, bipolar disorder, schizophrenia, anxiety disorder, and dysthymia.[25,26] Additionally, substance use, particularly alcohol and opioid use, significantly increases risk for suicidal ideation, attempts, and death.[27,28] Because of this link, healthcare providers helping individuals navigate care for mental illness and substance use are in a unique position to identify suicide risk and intervene to save lives, especially in the high-risk populations they serve, as discussed more in **Part II** below.

Firearms are, by far, the most common mechanism of suicide death, accounting for more than half of all suicide deaths in the general population. Between 2018 and 2022, the period spanning the COVID-19 pandemic, firearm suicide rates increased across all racial groups.[29] A similar pattern was seen among youth and younger adults ages 18–34; in this age group, firearm suicide rates increased by almost 23 percent from 2019 to 2021 while the rate of suicide by other methods declined or remained stable.[30]

The number of new gun owners has increased substantially in recent years. From 2019 to 2020, the annual number of new gun owners increased 58 percent, from 2.4 million in 2019 to 3.8 million in 2020. Approximately 7.5 million U.S. adults became new gun owners between January 1, 2019, and April 26, 2021.[31] Half of these new gun owners had no prior firearm safety training and had children in the home; 40 percent kept at least one gun stored without a lock.[32]

To understand the role of firearm access in suicide death, it is important to recognize that the vast majority (92 percent) of suicide attempts are nonfatal.[33] The most common method of attempt, poisoning/overdose, has only a 2 percent fatality rate. In contrast, people who use a firearm in a suicide attempt rarely survive; the case fatality rate is nearly 90 percent. Thus, while guns are used in only 5 percent of suicide attempts,[34] they account for 55 percent of suicide deaths in the United States.[35]

Suicide is often an impulsive act. In one study, 24 percent of suicide attempt survivors reported spending less than 5 minutes between the decision to attempt suicide and the actual attempt.[36] Among those who survive a serious attempt, less than 6 percent ever go on to die by suicide.[37,38] In most cases, it is only if the method available during the impulsive suicidal period is a particularly lethal one, such as a gun, that a fatality occurs. Without a lethal method at hand, most people who attempt suicide survive and are able to obtain help and eventually recover. Access to a firearm approximately triples the risk that an individual who attempts suicide will die by suicide.[39] This risk is even more pronounced in youth, who sustain a fourfold increase in risk of suicide if they have access to a firearm.[40] Knopov and colleagues in 2019 found that for every 10 percent increase in household gun ownership in a state, the youth suicide rate increased by 27 percent.[41] Despite broad knowledge of these risks, firearms are often left accessible to children and others to whom firearms could pose a danger. Less than half of gun owners store all their guns safely.[42,43,44] To address these risks, and acknowledging that 1 in 3 American households own at least one gun,[45] this paper discusses several existing gun violence prevention strategies, tools, and approaches.

Interpersonal violence, firearms, and mental illness

The general features of firearm-related violence toward others in the United States can be understood in several different but overlapping contexts, including community violence, domestic and intimate partner violence, and mass shootings.

COMMUNITY VIOLENCE AND FIREARM HOMICIDE

Firearm homicides are a major component of community violence, which occurs in various public or private places between people who may or may not know one another.[46] These homicides tend to occur disproportionately in urban areas,[47] where they are concentrated in low-income settings and predominately racial, ethnic, and religious minority communities.[48,49,50] Rural areas and smaller communities are affected more by firearm suicides.

Firearm homicides are rising, and the trend corresponds to an increase in firearm purchases during the COVID-19 pandemic, as described in the previous section on suicide.[51,52] In 2018, there were 18,830 homicides in the United States, with 74 percent involving firearms. In 2022, there were 24,849 homicides, with 79 percent involving firearms. The first two years of the pandemic (2020–2021) saw a 32 percent increase in the estimated national crude rate of firearm homicides compared to the pre-pandemic period (2018–2019), from 4.3 to 6.3 per 100,000 people.[53] However, CDC provisional data for 2023 show the number of firearm homicides decreased by 8.6 percent from the previous year.[54] Additional data reported by the Council on Criminal Justice show an overall decline in homicides in the first half of 2024 compared to the first half of 2023, indicating a downward trend may be beginning.[55]

- **2018:** 18,830 total homicides, with 13,958 (74%) due to firearms
- **2022:** 24,849 homicides, with 19,651 (79%) due to firearms

Source: Centers for Disease Control and Prevention. (2024). 2022 firearm deaths in the US. Underlying cause of death, 2018-2022, single race request.

The prevalence of firearm homicide varies substantially by geography, with the highest rates found in Southern and Southeastern states. Firearm homicide occurs more frequently in urban settings, among African American or Black and Hispanic or Latino men,[56] and among younger individuals. Firearm-related injuries are now the leading cause of death among children and teens ages 1 to 19 in the United States.[57] Firearm-related suicide and homicide have broad social costs in terms of community and economic impact, quality of life, health care, and law enforcement resources.

Non-fatal firearm injuries can also have a lasting impact on survivors. Injuries can range from superficial soft-tissue wounds to devastating loss of limbs, loss of vision, and injury to vital organs. Survivors may also experience poor mental health outcomes, including anxiety, depression, substance use and posttraumatic stress disorder (PTSD).[58] In purely economic terms, the cost of fatal and non-fatal firearm injuries was estimated to be nearly $500 billion in 2020.[59] From 2009 to 2017, emergency department visits for non-fatal firearm injuries in the United States, averaged 85,694 annually, and assault by firearm accounted for nearly 40 percent of those visits.[60] In addition to impacting survivors, the presence of firearm violence affects the health and well-being of communities. Since firearm violence disproportionately affects young people, this impact can lead to long-term challenges with employment, family relationships, and overall quality of life.

INTIMATE PARTNER AND DOMESTIC VIOLENCE

Over the past 30 years, several studies have reached the consensus that greater access to firearms in the home, regardless of ownership, increases the burden of firearm violence and homicide in communities and households,[61] and that violence tends to be directed toward intimate partners, household members, and acquaintances more often than strangers.[62,63] Women are particularly at risk, with homicide being among the leading causes of death among women ages 44 and younger, and half of all female homicides occurring in the context of intimate partner violence.[64] Between 2010 and 2017, half (52 percent) of women homicide victims died by a firearm, and 44 percent of all-cause homicides among women were perpetrated by an intimate partner. By comparison, three-quarters (75 percent) of male homicide victims died by firearm, and most often the perpetrator was not an intimate partner.[65] A separate study examining 1994–2004 data estimated that the presence of a firearm increased the risk of death by intimate partner violence by a factor of five.[66] Also, domestic violence accounted for nearly 60 percent of fatal multiple casualty shootings between 2014 and 2019.[67]

MASS SHOOTINGS

There is no standardized definition of a “mass shooting,” and several well-known firearm violence databases use differing definitions.[68] The Federal Bureau of Investigation, which maintains the Supplementary Homicide Report, defines a “mass killing” as an event involving three or more people with a fatal violent injury, excluding the shooter.[69,70] This narrow definition includes only fatal outcomes of mass shootings and does not capture the broader context and impact of firearm violence; it also excludes some contexts such as gang-related violence. The Gun Violence Archive (GVA), an organization that maintains a database of confirmed, contextualized mass shootings in the United States and controls for appropriate defensive gun use, uses a definition of four or more fatal or nonfatal firearm injuries, excluding injury to the perpetrator.[71] Because of these differing definitions, studies may use similar datasets but reach different conclusions regarding the incidence and prevalence of firearm-related mass violence events. This is a major limitation when reconciling information presented by studies using different definitions of mass violence.[72]

The GVA reports that there were 3,019 mass shootings from January 2019 to December 2023, resulting in 2,947 fatalities and 12,350 nonfatal injuries. Seven events resulted in 10 or more fatalities. In 2019, the number of mass shootings recorded was approximately 40 percent higher than in 2023. A separate analysis of GVA data from 2014 to 2022 that included fatal and non-fatal firearm injuries found that mass shootings most frequently occurred in association with social factors, crime, or domestic violence. Only 1.5 percent of mass shootings occurred in a school setting.[73] The vast majority of child and adolescent deaths by firearm violence occur in the community rather than in school settings.

Associations between violence and mental illness

Violent behavior is frequently mistakenly attributed to mental illness. Drivers of violence are multifactorial, including provocation elements, adverse childhood experiences, socioeconomic inequities, availability of lethal means, and temperamental tendencies toward aggression or impulsivity.[74,75,76] Aggressive behavior is typically not specifically related to mental illness, and a violent response to emotional provocation is not likely to be rooted in psychopathology. Physical violence also occurs on a spectrum, ranging from minor assaultive behaviors such as pushing and shoving to serious injurious acts such as stabbings and shootings. Some individuals have personality characteristics with a tendency toward rapid mood changes and aggressive behavior.[77] Traumatic childhood experiences, particularly those involving caregivers and abusers, can result in maladaptive coping and impulsivity.[78] The acquisition or development of neurologic conditions such as traumatic brain injuries[79] and dementia[80] can result in neuropsychiatric manifestations characterized by personality change, behavioral disinhibition, and low stress tolerance. Substance use, both intoxication and withdrawal syndromes, can increase underlying tendencies toward behavioral disinhibition, impulsivity, aggression, and lowered distress tolerance.[81] The cognitive reserve for rational thinking diminishes during periods of intense emotion or crisis and lowers the threshold for engaging in impulsive behavior.[82] The presence of a firearm during an impassioned moment can prove fatal.

Substance use alone, especially use of alcohol, may also be a risk factor for violence.[83] Although substance use, especially use of alcohol, increases the likelihood of violence, most people who use illegal drugs and people with substance use disorders (SUDs) are not violent. Substance use is also associated with increased odds of victimization, especially among women,[84,85] and experiencing victimization increases the risk of substance use in the first place.[86] People with SUDs are also at increased risk for suicide.[87,88] Therefore, researchers believe the relationship between gun violence and SUDs is likely influenced by sociodemographic factors, in addition to behavioral factors.[89]

Drug and alcohol use disorders are far more common than SMI.[90] Approximately 48.5 million people age 12 or older in the United States had a SUD in 2023.[91] This represents about 17.1 percent of the population in that age group. Among people age 12 or older, 3.5 million had received treatment in the past year for drug use disorder, 1.6 million had received treatment for alcohol use disorder, and 1.1 million had received treatment for both alcohol and drug use disorder.[92] This high prevalence suggests that problematic substance use and SUDs should be included in any efforts to address violence. The increased risk of harm associated with substance use can be related to an exacerbation of the effects of certain psychiatric symptoms such as delusions, hostility, and depressed mood. Substance intoxication can distort a person's judgment and perception of threat and provocation from others, possibly increasing risk of conflict.[93] A larger literature documents the association between alcohol misuse and intimate partner violence and gun violence in general.[94,95]

SAMHSA estimates that 59.3 million adults in the United States had some form of mental illness in 2022.[96] Of the 15.4 million with SMI, defined as disorders of mood and thought that lead to severe functional impairment, including schizophrenia and mood disorders such as bipolar 1 disorder and major depression, only 10.2 million received any treatment in that year. The fact that approximately 5.2 million adults with SMI did not receive any treatment in a year highlights the significant treatment gap for mental health conditions and SUDs in the United States. There are significant challenges hindering access to care in a healthcare system that is overburdened, under-resourced, and often fragmented.

Like anyone in the general population, people with SMI are capable of violence, but they rarely are actually violent.[97] Early studies investigating the association between mental illness and violence were

limited by selection bias because investigators drew samples from criminal justice, clinical and forensic settings. The National Institute of Mental Health's Epidemiologic Catchment Area surveys in the late 1980s provided the first community-representative estimates of the prevalence of any interpersonal violent behavior in people with and without diagnosable psychiatric disorders.[98] The 12-month prevalence of any form of self-reported violence among those with SMI in the community was slightly below 12 percent, and 7 percent in those without comorbid substance use. By comparison, 2 percent of the general population without any psychiatric disorder or substance use reported violence in the past 12 months. Comorbid substance use increased the likelihood of violence; the population attributable risk of violence associated with SUD was 34 percent, compared to 4 percent associated with mental disorder alone.[99] Despite heterogeneity in methodology, a recent review of 14 studies investigating associations between SMI victimization and violence perpetration reports overall concordant findings.[100]

A large study in the United States found that adults with schizophrenia who did not adhere to prescribed treatment or respond to treatment and had active psychotic symptoms, including hallucinations or delusions, had a greater likelihood of engaging in violence than treatment-adherent individuals whose symptoms responded.[101] In a systematic review of 24 register-based studies of violence in individuals with schizophrenia spectrum disorders, Whiting and colleagues found that the absolute risk of perpetrating violence was less than 1 in 20 in women and less than 1 in 4 in men with schizophrenia over a 35-year period.[102] Certain combinations of psychotic symptoms—for example, delusional thinking and excessive perception of threat from others, along with hostility—are associated with increased risk of at least minor violent behavior.[103]

Research also suggests that genetic and social-environmental factors each account for some of this risk of violence, for example, in studies with sibling controls.[104] Experiences such as homelessness and violent victimization are associated with independent risks of violence separate from mental illness.[105] One study of discharged psychiatric patients found that 2 percent committed a violent act or threat with a firearm in the year after hospitalization, and 1 percent committed a violent act or threat involving a firearm directed at someone unknown to them.[106] Importantly, none of those who committed an act of gun violence had a psychotic admission diagnosis. Some of the individuals had only SUD. Alcohol and drug use contributed to the risk, and trauma histories were prominent in the at-risk population. Another study found that 90 percent of criminal charges involving individuals with SMI were minor offenses such as trespassing or drug related and 10 percent were violent crimes.[107] Importantly, those with mental illness and SUDs were more likely to be victims of violence compared to the general population.[108]

In summary, there is marginal increased relative risk and low absolute risk of violence among those with SMI. Substance use alone, especially use of alcohol, may also be a risk factor for violence. This risk is increased by an exacerbation of SMI symptoms and the presence of other factors such as trauma histories, personality tendencies toward impulsivity and aggression, socioeconomic inequities, structural factors such as lack of housing and unemployment, and access to lethal means. However, nearly half of Americans surveyed in 2013 believed that people with mental illness were more dangerous than the general population.[109] A study from the General Social Survey found that 60 percent of adults believe that people with an illness like schizophrenia are likely or very likely to be dangerous.[110] In contrast to this perception, studies find that people with schizophrenia are highly unlikely to engage in violence. As noted above, the population attributable risk of violence associated with SMI alone has been estimated at 4 percent.[111]

Part II. Gun safety approaches, strategies, and tools

A public health approach to firearm violence and suicide includes reducing harm by limiting access to lethal means. There are various approaches to creating space between an individual in crisis and access to firearms, including regulatory tools, education, and other public health policies. Two of such strategies to limit access, lethal means counseling and safe storage, are described in this section. ERPOs, another such strategy, are discussed in **Part III**.[112,113]

Lethal means counseling

Lethal means counseling for firearms is an important suicide prevention approach.[114] It is primarily a healthcare-based intervention that aims to reduce access to items or structures that can be associated with fatal consequences, such as firearms. By reducing access, a person's risk of suicide, homicide, and unintentional injury or death can be lowered. The approach involves assessing whether a person at risk for suicide has access to a firearm or other lethal means and working with them and their family or other support system to limit their access until they are no longer at elevated risk.[115,116]

Note: Lethal means counseling (LMC) may also be referred to as counseling on access to lethal means, lethal means safety counseling (LMSC) or lethal means restriction counseling (LMRC).

Firearm lethal means counseling includes clinicians speaking with a patient about their thoughts of suicide and about using firearms, speaking with a support person for the individual, advising on safety issues (such as safe firearm storage), and problem solving around ways to limit firearm access.[117] Clinicians will also work the individual in care a plan addressing timelines and roles regarding who will do what with the firearms, and then documenting and following up on the plan. Lethal means counseling provides a way for a clinician to work with an individual and their support system to help reduce access to lethal means as one strategy to help reduce suicide risk. The U.S. Department of Defense and Department of Veterans Affairs recommend that providers utilize lethal means counseling when patients currently have suicidal thoughts; are in distress and have attempted suicide in the past; are struggling with mental health or substance use issues and are exhibiting risk factors, such as hopelessness, withdrawal or lacking reasons for living; or are struggling with stressful life events that may serve as triggers for suicidal behavior, such as financial, occupational or relationship problems.[118]

Research suggests that lethal means counseling is effective in reducing access to lethal means among individuals at risk for death by suicide.[119] One study, for example, showed that lethal means counseling and providing cable locks helped sustain improved firearm storage for National Guardsmen.[120] Another study showed that lethal means counseling in an emergency department improved safe storage planning for firearms.[121] A review of eight studies published between 1998 and 2020 suggested that lethal means counseling on various lethal means (such as alcohol, medications and firearm storage) may benefit from further skills development for the staff administering the counseling and a focus on the specific lethal means relevant to the individual.[122] A recent study of almost 50,000 well-child visits in pediatric primary care settings in Michigan and Colorado found that using an electronic health record

documentation template with implementation support was effective at promoting lethal means counseling in pediatric settings.[123]

The Suicide Prevention Resource Center has a Counseling on Access to Lethal Means course for mental health professionals and others who may work with people at risk for suicide such as social service professionals and other healthcare providers. It is available for free **online**.

Promoting the use of lethal means counseling to reduce access to lethal means for people at risk of suicidal behaviors is a recommendation in the U.S. Department of Health and Human Services' 2024 National Strategy for Suicide Prevention released earlier this year.[124]

Safe and secure storage of firearms

Safe storage of firearms is a critically important practice for gun violence prevention in the United States, given the prevalence of guns in households and their ubiquity in some communities. Safely and securely storing firearms can reduce the risk of gun injuries and deaths, and is a practice supported by researchers, health care professionals, and gun owners. Data from the Centers for Disease Control and Prevention, however, suggests that uptake of safe and secure firearm practices is limited among firearm owners.[125] Among eight states with data available, 25–41 percent of firearm owners with a child or adolescent in the house reported that their firearm was kept loaded and unlocked.

The U.S. Department of Justice released a guide on safe firearm storage, *Safe Storage of Firearms: Unload It, Lock It, Store It* in January 2024 that details suggested safe storage practices for firearm owners and for federal firearms licensees.

Firearm storage practices exist on a spectrum of safety. On one end is the least safe and secure option: having a loaded, unsecured handgun somewhere in the house, or even multiple unsecured handguns in different locations in a house. At the other end is the most secure method: storing the firearm unloaded and locked in a gun safe or lockbox.

Each step closer to the gun being ready to fire introduces increased risk for injury, as proximity to a gun being ready to fire introduces opportunities for both unintentional and intentional injury. Ideally, ammunition should be stored in a different lockbox, but for some people the idea of storing ammunition separately is not appealing. If the gun owner is unwilling to follow the safest gun storage practices, risk of harm can still be mitigated to some extent by locking guns in a quick-access safe along with the ammunition.

There are also options for safely storing a firearm outside of one's own home. Some states, such as Colorado, Louisiana, Maryland, Mississippi, New Jersey, and Washington have implemented statewide safe firearm storage map that show available options for safely storing a firearm temporarily. However, state laws vary regarding temporary storage of firearms and who is legally allowed to keep someone else's firearm for their safety.[126]

Part III: Extreme risk protection orders as a gun violence prevention tool[127]

The massacre of 26 children and teachers at Sandy Hook Elementary School in Newtown, Connecticut on December 14, 2012, resurfaced a long-standing challenge in the United States: how to construct a legal and regulatory framework that respects civilian firearm ownership as a constitutionally protected right (with limits) and also protects the public from foreseeable tragedies that result from ready access to firearms.[128] In the aftermath of the Sandy Hook shooting, one of the dominant narratives that emerged focused on mental illness and the need for policies that prohibit (presumably dangerous) individuals with mental illnesses from purchasing and possessing firearms.[129]

In March 2013, a group of researchers, advocates, and professionals involved with gun violence prevention and/or mental health gathered in Baltimore, Maryland to examine the evidence about the relationship between mental illness and violence.[130] At the conclusion of the day and a half meeting, the group had reached a consensus on two central points. First, mental illness is not a good predictor of interpersonal firearm violence. Second, dangerous behaviors, not mental illness, are the best predictors of violence risk, and the basis on which firearm violence prevention policies should be made.

The Basic Components and Process of an Extreme Risk Protection Order

Courts' ERPO procedures usually include a two-step process in which a petitioner first completes a petition, appears before a judge, and describes the dangerous behaviors that motivated the petition. The judge decides, based on the information provided in court, whether to grant an initial ERPO. If the ERPO is granted, its duration is brief (between 7 days and 1-month) and it includes a second court date when the petitioner and the respondent to the order (the person named in the petition as behaving dangerously) will return to court and explain to the judge why the initial order should be extended (for up to a year in most states) or allowed to expire. After issuing the initial short-term order, law enforcement serves the respondent the petition, explains the terms of the order, and in some instances, takes possession of any firearms to facilitate compliance with the ERPO. At this time, law enforcement updates the background check system to reflect that the respondent is not legally able to purchase firearms. In most states, if the petitioner does not request another ERPO at the conclusion of the first, it will expire and any firearms that were removed by law enforcement will be returned, provided the respondent is not otherwise prohibited from taking possession of them.

To address the second conclusion, the group (now known as the Consortium for Risk-Based Firearm Policy, or Consortium) committed to developing and disseminating the policy recommendations that had emerged from the meeting.[131] One of those recommendations was for states to create a new civil court order, now known as an ERPO, that would allow a judge to temporarily prohibit someone who is behaving dangerously and at risk of committing violence or dying by suicide from purchasing and possessing firearms. This process could be initiated by family members, partners, or law enforcement

and would operate in similar fashion to the domestic violence protection order processes in place in all 50 states.[132]

Logic and legal design

ERPO laws are a response to the recognition that threatening violence is one of the best predictors of violence.[133] Given the lethality of firearms,[134] and that most people who die by homicide or suicide are killed by guns,[135] when someone is behaving dangerously and at risk of violence one logical response is to intervene to prevent ready access to firearms. This rationale is based in part on the robust literature on suicide risk, which concludes that access to lethal means—and, specifically, access to firearms—matters.[136,137] It is estimated that one death by suicide is prevented for every 17–22 ERPOs issued.[138]

The rationale for ERPO laws also stems from compelling evidence that state domestic violence protection order laws that temporarily prohibit the purchase and possession of firearms are associated with statistically significant reductions in intimate partner homicide generally, and intimate partner firearm homicide in particular.[139] The processes for removing firearms from individuals who are exhibiting behaviors that clearly indicate that they are at risk of committing violence are just as important as, if not more important than the extensive safeguards in place to facilitate firearm access. However, little attention is devoted to dispossession processes when risks or actions make clear that an individual is no longer safe with firearms. The resulting gap between when an individual expresses their tendency toward violence, and the commission of violence that constitutes a crime (and when legal intervention typically occurs) is a missed opportunity for prevention.[140]

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The Consortium’s recommendation that states adopt ERPO policies to address this gap and provide a mechanism to temporarily dispossess an individual of firearms and prohibit new firearm purchases if they are behaving dangerously and at risk of committing violence was informed by two types of policies. Civil domestic violence protection orders are in place in all 50 states and the District of Columbia and are recognized as an essential tool for people experiencing partner violence. About half of these state laws specify that respondents to domestic violence protection orders are subject to restrictions on the purchase and possession of firearms for the duration of the order.[141] Importantly for the Consortium, these laws are associated with a reduction in intimate partner homicide,[142] are prevention-oriented, have withstood constitutional challenges,[143] include due process protections so consideration of respondents’ rights are inherent, and do not rely on criminal prosecution. The Consortium also considered laws in Connecticut[144] and Indiana that specified processes for law enforcement to remove firearms in response to a risk of violence, but without evidence of a crime. At the time, a descriptive study of the Indiana law in Marion County (home to Indianapolis) concluded that the law was most often used (68 percent of the time) in response to suicide risk, and that it “functioned as a months-long cooling off period for those who did not seek the return of their guns.”[145] Similar to domestic violence protection order policies, the Connecticut and Indiana laws were prevention oriented and did not rely on a criminal finding in order to remove firearms.

“As state mental health leaders consider how best to support professionals on the front lines of responding to people in crisis, ensuring these professionals are knowledgeable about ERPO laws in their states stands out as an important part of the mission to provide effective supports during crisis.

ERPO laws borrow from and expand these two policies by establishing a civil court order to allow for the temporary removal of firearms from individuals who are behaving dangerously and at risk of committing violence. Recognizing that there is a place in American jurisprudence for meaningful intervention before a crime occurs is an important complement to existing firearm violence prevention policy options, and this recognition advances opportunities for prevention in meaningful ways. As state mental health leaders consider how best to support professionals on the front lines of responding to people in crisis, ensuring that these professionals are knowledgeable about ERPO laws in their states stands out as an important part of the mission to provide effective supports during crisis.

It is important to consider some points that are part of the ongoing discussion about ERPO implementation that may be relevant to the behavioral health community. ERPO policies are relatively new, and many laws passed by states have been amended to reflect lessons learned from practice. Furthermore, amendments are likely to continue to be passed as ERPO uptake increases. ERPO laws differ between states and implementation practices vary within and across states (as will be discussed in the next section). States also differ in how they protect the privacy and confidentiality of ERPO records. This variety of approaches and experiences creates the opportunity for policymakers to replicate, innovate, and lead with the components of ERPO policy and practice that best meet the needs of the communities they serve.

ERPO Implementation: Considerations for the Behavioral Health Community

1. How do you envision the behavioral health community using ERPO?
2. Who should be or is authorized to petition for ERPOs?
3. What policies or procedures are needed to protect the privacy of individuals while also ensuring collaboration among petitioners, courts and providers?
4. When drafting legislation, what are the potential benefits and drawbacks of including clinicians as ERPO petitioners?
5. Because ERPOs often involve firearm dispossession, law enforcement will always be part of the process. What role do you see for law enforcement in this process?
6. How can ERPOs be implemented to reduce this risk of a disproportionate and unfair impact on any particular community?
7. To what extent can ERPOs function to direct people into needed behavioral health interventions before they reach the point of needing to engage with the criminal legal system?
8. What policies or procedures can be put into place to limit stigma and any potential adverse effects after an ERPO is granted?
9. Who or what groups should be involved in ERPO implementation and decisions about state ERPO policy?

State response and initial uptake: current efforts

On September 30, 2014, former Governor Jerry Brown signed Assembly Bill (AB) 1014 into law, and California became the first state to take up the Consortium's ERPO recommendation. The legislation was a response to a shooting that occurred near the University of California, Santa Barbara campus where 6 people were killed and another 14 injured.[146] Prior to this mass killing, sheriff's deputies had visited the shooter's home for a welfare check at the request of his family but had no reason to pursue an emergency petition for civil commitment and left without taking further action since there had been no criminal act. Advocates supporting AB 1014 pointed to the missed opportunity to intervene and remove firearms when those who knew the shooter were expressing concern about his well-being. This likely persuaded the legislature that an ERPO law would complement the state's existing gun violence prevention policies.

As of May 2024, 21 states and the District of Columbia have enacted ERPO laws (see box at right). Like California, many of these states enacted ERPO laws following horrendous mass shootings.[147] The laws share several basic core components: a civil court order based on dangerous behaviors and a risk of violence (self-directed, interpersonal, or both) that allows for a temporary prohibition on the purchase and possession of firearms, regardless of whether the person behaving dangerously possesses firearms.[148]

Although ERPO laws are quite similar across the states, a few differences are worth noting because of their relevance to the behavioral health community. The first regards who is authorized to petition or initiate a court hearing when someone is behaving dangerously and at risk of committing violence. In all states where ERPOs are available, law enforcement is authorized to petition. Most states also allow some family members, partners, and/or household members to petition. A smaller number of states authorize clinicians to petition; however, the definition of "clinician" varies among those states that name clinicians as authorized petitioners. As of May 2024, Colorado, Connecticut, Hawaii, Maryland, Michigan, New York, and the District of Columbia all include clinicians as ERPO petitioners. Some states also authorize school administrators, employers, and co-workers to petition, although these are few in number.

The second difference regards judicial officers' availability to hear ERPO petitions in court. A small number of states (California, Maryland, and Washington) support an infrastructure to hear ERPO petitions 24 hours a day, 7 days a week. Providing access to the court when people are in need recognizes the emergency nature of these proceedings and the fact that dangerous behaviors may present outside of standard court hours. The SAMHSA-funded paper, *Legal Issues in Crisis Services* provided an initial review of how ERPO laws might play a role as crisis services were emerging through 988 call center development.[149] As the behavioral health community becomes more engaged with ERPO policies and their

States/Territories with ERPO Laws as of December 2024

California
Colorado*
Connecticut*
Delaware
District of Columbia*
Florida
Hawaii*
Illinois
Indiana
Maryland*
Massachusetts
Michigan*
Minnesota
Nevada
New Jersey
New Mexico
New York*
Oregon
Rhode Island
Vermont
Virginia
Washington

*Clinicians are authorized petitioners

implementation, input from those working within the crisis response system, including 988 call centers, about the emergency nature of these petitions would be a valuable addition to the ongoing discussions that are influencing how ERPO laws are written and put into practice.[150]

As the following section summarizing the current evidence on ERPOs will detail, the most notable differences in ERPO laws lie not in the specifics written by policymakers but rather in the implementation within and across states. ERPO laws enable participation by those authorized to petition, and they operate within an infrastructure that requires resources to be devoted to creating forms, training court personnel, and holding hearings. Petitioners need training on how to use the law and engage with the court system to allow for their petitions to be heard, and they need to recognize when an ERPO is an appropriate tool and apply it accordingly. ERPO implementation presents an opportunity for the behavioral health community to both engage with this new tool and shape how it is used. Input from people who are working on the front lines of crisis response can inform how ERPO implementation evolves and determine whether it is a tool that will be used to complement and enhance existing crisis response.

“ERPO implementation presents an opportunity for the behavioral health community to both engage with this new tool and shape how it is used. Input from people who are working on the front lines of crisis response can inform how ERPO implementation evolves and determine whether it is a tool that will be used to complement and enhance existing crisis response.

Evidence on the effectiveness of ERPOs for violence prevention

ERPO laws are new, and as a result the research and related scholarship are limited. However, the early literature sheds light on how these laws are being used and can provide some insights and guidance moving forward. Most of the research is descriptive, with a few studies that begin to answer questions about the law’s impact on firearm deaths.[151] A summary of both types of research is included here, with particular attention to evidence related to clinician petitioners.

DESCRIPTIONS OF ERPO USE

Most evidence regarding ERPO laws is at the state level and describes implementation outcomes (e.g., how many petitions, who is petitioning, what are the dangerous behaviors motivating the petitions, and whether petitions are granted), although multi-state analyses are underway and a few papers from those initial efforts are available.[152,153] The descriptive research documents wide variations in uptake, both within and across states. In many states, ERPO implementation begins in limited locales and at a slow pace, with years passing before frequency of use reaches a level that might have an impact large enough to measure.[154,155,156] Where ERPO uptake is robust and outpaces that of other jurisdictions, there is usually an “ERPO champion” who has passionately taken on this work.

There is a clear role for the behavioral health system in championing ERPO implementation. In states where ERPO laws are in place, the literature suggests that how ERPO laws are being implemented is

determined by those who are stepping into those implementation roles. For example, Florida far outpaces all other states in terms of the number of ERPOs granted and is a state where champions in several local jurisdictions are influencing uptake.

The descriptive studies affirm that ERPOs are being applied in response to scenarios involving different types of firearm violence, including self-directed violence, interpersonal violence, and instances in which both types of violence are threatened. Within the category of interpersonal violence, partner violence, community violence, and mass violence are all documented as precipitating ERPO petitions. Findings from a six-state review of ERPO case files revealed that 10 percent of the more than 6,500 petitions reviewed were filed in response to a multiple-victim/mass shooting threat in which three or more people were targeted.[157]

In states where multiple types of petitioners are authorized, law enforcement is filing the majority of petitions,[158] although there are instances in which family members and partners constitute a large minority share of petitioners.[159] In the states where clinicians can petition, only one state has sufficient implementation experience to provide insight (Maryland) and the data suggests that clinicians are not substantively engaged in petitioning. Clinician petitioners make up less than 1 percent of those who file for an ERPO in Maryland, and survey and interview data suggest that among physicians, low participation is explained by a lack of time to add ERPO paperwork and court testimony into clinic schedules, and a lack of knowledge about the law and how to use it.[160,161] Special attention must be paid to physicians' unique role and responsibility as healers in the implementation of ERPOs.[162]

The lack of uptake by clinicians in the initial years of Maryland's ERPO law does not equate to a lack of interest in using the tool in clinical settings or an absence of need. In one (albeit small) survey of physicians from the departments of emergency medicine, psychiatry, and pediatrics in one hospital, less than 10 percent of respondents reported that they "never encounter a patient at extreme risk of violence or suicide who they would consider for an ERPO," and almost 70 percent of respondents from emergency medicine reported that they encounter such individuals at least monthly.[163] Furthermore, survey data from ERPO states in which clinicians are not authorized petitioners suggests that social workers are willing to engage with petitioners about pursuing ERPOs for individuals in their care.[164] Qualitative data reveal that clinicians can be engaged with ERPO petitions through conversations with law enforcement and family, although support for initiating those contacts varies across clinical roles.[165] Instances of clinicians serving as the point of contact for law enforcement petitioners are reported in the literature and known through anecdotes shared with this team of authors.[166] Further discussion of clinicians as petitioners is included in **Part IV**.

INSIGHTS ON ERPO IMPACTS

Two methodologies—a counterfactual comparative approach and synthetic control modeling—have been used to begin to answer questions about whether ERPO laws and ERPOs are reducing gun violence. In both cases, the analyses focus on the outcome of suicide, in part because a change in firearm suicide deaths is easier to detect through research than a change in firearm homicide; more people die by firearm suicide relative to firearm homicide and early use of ERPOs (in Connecticut and Indiana, the first two states to pass ERPO-style laws and the subject of these analyses) tended to be more often in response to suicide risk. Using both methodologies, the results suggest that ERPO is associated with reductions in suicide. The results from the Connecticut counterfactual analysis yielded an often-cited finding with regard to ERPO impact: for every 10–20 gun dispossessions, one suicide death was prevented.[167] One replication of that analysis using data from Indiana resulted in even more compelling data: one suicide was averted for every 10 gun dispossessions.[168] A more recent replication of the study using data on 4,583 ERPOs in four states estimated that for every 17 ERPOs one life was

saved; the number is likely to vary depending on local implementation of ERPOs and assumptions in the estimation model.[169]

A comparison of trends in population-level suicide rates in Connecticut and Indiana with trends in synthetic control populations constructed from states without ERPO laws yielded estimates that Indiana's gun removal law was associated with a 7.5 percent reduction in gun suicides over 10 years and that Connecticut's law was associated with a 13.7 percent reduction during the "post–Virginia Tech [mass shooting] period."[170] A published commentary discussed the uncertainty of this type of study's conclusions with respect to population-level outcomes, given the relatively small number of individuals actually exposed to the law's restrictions.[171]

A recently published systematic review of ERPOs in the United States included 36 published studies on ERPO laws, their use, and their effectiveness.[172] The review found that the results are promising, especially regarding preventing firearm suicides, though more research is needed regarding ERPOs impacts on interpersonal violence.[173] With the increasing number of states enacting and implementing ERPO laws, more expansive literature that can speak to the impact of ERPOs on violence is within reach.

Constitutional landscape and due process concerns

Due process protections are a defining feature of state ERPO laws. Because ERPOs derive their legal design from domestic violence protection orders, the framework for ensuring due process protections leans heavily on the experience with those policies, which have been in place in all 50 states for decades and have withstood decades of court challenges.

ERPO laws, and the domestic violence protection order policies that inspired them, strike a balance between the individual's right to keep and bear arms and the responsibility of the government to protect the public from foreseeable harm in a way that resonates with the majority of the public,[174] policymakers, and the courts.[175,176,177] As of December 2024, courts have ruled on dozens of cases challenging ERPO laws.

Questions about the constitutionality of ERPO laws tend to focus on due process and the initial ERPO hearing, which can occur in the absence of the respondent. ERPO laws provide due process protections that include but are not limited to allowing only judicial officials to issue ERPOs, providing for short term ex parte ERPOs (between 7 and 21 days, depending on the state), and ensuring that ERPO respondents have a right to notice and a hearing before a judge.[178]

In 2023, a Texas court ruled that the firearm prohibitions associated with domestic violence protection orders violated the Second Amendment to the U.S. Constitution.[179,180] This finding was issued in light of a 2022 ruling by the U.S. Supreme Court that requires courts to consider whether firearm policies are consistent with the original intent of the Founding Fathers when they drafted the Second Amendment.[181,182] The U.S. Supreme Court heard oral arguments in November 2023 for the case, *United States v. Rahimi*,[183] which applies this standard to domestic violence protection orders, and a decision was issued in June 2024. The Supreme Court upheld the law, rejecting the Second Amendment challenge. Chief Justice John G. Roberts Jr. wrote in the majority opinion, "since the founding, our nation's firearm laws have included provisions preventing individuals who threaten physical harm to others from misusing firearms."[184]

Summary of Bipartisan Safer Communities Act and executive order on reducing gun violence and making our communities safer

In June 2022, Congress passed the Bipartisan Safer Communities Act (BSCA), which President Biden signed into law on June 25, 2022 (**Figure 1**).

Figure 1. Bipartisan Safer Communities Act Contents

BSCA included $750 million to implement ERPO laws and support other crisis intervention services. All 50 states, the District of Columbia, and the territories are eligible to apply for formula funds from the U.S. Department of Justice's Bureau of Justice Assistance (BJA), which administers the BSCA funding for the Byrne State Crisis Intervention Program (SCIP); details of the first year of funding awarded under this program are available on the BJA website.

Action: Readers interested in learning more about their state's programming under SCIP can reach out to the state agency responsible for administering the award for their jurisdiction.

BJA also invited applications for three centers to support the BSCA-funded programing, including one designated for "developing and supporting Extreme Risk Protection Order Programs." A team from the Johns Hopkins Center for Gun Violence Solutions received that award and established the National ERPO Resource Center available at erpo.org, which provides training and technical assistance to states and localities funded through Byrne SCIP to support ERPO implementation.

In March 2023, President Biden signed the Executive Order on Reducing Gun Violence and Making Our Communities Safer.[185] The executive order called for implementation progress on BSCA and included several additional federal agency actions to reduce gun violence, including promoting "efforts to encourage effective use of extreme risk protection orders ('red flag' laws), partnering with law enforcement, health care providers, educators, and other community leaders." The Vice President reiterated the Administration's support of state efforts to implement ERPO during remarks she made in March 2024.[186]

Part IV: Role of clinicians and health systems in implementing ERPOs

Formal role in states that authorize clinicians to petition courts directly

Among the differences in ERPO laws across the country, the variation in allowed petitioners is one of the most important, and only a few states currently list clinicians as potential ERPO petitioners. Maryland was the first state to open the door for authorized clinician petitioners in 2018, with the District of Columbia and Hawaii soon following. New York, Connecticut, Michigan, and Colorado have also recently begun allowing clinicians to file ERPOs. Clinicians can play a role in the ERPO process in all states, but they have a much more formal role in states where their petitioner status is legislated.[187,188]

The type of licensed healthcare providers that can serve as authorized petitioners varies across states (see box on pg. 20). In Maryland, authorized clinician petitioners include the following:

- Physician
- Psychologist
- Clinical social worker
- Licensed clinical professional counselor
- Clinical nurse specialist in psychiatric and mental health nursing
- Psychiatric nurse practitioner
- Licensed clinical marriage or family therapist
- Health officer or designee of a health officer who has examined the individual

In states that include clinicians as codified petitioners, the clinician is not only an important gatekeeper but has an obligation to act on any identification of risk to the individual or others, and with the authorization to petition, can do so with the added tool of an ERPO when the risk is specifically related to firearms. Clinicians are positioned to gauge the dangerousness of suicidal thoughts and violent behaviors,[189,190] and they are known and often accessible to families who may have their own concerns about a potential crisis involving their loved one. Clinicians are already working on the front lines of firearm risk mitigation in a variety of capacities, such as providing lethal means counseling to individuals in their care and disseminating information and resources to families, providing counseling on crisis hotlines, and even enacting emergency measures such as acute hospitalization.[191]

Mental health clinicians may be better trained in particular risk assessments than police or family members; however, clinical suicide risk assessments are not always accurate.[192] Predicting gun violence directed toward others may be even further removed from a clinician's skill set and less relevant to clinical populations, as homicides are not strongly associated with mental illness. One exception to this may be gun violence in the context of intimate partner violence. Clinicians are frequently able to identify victims of intimate partner violence during routine screening[193] and can identify perpetrators among individuals in their care who feel more comfortable sharing their own roles in domestic conflicts when alone in dialogue with a trusted clinician.[194]

Granting clinicians the ability to file ERPO petitions also has other potential impacts on healthcare systems. In Maryland, there have been several cases of ERPOs being used to shorten the length of hospital stays or emergency department involuntary holds.[195] Individuals who are held in the hospital or emergency department due to risk of harm to themselves or others are continually reassessed so that levels of risk can be updated. However, such risk is not a binary finding. Individuals cannot be held until they are at 0 percent risk, as no person is ever at 0 percent risk. Rather, hospital or emergency department discharge decisions are made by balancing the risk of discharge against the consequences of imposing restrictions on a person's freedom and self-determination. Discharges must therefore be authorized as soon as the risk of leaving the emergency department falls into an acceptable range, as determined by the clinician and care team. When the home environment can be made safer through lethal means removal, an individual's risk can be mitigated, and discharge can may happen sooner.[196] The temporary restriction of gun access is much less restrictive than continued involuntary holds or even hospitalization.[197]

> "When the home environment can be made safer through lethal means removal, an individual's risk can be mitigated, and discharge may happen much sooner. The temporary restriction of gun access is much less restrictive than continued involuntary holds or even hospitalization.

Although initial ERPO laws did not provide for clinicians as petitioners, states are increasingly including them. One reason is that clinicians are largely accepted as credible experts in court. This credibility also adds to the perceived legitimacy of these petitions by the community at large, as the integration of healthcare workers in the proceedings can serve to remind both the respondent and the public at large that ERPOs are a public health measure and not a punitive or criminal proceeding.[198] Any gun-removal order, once granted, must still involve law enforcement in the act of removal and enforcement, but having law enforcement initiate the process may be more problematic, especially in communities with strained relationships with law enforcement, often related to long histories of structural discrimination affecting communities of color. In the United States, many individuals, particularly in communities of color, may not easily trust the motives of police officers who want to disarm them. If the original conversation about gun safety and the risk of lethal means access takes place in the doctor's office, community members may be more willing to accept a need for removal.

The role of the clinician nevertheless involves a different set of responsibilities and a different type of relationship with a patient than the individual may have with a family member, a caregiver, or the police. The patient-clinician relationship is dependent on trust and an expectation of privacy, especially in behavioral healthcare settings. There is also a legal expectation of privacy, implemented as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR Part 160 and Part 164 Subparts A and E), which forbids covered entities from disclosing private clinical information unless specifically permitted, such as in situations in which law enforcement may need to act to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.[199] Almost by definition, when a clinician

The U.S. Department of Health and Human Services released guidance on the HIPAA Privacy Rule and disclosures of protected health information for ERPOs in December 2021. It details the circumstances in which a covered health care provider can disclose protected health information about an individual to support an application for an ERPO.

believes that there is a need for an ERPO, there is some danger at hand. The weighing of privacy versus danger can complicate a clinician's role in this process, as discussed below.

The patient-clinician relationship is built on trust and open communication and an alliance that is therapeutic and in the interest of the patient.[200] The act of filing an ERPO can be construed as paternalistic and potentially adversarial, because while the clinician is acting in the patient's best interest to prevent suicide or violence, they may also be acting against the immediate wishes of the patient. Clinicians, especially mental health clinicians, are familiar with this tension. The filing of emergency petitions (variously known across the country as pink papers, Section 12s, Baker Acts, 5150s, etc.) always risk the integrity of the therapeutic alliance. However, their use, like that of ERPOs, can be lifesaving and is understood to be undertaken only when there is significant potential for harm. Clinicians are generally trusted to exercise the requisite discretion when invoking these measures and are already trusted with a duty to warn and a duty to protect in cases of risk of harm to the patient or to others.[201] ERPO merely represents a new, narrower and more exact tool for clinicians to use to prevent harm, which is less restrictive than hospitalization and arguably less of a privacy violation than warning someone of the danger an individual may pose to them.[202]

Finally, it is worth considering workflow issues inherent in legislating a new set of tasks for clinicians. In states where a clinician is permitted to serve as a petitioner, the expectation is for them to file the petition and then later attend courtroom hearings on a judge's schedule. Most clinicians do not have the flexibility to leave their unit, office, practice, or emergency department to provide testimony off-site. In fact, a survey of clinicians in an academic hospital in Maryland revealed that a lack of time for paperwork and court appearances was seen as the most common barrier to the use of ERPOs, with almost three-quarters of respondents reporting this issue as a reason they would not file petitions—almost twice the proportion that had been concerned about issues of therapeutic alliance.[203] Similar responses were seen in a larger survey of clinicians in Washington state, where clinicians are not yet eligible to petition.[204] Respondents to this survey overwhelmingly supported the idea of a trained clinical coordinator completing and following through with these petitions in place of the clinicians.

At the point of the initial filing of an ERPO, the clinician may often take several parallel measures. When identifying a patient at risk, it may also or instead be appropriate to consider voluntary or involuntary hospitalization. In many states, a petition for forcible emergency psychiatric evaluation can be filed alongside the ERPO petition, while in other situations clinicians may need to choose among these alternatives. There may also be duties to protect potential victims that may need to be carried out, depending on state law, as firearms are not the only way in which harm can be inflicted. Similarly, for people at risk of suicide, there are other lethal methods that may need to be addressed, such as medication stockpiles, car keys, and so on, if the risk exists but does not rise to the level requiring hospitalization.

Once the final ERPO is granted, it generally lasts for one year (with some variation by state), during which time the clinician's role may vary based on the clinical relationship they have with the patient. If the petitioner was an emergency department physician, for instance, their role may end there. However, if the clinician was the respondent's outpatient psychiatrist, it would be appropriate for them to continue providing treatment, just as they would after other risk mitigation measures such as involuntary hospitalization.

Informal role in ERPO states that do not authorize clinician petitioners

Although only a few states include healthcare workers as authorized petitioners, almost all state ERPO laws allow for clinician input to assist the court.[205] Clinicians may serve as witnesses, evaluators, or the providers of clinical records relevant to the assessment of risk. They also can play an important role in spreading awareness of these laws to the public, especially to the family members of individuals with mental illness, for whom an ERPO may be a valuable lifesaving tool. Of course, even in states where clinicians cannot petition directly, they are always able to recommend the application of ERPOs to be carried out by local law enforcement or family members. Law enforcement agencies may not feel comfortable acting on the opinion of an outside clinician or may resist taking on the added work of filing a petition in a case that they themselves had not assessed to be at risk. Responses by law enforcement to clinical concerns about risk may also vary by departmental protocols and individual decisions.[206] Depending on the situation, clinicians may also turn to family members, caregivers, educators, or roommates as potential alternate petitioners. These types of petitioners may not be as equipped to articulate their concerns, may be reluctant to erode trust, or may simply not have the resources to serve as petitioners themselves. Nonetheless, encouragement from a clinician in cases such as these may prove lifesaving.

Barriers to clinicians' use of ERPOs

RISK ASSESSMENT: FALSE POSITIVES AND NEGATIVES

Clinicians across all settings conduct risk assessments as a standard element of patient care. In crisis care, risk assessments are a key component because an individual often presents to such settings with some behavior that raises concerns about their risk of harm to themselves or others. Clinical risk assessments generally include assessing the patient's mental health and substance use history; their current presentation including their mental status examination and thoughts, ideas, and intent toward harm; and any specific dynamics that may increase or reduce their risk of doing harm to themselves or others.

Violence risk assessment instruments have evolved over time, and understanding the purpose of such instruments and their utility for a particular individual is important before broadly incorporating their use.[207] One systematic review of the literature examining violence risk assessment tools used in emergency care, for example, showed that though some tools may help predict patient violence in those settings, their use did not result in a reduction in restraint use.[208] Moreover, individuals with mental illness and other complex needs such as an intellectual or developmental disability or dementia may not have been included in the development of the risk assessment instrument and therefore require a careful approach that takes into account their clinical complexity.

Suicide violence risk assessments are conducted by clinicians to help identify individuals whose safety may be at issue and for whom a more intensive intervention may be required. It is important to minimize false-positive and false-negative risk assessment results, as both may cause harm to the individual or society. For example, situations identified as high risk may catalyze actions that can impinge on the rights of the individual such as court-ordered care through civil inpatient or outpatient commitment, and firearms restrictions, as well as leading to compromised confidentiality, relationship disruption, employment implications, school removals, or even arrest, and should therefore be taking only if necessary. Conversely, situations that are incorrectly identified as being low risk may result in harm to the individual, their family, caregivers or the public. Biases may also be introduced that can lead to

disparate approaches to different groups.[209] Thus, over-prediction and under-prediction (false positives and false negatives) can both be fraught.[210]

As the research literature in this field has evolved, the idea of risk assessment and ongoing risk management, rather than just a calculated prediction of whether someone will act in a violent way, has been seen as the best approach in clinical settings to actually mitigate potential harms. Even these assessments are complicated, although there are tools available to support clinical decisions.[211] Predictions become problematic as false positives (overpredicting that someone will be violent when they will not) or false negatives (assuming someone will not be violent when they will be) are both challenging and can have social consequences for people impacted by the outcome of the false prediction.[212] Regarding firearm-related violence and the desire to mitigate that risk specifically, pursuit of a petition for gun removal may be the most prudent action when there is a serious concern of danger related to the firearm access, regardless of the individual's mental health issues. In this way, gun removal via an ERPO may be one of the ways to help reduce risk in the immediate time frame, while ongoing assessments and management of long-term risk continue.

In clinician-petitioner states, it is important for each clinician to weigh thoughtfully the use of ERPOs, keeping in mind that these are potentially life-saving measures but also an act that overrides a patient's autonomy and self-determination, albeit motivated by the desire to prevent injury. The doctor-patient relationship works only when there is a willingness to be open and forthcoming about such dilemmas and responses.

However, it may be dangerous for clinicians to maintain too high of a bar for ERPO filing.[213] Ignoring a potentially life-saving tool may put people at risk. It may also expose such clinicians to legal risk, if a patient is involved in violence involving a firearm that might have been prevented if an ERPO had been requested as a clinical intervention.

PATIENT PRIVACY CONCERNS

Clinicians who are HIPAA covered entities are obligated to keep patient information confidential. HIPAA and 42 CFR Part 2 are both federal mandates that provide critical guidelines for preserving confidentiality in patient care—for health and mental health care in the former, and for substance use treatment in the latter. There are certain exceptions to patient confidentiality, such as is seen with mandated reporting of elder abuse, child abuse and abuse of disabled persons. Emergency care also involves mandated reporting of gunshot wounds and certain communicable diseases. Some states have permissive reporting, for example, when a patient may be an impaired driver.[214] Laws involving a duty to protect third parties from harm by someone in mental health care may provide for either permissive or mandatory actions that include permission to breach confidentiality in specific circumstances (e.g., the "Tarasoff" duty to warn).[215] As noted elsewhere in this paper, where ERPO laws are concerned, a growing number of states authorize clinicians to petition for gun removal, and these allowances help reduce risk of clinician liability by permitting disclosure of confidential information, though the specifics vary depending on how the statutes are structured. In jurisdictions that do not permit clinician action under ERPO provisions, emergency situations may allow for exceptions to confidentiality and a need for a clinician to disclose relevant patient information in order to work with the individual's family to help reduce risks or take alternative actions when petitioning for an ERPO themselves is not feasible.[216]

WORKING ALLIANCE CONCERNS

The therapeutic alliance may be threatened by the filing of an ERPO petition. Even in contexts of duty-to-protect statutes, bringing the patient into discussions about clinicians' duties to take action can be

helpful in preserving the relationship between clinician and patient.[217] At a minimum, a specific conversation about the ERPO and hearing, along with a renewing of role induction and alliance strengthening, is warranted.

In a patient encounter involving the use of ERPO provisions, it is important for clinicians to answer questions that patients or members of their support system may have regarding the immediate or long-term impacts on firearms access and rights. Providing information can help foster an alliance that may increase the patient's receptiveness to accepting care. As Pinals and Anacker have noted, in a firearms related risk assessment with a patient, gun access and safety are only one part of the assessment.[218] Understanding a patient's relationship with firearms and the associated dynamics (e.g., such as for a Veteran or a police officer, for whom the firearm may have deeper significance) can be important to help foster an alliance with the patient, even when in the end, the patient may need to be hospitalized or an ERPO may need to be issued. Respect for others and recognition of their rights is always important in fostering a working alliance and in helping to engender a sense of fairness and trust in the healthcare system. Many studies have examined aspects of perceived coercion in psychiatric care show that coercive practices can impact individual's perceptions of even voluntary treatment downstream.[219] Although these studies generally center around involuntary hospitalization practices, the research can serve as a reminder that clinician's work with individuals should prioritize respect, transparency, and information sharing when possible, even when the outcome or act (e.g., gun removal) is not what the person wants.

LEGAL JEOPARDY

There are two risks that may attach legal liability to clinician conduct: acting when they should not have acted, and not acting when they should have acted. This is the quintessential challenge for practitioners when conducting risk assessments and determining whether an intervention is needed even when the person in care may not agree, such as with ERPO. Certain decisions that may result in an individual patient's rights being breached, that involve competing obligations of the clinical provider, can be especially fraught. When in doubt, clinicians acting on ERPO laws may wish to consider whether it makes sense to consult with legal counsel or risk management under their malpractice insurance.

Emerging best practices and innovative ERPO programs

As ERPO implementation evolves, best practices about how to incorporate ERPOs into clinical practice, and innovations within communities regarding promising models, are emerging. Following are descriptions of two key initiatives that demonstrate the value of connections when using ERPOs in response to crisis.

ERPO NAVIGATORS IN BALTIMORE, MARYLAND: CONNECTING HOSPITAL AND COMMUNITY PROVIDERS

As a growing number of states' statutes include clinicians as ERPO petitioners, it is becoming clear that expecting clinicians to incorporate a process into their clinical practice that requires additional paperwork and court appearance is impractical. Clinical providers generally view ERPO laws favorably, and limited empirical evidence suggests that they are quick to identify scenarios in which they would incorporate ERPOs into patient care.[220,221] However, barriers to operationalizing ERPOs are also evident in the literature: Lack of time; the need for education and training about when and how to file an ERPO petition; and, for some, consideration of the impact of filing an ERPO petition on their relationship with patients can temper support for ERPO use in clinical settings.[222] These challenges are discussed in more detail below.

In Baltimore, Maryland, a partnership between Baltimore Crisis Response, Inc. (BCRI), the Johns Hopkins Hospital / School of Medicine, and the Johns Hopkins Bloomberg School of Public Health offers a response to these challenges. BCRI, "the City's first and only comprehensive crisis center," staffs the 988 Suicide & Crisis Lifeline for the Baltimore metro area and 911 diversion, responds to crisis calls through its mobile crisis response unit, and provides residential services and community support. As of January 2024, BCRI staff includes a team of ERPO navigators. The navigators are licensed clinical social workers trained in ERPO law and knowledgeable about the process of filing ERPO petitions (licensed clinical social workers are authorized ERPO petitioners under Maryland law.) As part of a pilot program, the navigators are on call and available when a Johns Hopkins physician identifies a patient who may benefit from an ERPO. Engaging with the BCRI ERPO navigators begins with a request for a navigator consult. After receiving a request, a BCRI ERPO navigator connects with someone from the Johns Hopkins Hospital team that made the request, learns about the patient, hears the hospital team's assessment, and reviews the case notes in preparation for conducting their own evaluation of the patient. The evaluations take place virtually or in person and follow a standard protocol. BCRI has a case note system that documents the initial evaluation and whether the team moved forward with an ERPO. In cases in which an ERPO is judged to be warranted, the navigator completes the paperwork for an ERPO petition, files that petition in court, and testifies in the hearing. If the order is granted, the navigator returns to court and provides testimony in the second hearing to inform the judge's decision as to whether to extend the initial ERPO for up to a year.

As part of the pilot, BCRI navigators conduct frequent (twice per month or as needed) follow-up visits with the individuals (and their families and/or friends) they connect with through the hospital. Early reflections on the ERPO navigator pilot suggest that regular contact between the ERPO navigators and the hospital staff overseeing the pilot is important in enabling the team to quickly address unanticipated threats to the model and respond to opportunities to maximize the program's impact. The evaluation of this program is capturing all these elements and will include information from patients / ERPO respondents. The results will be disseminated widely once available.

It bears noting that BCRI and the Johns Hopkins Hospital have a longstanding partnership and the ERPO navigator program is an extension of the existing arrangement. The ERPO navigator pilot is funded with support from the Baltimore City Mayor's Office, and an evaluation of the pilot is being supported by the Fund for a Safer Future. With foundation support for the evaluation, the ERPO navigator project is an example of how public-private connections are offering an innovative response to crisis in Baltimore.

WASHINGTON'S REGIONAL DOMESTIC VIOLENCE FIREARMS UNIT: CONNECTING PROSECUTORS, POLICE, SHERIFFS, COURTS, AND ADVOCATES

The Washington state ERPO law took effect in December 2016. This coincided with the efforts of a group of innovative leaders in King County (which includes Seattle) who were developing a coordinated infrastructure to support implementation of the state's domestic violence protection order firearm prohibition. The centerpiece of their plan was a team of law enforcement representatives from multiple agencies (police, sheriffs, courts, prosecutors) and advocates who would work together to ensure that when a judge grants a domestic violence protection order, a systemic response facilitates firearm dispossession from respondents to those orders. The resulting Regional Domestic Violence Firearms Unit (Firearms Unit) was ideally suited to also oversee ERPO processes and other court orders involving firearm dispossession.

The Firearms Unit is home to a team of firearm law experts committed to enforcing firearm dispossession laws, including ERPO. The professionals in this unit witness the preventive benefits

associated with temporarily removing firearms from people whose dangerous behaviors cause someone in the community to reach out for help—usually from law enforcement who are well versed in the circumstances in which an ERPO can be part of the response. When a decision is made to file an ERPO petition, the Firearms Unit can support the parties involved so the process is transparent and consistent with state law. Members of the Firearms Unit have testified before Congress and been featured in media coverage of how ERPO is implemented in King County. As the program has evolved, connections with behavioral health professionals and social service agencies are building from the initial focus on firearm dispossession to include a more holistic response to people in crisis.

The approach to ERPO implementation as practiced by the Firearms Unit is one that offers a prevention-oriented path forward for law enforcement. In assessing the landscape of ERPO implementation, several examples demonstrate this type of expanded law enforcement practice. Indeed, there are examples, such as the Firearms Unit, that extend beyond that the initial purpose—of intervening early to remove firearms without criminal charges—to incorporate connections with social support services.

The evolution of local jurisdiction ERPO initiatives creates opportunities for more connections with behavioral health partners in both the clinical and community settings.

CLINICIANS AS GUN VIOLENCE PROTECTION EDUCATORS

To mitigate firearm violence, clinicians work as educators for three main constituencies: (1) professional peers and trainees through direct teaching and mentoring; (2) patients and families through guidance and counseling; (3) government agencies and lawmakers through education and advisement.

Most healthcare professional bodies have issued position statements outlining best practices on addressing firearm violence in clinical and community settings. Bridging position statements to clinical practice remains a challenge, however. Some states have attempted to implement laws that limit clinicians' scope of inquiry into patient firearm practices.[223,224] The 2011 "Firearm Owners' Privacy Act" passed in Florida was challenged by physicians and medical societies and ultimately ruled as infringing on physicians' First Amendment rights to free speech.[225] Several states have adopted similar laws that seek to restrict communication between clinicians and patients, but enforcement.[226] Although the legal and ethical implications of these restrictions are outside the scope of this paper, they serve to highlight some potential barriers to implementing firearm inquiry and counseling in appropriate clinical contexts.

The majority of survey respondents in a nationally representative sample of firearm owners,[7] including Veterans,[8] agreed that receiving counseling on firearm safety was important in some mental health contexts, such as when patients or family members are encountering current hardships. However, there is limited literature outlining a standardized curriculum to address educational gaps. In addition, clinicians can have explicit or implicit biases toward firearms and firearm owners, which can create barriers to effective counseling in clinical settings.[227]

To address educational gaps and potential biases that can interfere with productive counseling, Hoops and colleagues developed a consensus-driven firearm curriculum that was informed by clinicians, researchers, and firearm owners. The curriculum includes training on the availability of safe storage sites and the use of ERPOs in states that have such tools, and it can be tailored to different programmatic, institutional, or geographical needs.[228]

Part V. Future aspirations and next steps

The following recommendations can guide behavioral health, public health, public safety, and community leaders on using Extreme Risk Protection Orders to address gun violence.

Recommendations

1. **Public mental health systems should be knowledgeable about ERPO laws and their use.** State mental health leaders should consider developing formalized training to educate the behavioral health workforce on ERPOs, including integrating knowledge of ERPOs into lethal means counseling practice in states where ERPOs are authorized. Training should include other partners involved in the ERPO process, such as law enforcement and court personnel.
2. **Communities should enhance cross-sector collaboration for effective ERPO implementation.** Strengthening alliances between mental health leaders, law enforcement, and the judiciary is crucial to ensure a cohesive approach to addressing firearm violence in the community. Communities should leverage the strengths of each sector to optimize ERPO implementation. State leaders should ensure ERPO implementation does not disproportionally or unfairly affect any particular community, including individuals with serious mental illness, or individuals from different social or cultural backgrounds.
3. **Data collection and research should be prioritized to ensure that ERPO laws and programs achieve the desired goals and inform best practices.** States and communities should take a systematic approach to gathering data on ERPOs to assess their effectiveness and guide future enhancements. Research funders and academic institutions should fund and conduct long-term studies to evaluate the effectiveness of ERPOs in reducing gun violence and suicides and what education and other implementation strategies are most critical to ensure ERPO effectiveness, using these findings to inform future policies and practices.

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