Letters to the Editor

Firearms Policy and Suicide Prevention

TO THE EDITOR: The recent article by Olfson and colleagues (1), published in the August 2017 issue of the *Journal*, confirms markedly elevated suicide rates following nonfatal self-harm. An accompanying editorial (2) recommends removing firearms from the home of a person who has attempted suicide in order to mitigate this risk. The legality of this recommendation, however, might depend on state laws regulating firearm transfers. For example, universal background check laws might present legal obstacles to temporary firearm transfers during a suicidal crisis unless specific exceptions to the universal background check exist in case law or statute (3). Here, I describe the collaborative approach taken in Washington State to amend an existing universal background check law with exceptions to facilitate temporary firearm transfers during periods of elevated suicide risk.

In 2016, a work group with representation from the Alliance for Gun Responsibility, Forefront Suicide Prevention, the National Rifle Association, the Second Amendment Foundation, the Washington State Office of the Attorney General, Washington State Patrol, and the Washington State Psychiatric Association was formed to discuss amending the universal background check law (RCW 9.41.113). Together with a state legislator, the group reached unanimous agreement on language allowing for an exception to the need for a background check if all the following criteria were met:

- The temporary transfer is intended to prevent suicide.
- The temporary transfer lasts only as long as reasonably necessary to prevent death.
- The firearm is not utilized by the transferee for any purpose for the duration of the temporary transfer.

The group also proposed expanding the list of family members who could receive a gift or loan of a firearm to include parents-in-law and siblings-in-law. This change recognized that men account for approximately 85% of firearm suicide deaths in Washington (4), and a suicidal man's wife or sister might engage her father, brother, or husband (an in-law to the man at risk) for assistance in removing a firearm.

With its broad base of support, the consensus language raised little controversy in the legislature and was signed into law in May 2017 as part of Senate Bill 5552.

Given the high lethality of firearms, removing a gun from the home of a suicidal person may indeed save a life. It is therefore imperative that psychiatrists become familiar with laws related to firearm transfers during a suicidal crisis and advocate for policies that facilitate this means of improving safety. Our experience in Washington confirms that collaboration with diverse stakeholders, including firearms organizations, is essential to the success of this advocacy.

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Facilitating Temporary, Safe Firearms Restrictions Among Individuals at High Risk of Suicide: Response to Sung

TO THE EDITOR: Over the last decade, deaths by suicide in the United States have increased by roughly 2% per year (1), and firearms have accounted for roughly half of all suicide deaths (2). Despite average suicide rates by international standards, the firearms suicide rate is eight times greater in the United States than in other high-income countries (3). In this context, it is critically important to develop public policies that restrict individuals at high risk of suicide from access to firearms.

We applaud the successful efforts of Dr. Sung and the Washington State Psychiatric Association in working with a wide range of stakeholders to amend Washington State law concerning firearm transfers during suicidal crises. Universal background checks, particularly when paired with mandatory waiting periods, are associated with significant reductions in statewide suicide rates (4). Nevertheless, because several states also require background checks of friends or family members before receiving voluntary firearm transfers from suicidal individuals (5), this aspect of universal background checks can impede potentially lifesaving firearm transfers. In addition to legislation requiring universal background checks, complementary legislation such as the Washington State statute

described by Dr. Sung, which exempts suicide risk–related transfers from background checks, can facilitate temporary, safe storage of firearms.

Although legislation governing firearm safety is largely a matter of state law, there is also a role for national leadership. We urge the American Psychiatric Association to work with interested national stakeholders to draft model state legislation concerning firearm safety during suicidal crises. If widely adopted, such legislation could help combat the national crisis in firearm-related suicides. A model state law would enable psychiatrists, other physicians, and other licensed mental health professionals to authorize temporary firearm transfers from suicidal individuals to other responsible adults.

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Disability Enrollment in a Community-Based Coordinated Specialty Care Program

TO THE EDITOR: Rosenheck et al. (1) published findings in the September 2017 issue of the *Journal* from the Recovery After an Initial Schizophrenia Episode–Early Treatment Program (RAISE-ETP) study regarding the receipt of Social Security Administration (SSA) disability benefits (Supplemental Security Income or Social Security Disability Insurance) in early psychosis. The authors found no difference between the coordinated specialty care treatment, NAVIGATE, and usual care. Overall, 9.0% (36/399) of participants received SSA disability benefits at baseline; 34.1% (124/363) of remaining participants obtained benefits during the 2-year study period.

TABLE 1. Estimates of Percentage of OnTrackNY Participants Enrolled in SSI or SSDI, in 3-Month Intervals[a]

	Enrollees in SSI or SSDI (N=679)		
Month	N	%	95% CI
0 (at admission)	17	2.5	1.6–4.0
3	25	4.0	2.7–5.8
6	35	6.3	4.5–8.9
9	48	10.1	7.6–13.3
12 (1 year)	51	11.2	8.5–14.6
15	56	13.3	10.2–17.3
18	60	15.7	12.0–20.3
21	62	17.1	13.1–22.2
24 (2 years)	63	18.3	13.9–23.9
27	64	20.7	14.9–28.4

[a] Estimates are based on the Kaplan-Meier method to take into account censored data; therefore, percentages are not computed directly from the Ns presented in the table. SSI=Supplemental Security Income; SSDI=Social Security Disability Insurance.

More severe psychotic symptoms and greater dysfunction predicted obtaining benefits.

We examine the rates of receiving SSA disability benefits among participants in OnTrackNY, New York State's 19-site coordinated specialty care program. Inclusion criteria are a diagnosis of nonaffective psychosis (DSM-IV); other specified/unspecified schizophrenia spectrum or other psychotic disorder (DSM-5); onset of psychosis ≥1 week and ≤2 years prior; age 16–30; and New York State residence, regardless of insurance or income. OnTrackNY treatment length is expected to average 2 years. The institutional review board of the New York State Psychiatric Institute approved study procedures. Clinical staff report on receipt of SSA disability benefits and on scores on the Mental Illness Research, Education, and Clinical Center (MIRECC) Global Assessment of Functioning Scale (GAF) at admission and quarterly.

The Kaplan-Meier method was used to estimate rates of SSA disability benefits across time. Cox proportional hazards regression examined predictors of time until receipt of SSA disability benefits with each demographic and clinical covariate separately and then simultaneously for all clients who were not receiving SSA disability benefits at admission.

The sample includes 679 OnTrackNY enrollees admitted between October 2013 and June 2017. At admission, 2.5% (17/679) of clients were receiving SSA disability benefits. Kaplan-Meier estimates projected that 18.3% (95% CI=13.9−23.9) of clients followed for 2 years obtained disability benefits (Table 1). In bivariate Cox regression analyses, individuals with lower (worse) MIRECC GAF occupational and social functioning scores had significantly greater risk of disability enrollment than individuals with higher scores (hazard ratio of 0.97 and 0.98, respectively; $p<0.01$ for both). Age, gender, race, ethnicity, and MIRECC GAF symptom scores were not significantly associated with disability enrollment. In multivariate analysis, lower occupational functioning was found to be associated with greater risk of disability (hazard ratio= 0.98, $p<0.05$). Receipt of other cash assistance was low. Four percent (27/679) of participants received Temporary