

Firearm Suicide as a Human Rights Priority for Prevention

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Rising rates warrant firearm suicide as a major public health issue for the United States. From 2006 to 2016, the rate of firearm suicide rose by 21%¹ and approximately 22,000 people die by firearm suicide in the U.S. each year.² Firearm is the most common method of suicide and using a firearm has an approximate fatality rate of 85%.³ People who live in states with high rates of household firearm ownership may be four times more likely to die by firearm suicide than people living in states with fewer household gun owners, even when controlling for poverty, serious mental illness, and substance abuse.⁴

Firearm suicide is a large component of the gun violence epidemic in the United States, as it makes up nearly two-thirds of gun-related deaths.⁵ Gun violence includes firearm injuries—both lethal and non-lethal—including suicides, homicides, legal interventions, and accidental injuries.⁶

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1. Scott R. Kegler et al., *Firearm Homicides and Suicides in Major Metropolitan Areas – United States, 2012–2013 and 2015–2016*, 67 MORBIDITY & MORTALITY WKLY REP. 1233, 1236 (2018), <http://dx.doi.org/10.15585/mmwr.mm6744a3>.

2. CTRS. FOR DISEASE CONTROL & PREVENTION, 10 LEADING CAUSES OF INJURY DEATHS BY AGE GROUP HIGHLIGHTING VIOLENCE-RELATED INJURY DEATHS, UNITED STATES – 2016 (2016), <https://www.cdc.gov/injury/wisqars/index.html> (last visited Jan. 19, 2019).

3. Matthew Miller et al., *The Epidemiology of Case Fatality Rates for Suicide in the Northeast*, 43 ANNALS OF EMERGENCY MED. 723, 726 (2004); Matthew Miller et al., *Suicide Mortality in the United States: The Importance of Attending to Method in Understanding Population-Level Disparities in the Burden of Suicide*, 33 ANN. R. PUB. HEALTH 393, 397 (2012).

4. Matthew Miller et al., *Household Firearm Ownership and Rates of Suicide Across the 50 United States*, 62 J. TRAUMA: INJ. INFECTION CRITICAL CARE 1029 (2007).

5. Kenneth D. Kochanek et al., *Deaths: Final Data for 2014*, 65(4) NAT'L VITAL STAT. REPS. 1, 12 (2014), https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf.

6. NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION, UNITED STATES SUICIDE DEATHS AND RATES PER 100,000 (2017), <http://www.cdc.gov/inj>

As a member of the United Nations and through various human rights instruments that make treaties “supreme law of the land,” the United States is obligated to follow international human rights.⁷ Yet members of the United Nations High Commissioner for Human Rights have expressed concerns about the large number of gun-related injuries and deaths in the United States.⁸ Therefore, in addition to being a public health crisis, firearm suicide poses an ongoing threat to the human rights of U.S. residents. In this article, we (1) review the current statistics on firearm suicide in the United States, (2) outline how the United States violates human rights set by the U.N.’s Universal Declaration of Human Rights (“UDHR”) through its firearms policies, and (3) provide priorities for policy, public health intervention, and interdisciplinary education regarding access to firearms.

I. PREVALENCE AND IMPACT OF FIREARM SUICIDE

Rates of firearm suicide vary by demographic. Men are six times more likely than women to die by firearm suicide.⁹ Men ages sixty-five and older have the highest rate of firearm suicide, while firearm suicide rates are highest for women between the ages forty-five to sixty years old.¹⁰ Since the 1980s, firearm has been the most common method of suicide for youth ages 10 to 24 years old.¹¹ Among children and youth ages 0 to 19, the rate of firearm suicide has increased by 61 % from 2007 to 2016.¹²

ury/wisqars/fatal.html.

7. U.S. CONST. art. VI., cl. 2. (“All Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land, and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any state to the Contrary notwithstanding.”).

8. Human Rights Council, Advance Questions to the United States of America – ADD. 4, available at <https://www.ohchr.org/EN/HRBodies/UPR/Pages/USIndex.aspx>.

9. WEB-BASED INQUIRY STAT. QUERY & REPORTING SYS., CTRS. FOR DISEASE CONTROL & PREVENTION, FATAL INJURY REPORTS, NATIONAL, REGIONAL, AND STATE, 1981 – 2017 (2018), <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html> (last updated Jan. 18, 2019).

10. *Id.*

11. Erin M. Sullivan et al., *Suicide Trends Among Persons Aged 10–24 years—United States*, 64 MORBIDITY & MORTALITY WKLY. REP. 201, 205 (2015).

12. WEB-BASED INQUIRY STAT. QUERY & REPORTING SYS., CTRS. FOR DISEASE CONTROL & PREVENTION, FATAL INJURY REPORTS, NATIONAL, REGIONAL, AND STATE, 1981 – 2017 (2018), <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html> (last updated Jan. 18, 2019).

The proportion of suicides using a firearm for both male and female veterans is higher than for their civilian counterparts. In 2014, 68% of male veteran and 41% of female veteran suicides involved a firearm, as compared to 56% and 32% of male and female suicides in the United States that year, respectively.¹³

National studies have suggested that non-Hispanic White people have the highest rate of firearm suicide by ethnicity, representing 87% of firearm suicide victims.¹⁴ Yet, emerging research demonstrates that the rate of firearm suicide among Black and non-Hispanic populations varies widely by both state¹⁵ and age group.¹⁶ Misclassification on death records may further skew the rates of firearm suicide among ethnic minority populations.¹⁷

Firearm suicide is most common among populations living in rural and nonmetropolitan areas.¹⁸ This is often attributed to the widespread ownership of firearms in rural settings, as approximately 46% of rural residents own guns, compared to 19% of urban dwellers.¹⁹ Additionally, resources for suicide prevention and psychiatric treatments are often limited in rural areas.²⁰ Yet, recent trends suggest that firearm suicide is now increasing in both rural and urban settings.²¹

13. OFFICE OF SUICIDE PREVENTION, U.S. DEP'T OF VETERANS AFFAIRS, SUICIDE AMONG VETERANS AND OTHER AMERICANS, 2001–2014 39–40 (2016), www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf.

14. WEB-BASED INQUIRY STAT. QUERY & REPORTING SYS., CTRS. FOR DISEASE CONTROL & PREVENTION, FATAL INJURY REPORTS, NATIONAL, REGIONAL, AND STATE, 1981 – 2017 (2018), <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html> (last updated Jan. 18, 2019).

15. Corinne A. Riddell et al., *Comparison of Rates of Firearm and Nonfirearm Homicide and Suicide in Black and White Non-Hispanic Men, by U.S. State*, 168 ANNALS OF INTERNAL MED. 712, 713 (2018).

16. Sean Joe et al., *Racial Differences in the Characteristics of Firearm Suicide Decedents in the United States*, 77 AM. J. OF ORTHOPSYCHIATRY 124, 124 (2007).

17. Elizabeth Arias et al., *The Validity of Race and Hispanic Origin Reporting on Death Certificates in the United States*, 2 VITAL HEALTH STAT. 1, 9–10 (2008).

18. Asha Z. Ivey-Stephenson et al., *Suicide Trends Among and Within Urbanization Levels by Sex, Race/ethnicity, Age Group, and Mechanism of Death—United States, 2001–2015*, Oct. 6 2017, at 1, 16.

19. Kim Parker et al., *The Demographics of Gun Ownership*, PEW RESEARCH CTR. (June 22, 2017), <http://www.pewsocialtrends.org/2017/06/22/the-demographics-of-gun-ownership/>.

20. Jameson Kenneth Hirsch, *A Review of the Literature on Rural Suicide: Risk and Protective Factors, Incidence, and Prevention*, 27 CRISIS J. CRISIS INTERVENTION & SUICIDE PREVENTION 189,

Firearm suicide has both economic and social costs for the United States. Accounting for medical and indirect expenses, deaths by suicide and suicide attempts cost the nation over \$93 billion in 2013.²² This study updated the CDC's 2010 estimated cost of \$44.7 billion.²³ As approximately 7% of the U.S. population knows someone who has died by suicide in the past twelve months, the emotional and social toll of suicide is also immense.²⁴

Mental illness is a common target for firearm suicide prevention.²⁵ Yet, emerging research suggests a weaker association between firearm suicide and mental illness than originally believed.²⁶ Risk factors for firearm suicide extend beyond mental health issues to include psychosocial stressors such as financial insecurity and housing instability.²⁷ Predictors of dying by firearm suicide may also include other recent life crises and physical health issues.²⁸ Therefore, multiple factors affect firearm suicide risk.²⁹

II. FIREARM SUICIDE AS A HUMAN RIGHTS ISSUE

The Universal Declaration of Human Rights (“UDHR”) is an international document that outlines the basic rights and freedoms to

192 (2006).

21. Deborah M. Stone et al., *Vital Signs: Trends in State Suicide Rates—United States, 1999–2016 and Circumstances Contributing to Suicide—27 States*, 67 MORBIDITY & MORTALITY WKLY. REP. 617, 619 (2017); Scott R. Kegler et al., *Trends in Suicide by Level of Urbanization—United States, 1999–2015*, 67 MORBIDITY & MORTALITY WKLY. REP. 617, 619 (2017).

22. Donald Shepard et al., *Suicide and Suicidal Attempts in the United States: Costs and Policy Implications*, 46 SUICIDE & LIFE-THREATENING BEHAV. 352, 358 (2016).

23. *Id.*

24. Alex E. Crosby & Jeffrey J. Sacks, *Exposure to Suicide: Incidence and Association with Suicidal Ideation and Behavior: United States, 1994*, 32 SUICIDE & LIFE-THREATENING BEHAV. 321 (2002).

25. Jeffrey W. Swanson et al., *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy*, 25 ANNALS EPIDEMIOLOGY 366 (2015).

26. Jennifer M. Boggs et al., Brief Research Report, *The Association of Firearm Suicide with Mental Illness, Substance Use Conditions, and Previous Suicide Attempts*, 167 ANNALS INTERNAL MED. 287 (2017); Miller et al., *supra* note 4, at 1030.

27. DEB STONE ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, PREVENTING SUICIDE 15 (2017).

28. Bindu Kalesan et al., *Sex and Age Modify the Relationship Between Life Circumstances and Use of a Firearm in Suicide Deaths Across 17 U.S. States*, 236 J. AFFECTIVE DISORDERS 105 (2018).

29. Kegler et al., *supra* note 1, at 1236.

which all persons are entitled. The UDHR was claimed and adopted by the United Nations General Assembly in 1948, and the United States served as one of its leading authors.³⁰ These human rights are included in several international treaties ratified by the U.S.,³¹ making them “supreme law of the land.”³² According to the U.S. State Department, the human rights embodied in the UDHR direct the nation’s foreign and domestic policy goals, such as to “promote the rule of law, seek accountability, and change cultures of impunity.”³³ Therefore, the gun violence and suicide epidemic are examples of how the United States has neglected to protect human rights on its own soil.³⁴ The following section discusses Articles 3, 5, and 25 from the UDHR that the U.S.’s firearm suicide public health crisis currently violates.

U.S. policies, such as the Dickey Amendment, have greatly reduced federal funding for research on gun-related violence.³⁵ These restrictions limit the understanding of the gravity and span of firearm suicide,³⁶ the development for evidence-based approaches to gun violence prevention, the surveillance of the epidemic and existing interventions, and the impact of prevention initiatives over time.³⁷ Therefore, data collection and research restrictions consequently deny residents the privilege stated by Article 3 “everyone has the right to life, liberty and security of person.”³⁸

30. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

31. See, e.g., *id.*; Organization of American States, American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123.

32. U.S. CONST. art. VI, cl. 2.

33. U.S. STATE DEP’T, HUMAN RIGHTS, <https://www.state.gov/j/drl/hr/> (last visited Jan. 25, 2019).

34. *Human Rights and the U.S.*, THE ADVOCATES FOR HUMAN RIGHTS, https://www.theadvocatesforhumanrights.org/human_rights_and_the_united_states (last visited Jan. 16, 2019).

35. Shelby Resnick et al., *Firearm Deaths in America: Can We Learn From 462,000 Lives Lost?*, 266 ANNALS SURGERY 432 (2017); Rita Rubin, *Tale of 2 Agencies: CDC Avoids Gun Violence Research But NIH Funds It*, 315 [J]AMA 1689 (2016).

36. *Consensus Recommendations for Reforms to Federal Gun Policies*, in REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 262 (Daniel W. Webster & Jon S. Vernick eds., 2013).

37. *Gun Safety & Public Health: Policy Recommendations for a More Secure America*, GIFFORDS LAW CTR. TO PREVENT GUN VIOLENCE, <http://smartgunlaws.org/gun-safety-public-health-policy-recommendations-for-a-more-secure-america/#BlockingResearch> (last visited Feb. 26, 2019).

38. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

The under-reporting and misclassification of firearm suicide among ethnic minority individuals,³⁹ and the overlooked rates of firearm suicide by ethnicity and age,⁴⁰ implies an assumption by some that not every loss of life needs to be counted, as not all persons have the right to life. While firearm suicide among veterans is a heavily documented problem,⁴¹ there is minimal Veterans Administration (“VA”)-lead research on national firearm storage options among U.S. veterans.⁴² or on VA-sponsored universal lethal-means restriction initiatives.⁴³ These knowledge gaps affect understanding of the current epidemiology and trajectory of the firearm suicide epidemic, while silencing the suffering of our country’s most vulnerable people.

Article 5 states that “no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”⁴⁴ Yet, the rising rates of firearm suicide suggests that many people who suffer from severe psychiatric and/or emotional distress are compelled to seek relief through violent means. The Three Step Theory of Suicide infers that people die by suicide when they experience excessive emotional pain, hopelessness, and isolation, and they can no longer keep themselves safe due to easy access to lethal means.⁴⁵ For example, a severely emotionally distressed person who perceives that they do not have support is more likely to attempt and die by suicide if they have immediate access to a loaded gun in the home.

While mental illness and substance abuse are known risk factors for suicide,⁴⁶ recent research suggests that persons who die by firearm suicide are less likely to have a history of mental health issues than persons who

39. Riddell et al., *supra* note 15, at 719; Arias et al., *supra* note 17, at 1.

40. Joe et al., *supra* note 16, at 124.

41. OFFICE OF SUICIDE PREVENTION, *supra* note 13, at 39.

42. Joseph A. Simonetti et al., *Firearm Storage Practices Among American Veterans*, 55 AM. J. PREVENTIVE MED. 445, 445–46 (2018).

43. Marcia Valenstein et al., *Acceptability of Potential Interventions to Increase Firearm Safety Among Patients in VA Mental Health Treatment*, 55 GEN. HOSP. PSYCHIATRY 77, 78 (2018).

44. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

45. David Klonsky et al., *Suicide, Suicide Attempts, and Suicidal Ideation*, 2016 ANN. REV. CLINICAL PSYCHOL. 307, 322 (2016).

46. Karl Roberts, *Correlates of Law Enforcement Suicide in the United States: A Comparison with Army and Firefighter Suicides Using Data from the National Violent Death Reporting System*, POLICE PRAC. & RES. 1, 1–13 (2018).

die by suicide by other means.⁴⁷ These findings suggest that mental health treatment and related policies may stigmatize and ostracize suicidal persons, who then refrain from seeking formal help and resort to sense-inflicted gun violence.⁴⁸ Nonetheless, psychological stress and mental illness greatly impair cognitive function and decision-making,⁴⁹ restricting access to guns among people who are demonstrating risk of suicide is a tangible strategy to prevent a death by suicide.⁵⁰

Recent research has highlighted that our active and veteran military populations have an increased risk for suicide given their training with, and access to, lethal means. Yet, research shows that lethal-means counseling is not a widespread practice in emergency departments, hospitals,⁵¹ and VA facilities.⁵² Swanson and colleagues'⁵³ study on psychological and cognitive issues and suicide risk supports the ban on gun sales to veterans who have been assigned a fiduciary to manage their benefits from the VA.⁵⁴ Although many are in favor of repealing this policy,⁵⁵ this repeal would be counterintuitive since it would convey that Congress believes a person's financial security trumps safeguarding their

47. Jennifer M. Boggs et al., *General Medical, Mental Health, and Demographic Risk Factors Associated with Suicide by Firearm Compared with Other Means*, 69 PSYCHIATRIC SERVS. 677, 684 (2018); Jennifer M. Boggs et al., *The Association of Firearm Suicide with Mental Illness, Substance Use Conditions, and Previous Suicide Attempts*, 167 ANNALS INTERNAL MED. 287, 288 (2017).

48. Paul S. Appelbaum, *Public Safety, Mental Disorders, and Guns*, 70 [J]AMA PSYCHIATRY 565, 566 (2013); Jeffrey Swanson, *Mental Illness and New Gun Law Reforms: The Promise and Peril of Crisis-Driven Policy*, 309 [J]AMA 1233, 1234 (2013).

49. Amy F. T. Arnsten, *Stress Signaling Pathways that Impair Prefrontal Cortex Structure and Function*, 10 NAT'L REV. NEUROSCIENCE 410 (2009); Scott C. Brown et al., *The Relationship of Pain and Depression to Cognitive Function in Rheumatoid Arthritis Patients*, 96 PAIN 279 (2002).

50. J. John Mann et al., *Suicide Prevention Strategies: A Systematic Review*, 294 [J]AMA 2064 (2005).

51. Carol W. Runyan et al., *Hospital Emergency Department Lethal Means Counseling for Suicidal Patients*, 54 AM. J. PREVENTIVE MED. 259 (2018).

52. Valenstein et al., *supra* note 43, at 83.

53. Jeffrey Swanson et al., *Informing Federal Policy on Firearm Restrictions for Veterans with Fiduciaries: Risk Indicators in the Post-Deployment Mental Health Study*, 45 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 1 673 (2018).

54. The Veterans Benefits Administration (VBA) appoints a fiduciary to handle a veteran's benefits once it is determined that due to injury or disease, the person lacks the mental clarity to contract or manage his or her own affairs. See 38 C.F.R. § 3.353 (2018).

55. James Clark, *Congress Tries Again to Restore Gun Rights to Veterans with Caretakers*, TASK & PURPOSE (Feb. 9, 2018, 12:45 PM), <https://taskandpurpose.com/congress-tries-restore-gun-rights-veterans-caretakers>.

vulnerability for self-inflicted violence. Lethal-means restriction is an empirically founded preventive intervention to reduce risk of suicide and to enhance opportunities for human mental health treatment.⁵⁶

Lastly, Article 25 declares “everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family.”⁵⁷ Firearm suicide prevents a significant proportion of the population from living healthy and quality lives. The widespread prevalence of firearm suicide also suggests that this public health crisis is the “canary in the coalmine” for a much larger social and cultural problem.

Emerging research suggests that risk factors for firearm suicide can run the gambit from histories of mental illnesses to acute personal crises, but that some firearm suicide decedents do not fit this profile. Boggs and colleagues found that more people without a mental health or substance condition died by firearm suicide than persons without those conditions.⁵⁸ In one study examining associations between life circumstances (including histories of suicide attempts and alcohol dependency) and firearm suicide, recent life crises, financial problems and physical health issues were strong predictors of dying by firearm suicide.⁵⁹ Therefore, a psychosocial and multi-systemic lens is needed to provide a more accurate understanding of why people die by firearm suicide.⁶⁰

The above-mentioned studies offer insight as to how firearm suicide is not a multi-dimensional impingement on the human rights of U.S. residents. Our human right to lead healthy lives continues to be threatened while the life expectancy continues to drop in the U.S.⁶¹ The CDC attributes this life expectancy decrease to the increasing trends in suicide and drug overdoses,⁶² which are both high-risk behaviors that require

56. Mann et al., *supra* note 50, at 2070.

57. G.A. Res 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

58. Jennifer M. Boggs et al., *The Association of Firearm Suicide with Mental Illness, Substance Use Conditions, and Previous Suicide Attempts*, 167 ANNALS INTERNAL MED. 287, 288 (2017).

59. Kalesan et al., *supra* note 28.

60. U.S. SURGEON GEN. & NAT'L ACTION ALL. SUICIDE PREVENTION, 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION: GOALS AND OBJECTIVES FOR ACTION (2012).

61. SHERRY L. MURPHY, ET AL., U.S. DEP'T HEALTH & HUM. SERV., NCHS DATA BRIEF NO. 328, MORTALITY IN THE UNITED STATES, 2017 (2018).

62. *Id.*

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multidimensional assessments and interventions.⁶³ Thus, in the following section, we suggest interdisciplinary approaches to understanding and addressing firearm suicide as a human rights issue.

III. SUGGESTIONS FOR INTERDISCIPLINARY ACTION

In this section, we propose starting points to protect the human rights of U.S. residents within the context of firearm suicide public health crisis. These suggestions are by no means exhaustive. We provide evidence-informed approaches for considerations as to how people across disciplines involving human rights practices can educate the public on the risk of firearm suicide and advocate for policy reform and specific public health interventions.

A. Increase Lethal-Means Counseling and /or Means Restrictions

Lethal (or safe) means counseling is an effective intervention for reducing firearm suicide,⁶⁴ as it decreasing access to and increasing safe storage of lethal means “might represent an opportunity to address an important aspect of [acquired] capability for suicide.”⁶⁵ Lethal means counseling is the practice of evidence-based strategies to both assess for access to lethal means (i.e. firearms, pesticides, prescription drugs) and to collaborate with a client and their family members on ways to reduce access to such means.⁶⁶ Medical and clinical providers should be mandated to conduct safe-means counseling with an individual who is at risk of suicide and who is in possession of a firearm. Hospitals and clinics also need to further encourage and monitor safe-means counseling for all patients, no matter their age, ethnicity or background. Considering the

63. *Suicide Is a Complex Problem, But It Can Be Prevented*, AM. PSYCHOL. ASS'N, <https://www.apa.org/advocacy/suicide-prevention/testimony.aspx> (last visited Jan. 16, 2019).

64. Mann et al., *supra* note 50.

65. Michael D Anestis et al., *Treating The Capability for Suicide: A Vital and Understudied Frontier in Suicide Prevention*, 47 SUICIDE & LIFE-THREATENING BEHAV. 523, 537 (2017).

66. *CALM: Counseling on Access to Lethal Means*, SUICIDE PREVENTION RESOURCE CTR., <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means> (last visited Jan. 16, 2019).

high rate of firearm suicide among veterans and the population's access to guns, implementation of a universal lethal-means counseling program is imperative for the VA. Trainings on lethal-means counseling, such as the Counseling on the Access to Lethal Means (CALM) are available.⁶⁷

*B. To Support Broader Assessment of Guns in The Home
And Access to Lethal Weapons.*

Primary care providers and clinical providers are the frontlines for the prevention of firearm suicide.⁶⁸ It is the duty of providers to ask questions about gun access, as it also involves the safety of the individual and their loved ones. Medical providers have the right to discuss a patient's gun ownership, since it can jeopardize the patient's immediate safety, quality of life, and longevity.⁶⁹ As firearm suicide does not discriminate by age, assessing for firearms should also include the participation of youth educators and elderly care providers. Access to firearms should not be an assessment designated only for persons with histories of suicidality, but for all people who interface with healthcare professionals and public services. Medical and related health providers and national provider organizations should advocate for widespread training in and implementation of lethal means assessment and counseling protocols, such as CALM, in clinics, hospitals, and outpatient services.

C. To Increase Opportunities for Safe Storage of Firearms.

Emerging research suggests that health providers can effectively collaborate with gun owners to safely store firearms and ultimately

67. *Id.*

68. A study of 5000 people who had completed suicide found about half of them had visited a medical facility one month to their death and did not have a mental health diagnosis. Brian K. Ahmedani et al., *Health Care Contacts in the Year Before Suicide Death*, 29 J. GEN. INTERNAL MED. 870 (2014).

69. Bethany L. Strong et al., *The American College of Preventive Medicine Policy Recommendations on Reducing and Preventing Firearm-Related Injuries and Deaths*, 51 AM. J. PREVENTIVE MED. 1084 (2016).

prevent suicide.⁷⁰ The gun-owning community (including gun shops) have been identified as partners in assisting with the temporary removal of a person's firearm, which is when the at-risk person has no access during the period of severe symptomology.⁷¹ There is limited research on the availability of safe storage of firearms across the United States, as few existing state policies support a mode of safe storage.⁷² Available literature indicates that more people need assistance with safe storage of firearms. Schuster and colleagues found that, of households with firearms, 55% reported to have at least one loaded gun in an unlocked place, and 43% reported keeping guns without a trigger lock in an unlocked place.⁷³

D. To Increase Opportunities for Mandated Removal of Firearms.

As a last resort, the Extreme Risk Protection Order ("ERPO") allows courts to prohibit a person's access to firearms in cases where family members and/or law enforcement believes that the person is a threat to themselves or others.⁷⁴ ERPO laws are not a national policy, and only Oregon, Washington State, and California have enacted the law.⁷⁵ Connecticut and Indiana have in place similar laws.⁷⁶ Swanson and colleagues studied the impact of Connecticut's gun removal law and estimated that the law averted 72 suicides between 1999 to 2013.⁷⁷ ERPO

70. Mary Vriniotis et al., *A Suicide Prevention Campaign for Firearm Dealers in New Hampshire*, 45 SUICIDE & LIFE-THREATENING BEHAV. 157, 158–59 (2014); Michael D. Anestis et al., *Handgun Legislation and Changes in Statewide Overall Suicide Rates*, 107 AM. J. OF PUB. HEALTH 579, 579–81 (2017).

71. See Vriniotis et al., *supra* note 70, at 159.

72. Strong et al., *supra* note 69, at 187. Furthermore, the Supreme Court has found one method of safely storing firearms, trigger locks, to be unconstitutional. *D.C. v. Heller*, 554 U.S. 570, 630 (2008).

73. Mark A. Schuster et al., *Firearm Storage Patterns in U.S. Homes with Children*, 90 AM. J. PUB. HEALTH 588, 590 (2000).

74. EVERYTOWN FOR GUN SAFETY, EXTREME PROTECTION ORDERS AND SUICIDE, https://everytownresearch.org/erpo/#foot_note_anchor_9 (last visited Jan. 16, 2019).

75. *Id.*

76. Connecticut and Indiana enacted earlier laws allowing law enforcement officers or certain other individuals to obtain court order removing firearms from a dangerous person. Jeffrey W. Swanson et al., *Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does It Prevent Suicides?* 80 LAW & CONTEMP. PROBS. 179, 208 (2017).

77. Jeffrey W. Swanson et al., *Implementation and effectiveness of Connecticut's risk-based gun removal law: does it prevent suicides?* 80 LAW & CONTEMPORARY PROBS. 179, 208 (2017).

laws enable families, law enforcement, and the at-risk person to discuss the person's safety before a fatal injury or hospitalization occurs.⁷⁸

E. To Call on Congress to Provide Adequate Funding for Firearm Research.

The Dickey Amendment has restricted funding for firearm research in the United States since 1997⁷⁹. The amendment directly bans advocacy and promotion; it has also crippled federal-level funding of firearm-related epidemiologic, intervention, and evaluation research.⁸⁰ Current research is limited by poor information on the prevalence of gun ownership and firearm suicide and the reliance on proxy measures.⁸¹ Without adequate funding it will be impossible to understand firearm suicide, to identify how legislation affects the rising rates, and to develop and implement preventive strategies on a population-level.⁸²

F. To Increase Political Pressure for Gun Reform.

Constituents, regardless of professional affiliation, can call for stricter gun ownership policies. States with stricter gun ownership laws often experience fewer firearm-related suicides versus states with more lenient laws.⁸³ States with permit-to-purchase ("PTP") laws require potential gun owners to have a permit and a background check when purchasing a

78. See *supra* note 76.

79. Pub. L. No. 104-208, 1110 Stat. 3009 (1996). The "Dickey Amendment" was introduced by the Omnibus Consolidations Appropriations Act of 1997 and directly restricted funding from the CDC to research on gun control. The Consolidated Appropriations Act of 2012 applied the same language to NIH, but the agency has reacted to the amendment less strongly. See Rita Rubin, *Tale of 2 Agencies: CDC Avoids Gun Violence Research But NIH Funds It*, 315 [J]AMA1689 (2016).

80. Strong et al., *supra* note 69, at 1087.

81. RAND CORP., RELATIONSHIP BETWEEN FIREARM AVAILABILITY AND SUICIDE, <https://www.rand.org/research/gun-policy/analysis/supplementary/firearm-availability-suicide.html> (last visited Jan. 16, 2019).

82. Strong et al., *supra* note 69, at 1087.

83. The authors analyzed cross-sectional data for 2010-2014 for firearm suicide and homicide deaths for 3108 counties in the contiguous states of the U.S. Stronger (stricter) firearm laws in a state were associated with lower overall suicide rates. Elinore J. Kaufman et al., *State Firearm Laws and Interstate Firearm Deaths from Homicide and Suicide in the United States: A Cross-Sectional Analysis of Data by County* 178 [J]AMA INTERNAL MED. 692, 700 (2018).

firearm; these states also see reductions in firearm suicide rates.⁸⁴ U.S. residents may also call on their local representatives to support mandatory waiting periods for gun ownership. A waiting period law requires a several day time-lapse in between the purchase of a gun and when the owner can actually have possession of the gun. Such policies are associated with reduced rates of firearm suicide in participating states.⁸⁵ While it may be difficult to reform gun policy within certain states, constituents may look to non-legislative and local opportunities for lethal means safety efforts.⁸⁶

CONCLUSION

Available research continues to affirm that firearm suicide is a public health issue unique to the U.S.⁸⁷ While firearm suicide was once thought to be an issue that only affected older white men living in rural areas,⁸⁸ there is evidence that firearm suicide reflects threats to life, security, and standards of living for most demographics. Thus, the U.S.'s neglect to advance suicide prevention through firearm policy reform has resulted in a human rights crisis.

In this brief report, we outlined how the firearm suicide epidemic violates Articles 1, 3, and 25 of the UDHR, rights that are intended for residents of the United States and the world. We highlighted how restrictions on gun research and gun reform have consequently veiled the population-level reach of the epidemic, thus signifying that certain lives are less important than others. Additionally, the lack of widespread lethal-means restrictions for persons in personal and/or psychiatric crises shows

84. Cassandra K. Crifasi et al., *Effects of Changes to Permit-to-Purchase Handgun Laws in Connecticut and Missouri on Suicide Rates*, 79 PREVENTIVE MED. 43, 48 (2015).

85. Anestis et al., *supra* note 70, at 580.

86. Steven A. Sumner et al., *Firearm Death Rates and Association with Level of Firearm Purchase Background Check*, 35 AM. J. PREVENTIVE MED. 1 (2008); Michael D. Anestis et al., *Rising Longitudinal Trajectories in Suicide Rates: The Role of Firearm Suicide Rates and Firearm Legislation*, 100 PREVENTIVE MED. 159, 164 (2017).

87. Eric Grinshteyn & David Hemenway, *Violent Death Rates: The US Compared with Other High-Income OECD Countries*, 129 AM. J. MED. 266, 266.

88. Men represent 86% of firearm suicides and among men, firearm suicide rates are the highest for ages 65 and older. White Americans represent 87 percent of all firearm suicide victims. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 2. Using national mortality data, the authors found that between 2001-2015 suicide rates were highest in nonmetropolitan and rural counties than in medium/small or large metropolitan counties. Ivey-Stephenson et al., *supra* note 18, at 16.

a lapse in our duty to protect vulnerable persons. Lastly, firearm suicide is a product of psychological, social, and environmental factors, indicating that many people do not experience a standard living that provides emotional and physical wellness.

Based on these articles, we propose priorities to address access to and storage of firearms at home and in the community. Assessment and counseling around gun access demonstrate the respect for life and for personal safety.^{89 90} Action must also occur on both the state and national levels. Considering the gaps in knowledge regarding who dies by firearm suicide and why, restrictions on federal level funding for gun-related research need to be lifted.⁹¹ These restrictions also limit the implementation and evaluation of preventive initiatives. Stricter gun ownership policies are another strategy that can yield a larger impact on firearm suicide rates.⁹²

Overall, the current level of access to firearms, advanced particularly by regulations in the United States, jeopardizes the right to life, security, and the ability to lead quality lives. We call for our social science, medical, and legal colleagues to acknowledge that the rate of firearm suicide now qualifies this phenomenon as a human rights issue. Interdisciplinary and inter-professional collaborations are essential in order to safeguard these rights—for children and youth, veterans, older adults, and ourselves.

89. Mann et al., *supra* note 50, at 2065.

90. Simonetti et al., *supra* note 42, at 453.

91. Strong et al., *supra* note 69, at 1087.

92. Anestis et al., *supra* note 86, at 165.