

CE

CONTINUING EDUCATION TALKING TO PATIENTS ABOUT FIREARM SAFETY

BY ZARA ABRAMS

Derek* was obstinate—even hostile—when a clinician first asked how he stored his firearms. A member of the Mississippi National Guard who owned several guns, Derek was participating in Project Safe Guard, a randomized controlled trial testing safe storage and counseling for firearm suicide prevention (Anestis, M. D., et al., *American Journal of Public Health*, Vol. 111, No. 2, 2021).



CE credits: 1

Learning Objectives: After reading this article, CE candidates will be able to:

1. Discuss the reasons for firearm ownership and the risks firearms pose for patients and their families.
2. Describe several methods of enhancing firearm safety as well as strategies for approaching the topic with a patient.
3. Explain what legal channels are available to reduce access to firearms if involuntary intervention is needed.

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*Name changed to protect patient privacy.

Three months later, his answer was the same: “I am not suicidal, I never will be, and even if I was, none of this would make a difference.” His clinician listened, thanked him for his honesty, and stuck to Project Safe Guard’s motivational interviewing protocols.

But by Derek’s next appointment, things had changed. He had split with his fiancée and started having thoughts of suicide. Remembering his counseling sessions, he gave his firearms to his brother for safekeeping. Derek later reported that this action likely saved his life.

In 2021, firearms caused more than 44,000 U.S. deaths—including suicides, homicides, and accidents—and 40,000 injuries, according to the nonprofit Gun Violence Archive. One in three U.S. households has at least one firearm, millions of which are stored loaded and unlocked (Azrael, D., et al., *Journal of Urban Health*, Vol. 95, 2018). And the COVID-19 pandemic spurred a surge in firearm purchasing that is unparalleled in U.S. history: Sales rose an estimated 40% between 2019 and 2020 (FBI, National Instant Criminal Background Check System).

But clinicians, including mental health care providers, often hesitate to discuss firearm safety with their patients because “they worry the conversation will ruin rapport—or veer into political territory and go off the rails,” said clinical psychologist Michael Anestis, PhD, an associate professor in

the Rutgers University School of Public Health, director of the New Jersey Gun Violence Research Center, and a leader of Project Safe Guard. “But these conversations are often friendly—and even the rare ones that aren’t can still make a difference.”

Providers can help reduce injuries and deaths by talking with patients about safe storage and temporary transfers during high-risk periods—for example, if a patient is having thoughts of suicide. But those conversations need to be rational, nonpolitical, and focus on harm reduction, said Amy Barnhorst, MD, an associate clinical professor of psychiatry and behavioral sciences and vice chair of community mental health at the University of California, Davis.

“Firearm ownership may be a core aspect of a patient’s identity, so it’s important to approach these conversations in a nonstigmatizing way,” said Barnhorst, who also directs the BulletPoints project, a state-funded effort that creates and disseminates clinical tools for firearm injury prevention.

That requires providers to be knowledgeable about firearm ownership and storage and to make informed, tailored recommendations through a collaborative process. In some cases, they can also use legal protections to temporarily separate patients from their firearms.

“Everybody can get behind the idea that we would like less people dying from firearm-related injuries,” said

Patrick Carter, MD, codirector of the Institute for Firearm Injury Prevention at the University of Michigan. “How can we honor patients’ values but also keep them safer?”

CRITICAL MOMENTS FOR INTERVENTION

As gun ownership increases, demographics are also shifting: First-time buyers are more likely to be women or people of color than in the past (Miller, M., et al., *Annals of Internal Medicine*, 2022). Nearly two thirds of firearm owners say self-protection is a primary reason for ownership; other reasons include hunting, sporting, and collection (Azrael, D., et al., *RSF: The Russell Sage Foundation Journal of the Social Sciences*, Vol. 3, No. 5, 2017).

Though public mass shootings receive a lot of attention, they represent less than 1% of firearm deaths in the United States. Suicides, on the other hand, account for 57% of firearm deaths since 2019, according to the Gun Violence Archive. One reason is that guns are highly lethal. Only about 4% of all suicide attempts result in death; when a gun is used, 90% of attempts are fatal (“Facts About Suicide,” U.S. Centers for Disease Control and Prevention, 2021; Conner, A., et al., *Annals of Internal Medicine*, Vol. 171, No. 12, 2019).

“We know people will feel hopeless and attempt suicide sometimes,” said clinical psychologist Susan B. Sorenson, PhD, a professor of social policy and health and societies at the University of Pennsylvania. “But if someone attempts suicide with a gun, they rarely get a second chance at life.”



People who purchased firearms during the 2020 surge, especially first-time buyers, are also more likely to have had suicidal thoughts over the past month, past year, and during their lives than other firearm owners or non-firearm owners, Anestis and his colleagues found (*American Journal of Preventive Medicine*, Vol. 60, No. 3, 2021; *JAMA Network Open*, Vol. 4, No. 10, 2021). That does not necessarily mean firearms were purchased with suicidal intent, Anestis said, but it is still a cause for concern.

“Historically, firearm access is not related to suicidal thoughts, but this cohort appears to be different,” he said. “This means that the risk profile for many homes is fundamentally different now.”

Suicidality also plays an outsized role in mass shootings, especially when attackers leak their plans beforehand, according to data from The Violence Project, a nonprofit think tank that has

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studied 168 mass shootings since 1966. Nearly 3 in 4 shooters in the database were suicidal before or during their attack (Peterson, J., & Densley, J., *The Violence Project: How to Stop a Mass Shooting Epidemic*, Abrams Press, 2021), which may provide clues about how to prevent future shooting sprees.

For example, if a teenager says, “I want to shoot up the school tomorrow,” we hear a scary, violent threat, said psychologist Jillian Peterson, PhD, an associate professor of criminology and criminal justice at Hamline University in St. Paul, Minnesota, and cofounder of The Violence Project.

“But we also know that most shooters who do this tend to commit suicide during the attack. So, if we actually hear that more as ‘I don’t care if I live or die tomorrow,’ it launches a very different kind of response,” she said.

Rather than initiating a punitive process, schools can treat such threats as critical moments for mental health intervention, Peterson said. Clinicians can also watch for warning signs that a patient may be planning an attack during the course of treatment. The Violence Project has identified several features and behaviors that tend to precede mass shootings, including significant early childhood trauma, a history of violence, a marked change in behavior, and interest in past shooters or attacks.

Though media reports often imply that serious mental illness (SMI) is a primary driver of such violence, the relationship is weaker than some might think, Barnhorst said. Data do show that people with SMI—including schizophrenia, bipolar disorder, major depressive disorder, or severe post-traumatic stress disorder—are more likely to enact violence during the onset of a psychotic illness or during the period surrounding psychiatric hospitalization. But other factors play a much bigger role. For instance, whereas a person with SMI is 2.4 times more likely to enact violence than someone without SMI, a person with a problematic drinking history is 6.8 times more likely to enact violence than someone without that history (Swanson, J. W., “Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach,” in Monahan, J., & Steadman, H. J. (Eds.), *Violence and Mental Disorder*, University of Chicago Press, 1994).

Of course, the vast majority of firearm homicides are not part of mass shootings; domestic and

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RESOURCES

What mental health clinicians can do to reduce firearm violence and suicide (on-demand webinar)
Barnhorst, A.
APA, 2021

Consensus-driven priorities for firearm injury education among medical professionals
Hoops, K., et al.
Academic Medicine, 2022

Prevention of firearm injuries among children and adolescents: Consensus-driven research agenda from the Firearm Safety Among Children and Teens (FACTS) Consortium
Cunningham, R. M., et al.
JAMA Pediatrics, 2019



gang violence are more common. Intimate partner firearm violence in particular is a key target for clinical intervention, Sorenson said—for instance, if a patient reports being threatened with a gun by their partner. (Legal protection may be less feasible at an early stage because many domestic violence laws require physical evidence, such as documentation of an injury, in order for an arrest to be made at the scene.)

“Firearms play a unique role in domestic violence, because someone who displays a gun can get their partner to do something without ever touching them,” Sorenson said.

DIRECT QUESTIONS ABOUT SAFETY AND RISK

Clinicians who shy away from discussing firearm safety often do so because they are worried about alienating their patients. But research suggests that most patients find it appropriate for a therapist or other health care provider to initiate conversations about firearms (Wintemute, G. J., et al., *Annals of Internal Medicine*, Vol. 165, No. 3, 2016; Pallin, R., et al., *Behavioral Science & the Law*, Vol. 37, 2019). This is especially true if someone in the home is at increased risk of death or injury, including if a patient is having thoughts of suicide; if a patient



experiences periods of impaired judgment because of SMI, substance misuse, or dementia; or if children or teens live in the home.

"These cases are pretty straightforward because you have a clear clinical justification for asking questions about firearms in the home and for instructing people to secure them," said Brian Stagner, PhD, an emeritus clinical professor of psychological and brain sciences at Texas A&M University and director of professional affairs for the Texas Psychological Association.

Psychologists diverge on the question of universal screening. On the one hand, a blanket

question about firearm ownership may elicit pushback from some gun owners if there is no clear risk, Stagner said. But others point out that the question may be better received as part of larger conversations about family safety (cars, swimming pools) or suicide (medication, sharp objects) and can help people make a plan before a crisis occurs.

"Clinicians should also know that there are no state or federal statutes that prohibit them from talking with patients about access to firearms," Barnhorst said. (A Florida law that attempted to curtail such conversations was

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overturned in 2017 because it violated clinicians' First Amendment rights.)

Before approaching patients, providers should develop basic knowledge about firearms so that they can speak confidently and use appropriate language. (BulletPoints offers online educational resources on firearms, storage, and various clinical scenarios.) They should then work with patients to find a risk reduction approach that works for them. An individual who uses firearms primarily for hunting or target shooting may be open to storing them outside the home, but that option may be impractical for someone who owns a gun for self-protection.

For many gun owners, safe storage and temporary transfers are the most effective ways to reduce risk. The safest way to store a firearm is unloaded, locked (using a device such as a gun lock or safe), and separated from ammunition. Keys or combinations to the locking device should also be safeguarded. Biometric lockboxes, which are typically opened using a fingerprint, may be the best storage option for owners who want quick access to a loaded firearm.

Temporarily transferring firearms to a trusted person or establishment—such as a local gun range, gun shop, or law enforcement agency—can be helpful during a crisis, for example, if a patient or family member is having thoughts of suicide. Providers should familiarize themselves with local background check requirements before suggesting that a patient transfers firearms to a friend or family

member. For example, California allows temporary transfers without a background check if a gun owner is feeling suicidal (Section 27882, California Penal Code). Increasingly, states (including Colorado, Washington, Maryland, New Jersey, and Mississippi) are providing online maps that identify gun shops and other establishments that will temporarily hold firearms, an option that may feel palatable to gun owners.

One approach to these conversations is a focus on family safety, said Barnhorst. For example: “You have a teenager at home with depression, and I really worry about access to your guns. Can you tell me how you store them and we can brainstorm some solutions?”

Parents who do not own firearms may be unlikely to have considered the risk of shooting accidents when their child or teenager visits another home for a playdate or a sleepover, so counseling them about safety is also important, said Carter, who is part of the leadership team for the Firearm Safety Among Children and Teens Consortium.

For example, a parent might take the onus onto themselves when speaking with another parent or a family member: “My child is very curious and does a lot of exploring. I just want to make sure there are not any unsecured firearms in your home, because I would hate for an accident to happen.”

If a patient is feeling suicidal, Barnhorst recommends something along the lines of: “I see many patients with guns at home. Sometimes when someone is going through a hard time, they

store their guns elsewhere, such as with a friend or at a gun store. This is just temporary until they feel better. Would you be willing to consider this?”

Motivational interviewing principles, which inform Project Safe Guard, can be helpful if a clinician anticipates pushback. Rather than entering the conversation as an expert providing instruction, said Anestis, ask the patient some questions: “Tell me about your firearms: How do you store them? Why do you choose to store them that way? Can you think of any scenarios where it might be beneficial to store them differently?” If a patient hints at a willingness to change their behavior, lean into that inclination.

“This work is often about planting seeds, not picking flowers. You don’t get an immediate payoff,” Anestis said. “But if you do this right, when the time comes, what you get is the outcome you’re looking for.”

REACHING HIGHEST RISK PATIENTS

In some cases, a patient may be at high risk for violence or suicide and unwilling to collaborate with their provider. Involuntary intervention may be necessary at this point to prevent harm.

Long-standing mental health-related prohibitions, namely the federal Gun Control Act of 1968 and similar state-level policies, are blunt tools that tend to miss those at highest risk, Barnhorst said. The federal law prohibits firearm ownership by convicted felons, those subject to some domestic violence restraining orders or convicted of domestic violence crimes, and people who

have been involuntarily admitted to a psychiatric hospital.

Most states have “duty to warn” laws that require mental health practitioners to alert law enforcement officials and/or potential victims if a patient makes an explicit threat of violence. Providers can also initiate emergency psychiatric hospitalization for patients who need immediate mental health care, typically for a period of 72 hours (Hedman, L. C., et al., *Psychiatric Services*, Vol. 67, No. 5, 2016).

But these statutes have left clinicians and authorities powerless to prevent some types of crises. In April 2014, a young man living in Isla Vista, California, made disturbing posts online that prompted his mother to contact his therapist, who reported the behavior to local law enforcement. Sheriff’s deputies visited his apartment but could not conduct a search or confiscate firearms because the man had not committed a crime. Less than a month later, he killed six people and injured 14 others.

In response to the Isla Vista killings, Barnhorst helped develop a California law that allows family members or police officers concerned about imminent violence to petition a court to temporarily confiscate a person’s firearms. Eighteen other states and the District of Columbia now have similar laws, known as “red flag” laws or extreme risk protection orders (ERPOs). In some states, clinicians, employers, and school officials can also petition courts. Connecting with local law enforcement is a good way for clinicians to learn about their state’s ERPO laws, Barnhorst said.

KEY POINTS

1

The majority of firearm deaths in the United States each year are suicides.

2

Clinicians can help reduce firearm suicides, homicides, and accidents by talking with patients about safe storage and temporary transfers in high-risk situations.

3

Several legal channels are available to briefly separate patients from their firearms during a crisis.

Though it is not possible to infer causality, research suggests that California's law helped prevent at least 21 mass shootings between 2016 and 2018 (Wintemute, G. J., et al., *Annals of Internal Medicine*, Vol. 171, No. 9, 2019). ERPOs also appear to have utility for suicide prevention. In the 10 years following the enactment of an ERPO law in Indiana, firearm suicides decreased by 7.5% (Kivisto, A. J., & Phalen, P. L., *Psychiatric Services*, Vol. 69, No. 8, 2018).

A restraining or protective order is typically the best option for domestic violence threats, Sorenson said, because federal

law prohibits those subject to such an order from purchasing or possessing a firearm. Providers can help patients with safety planning and connect them with local domestic violence agencies for additional support. If a patient is not ready to take action, Sorenson recommends underscoring how quickly firearm threats can escalate and working with the patient to determine what circumstances would prompt them to seek a restraining order.

"Clinicians should create and reinforce the assumption that action will probably need to be taken at some point," she said.

FIREARM DEATHS BY INTENT: 2021

54%

Suicide

42%

Homicide

4%

Unintentional

Total:
44,838

Source:
Gun Violence Archive

During any conversation about firearms, clinicians should keep in mind their patients' reasons for ownership, where they fall on the safety spectrum, and how to reduce harm while still respecting their values, Carter said.

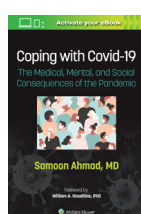
"If we approach it in that way, we avoid potential points of disagreement and we stay aligned with the science," he said. "That's really where our focus should be." ■

Psychologists who have concerns about potentially dangerous clients should schedule a consult with their malpractice carrier. APA members may also contact practlegal@apa.org for a consultation and other resources.



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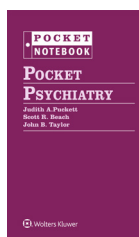


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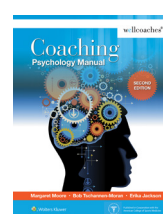


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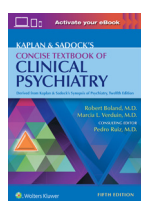


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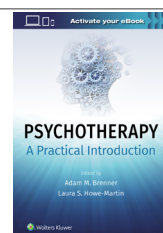


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