

# BREAKING THROUGH BARRIERS

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## THE EMERGING ROLE OF HEALTHCARE PROVIDER TRAINING PROGRAMS IN FIREARM SUICIDE PREVENTION



CONSORTIUM FOR  
**RISK-BASED FIREARM POLICY**

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# **Breaking Through Barriers:**

## **The Emerging Role of Healthcare Provider Training Programs in Firearm Suicide Prevention**

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On behalf of the Consortium for Risk-Based Firearm Policy

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## **CONSORTIUM FOR RISK-BASED FIREARM POLICY**

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### *About the Consortium*

The Consortium includes many of the nation's leading researchers, practitioners, and advocates in gun violence prevention and mental health (members listed below). In March of 2013, members of the Consortium met for a two-day conference to discuss research evidence and identify areas of consensus. This initial meeting resulted in a commitment to advance evidence-based gun violence prevention policy recommendations through the newly formed Consortium. Since the initial meeting, the Consortium has published reports on evidence-based recommendations for state and federal policy, including a report on best practices for firearm removal in cases of domestic violence. The Consortium met again in May of 2015 and February of 2017 and continues to develop evidence-based gun violence prevention policies.

### *Mission Statement*

The Consortium seeks to: (1) synthesize and translate existing research and the best available scientific evidence to develop gun violence prevention policy recommendations to address access to firearms by persons who are at an elevated risk for committing interpersonal violence or dying by suicide; and (2) inform relevant stakeholders of these policy recommendations by developing educational materials, including reports and issue briefs, conducting public forums, and submitting expert testimony.

### *Consortium Membership*

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### *The Educational Fund to Stop Gun Violence*

The Consortium is organized and managed by the Educational Fund to Stop Gun Violence (Ed Fund). The Ed Fund was founded in 1978 as a 501(c)(3) organization that makes communities safer by translating research into policy. The Ed Fund achieves this by engaging in policy development, advocacy, community and stakeholder engagement, and technical assistance.

### *Funding Source*

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## I. Executive Summary

Suicide is a growing public health crisis in the United States (US).<sup>1</sup> Firearms make up half of all US suicides and take an average of 20,000 lives each year - over 50 every single day.<sup>2</sup> These firearm suicide deaths also constitute 6 of every 10 US firearm deaths.<sup>3</sup> Firearms are among the most lethal suicide attempt methods, with approximately 9 out of 10 firearm suicide attempts resulting in death.<sup>4</sup> Temporarily removing firearms from individuals during or in anticipation of a suicidal crisis makes it less likely an individual will die during a suicide attempt, as other means are less lethal.

### *What is Lethal Means Safety Counseling?*

Lethal means safety counseling is a form of anticipatory guidance, the provision of preventive advice by an expert (often a healthcare provider) to a patient or their guardian to prepare them for an “anticipated developmental and/or situational crisis.”<sup>5</sup> Specifically, lethal means safety counseling is the process that healthcare providers undertake to:

- (a) determine if an individual at risk for suicide has access to lethal means of suicide attempt; and
- (b) work with the individual and their family or friends to reduce access until the risk of suicide decreases.

### *Who Should Receive Lethal Means Safety Counseling?*

Any patient at an elevated risk for suicide should receive counseling, especially if they have disclosed suicidal ideation or attempt, even if the individual does not have access to a firearm at the time of the clinical interaction. Instituting safety measures before a crisis occurs is preferred over addressing means safety once a crisis is already underway, particularly since suicidal crises can have a sudden onset. Broader information on firearms safety is recommended for all.

### *Who Should be Trained in Lethal Means Safety Counseling?*

Lethal means safety counseling training should be provided to all trainees in medicine, mental health, nursing, and related clinical healthcare fields. Additional in-depth training should reach providers in the following settings:

- Primary care (family medicine, internal medicine, pediatrics, geriatrics, and OB-GYN)
- Emergency and urgent care, as well as crisis centers
- Behavioral health

The types of providers receiving training should include:

- Physicians
- Physician assistants
- Nurses and nurse practitioners
- Psychologists
- Counselors
- Social workers

### *What Should Lethal Means Safety Counseling Training Include?*

Lethal means safety counseling training should include evidence to address common misconceptions, an overview of best counseling techniques, information about firearms, tools for providers for when a patient indicates that they do have access to a firearm, and important legal information regarding firearms laws at the local, state, and federal levels. Training should be parsimonious, relevant to providers' work with a clear benefit, engaging for participants, practice-oriented, and supplemented with resources that providers can refer to later.

### *The Consortium for Risk-Based Firearm Policy's Recommendations*

Lethal means safety counseling should be an essential part of comprehensive provider-based suicide prevention programs. Most providers receive little to no formal training on how to speak to their patients or clients about firearm safety. Those who are engaged in curricula development for and training of healthcare providers have an opportunity to shift the landscape of firearm suicide prevention by developing, implementing, and evaluating lethal means safety training programs at every level and stage of clinical education and practice.

The Consortium for Risk-Based Firearm Policy endorses and supports efforts among training programs that will equip healthcare providers to deal tactfully, respectfully, and directly with the issue of firearms and suicide. Provider training programs should include lethal means safety counseling training, either as a standalone module or integrated into existing curriculum on suicide risk assessment. This training should be offered to all trainees and repeated throughout the lifecycle of clinical practice. The Consortium strongly supports and encourages additional research to further elucidate best practices on lethal means safety counseling and best practices for training healthcare providers on how to provide the most effective method of counseling.



## II. INTRODUCTION

### *Premise*

Suicide is a leading cause of preventable death in the United States (US). Firearms are among the most lethal and most commonly used methods in suicides in the US. Suicide rates, both overall and by firearms, are generally higher in places where household firearm ownership is more common. By contrast, rates of suicide by methods other than firearms are not significantly correlated with rates of household firearm ownership. In the US, where firearms are the method used in approximately 50% of all suicides and where roughly 1 in 3 homes contains firearms, even small relative declines in the use of firearms in suicide acts could result in large reductions in the number of suicides, depending on what, if any, method would be substituted for firearms. Thus, temporarily separating an individual who is at risk of suicide from firearms is an important component of suicide prevention.

Healthcare providers have an opportunity to engage patients by discussing lethal means safety and to work with them and their families to reduce access to lethal means of suicide, particularly firearms, ahead of suicidal crises as an integral part of suicide prevention strategies. Training healthcare providers on how to best counsel their patients on access to firearms is imperative for effective firearm suicide prevention. To address this, healthcare provider training programs should integrate lethal means safety counseling training as part of the core curriculum on suicide risk assessment.

### *Process*

The topic of lethal means safety counseling was discussed at the second convening of the Consortium for Risk-Based Firearm Policy in 2015. This report integrates the best available research with expert recommendations by the Consortium. From April through May 2016, nine in-depth interviews were conducted with members of the Consortium's Lethal Means Safety Workgroup, eight of which used a semi-structured interview protocol. This multidisciplinary workgroup is comprised of professionals working in injury and violence research, medical schools and continuing education, and clinical settings that include psychiatry, psychology, and emergency medicine. Many workgroup members are engaged in direct lethal means safety counseling and training. The findings from these interviews were used to develop this report.

### *This Report Will:*

- (a) provide a brief overview of firearm suicide epidemiology, risk factors for suicide, and the evidence in support of temporary risk-based firearm removal for suicide prevention;
- (b) introduce the concept of lethal means safety counseling, including the best available evidence for its efficacy and the Consortium's recommendations for its practice;
- (c) discuss the importance of incorporating lethal means safety counseling training into healthcare provider training programs, outline current best practices for training, and provide guidance by the Consortium on to whom, by whom, and how such training may be provided;
- (d) highlight gaps in current knowledge of lethal means safety counseling and training and prioritize efforts to fill them; and

- (e) call upon those who are engaged in curricula development for and training of healthcare providers to develop, implement, and evaluate lethal means safety training programs.

### *Audience*

This report is designed for those who administer, develop curricula for, teach, or practice in healthcare fields or who are otherwise involved in lethal means safety counseling and suicide prevention. This includes but is not limited to: trainers, trainees, and professionals in the fields of medicine (physicians, physician assistants), nursing, and behavioral health care (psychologists, counselors, social workers, substance abuse treatment, marriage and family counseling, pastoral counseling, etc.).

**National Suicide Prevention Lifeline:** If you need help, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or go to [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org). If you are deaf or hard of hearing, you can contact the Lifeline via TTY at 1-800-799-4889.

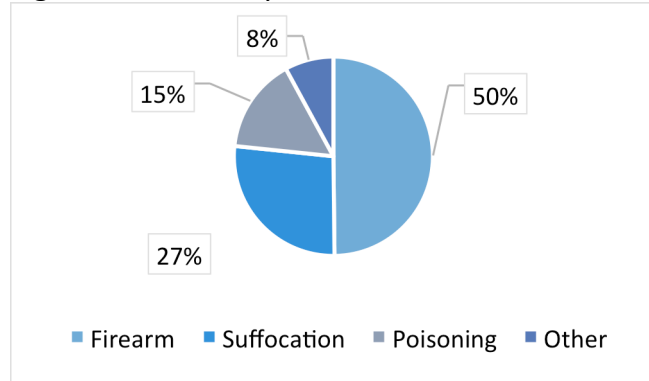
### III. FIREARM SUICIDE IN THE UNITED STATES

#### Firearm Suicide Epidemiology

Suicide is a growing public health crisis in the US.<sup>6</sup> Over the last decade, suicide was the 10th leading cause of death in the country overall.<sup>7</sup> Firearms contribute significantly to this problem, making up half of all US suicides (Figure 1) and taking an average of 20,000 lives each year - over 50 every single day (Figure 2).<sup>8</sup> These firearm suicide deaths also constitute 6 of every 10 US firearm deaths.<sup>9</sup>

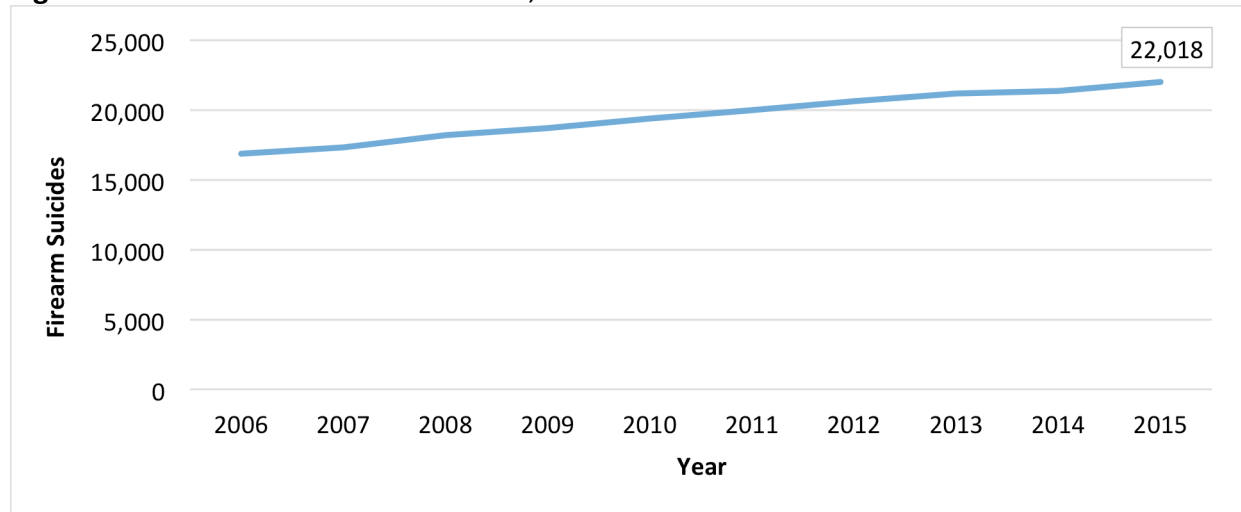
Firearm suicide is the leading cause of violent death in the United States.

**Figure 1. Suicides by Method, 2015**



Source: National Center for Injury Prevention and Control, CDC. US Suicide Deaths and Rates per 100,000. Fatal Injury Reports, 1999-2015. Retrieved May 15, 2017, from <http://www.cdc.gov/injury/wisqars/fatal.html>.

**Figure 2. United States Firearm Suicides, 2006-2015**

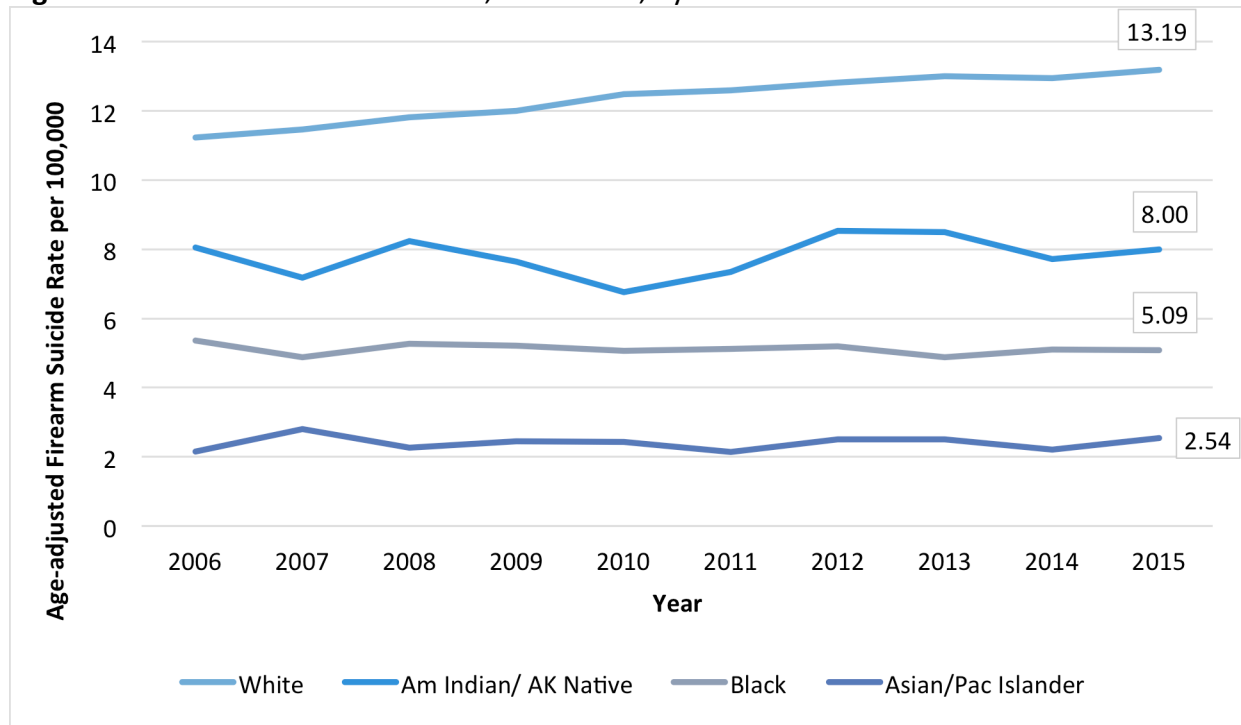


Source: National Center for Injury Prevention and Control, CDC. US Suicide Deaths and Rates per 100,000. Fatal Injury Reports, 1999-2015. Retrieved May 15, 2017, from <http://www.cdc.gov/injury/wisqars/fatal.html>.

Over the last decade (2006-2015), greater than 86% of firearm suicide victims were males; 92% and 94% of male and female victims were non-Hispanic white, respectively. In this same time period, among youths aged 10-19 and young adults aged 20-34, firearm suicide was the third and second leading cause of violent death. From age 35 on, firearm suicide was the leading cause of violent death, and rates continued to increase with age across the lifespan.<sup>10,11</sup> See Figures 3, 4, and 5 to see age and race differences by sex in firearm suicide rates. The rates of firearm suicide also vary substantially between states (Figure 6). The toll of firearm suicide on American families and communities is considerable.

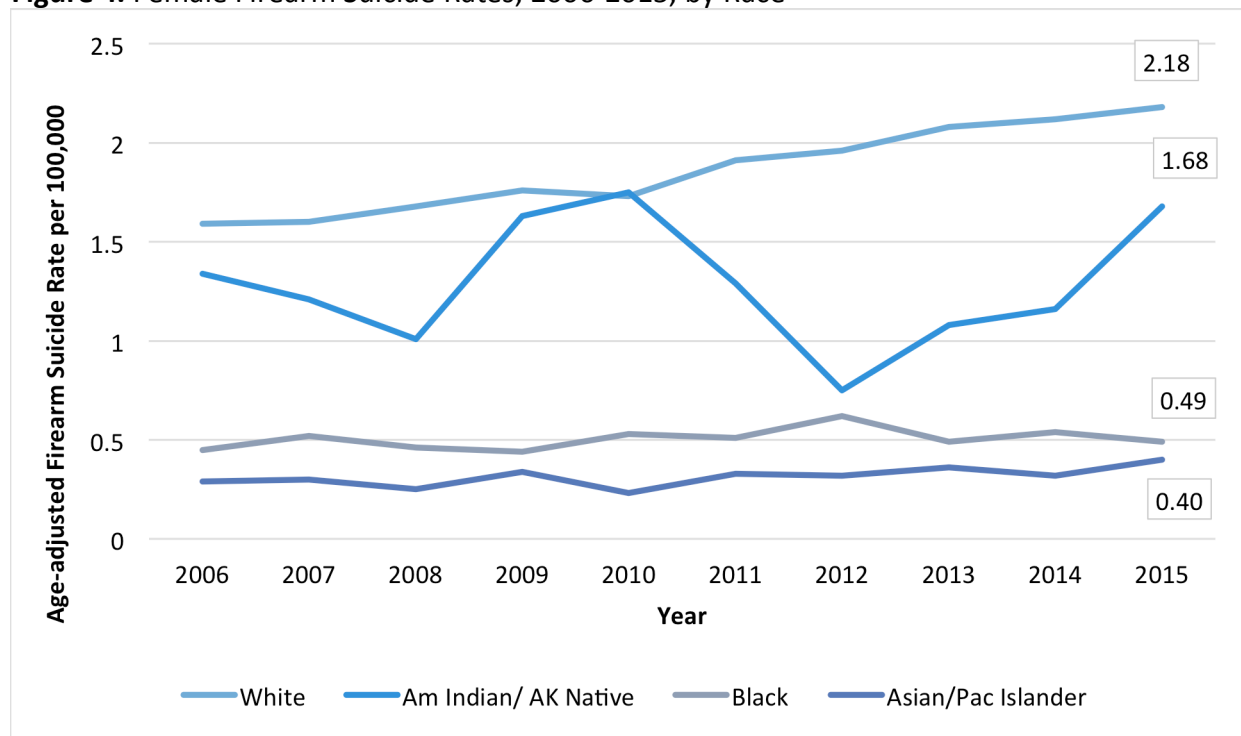


**Figure 3. Male Firearm Suicide Rates, 2006-2015, by Race**



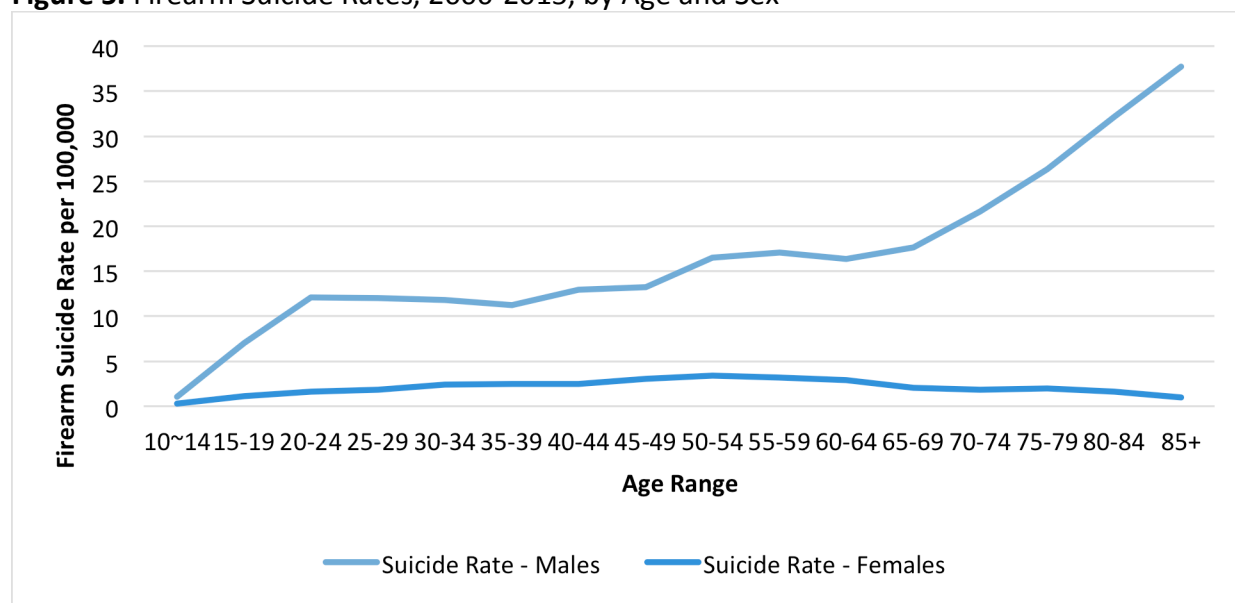
Source: National Center for Injury Prevention and Control, CDC. US Suicide Deaths and Rates per 100,000. Fatal Injury Reports, 1999-2015. Retrieved May 15, 2017, from <http://www.cdc.gov/injury/wisqars/fatal.html>.

**Figure 4. Female Firearm Suicide Rates, 2006-2015, by Race**



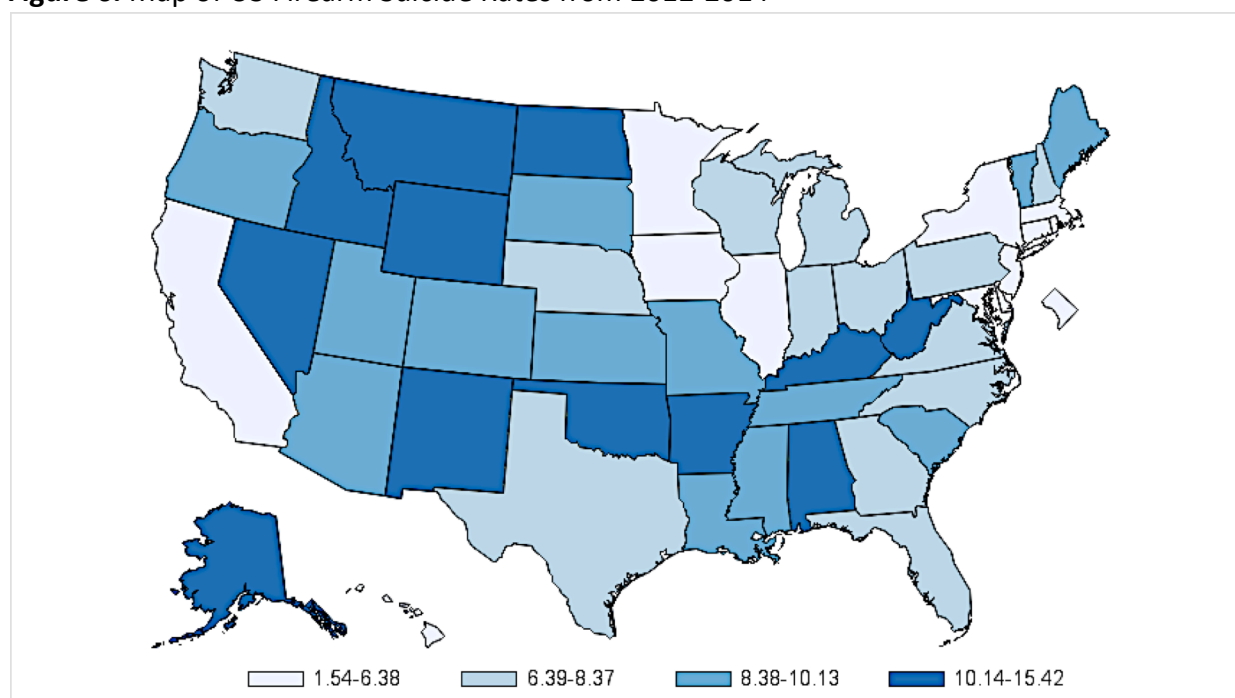
Source: National Center for Injury Prevention and Control, CDC. US Suicide Deaths and Rates per 100,000. Fatal Injury Reports, 1999-2015. Retrieved May 15, 2017, from <http://www.cdc.gov/injury/wisqars/fatal.html>.

**Figure 5. Firearm Suicide Rates, 2006-2015, by Age and Sex**



Note: The firearm suicide rates for ages 0-4 and 5-9 were unstable due to 20 or fewer deaths being reported in 2015.  
Source: National Center for Injury Prevention and Control, CDC. US Suicide Deaths and Rates per 100,000. Fatal Injury Reports, 1999-2015. Retrieved May 15, 2017, from <http://www.cdc.gov/injury/wisqars/fatal.html>.

**Figure 6. Map of US Firearm Suicide Rates from 2012-2014**



Source: Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC. Data from NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Losing a family member, friend, close contact, or other community member to firearm suicide is traumatic, and suicide bereavement can impact survivors for years to come. Suicide bereavement is distinct from other forms of grief and can increase suicide risk among the bereaved, in addition to having other adverse effects on mortality, mental health, and social functioning.<sup>12,13</sup>

Beyond direct human impact, firearm suicide has a broad and substantial negative impact on the US economy. The average medical and lifetime work loss costs of a single firearm suicide is \$1,087,866, meaning that all firearm suicide deaths cost a total of over \$21 billion per year.<sup>14</sup>

### *Risk Factors for Suicide*

A variety of factors influence an individual's risk for suicide. It is important to note that risk factors are different than warning signs; warning signs indicate an *immediate* concern that an individual may try to take their life whereas risk factors are characteristics or conditions that increases an individual's risk for suicide. One such risk factor is alcohol abuse. A study using National Violent Death Reporting System data found that alcohol was present in about one-third of individuals who died by suicide using the top three methods (firearm, hanging, and poisoning).<sup>15</sup> Controlled substance abuse is also a risk factor for suicide.<sup>16</sup> Notably, the population attributable risk of serious mental illness for suicide is between 47-74%.<sup>17</sup> Other risk factors include bullying, a history of abuse, recent arrests or convictions, and certain major physical health conditions, among others.<sup>18,19</sup> Though most individuals in the United States who die by suicide have not previously attempted it,<sup>20</sup> a history of suicide attempt is a significant risk factor for dying by suicide.<sup>21</sup> For a thorough overview of both dynamic and static risk factors for suicide across the lifespan, see Steele, et al. (2017).<sup>22</sup>

### *Access to Firearms and Risk of Suicide*

Notably, the link between firearms and suicide is well-established. Empirical evidence from ecologic and individual-level studies has consistently shown that access to firearms increases the risk of suicide. Suicide rates, both overall and by firearms, are generally higher in places where household firearm ownership is more common.<sup>23,24,25</sup> In contrast, rates of non-firearm suicide are not significantly correlated with household firearm ownership. Furthermore, the relationship

Access to a gun in the home increased the odds of suicide more than three-fold.

between firearm ownership rates and suicide rates is maintained even when confounding factors - including suicide attempt rates and suicidal ideation - are controlled for.<sup>26,27,28</sup> While increases in relative suicide risk vary based on population and storage practices,<sup>29,30,31,32,33</sup> a meta-analysis of individual-level studies found that access to a gun in the home increased the odds of suicide more than three-fold.<sup>34</sup>

In the only large US cohort study examining the relationship between firearms and suicide to date, California residents who purchased a handgun from a licensed dealer experienced a suicide rate more than double that of matched members of the general population. This risk of suicide increased immediately after the purchase, remained elevated throughout the six year study period, and was entirely attributable to increased risk of firearm suicide.<sup>35</sup>



Finally, firearm suicide risk appears to increase further when there is easy access to a gun that is stored loaded and unlocked.<sup>36</sup> In the US, where roughly 1 in 3 homes contains guns,<sup>37,38,39</sup> the ready availability of firearms is a significant risk factor for suicide and is critical to consider in prevention efforts.

For an in-depth review of the relationship between firearms and suicide, see Miller, Barber, and Azrael's chapter entitled, *Firearms and Suicide in the United States* (in Gold & Simon, Eds., 2016).<sup>40</sup>

### *Lethality of Firearms*

Firearms are among the most lethal suicide attempt methods, with approximately 9 out of 10 firearm suicide attempts resulting in death. By comparison, the most frequently chosen methods of suicide attempt are significantly less fatal: poisoning/overdose and cut/pierce result in death in just 0.5-2% and 1-3% of attempts, respectively.<sup>41</sup> This means that many people who attempt suicide survive because they have chosen less fatal methods than firearms.

**Table 1.** Case Fatality Ratios for Selected Methods Commonly Used in Intentional Self-Harm

Suicide Method	Case Fatality Ratio (Range)
Firearm (Miller, Hemenway, et al., 2004; Spicer & Miller, 2000; Vyrostek et al., 2004)	83%–91%
Drowning (Miller, Hemenway, et al., 2004; Spicer & Miller, 2000)	66%–84%
Suffocation/Hanging (Elnour & Harrison, 2008; Miller, Hemenway, et al., 2004; Spicer & Miller, 2000; Vyrostek et al., 2004)	61%–83%
Charcoal Burning (Lee et al., 2014)	50%
Poison, Gas (Elnour & Harrison, 2008; Miller, Hemenway, et al., 2004; Spicer & Miller, 2000)	42%–64%
Jump (Elnour & Harrison, 2008; Miller, Hemenway, et al., 2004; Spicer & Miller, 2000; Vyrostek et al., 2004)	31-79%
Cut/Pierce (Elnour & Harrison, 2008; Miller, Hemenway, et al., 2004; Spicer & Miller, 2000; Vyrostek et al., 2004)	1-3%
Poison, Drug (Elnour & Harrison, 2008; Gunnell, Ho, & Murray, 2004; Miller, Hemenway, et al., 2004; Spicer & Miller, 2000)	<0.5%–2%

Source: Adapted from Table 36.1 in book chapter, *Reducing Access to Lethal Means: A Review of the Evidence Base*, by Azrael and Miller.<sup>42</sup>

Due to their high lethality, this report focuses on firearms with regard to access to lethal means; however, access to other means of suicide attempt should also be considered and counseled on as appropriate. Case-fatality ratios of selected suicide attempt methods are shown in Table 1 and can be used to guide additional efforts to reduce access to lethal means.

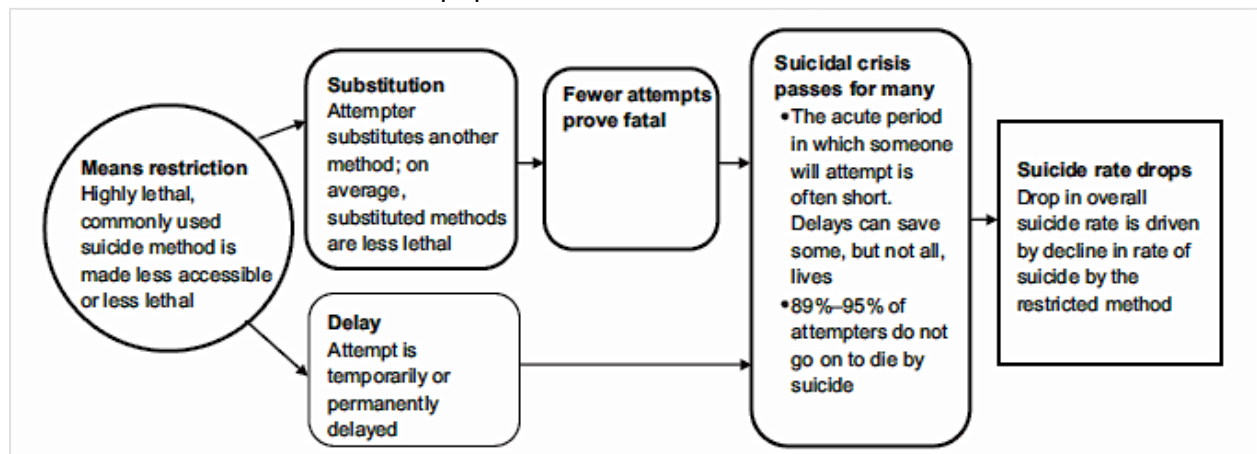
## Suicide Prevention Through Reduced Access to Lethal Means

### Suicidal Crises

Though suicidal ideation may precipitate a crisis for an extended period of time and thus provide opportunities for intervention and risk reduction, including through behavioral health treatment, suicidal crises peak relatively quickly for many people. An individual's access to lethal means during that crisis is a critical factor in whether or not they will survive. In a survey of people 13-34 years of age who survived a suicide attempt, nearly a quarter reported that only five minutes or less had passed from when they decided to attempt suicide to when they actually attempted suicide. Nearly half of the survey respondents said that time was an hour or less.<sup>43,44</sup>

As such, temporarily removing firearms from individuals during or in anticipation of a suicidal crisis makes it less likely an individual will die during a suicide attempt, as other means are less lethal. Additionally, research shows that few individuals substitute means for suicide if their preferred method is not available,<sup>45</sup> and 90% of individuals who attempt suicide *do not* eventually go on to die by suicide.<sup>46</sup> The conceptual model developed by Barber and Miller depicts how reducing access to lethal means, like firearms, could save lives (Figure 7).<sup>47</sup>

**Figure 7.** Conceptual model of how reducing access to a highly lethal and commonly used suicide method saves lives at the population level



Source: Barber and Miller (2014).<sup>48</sup>

In recognition of the risks posed by easy access to firearms and other lethal means, leading suicide prevention organizations, such as the Suicide Prevention Resource Center, Suicide Awareness Voices of Education, and the Defense Suicide Prevention Office, have identified reducing access to lethal means as a key component of comprehensive suicide prevention strategies.<sup>49,50,51</sup> Perhaps most prominently, the 2012 *National Strategy for Suicide Prevention (NSSP)*, jointly released by the National Action Alliance for Suicide Prevention and the US Surgeon General, includes both the provision of and training in lethal means safety counseling as key priorities in reaching the goal of a 20% reduction in the annual US suicide rate by 2025.<sup>52</sup>

### *Healthcare Providers' Interactions with Suicidal Patients*

During an acute suicidal crisis, an individual is most likely to be seen in an emergency or behavioral health treatment setting, and lethal means safety counseling should be included as part of suicide assessment. However, many individuals with risk factors for suicide who later experience suicidal crises engage with the healthcare system in the time leading up to the crisis. One study of more than 20,000 individuals who attempted suicide found that 38% of individuals saw a physician in the week before their suicide attempt, 64% saw a physician in the month before their suicide attempt, and nearly all study participants saw a doctor in the year before their suicide attempt.<sup>53</sup> This means that patients/clients with more chronic risk factors (e.g. depression, chronic pain, etc.) seen in primary care or similar non-emergent settings are also good candidates for lethal means safety counseling as integrated with a comprehensive care approach.

### *Temporarily Removing Firearms from Individuals at Risk for Suicide*

It is clear that reducing firearms access during times of risk is an important component of a robust suicide prevention plan. Some states have legal tools available such as Gun Violence Protection Order (GVPO) laws (also known as Extreme Risk Protection Orders, among other names), which allow families and law enforcement to petition a court to temporarily remove firearms from individuals who are dangerous to themselves or others. Currently, California, Washington, and Oregon have GVPO-type laws, and Indiana and Connecticut have similar laws that are available to law enforcement agencies but not family (Table 2).

There is emerging research on Connecticut's risk-warrant law that shows it may be an effective tool for suicide prevention. A recent study examining risk-warrants issued between 1999 and 2013 found that suicidality or self-injury was listed as a reason for the warrant in greater than 60% of cases where such information was available. Moreover, researchers estimated that for every 10 to 20 risk-warrants issued, one suicide was averted.<sup>54</sup> These findings lend support to the effectiveness of preemptive firearms removal laws in suicide prevention.

**Table 2.** States with Gun Violence Protection Order-type Laws

State	Name of Law
California	Gun Violence Restraining Order
Connecticut	Risk-warrant
Indiana	Proceedings for the Seizure and Retention of a Firearm
Oregon	Extreme Risk Protection Order
Washington	Extreme Risk Protection Order

Sources: Conn. Gen. Stat. § 29-38C; Ind. Code Ann. § 35-47-14; Cal. Penal Code § 18100 \_et seq.; Senate Bill 719, 2017 Reg. Sess. (Or.2017); Wash. Rev. Code Ann. § 7.94.010 \_et seq.

While approximately 20 states introduced GVPO-type legislation in the 2017 legislative session,<sup>55</sup> most states have not yet enacted such laws. Furthermore, as legal orders, GVPO-type policies are designed to complement voluntary safer firearms storage practices including

temporarily transferring firearms to others; ideally, GVPO-type orders should be considered after voluntary measures have been attempted or in emergency situations. The lack of legal interventions currently available in most states puts additional pressure on healthcare providers to intervene appropriately. As such, healthcare providers have an opportunity to help patients, in conjunction with their families or friends, to reduce firearms access during times of elevated risk through lethal means safety counseling.

## IV. LETHAL MEANS SAFETY COUNSELING

### Overview of Lethal Means Safety Counseling

#### *Introduction*

Lethal means safety counseling is a form of anticipatory guidance, the provision of preventive advice by an expert (often a healthcare provider) to a patient or their guardian to prepare them for an “anticipated developmental and/or situational crisis.”<sup>56</sup> Specifically, lethal means safety counseling is the process that healthcare providers undertake to:

- (a) determine if an individual at risk for suicide has access to lethal means of suicide attempt; and
- (b) work with the individual and their family or friends to reduce access until the risk of suicide decreases.

While lethal means safety counseling may refer to reducing access to a variety of means of suicide attempt, the focus is often on firearms and ammunition given the elevated lethality, availability, and common use of that attempt method. As this report focuses on reducing firearm suicide, references to lethal means counseling will concentrate on reducing access to firearms.

#### *Terminology - “Restriction” vs. “Safety”*

The terms “means restriction” and “means safety” are often used interchangeably when discussing lethal means and reducing access to firearms. A recent study in which participants were randomized to read a vignette on a clinical scenario in which either “means safety” or “means restriction” was used to discuss managing firearm ownership and access found that participants rated “means safety” as significantly more acceptable than “means restriction.” Moreover, participants who were randomized to the “means safety” arm “reported greater intentions to adhere to clinicians’ recommendations to limit access to a firearm for safety purposes.”<sup>57</sup> Given these research findings, providers may want to consider using the terminology “means safety” when discussing limiting access to firearms.

#### *Research on Lethal Means Safety Counseling*

Relatively little research has been conducted to determine best practices for counseling patients on access to lethal means. The majority of existing research on lethal means safety counseling assesses 1) if providers are counseling on access to lethal means, and 2) clinician attitudes towards lethal means safety counseling. A 2015 systematic review on clinical firearm injury prevention screening and interventions by Roszko, et al. found that providers rarely counsel their patients about firearm safety.<sup>58</sup> Importantly, the review found that **no studies showed harm** as a result of providing such screenings and interventions.

Regarding clinician attitudes, one 2015 study of internists representative of the American College of Physicians’ members found that 66% of physicians believed they should have the right to counsel their patients on preventing gun deaths and injuries.<sup>59</sup> Provider beliefs about which patients should receive counseling vary based on patient characteristics. One survey of pediatricians found 98% believed that gun-owning families should receive firearm injury



prevention counseling but only 55% believed that counseling for all families (regardless of gun ownership) was indicated.<sup>60</sup> Notably, there is a persistent gap between clinician attitudes and reported behavior, as demonstrated by study findings that 61-87% of clinicians surveyed thought they *should* be engaged in firearm safety screening and counseling while only 12-59% reported that they actually did so in patient care.<sup>61,62,63,64</sup>

In addition to examining clinician attitudes, patient attitudes toward firearms counseling is another area of relevant research - with mixed findings. Research in the 1990s found that more than half of patients thought that physicians *should* counsel patients about guns in the home;<sup>65</sup> 90% of parents thought that firearms safety counseling by a pediatrician would be acceptable;<sup>66</sup> and 80% of parents would find such information useful.<sup>67</sup> Still, there may be a gap between a parent's desire to learn more and their expected likelihood of following a physician's advice.<sup>68</sup> More recent research among veterans and older adults, both populations at higher risk of firearm suicide than the general population, indicates that screening for gun access and clinician interventions to reduce firearms access during periods or conditions of high risk are generally acceptable.<sup>69,70</sup> Results from a 2016 study using a national sample found that a majority of respondents (66%), and over half of gun owners, reported it is at least sometimes appropriate for providers to talk to patients about firearms.<sup>71</sup>

While research on patient attitudes on the acceptability of lethal means safety counseling is mixed, research by Bonds and colleagues found that prior screening about specific sensitive health behaviors, including firearms-related, increased acceptance of routine screening for that behavior.<sup>72</sup> This suggests that as providers' engagement in lethal means safety counseling becomes more commonplace, such interventions will become more acceptable among patients.

As such, despite a limited amount of research on best practices for actually engaging in lethal means safety counseling, providers should feel encouraged to engage in conversations with their patients regarding access to firearms.

### *Why Should Healthcare Providers Counsel on Lethal Means Safety?*

Though limited, research shows that interventions by healthcare providers can affect a patient's storage of firearms which in turn can substantially reduce risk for suicide or other firearm-related injury.<sup>73</sup> For example, one study that sought to see whether firearms safety counseling by family physicians affected firearm storage among patients who answered yes to the question "Does anyone in your home own a gun?" found that patients who received a physician's verbal or written recommendation were three times more likely to make safe changes in firearms storage practices than patients who did not receive counseling.<sup>74</sup> Another study found that for every 2.5 gun-owning parents who received a pediatrician's counseling and free cable locks, one parent reported using the cable locks six months later.<sup>75</sup> The potential for lethal means safety counseling to save lives warrants engagement in such counseling, training, and further research on best practices.

### **What Lethal Means Safety Counseling Looks Like in Practice**

While there is a clear necessity and evidence for engaging in lethal means safety counseling, there are not yet evidence-based guidelines for *how* lethal means counseling should be

conducted. As researchers continue to establish the evidence base, it is critical to develop best practices and engagement in lethal means safety counseling and evaluate the efficacy of such interventions. The following is a brief overview of lethal means safety counseling best practices as developed by the Consortium.

### *Who Should be Counseled?*

Any patient at an elevated risk for suicide, such as an individual who is depressed or who is suffering from alcohol abuse, and especially if they have disclosed suicidal ideation or attempt, should receive lethal means safety counseling. Lethal means safety counseling should be provided even if the at-risk individual does not have access to a firearm at the time of the clinical interaction, as they might purchase or otherwise access firearms in the future. Family or friends should be included in the counseling if possible.

**Table 3.** Conditions When Firearm Information Might Be Particularly Relevant to the Health of a Patient and Potentially to Others

Condition	Examples	How to Respond When Patients Have Firearm Access
Acute risk for violence to self or others (based on information or behavior)	<ul style="list-style-type: none"> <li>• Suicidal ideation or intent</li> <li>• Homicidal ideation or intent</li> </ul>	<ul style="list-style-type: none"> <li>• This is an emergency</li> <li>• Act promptly to ensure safe storage, in cooperation with patient if possible</li> <li>• If necessary, disclose to others who are able to reduce risk (family, caregivers, psychiatric services, law enforcement)</li> </ul>
Individual-level risk factors for violence to self or others or unintentional firearm injury	<ul style="list-style-type: none"> <li>• History of violence</li> <li>• Alcohol or drug abuse</li> <li>• Serious mental illness, especially:</li> <li>• In combination with substance abuse or violence</li> <li>• During acute exacerbations</li> <li>• After violent victimization</li> <li>• Conditions impairing cognition and judgment</li> </ul>	<ul style="list-style-type: none"> <li>• Counsel on safe storage (5 Ls* or similar)</li> <li>• Counsel on risk reduction</li> <li>• When capacity is diminished, consider disclosure to others who are able to reduce risk</li> </ul>
Member of demographic group at increased risk for violence to self or others or unintentional firearm injury	<ul style="list-style-type: none"> <li>• Middle-aged and older white men</li> <li>• Young African American men</li> <li>• Children and adolescents</li> </ul>	<ul style="list-style-type: none"> <li>• Counsel on safe storage (5 Ls* or similar)</li> <li>• Counsel on risk reduction</li> <li>• For minors, involve parents</li> </ul>

\* 5Ls = Locked, Loaded, Little children, feeling Low, Learned owner. If the patient indicates that a firearm is in the home, questions on the following topics should be asked: "Is it loaded?" "Is it locked?" "Are there little children present?" "Is the operator feeling low?" "Is the operator learned about firearm safety?" and "Is the operator experiencing any type of cognitive impairment?"

Source: Wintemute, Betz, & Ranney (2016).<sup>76</sup>

Given that firearm suicide rates elevate with age, special attention should be paid to screening elderly patients who meet additional risk criteria.<sup>77</sup> On the other end of the age spectrum, if the patient or client is a child, their parent or guardian should receive lethal means safety counseling. One study found that of children who died by firearm suicide, approximately two-thirds used a firearm that was owned by a household member living with the victim.<sup>78</sup> Coupled with increasing firearm suicide rates among teenagers, parental or guardian involvement in lethal means safety counseling is critical.<sup>79</sup>

Notably, instituting safety measures before a crisis occurs is preferred over addressing means safety once a crisis is already underway, particularly since suicidal crises can have a sudden onset or someone other than the patient may be at elevated risk with access to the same firearm. Further, patient acceptability of firearms safety counseling may increase with exposure.<sup>80</sup> Thus, broader information on firearms safety is recommended for all.

Wintemute and colleagues (2016) provide a detailed outline of conditions for lethal means safety counseling including examples and suggested responses (Table 3).

#### *How to Approach Lethal Means Safety Counseling*

A patient or client may bring up suicidality and firearms and thus open the door to a conversation about lethals means safety. However, if this is not the case, lethal means safety counseling may be integrated into a patient/client interaction by embedding lethal means and firearms safety conversations into existing practices for as suicide risk assessment and prevention. For example, questions about firearms access may be embedded among clinical interview questions about an acute mental health crisis or diagnosis, suicidal ideation, alcohol or substance abuse, domestic violence, or exposure to community and peer violence. They should also be part of Safety Planning and other interventions for those at risk.<sup>81</sup>

Different approaches may be necessary for different counseling audiences. Clinical interviewing skills and sensitivity, as is the case when counseling about other risky behaviors such as smoking or drinking, will benefit a provider in tailoring lethal means safety counseling to the needs of the patient/client. Factors to consider include whether the patient/client is adult or pediatric, gun-owning or not, urban or rural, and other cultural characteristics. Indeed, Betz and Wintemute (2015) suggest that firearms safety counseling requires a “new kind of cultural competence” that includes: 1) recognizing biases and gaps in knowledge and working to address them; 2) being respectful and nonjudgmental in counseling approaches; 3) balancing an individualized approach with routine intervention for high-risk populations; 4) utilization of the principles of shared decision making; and 5) policies to support physician engagement in such safety counseling practices.<sup>82</sup>

#### *What Lethal Means Safety Counseling Should Include*

Lethal means safety counseling should be straightforward and practical. It should include asking about firearms access and intent to access, overviewing data on risk and lethal means, providing locale-specific safer storage options, and using motivational interviewing techniques as one way to explore barriers and pros/cons. The goal of lethal means safety counseling is to help patients

and their families or friends find ways to reduce firearms access, at least temporarily, during times of elevated risk.

**The goal of lethal means safety counseling** is to help patients and their families or friends find ways to reduce firearms access, at least temporarily, during times of elevated risk.

As stated above, specific questions about firearms access should be included in lethal means safety counseling. These questions should be prefaced with the reason why you are asking, such as your concerns for the patient's safety given presenting risk factors.<sup>83</sup> A statement such as "this is something I talk with all my patients about when I'm worried about suicide" might diffuse privacy concerns. The person delivering counseling could also consider explicit statements about respect for Second Amendment rights and a desire to work together to enhance safety. Suggested questions include:

- Do you have access to a gun?
- Is there a gun in or around your home or where you live?
- Where is the gun stored?
- Is the gun stored loaded?
- Where do you store ammunition?
- Who else has access to the gun?
- Are you planning on purchasing a gun?

Description of options for the safer storage of firearms should be readily accessible in a lethal means safety counseling session. Wintemute and colleagues (2016) compiled safer firearm storage options into a table that may be a helpful resource (Appendix 7). The authors note that "choice of storage method will likely depend on cost and acceptability," which is critical to consider when presenting options to a patient/client. Not all options may be appropriate for all patients/clients.<sup>84</sup>

In addition, handouts and resources may be helpful patient/client takeaways and may also increase clinicians' intention to provide counseling in the first place.<sup>85</sup> Such resources should include firearms-related safer storage options (storage brochures from firearms organizations might be particularly appealing to firearms owners - see Appendix 6) as well as other lethal means safety resources, suicide and other relevant crisis hotlines, and legal options such as Gun Violence Protection Orders as applicable.

#### *After Lethal Means Safety Counseling Occurs*

After lethal means safety counseling occurs, providers should work to engage or refer the individual to mental health treatment, if appropriate. Separating an individual from lethal means such as firearms may increase the chance that they survive a suicidal crisis; however, treatment may be needed to address the underlying reason(s) for the suicidal behavior, whether due to a diagnosis of a mental illness, alcohol and/or substance abuse, or other circumstances. Providing continuity of care after lethal means safety counseling creates a pathway for individuals to become healthier by addressing these underlying issues.

## Barriers to Lethal Means Safety Counseling and Strategies to Overcome Them

The Consortium identified four main barriers that may hinder a healthcare provider's ability to engage in effective lethal means safety counseling. Barriers include: 1) common misconceptions related to the effectiveness of reducing access to lethal means, 2) lack of knowledge and comfort discussing firearms, 3) concerns regarding “gag” laws and other legal obstacles, and 4) lack of provider training. These barriers are presented below with suggested strategies to overcome them.

### *1. Common Misconceptions Related to Lethal Means*

Healthcare providers are not immune from common misconceptions related to lethal means. Such misconceptions include: belief that if someone is suicidal, they will substitute equally lethal means if their preferred method is not available to them (contributing to skepticism about the preventability of suicide in general);<sup>86</sup> that asking about firearms is only necessary if someone is actively suicidal; that asking about gun ownership is an adequate assessment of access (as opposed to access to others' firearms or via plans to purchase); and that patients will receive lethal means safety counseling from another care provider (e.g. an expectation that counseling will be provided prior to inpatient discharge, such that an opportunity for counseling in an emergency department is missed if the patient is being admitted). Despite evidence to the contrary, a recent study found that almost three in four emergency physicians did not believe that firearm safety counseling would lead to a reduction in attempted or completed suicides.<sup>87</sup>

Misconceptions can result in missed opportunities. One study found that though pediatricians believed families with guns should receive firearm safety counseling, they underestimated the likelihood of gun ownership in specific families.<sup>88</sup> Another study found that 58% of internists surveyed did not ask patients about gun ownership, let alone access to firearms or future intentions to purchase firearms.<sup>89</sup> Key opportunities to provide lethal means safety counseling were missed because providers were relying on false assumptions.

Solution: Providers should be educated on suicide and the impact of access to lethal means, basic statistics related to gun ownership and risk of firearms in the home, and suicide risk assessment and interventions that decrease risk, including lethal means safety counseling, to help dispel myths and overcome common misconceptions.

### *2. Lack of Comfort/Knowledge of Firearms*

A majority of healthcare providers do not own and may not be familiar with firearms.<sup>90,91,92,93</sup> One study found that gun-owning physicians were less likely to express support for clinician counseling, but they were more likely to report that they actually counseled their patients on firearm safety, potentially indicating that personal familiarity with firearms increased comfort in discussing them.<sup>94</sup> However, another study found that emergency physicians who owned firearms were *less* confident than non-gun owning peers in using the “5 As” (Asking, Advising, Assessing, Assisting and Arranging follow-up contacts) to discuss firearms with their patients, perhaps mediated by support for physician counseling; lower confidence was associated with a lesser likelihood to counsel patients. In the same study, a majority of physicians did not believe that their patients would view them as a good source of information nor accept their guidance on

firearm safety; these physicians were also less likely to counsel patients than their peers.<sup>95</sup> Nearly half of psychiatrists surveys cited “lack of personal expertise on firearms” as a perceived barrier to discussing firearm safety with patients.<sup>96</sup>

While patients may be open and receptive to their physicians’ counseling on firearm safety (see *Research on Lethal Means Safety Counseling*, page 13), they do appear to share doubt about their providers’ knowledge about gun safety.<sup>97</sup> Additional research is needed to further understand the relationship between provider gun ownership, comfort discussing firearms, or knowledge and beliefs and practices regarding lethal means safety counseling.

Solution: For those unfamiliar with firearms, a brief overview as part of provider training on lethal means safety counseling could improve providers’ comfort level and confidence in inquiring about and discussing firearms. This firearms overview could be provided by a community partner with firearms expertise, such as a firearms instructor. For more information, see *Who Should Conduct the Training*, page 23.

### 3. “Gag Laws” and Other Legal Obstacles

Recent state legislative proposals, known as “gag laws,” have been aimed at hampering a clinician's ability to ask their patients about firearm ownership. These proposals have been opposed by numerous national medical, public health, and law organizations. Notably, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association (ABA) jointly “oppose state and federal mandates that interfere with physician free speech and the patient–physician relationship, including laws that forbid physicians to discuss a patient's gun ownership.”<sup>98</sup> This year, the full U.S. Court of Appeals for the Eleventh Circuit struck down portions of a Florida law that prohibited physicians from asking patients about firearms ownership, ruling that the law violated physicians’ First Amendment rights to free speech.<sup>99</sup> Despite this ruling, other states are likely to continue pushing forward with similar legislation; the issue of gag laws and free speech between provider and patient should be monitored.

Gag laws are not the only legal concern relevant to lethal means safety counseling. In some states, universal background check laws limit the persons to whom a firearm can be legally transferred for temporary safer storage. Clinicians are concerned that when recommending a patient store their firearm away from home, they have to be mindful of universal background check laws as they may lack understanding of local firearms transfer requirements. Other firearms statutes such as those regulating purchase and possession also vary by state. Clinicians are advised to be aware of laws where they practice and how they or their patients may be impacted by them.<sup>100</sup>

Solution: Provider trainings should provide an overview of relevant local and state laws and judicial decisions regarding their validity. For an overview, McCourt et al (2017) outlines each state’s background check laws and provides an overview of legal obstacles that may occur when temporarily transferring firearms out of the home.<sup>101</sup>



#### 4. Lack of Training

Across disciplines, too few providers are formally trained in lethal means safety counseling. A 1997 study of family physicians found that only 1 in 5 survey respondents received formal training on how to counsel patients on firearms safety,<sup>102</sup> and in 2000, just 1 in 3 pediatricians thought they were sufficiently trained to discuss firearms.<sup>103</sup> This has not been resolved in the decades since, as demonstrated by the following studies:

- Psychiatrists: Over half of respondents had not received information about firearms safety; of those who had, the most common sources were professional journals and meetings. Just over a quarter had a routine system for identifying patients who owned firearms.<sup>104</sup>
- Social Workers: Three-quarters of social workers surveyed had not received training on firearms safety counseling. While 1 in 3 assessed for firearms access with their clients on a regular basis, just 1 in 6 routinely counseled on firearm safety. Social workers who endorsed that they were not adequately trained on the topic of firearm safety were significantly less likely to assess or counsel on firearms.<sup>105</sup>
- Clinical psychologists: Nearly half had not received any training on firearm safety issues. Less than a quarter of psychologists surveyed had a routine system for identifying patients with access to firearms or routinely charted or kept record of whether patients had access to firearms.<sup>106</sup>
- Emergency physicians: Over 95% had never received formal training on firearm safety counseling and nearly 93% did not routinely chart patient information regarding gun ownership.<sup>107</sup>

It is no surprise that providers have not received training. A 2016 systematic review of literature on firearm safety training programs for healthcare providers and trainees found just four programs that met their inclusion criteria.<sup>108</sup> Those involved in administering training face barriers related to lack of materials, guidelines, and expertise. For example, a 2008 survey of psychiatric residency directors identified “lack of standardized teaching material for training the residents” and “lack of faculty expertise on firearm issues in our residency training program” as the two most common barriers to implementing firearm injury prevention training. Moreover, the survey found that the mean didactic time directors reported spending on firearm injury prevention training throughout residency was less than an hour, with 87 program directors reporting that they spent no time on the topic at all. Of importance, less than 5% of directors surveyed reported “patients are not interested in firearm injury prevention” and that “psychiatrists cannot affect patients’ gun behavior by counseling their patients” as perceived barriers.<sup>109</sup>

Similarly, a 2011 survey of graduate psychiatric nursing programs found that the main perceived barriers to providing firearm injury prevention training to their students were a lack of faculty expertise on firearm injury prevention, lack of professional guidelines, and lack of standardized teaching materials.<sup>110</sup>

Solution: Professional training is needed to teach providers how to counsel patients on lethals means safety; this report is intended to serve as guidance for organizations interested in developing of such training. Research has demonstrated that training can



improve clinician practice of firearms safety screening and counseling at various points in a clinician's career.<sup>111</sup> For example, a study of a web-based curriculum on delivering counseling for firearm injury prevention found an increase in pediatric residents' feelings of self-efficacy in providing such counseling to patient-families,<sup>112</sup> which in turn can increase likelihood of a clinician providing firearm safety counseling in the future.<sup>113,114</sup> In a study of more experienced providers, primary care physicians working with elderly patients (the highest-risk demographic for firearm suicide) were significantly more likely to assess access to firearms had they received continuing medical education training in suicide risk assessment,<sup>115</sup> indicating promise for similar impacts following training in lethal means safety counseling. Psychiatrists who received information on firearm safety were over 13 times more likely to counsel patients regarding firearms than the majority of their peers who had not received information on this topic.<sup>116</sup>

## V. TRAINING PROVIDERS ON LETHAL MEANS SAFETY COUNSELING

Despite the strong consensus among professional groups that healthcare providers should counsel patients at risk for suicide regarding their access to firearms, the field lacks guidelines for professional training. For example, the American Academy of Pediatrics recommends that pediatricians advise parents of children at risk for suicide to remove all guns and ammunition from the home,<sup>117</sup> but provides no guidance on how to best have these conversations. Moreover, there is no discussion on how pediatricians should be trained in order to gain these communication skills. However, there are indications that this tide may be turning. For example, the American Medical Association (AMA) has issued the following policy, updated in 2017, which states they will develop guidance on *how* to counsel on lethal means access:

Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.<sup>118</sup>

Healthcare providers, having identified the need for additional training in the course of their professional experiences, are supporting group efforts by speaking up independently. For example, in a recent opinion article in *JAMA Internal Medicine*, Dr. Chana Sacks highlights the need for more training on firearm counseling skills in undergraduate and graduate medical education as a way for the medical community to improve firearm suicide prevention efforts.<sup>119</sup> Medical students, too, are highlighting the need to be trained on how to ask questions about firearms and provide counseling on firearm safety.<sup>120</sup>

**Note on Recommendations:** The following subsections provide the Consortium’s recommendations for the training of healthcare providers on lethal means safety counseling. These recommendations are provisional, based on the best available research and collective expertise of the Consortium’s Lethal Means Safety Workgroup, and are subject to revision based on empirical studies yet to be conducted. As detailed in the next section, *Future Research*, there is a great need to devote resources to rigorously developing and evaluating empirically-based training interventions to further this body of knowledge.

### Training Logistics

#### *Who Should be Trained?*

Lethal means safety counseling training should be provided to all trainees in medicine, mental health, nursing, and related clinical healthcare fields, and made available to more experienced clinicians as well.

Additional specialization should be based on setting, such that those providers who interact with patients - especially if the patients are high-risk - at entry points to the healthcare system are trained. This in-depth training should reach providers in the following settings:

- Primary care (family medicine, internal medicine, pediatrics, geriatrics, and OB-GYN)
- Emergency and urgent care, as well as crisis centers
- Behavioral health

The types of providers receiving in-depth training across such settings should include:

- Physicians
- Physician assistants
- Nurses and nurse practitioners
- Psychologists
- Counselors
- Social workers

#### *Who Should Conduct the Training?*

Healthcare providers experienced in lethal means safety counseling as well as similarly qualified educators in healthcare education programs are potential trainers.

It may be valuable to include trainers with various backgrounds and expertise, such as pairing a healthcare provider with a firearms expert who can provide information about firearms as well as lend credibility or buy-in from the gun-owning community (gun store owner, range instructor, etc.). Programs such as the Gun Shop Project, which developed out of a partnership between the New Hampshire Firearms Safety Coalition, the Means Matter program at the Harvard T.H. Chan School of Public Health, and other stakeholders, are being replicated in approximately two dozen states. These partnerships provide examples of how public health and firearms professionals can work together on reducing access to lethal means for firearm suicide prevention.<sup>121,122</sup>

#### *When and Where Should Training Occur?*

Lethal means safety counseling training should be taught and repeated throughout the lifecycle of clinical practice. This multi-level process should start in the classroom, be practiced in supervised clinical training settings, and then be reinforced in continuing education:

- (a) Initial education: Providers should receive initial education on lethal means safety counseling while they are still in the classroom in their healthcare provider education programs. For example, lethal means safety counseling could be integrated into suicide prevention curriculum in medical students' first and second year classroom instruction.
- (b) Skills application: Lethal means safety counseling skills should be taught again and practiced in supervised clinical training settings such as practica, internships, fellowships, and residencies, both formally (e.g. in lectures) and informally (e.g. as relevant cases or topics arise in supervision). Continuing with the example of medical students, their skills could be developed and reinforced through instruction during relevant third and fourth year clinical rotations.

- (c) Skills maintenance/continuing education: Providers should be offered and receive continuing education on lethal means safety counseling. Continuing education should be modeled after existing refresher trainings on similar topics and could be integrated into grand rounds, society meetings and conferences, and web-based trainings. Opportunities should also be available for established providers to obtain introductory level education and skills practice if they have not yet learned about lethal means safety counseling.

## Training Content

Table 4 provides an overview of the five key features of lethal means safety counseling training: parsimony, relevance, engagement, practice, and resources.

**Table 4.** Recommended Features of Lethal Means Safety Counseling Training

Feature	Explanation
Parsimony	Clinicians and trainees balance extensive demands on their time and energy; thus, training should thus be quick and easy.
Relevance	Training should be relevant to providers' work and with clear benefit, including improved patient outcomes (preventing suicides) as well as professional development (such as by offering Continuing Education Credits for completing training).
Engagement	In-person training is ideal for participant engagement, but online options including webinars and podcasts are practical alternatives or supplements. Students could be assigned projects or papers on lethal means safety so that they develop a deeper understanding of the topic.
Practice	Practice via role play can help increase comfort broaching an uncomfortable topic. Supervised clinical training provides opportunities for real-world skills application and examples of how lethal means safety counseling may be conducted.
Resources	Trainings should include take-away materials for providers to refer to later. The format of these resources should be tailored to the audience and may include pocket cards, online resources, and acronyms for use as memory aids. For example, the <i>Means Matter</i> program at the Harvard T.H. Chan School of Public Health provides a handout, <i>Recommendations for Clinicians</i> , that serves as a quick and practical resource for clinicians. <sup>123</sup>

### *What Information Should be Included?*

Evidence to address common misconceptions: To overcome potential misconceptions that providers may hold about suicide and firearms, it is critical to include an overview of research evidence that establishes why reducing access to lethal means - particularly firearms - is important for suicide prevention. This should include risk factors for suicide, addressing common myths including those surrounding method substitution, suicide risks of gun ownership, preventability of suicide deaths, and support from firearms advocates. For additional resources on suicide prevention, lethal means, and lethal means safety counseling, see Appendices 1-2.

Counseling techniques: Trainings should include an introduction to or review of basic counseling skills, including how to assess for suicide risk factors, active listening techniques, and basic approaches to influencing behavior change such as motivational interviewing.

Information about firearms: One of the barriers to lethal means safety counseling is a lack of comfort with firearms. While healthcare providers are not expected to be nor need to be experts on guns, basic knowledge about firearms, how they work, and how they can be stored gives providers more credibility when talking about firearms with patients and may increase their comfort level in engaging in those conversations. This portion of training may be provided by an expert from the firearms community, as there are potential partners who are focused on firearm safety and responsibility. Collaborations such as the Gun Shop Project have been successfully replicated across the country (such as in Colorado) demonstrating that diverse stakeholders can and do build partnerships for firearm suicide prevention.<sup>124</sup> Some providers may also appreciate the opportunity to go to a gun range, take a gun safety class, and handle a firearm. Additionally, clear information on how and where patients can safely store firearms outside of their home is critical to include in training.

How to respond when patients have access to a gun: It is important that training address how a counselor may respond when an at-risk individual does have firearm access, including safer storage options both in and out of the home, safety planning, what to do if there are guns but the patient refuses safety steps (including roles/responsibility/liability for providers), and available legal mechanisms to temporarily separate at-risk individuals from firearms (for example, Gun Violence Protection Orders).

Legal information: It is important for trainees to have a basic understanding of relevant legal information. This includes state and local policies regarding the transfer of firearms to third parties and safe temporary storage of firearms, gag laws, and reporting requirements for the National Instant Criminal Background Check System (NICS). See the Law Center to Prevent Gun Violence (<http://smartgunlaws.org/>) and Everytown for Gun Safety's Gun Law Navigator (<https://everytownresearch.org/navigator/>) for good policy overviews.

Additional content resources: Researchers and providers experienced in lethal means safety counseling have also published papers with detailed and practical guidance for fellow clinicians and recommendations for training that may be useful in developing training content. Suggested examples include:

- Coverdale, Roberts, & Balon (2010)<sup>125</sup>
- Betz & Ranney (2016)<sup>126</sup>
- Wintemute, Betz, & Ranney (2016)<sup>127</sup>

**Integrating New Research:** New research is emerging regarding practical and specific information to include in lethal means safety counseling, including when, how, and what to ask patients about firearms and lethal means safety. As the body of research grows, the content of lethal means safety counseling training should also be updated to reflect the best available evidence-based practices.

## Models for and Examples of Lethal Means Safety Counseling Training

Lethal means safety counseling training could be developed into standalone modules and/or integrated into existing suicide prevention trainings. A standalone training in lethal means safety counseling could be modeled after an established and evidence-based training such as Applied Suicide Intervention Skills Training (ASIST), a two-day gatekeeper training program aimed at developing “suicide first aid” skills and competencies for laypersons.<sup>128</sup> Standalone modules have the potential benefit of providing a focused, in-depth training that may be implemented across diverse settings. Alternatively, discussions of firearms or lethal means could be added to existing suicide prevention trainings. Price and colleagues proposed that “firearms accessibility is a natural extension of current psychiatric practices of means restrictions” as related to medication-related suicides.<sup>129</sup> Integrating new content into existing training procedures may be easier to implement and require fewer resources.

Importantly, there are training courses for lethal means safety counseling publicly available. The most prominent of these is CALM: Counseling on Access to Lethal Means, which is presented by the Suicide Prevention Resource Center and is available both online and as an in-person course.<sup>130</sup> An evaluation of the CALM training demonstrated that 65% of training participants engaged in counseling about access to lethal means by a six-week follow-up, as well as reported changes in attitudes, beliefs, and skills regarding conducting lethal means safety counseling.<sup>131</sup> Additional webinar-style trainings are presented by the Massachusetts Medical Society (in both a free version as well as one offering CME credits)<sup>132</sup> and the American Psychiatric Association.<sup>133</sup> See Appendix 2 for a list of courses.

## VI. FUTURE RESEARCH

While the need for lethal means safety counseling is well-established, the evidence base for techniques in lethal means safety counseling and training requires further development. This provides researchers with a unique opportunity to advance the field of suicide prevention through establishing best practices for lethal means safety counseling and training.

### Research Needed to Fill Knowledge Gaps

#### *Best Practices in Effective Screening for Suicide Risk*

Research is needed to know how to effectively screen for suicide risk. A 2012 systematic review found that screening for suicide risk is critically important, but of the 56 unique studies examined there was little evidence that primary care screening tools could actually identify adults at an increased risk of suicide. Thus, additional research on screening is critically needed.<sup>134</sup>

#### *Best Practices in Lethal Means Safety Counseling*

Of utmost importance, best practices for techniques in lethal means safety counseling itself must be established. Specifically, research is needed to determine:

- (a) when to engage in a conversation on lethal means safety; and
- (b) which techniques or approaches are most effective in counseling on lethal means safety among different target audiences (including by varying demographics, locations, etc.).

#### *Best Practices in Training*

Best practices must also be established on how to train healthcare providers (and other potential messengers) on providing lethal means safety counseling to their clients, patients, or other audience. Specifically, research is needed to determine:

- (a) how healthcare providers should be trained;
- (b) what information about firearms and suicide is critical for lethal means safety counselors to know;
- (c) which training techniques are most effective; and
- (d) what costs are involved in lethal means safety training.

Any training program on lethal means safety counseling should be rigorously evaluated.

#### *Additional Research*

It may also be valuable to survey providers' knowledge of firearms safety and suicide more generally. Specifically, are healthcare providers informed about the risks of firearms and preventability of suicide? For example, do providers know that the presence of guns in the home increase risk of suicide by firearm? Are pediatricians aware that most children who are killed by guns die by suicide? In addition, are healthcare providers knowledgeable about firearm safety and storage, including the pros and cons of storage options and common attitudes regarding those options? Understanding the current status of healthcare providers' knowledge, which may



vary greatly by field/specialty, geography, and personal experience, could help to develop supplements to lethal means safety counseling training.

Finally, additional translational research is needed to guarantee that lethal means safety counseling is effectively disseminated and used in clinical settings.<sup>135</sup>

## Funding Needed to Support Research

### *Increasing Federal and State Funding and Lifting the Prohibition of CDC funding*

Research funding is needed to understand the best methods for conducting lethal means safety counseling and the best methods for how to train providers to counsel on lethal means safety. More generally, funding is desperately needed to further research the root causes and potential solutions to the gun violence epidemic. Federal and state funding would fill a critical need for the advancement of this area of public health research.

Over twenty years ago, Congressman Jay Dickey (R-AR) authored an amendment in the 1996 Omnibus Consolidated Appropriations Bill which mandated that, “none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control” (known as the “Dickey Amendment”).<sup>136</sup> The amendment further reallocated \$2.6 million in CDC funds, the exact amount which had been set aside for firearm injury research the previous year. The result has been an ongoing dearth of federal funding and a chilling effect on gun violence research for the past two decades, to the degree that gun violence, as compared to other leading causes of death, was the second least funded and the least researched cause of death in the US in relation to mortality rates from 2004-2015.<sup>137,138</sup>

#### CENTERS FOR DISEASE CONTROL AND PREVENTION

##### DISEASE CONTROL, RESEARCH, AND TRAINING

To carry out titles II, III, VII, XI, XV, XVII, and XIX of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, and sections 20, 21 and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980; including insurance of official motor vehicles in foreign countries; and hire, maintenance, and operation of aircraft, \$2,262,698,000, of which \$30,553,000 shall remain available until expended for equipment and construction and renovation of facilities, and of which \$32,000,000 shall remain available until September 30, 1998 for mine safety and health activities, and in addition, such sums as may be derived from authorized user fees, which shall be credited to this account: *Provided*, That in addition to amounts provided herein, up to \$48,400,000 shall be available from amounts available under section 241 of the Public Health Service Act, to carry out the National Center for Health Statistics surveys: *Provided further*, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control: *Provided further*, That the Director may redirect the total amount made available under authority of Public Law 101-502, section 3, dated November 3, 1990, to activities the Director may so designate: *Provided further*, That the Congress is to be notified promptly of any such transfer: *Provided further*, That the functions described in clause (1) of the first proviso under the subheading “mines and minerals” under the heading “Bureau of Mines” in the text of title I of the Department of the Interior and Related Agencies Appropriations Act, 1996, as enacted by section 101 (c) of the Omnibus Consolidated Rescissions and Appropriations Act of 1996 (Public Law 104-134), are hereby transferred to, and vested in, the Secretary of Health

The same language as the Dickey Amendment has also applied to the National Institutes of Health (NIH) since the Consolidated Appropriations Act of 2012, but the two agencies responded differently; the NIH funded a three-year violence research program with a focus on

gun violence from 2013-2016, but that program was not renewed at the end of its term.<sup>139,140</sup> The National Institute of Justice (NIJ) also issued a request for grant applicants for a three-year firearm violence prevention research program in 2016.<sup>141</sup> Reinstating, enhancing, and sustaining funding for these programs is critical for the advancement of public health research.

In 2016, 141 medical organizations, representing over one million healthcare professionals, signed onto a letter urging Congress to resume funding research on gun violence.<sup>142</sup> This letter, which begs for funding to research issues such as how to protect children from unintentional firearm injuries and how to prevent firearm suicide, represents a clear desire from the scientific community to better understand why gun violence claims so many lives in the United States. The Consortium wholly supports this effort and joins the call to Congress to resume funding research on gun violence.

## VII. CALL TO ACTION

Lethal means safety counseling should be an essential part of comprehensive provider-based suicide prevention programs. Most providers receive little to no formal training on how to speak to their patients or clients about firearm safety. Those who are engaged in curricula development for and training of healthcare providers have an opportunity to shift the landscape of firearm suicide prevention by developing, implementing, and evaluating lethal means safety training programs at every level and stage of clinical education and practice.

The Consortium for Risk-Based Firearm Policy endorses and supports efforts among training programs that will equip healthcare providers to deal tactfully, respectfully, and directly with the issue of firearms and suicide. Provider training programs should include lethal means safety counseling training, either as a standalone module or integrated into existing curriculum on suicide risk assessment. This training should be offered to all trainees and repeated throughout the lifecycle of clinical practice. The Consortium strongly supports and encourages additional research to further elucidate best practices on lethal means safety counseling and best practices for training healthcare providers on how to provide the most effective method of counseling.

The Consortium for Risk-Based Firearm Policy endorses and supports efforts among training programs that will equip healthcare providers to deal tactfully, respectfully, and directly with the issue of firearms and suicide.

## VIII. APPENDICES

### Appendix 1. Resources on Suicide Prevention

#### *National Suicide Prevention Lifeline*

If you need help, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or go to [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org). If you are deaf or hard of hearing, you can contact the Lifeline via TTY at 1-800-799-4889.

#### *Resources on Suicide Prevention*

There are a variety of excellent resources available on suicide prevention, many of which are tailored for specific audiences or populations. Listed below are a selection.

- American Association of Suicidology: <http://www.suicidology.org/>
- American Foundation for Suicide Prevention: <https://afsp.org/>
- Defense Suicide Prevention Office, Department of Defense: <http://www.dspo.mil/>
- National Action Alliance for Suicide Prevention: <http://actionallianceforsuicideprevention.org/>
- National Institute of Mental Health: <https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>
- Suicide Awareness Voices of Education: <https://save.org/>
- Suicide Prevention Resource Center: <http://www.sprc.org/>
- The Trevor Project: <http://www.thetrevorproject.org/>
- Violence Prevention Division, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention: <https://www.cdc.gov/violenceprevention/suicide/index.html>

## Appendix 2. Resources on Lethal Means Safety and Counseling

### *Resources on Lethal Means Safety*

The following resources provide information and resources on lethal means safety for a variety of different audiences:

- **Means Matter**, Harvard T.H. Chan School of Public Health. <https://www.hsph.harvard.edu/means-matter/>.
- **Reducing Access to Lethal Means**, Suicide Awareness Voices of Education. <https://save.org/about-suicide/preventing-suicide/reducing-access-to-means/>.
- **Firearms and Suicide Prevention Program**, American Foundation for Suicide Prevention in partnership with National Shooting Sports Foundation. <https://afsp.org/our-work/education/firearms-suicide-prevention-program/>.

### *Webinar Trainings on Lethal Means Safety Counseling*

The following trainings are available as webinars on lethal means safety counseling training:

- **CALM: Counseling on Access to Lethal Means**. Suicide Prevention Resource Center. <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>.
- **Prevention of Firearm Suicide in the United States: What Works and What Is Possible**. October 2016. Live American Journal of Psychiatry (AJP) Continuing Medical Education (CME). American Psychiatric Association. <http://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=3652>.
  - CME based on article of the same title published in AJP: Mann, J. J. & Michel, C. A. (2016). Prevention of firearm suicide in the United States: what works and what is possible. *American Journal of Psychiatry*, 173(10), 969-979. <https://doi.org/10.1176/appi.ajp.2016.16010069>
- **Talking to Patients About Gun Safety**. February 9, 2017. Massachusetts Medical Society.
  - Free Version: <http://www.massmed.org/Continuing-Education-and-Events/Conference-Proceeding-Archive/Talking-to-Patients-About-Gun-Safety-Webinar/#.WYuOamLyuUk>.
  - For those seeking CME Credits: <http://www.massmed.org/Continuing-Education-and-Events/Online-CME/Courses/Patient-Conversations-About-Firearms/Talking-to-Patients--About-Gun-Safety/>.
- **Preventing Suicide in Emergency Department Patients**. (2017). Suicide Prevention Resource Center. <http://training.sprc.org/enrol/index.php?id=8>.

## Appendix 3. Means Matter - Resources for Clinicians.

### Means Matter

Suicide, Guns & Public Health

#### Recommendations for Clinicians

If you're concerned that a patient or client is suicidal, in addition to using your standard clinical strategies to assess and manage suicidal risk, talk with them and their family members about whether there are firearms and other lethal means at home.

##### Speak with the Client's Family and Loved Ones

(If the client is an adult, follow your agency's protocols regarding gaining the client's permission to contact family/loved ones)

- Explain that you're concerned their loved one is at risk for suicide.
- Ask if there are firearms at home and explain why you're asking (the presence of a gun increases the chance that a suicide attempt will be fatal).
- Ask the men too. When clinicians speak with a parent, it is often the mother. Women don't always know when their male partner has a firearm at home. If possible, speak with all adults in the home.
- Ask about all firearms. If there's one gun, there's usually more than one.
- Assess each relevant household (e.g., for a teenager in a joint custody situation, ask about both parent's homes).
- Advise that the safest option is not having firearms at home until the situation improves. (See our *Questions about Removing or Storing Firearms* document.)
- Local law enforcement may be able to store the guns (or dispose of them). (Don't state that this is a definite option unless you're acquainted with the agency's policy; not all agencies provide this service.)
- Sympathize with gun owners who find the option of living without a firearm at home, even temporarily, very difficult. Don't minimize that this is a tough sacrifice. You're all on the same team trying to keep the patient safe. But be firm that the safest option is keeping guns out of a suicidal person's home.
- Storing the firearms at a trusted friend's or relative's until the situation improves may be an acceptable option to the owner. Not everyone can hold on to firearms, however.\*
- Locking the firearms up is also an option if the family won't remove the guns, but it's not the safest option. Lock all firearms unloaded in a safe designed for firearms or in a tamper-proof, locked storage place. Lock the ammunition separately. Better yet, advise the family not to keep ammunition at home until the situation improves. Be sure the keys or combinations aren't accessible to the person at risk.
- Hiding unlocked guns is not advised. Remember, kids know their parent's hiding places!
- Document in your notes that you've reviewed this information with the family.
- Don't limit your conversation to lethal means. Lethal means counseling is only one part of a comprehensive approach to activating the client's support system.

##### Speak with the Adult Client

- Review the same information as above.
- Express your concerns about his or her safety and your wish to keep them safe.
- Get releases to talk with important family members or other concerned parties. Enlist them in keeping lethal means out of the home and providing other support.

For more information: [www.meansmatter.org](http://www.meansmatter.org)

Last updated: 7/1/2008



- Help the client understand that risk sometimes escalates rapidly - for example right after a fight with a family member. Not having lethal means quickly at hand is like keeping the keys to the car away from a person who's been drinking. It reduces bad outcomes in volatile situations.
- Advise removing firearms and other lethal means if the client is at risk for suicide.
- Enlist a support person to make the actual transfer if doing so would be risky for the client.
- Document in your notes that you've reviewed this information with the client.
- Assess the client's compliance. Compliance is a good sign that they are trying to stay safe. If he or she is at high risk and has not agreed to remove guns (or, for example, has stockpiled medication and won't remove it), will he agree to do so if you think it could help him avoid hospitalization?
- Follow your agency's policies regarding taking more extreme steps such as contacting police and/or hospitalization if the person is in acute danger and has not removed lethal means or removing lethal means is not enough to keep them safe.
- Assess suicidal risk on an ongoing basis; things can improve or deteriorate rapidly.
- Note: Most people who kill themselves (except with pills) do so on their first attempt. Many never sought treatment for suicidal feelings. As a clinician, you may come into contact with them over some other issue--marriage counseling, court-remanded anger management, substance abuse treatment, etc. This underlines the importance of including suicide assessment with all clients.

## Medications

- Limit prescriptions of lethal medications to suicidal patients to a non-lethal quantity.
- Call the Poison Control Hotline if you need help determining a non-lethal quantity: 1-800-222-1222.
- Advise clients and families to remove lethal doses from the home. See Maine Medical Center's *Safe Medication Disposal Guidelines* available at: [http://www.mmc.org/mmc\\_body.cfm?id=4535](http://www.mmc.org/mmc_body.cfm?id=4535).

## \*People Prohibited from Receiving Firearms

Under federal law, 18 U.S.C. § 922(d), no person may purchase or possess a firearm if they fall into the following categories, nor may any person knowingly sell, deliver, or otherwise transfer a firearm to any person falling into these categories:

- Is under indictment for or has been convicted in any court of a felony;
- Is a fugitive from justice;
- Is an unlawful user of a controlled substance (drug user);
- Has been adjudicated as a mental defective or committed to a mental institution;
- Is an illegal alien;
- Has been dishonorably discharged from the armed forces;
- Has renounced his or her citizenship;
- Is subject to a court order issued after a hearing which restrains him or her from intimate partner violence; or
- Has been convicted of a misdemeanor domestic violence offense.

For more information: [www.meansmatter.org](http://www.meansmatter.org)

Last updated: 7/1/2008

Source: Harvard T.H. Chan School of Public Health. [https://cdn1.sph.harvard.edu/wp-content/uploads/sites/127/2012/09/Recommendations\\_for\\_Clinicians.pdf](https://cdn1.sph.harvard.edu/wp-content/uploads/sites/127/2012/09/Recommendations_for_Clinicians.pdf)



## Appendix 4. Talking to Patients About Gun Safety - Brochure.

### When should I engage with my patients about firearms?

There are a variety of clinical scenarios in which it may be useful to engage with patients about firearms. But these conversations are especially important where there is a particular risk of gun-related injury. For example, extra precaution might be needed if someone in the patient's household is a young child, is a teenager, suffers from suicidal thoughts or depression, has a history of violence, or suffers from a condition that results in an altered mental state such as drug addiction or dementia.



### How should I approach conversations with my patients about guns?

Your patients will have differing backgrounds and views when it comes to guns. Engaging in a conversation may be difficult, but we encourage you to take steps to have the discussion. Though the method of discussion will be factually and clinically specific, here are some general thoughts about how best to avoid a confrontational dialogue and provide clinically appropriate suggestions:

- Remember that most gun owners are knowledgeable about and committed to gun safety. Your gun-owning patients may have questions that you can help answer, but they may also already have all of the information they need.
- Focus on health. As a health care expert, you are equipped to advise patients about the potential health impact of guns and collaboratively brainstorm ways to reduce risk.
- Provide context for the questions. For example, include questions about firearms in routine

### Talking to Patients About Gun Safety



screening regarding household hazards for parents of toddlers and risk behavior for teens.

- Make sure the questions are not accusatory. For example, if a patient is struggling with suicidal thoughts, don't ask, "Do you have a gun?" Instead, you could say, "Some of my patients have guns at home, and some gun owners with suicidal thoughts choose to make their guns less accessible. Are you interested in talking about that?"
- Consider starting with open-ended questions to avoid sounding judgmental (e.g., "Do you have any concerns about the accessibility of your gun?" instead of "Is your gun safely secured?").
- Meet patients where they are. Where there is a risk, see if you can brainstorm harm-reduction measures with the patient, as opposed to prescribing one specific solution. For example, rather than advising a patient to get rid of a gun, you could suggest that there are a number of different ways to make guns less accessible, ranging from selling/surrendering the gun, to disposing of ammunition, to temporarily storing the gun outside the home.

Relevant Massachusetts law	Relevant Federal law
GL.c. 19A, § 15	45 C.F.R. 164.508
GL.c. 19C, § 10	45 C.F.R. 164.512(c), (e), (f), (j)
GL.c. 119, § 51(A)	45 C.F.R. 502(g)(3)
GL.c. 123, § 36B	

Health and Human Services has clarified that "the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person).

[www.hhs.gov/sites/default/files/ocr/office/letter/notification.pdf](http://www.hhs.gov/sites/default/files/ocr/office/letter/notification.pdf)  
Email questions/comments to [ProviderGuidance@hhs.gov](mailto:ProviderGuidance@hhs.gov)

Provided by:



Massachusetts Office  
of the Attorney General

Endorsed by:



MASSACHUSETTS  
MEDICAL SOCIETY

Massachusetts Chiefs  
of Police Association



Massachusetts Major  
City Chiefs of Police

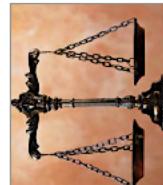


### Talking to Patients About Gun Safety

Firearm safety is a public health issue. As such, health care providers are uniquely situated to engage their patients and help prevent injury and death. Of course, most gun owners are responsible and deeply committed to gun safety. Nevertheless, they may have questions about how to keep themselves and their families safe. Some providers may not approach this topic because of concerns about how to talk about guns and what to do when troubling information is gleaned from patients.

This document is designed to provide guidance for talking to patients about guns, and on implications of those discussions for patient privacy and reporting obligations. For specific advice to give patients regarding firearm safety, please see our accompanying handout, "Gun Safety and Your Health."

### Are there any legal restrictions on my ability to talk to patients about gun safety?



No. In Massachusetts there are no restrictions on a provider's ability to discuss gun safety or to record information about those conversations in the patient's record.

### What protected health information must I report to law enforcement or to others outside of the provider-patient relationship?

#### Gunshot wounds

A physician or an administrator at his or her hospital must report all gunshot wounds to the state and local police. Providers should fill out the form provided by the Weapon-Related Injury Surveillance System (WRISS) or contact the State Police's Criminal Information Division and local police.

#### Abuse and neglect

Most health care providers are required to report any reasonable suspicion of child abuse and neglect, elder abuse, or abuse of a person with disabilities, including if such abuse or neglect involved a gun:

- Report suspected child abuse or neglect to Department of Children and Families.
- Report suspected elder abuse to the Department of Elder Affairs.
- Report suspected abuse of persons with disabilities to the Disabled Persons Protection Commission.

#### Warning or protecting potential victims

Licensed mental health care providers have a duty to warn or take steps to protect a patient's potential victim(s) if:

- The patient has communicated an explicit threat to kill or inflict serious bodily injury on a reasonably identified potential victim.
- The patient has a history of physical violence and the provider has reason to believe there is a clear and present danger that the patient will kill or inflict serious bodily injury on a reasonably identified potential victim.

In lieu of warning a patient's potential victim(s), a provider fulfills his or her duty by notifying law enforcement or initiating a voluntary or involuntary hospitalization — if these steps would be appropriate under the circumstances.

#### Court orders and subpoenas

Under state and federal law, providers must respond to court orders, grand jury subpoenas, and some administrative requests by law enforcement. This would most likely come up if a patient is a victim or suspect in a crime.



### What protected health information may I report to law enforcement or others outside the provider-patient relationship?

#### Serious and imminent threats

If a health care provider has a good faith belief that information constitutes a serious and imminent threat (to the patient or another person), the Health Insurance Portability and Accountability Act (HIPAA) allows him or her to report that information to any person, including family members and law enforcement officials, who would be reasonably able to prevent or lessen the threat.

#### Crime on the premises

A provider may report information to law enforcement if he or she believes it constitutes evidence of criminal conduct that occurred on the premises of the health care facility.

#### Crime in an emergency setting

When responding to a medical emergency, a provider may alert law enforcement to the commission and nature of a crime, as well as its location, victims, and perpetrators.

#### Minors' records

In most cases, providers can share all protected health information with a minor's parent.

#### Patient authorized information

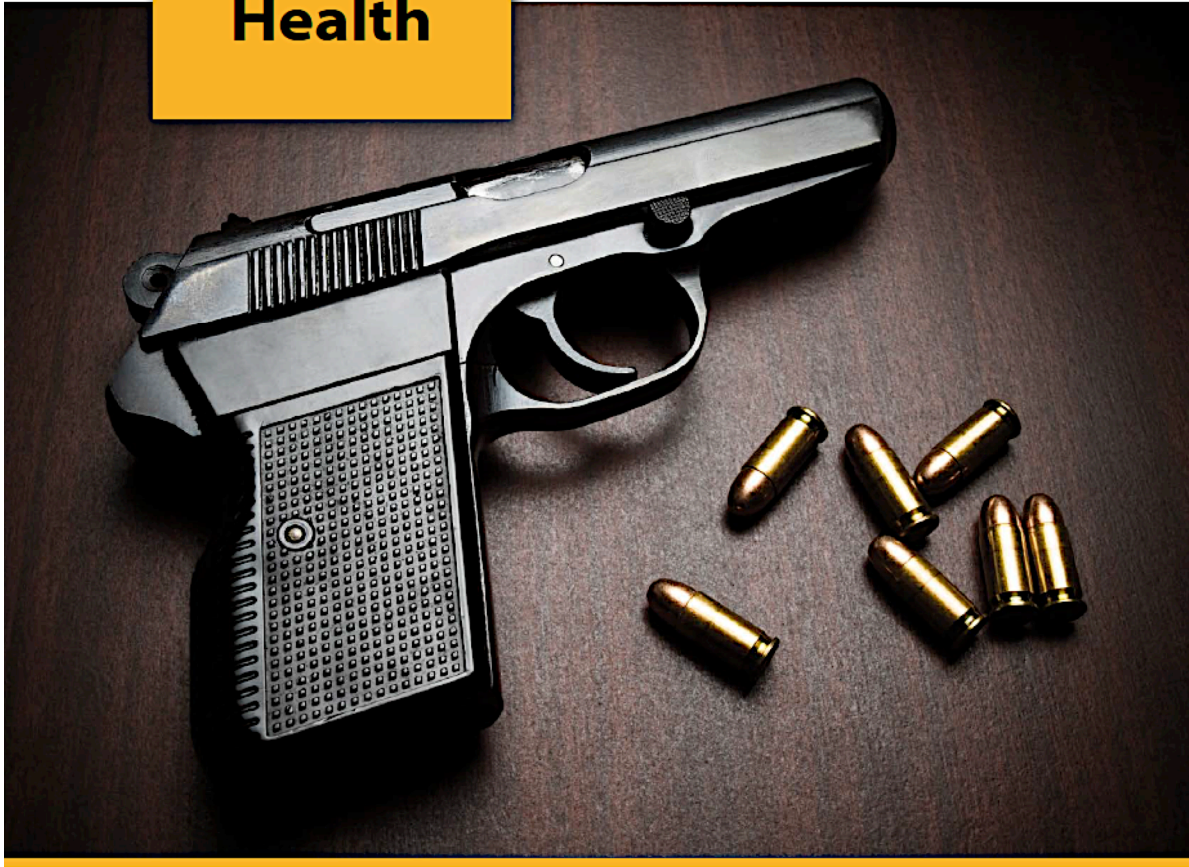
A provider may disclose information when a patient has signed a legally permissible written authorization for disclosure.

Source: Massachusetts Office of the Attorney General and Massachusetts Medical Society.  
[http://www.massmed.org/uploadedFiles/massmedorg/Patient\\_Care/Health\\_Topics/Firearm%20Guidance%20for%20Providers%20final.pdf](http://www.massmed.org/uploadedFiles/massmedorg/Patient_Care/Health_Topics/Firearm%20Guidance%20for%20Providers%20final.pdf)



## Appendix 5. Gun Safety and Your Health.

# Gun Safety and Your Health



*Provided by:*



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Massachusetts Major  
City Chiefs of Police

## Gun Safety and Your Health

Gun safety is an important part of your health and the public health. Most gun owners are responsible and deeply committed to gun safety. If you are a gun owner, live in a household where there is a gun, or otherwise might come in contact with guns, the following information may help you keep yourself and those around you safe.

Guns in the home are like any other potentially dangerous household risk, such as chemicals in cleaning supplies, backyard pools, alcohol and cigarettes, prescription medication, or fire hazards. With any of these potential hazards, you can take steps to protect yourself and your family.

Talk to your health care provider about any concerns you might have about gun safety and the potential impact on your health or the health of your loved ones.



## Safe Gun Storage

Safe gun storage is critical to the health and safety of you and your loved ones; it's also the law.

Under Massachusetts law, guns must be stored in a way that makes them impossible to operate by any person other than the owner or lawfully licensed user. This means that stored guns must be securely locked.

An owner may be fined or even imprisoned if his or her firearm is kept in a place where minors could access it. This is particularly important because more than two-thirds of gun-related deaths involving children could have been prevented if guns had been stored locked and unloaded.

The safest way to store a gun in your home is unloaded and securely locked, with the ammunition locked in a separate container.

There are many different options for gun storage, including trigger and cable locks, gun cases, lock boxes, gun cabinets,

and gun safes — all of which are widely available online and at various retail locations.

## Making a Gun Less Accessible

Guns in the home increase risk under certain circumstances. You may want to take additional steps to keep your family safe if someone in your household:

- Is a young child
- Is a teenager
- Suffers from suicidal thoughts or depression
- Has a history of violence
- Suffers from a condition that results in an altered mental state such as drug addiction or dementia

Because people in these groups are more likely to accidentally or purposely discharge a gun to hurt themselves or others, additional safety steps for your household might include storing a gun at a remote location, making ammunition inaccessible, deactivating the gun, or disposing of an unwanted gun.

### Storage at a Remote Location

As long as a gun is properly stored so that it is inaccessible to unlicensed persons, it does not legally need to be kept in the owner's home. For instance, if a gun is primarily used for hunting, it could be stored in another location when not being used for that purpose. Examples of remote locations might include:

- At another licensed person's home
- In a secure storage unit
- In a bonded warehouse for gun storage
- In a second home

An owner could also store the key to access a gun in a remote location.



### Making Ammunition Inaccessible

To reduce the chance that someone in the household uses a gun to hurt himself or herself or others, a gun

owner can dispose of ammunition or store it in another location, as long as it can't be accessed by someone without a license.

### Deactivation

A gunsmith or other certified professional can make changes to a gun so that it can no longer be fired.





## Disposing of an Unwanted Gun

There are several different options for disposing of a gun that is no longer wanted.

### *Sale to Dealers or Individuals*

Guns can be sold to licensed dealers or individuals. This is often the best option for a legally owned firearm, as it allows the owner to be fully compensated for the value of the weapon.

### *Surrender Programs*

In Massachusetts, anyone can surrender a gun to their local police department. To surrender a weapon, a person should contact the local police department to arrange a time to turn it in. The surrender program offers full immunity from prosecution for possessing the firearm.

### *Gun Buy-Back Programs*



Many cities offer gun buy-back programs, during which gun owners

receive cash, gift certificates, tax credits, or vouchers in exchange for giving their guns to the local police. Some buy-back programs are anonymous and offer immunity from prosecution for possession.

Contact your local law enforcement officials to find out if there is a buy-back program in your area.

### *Donation to Training Programs*

Some law enforcement agencies and gun safety organizations have limited budgets for purchasing weapons and will accept donations to further their training programs.

## *What to Do When a Gun Owner Who Is a Friend or Family Member Is at Risk of Violence, Suicide, or Accidental Injury*

You may want to talk to your friend or family member about safe storage or gun disposal options, as appropriate.

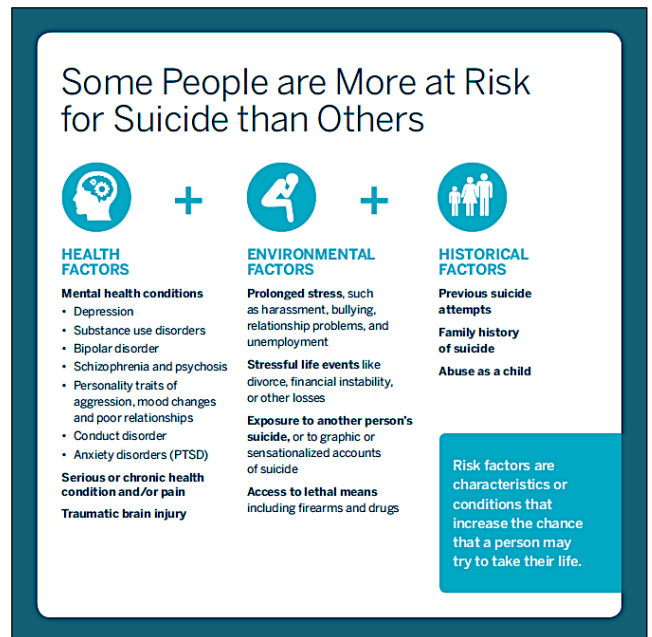
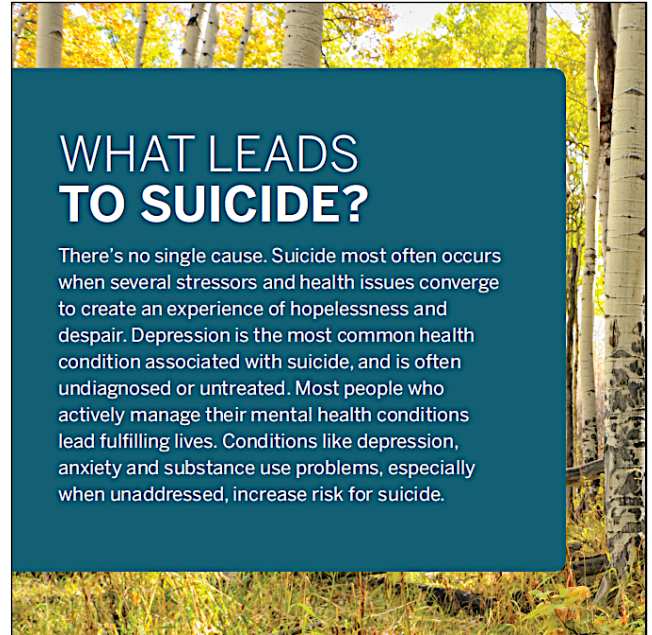
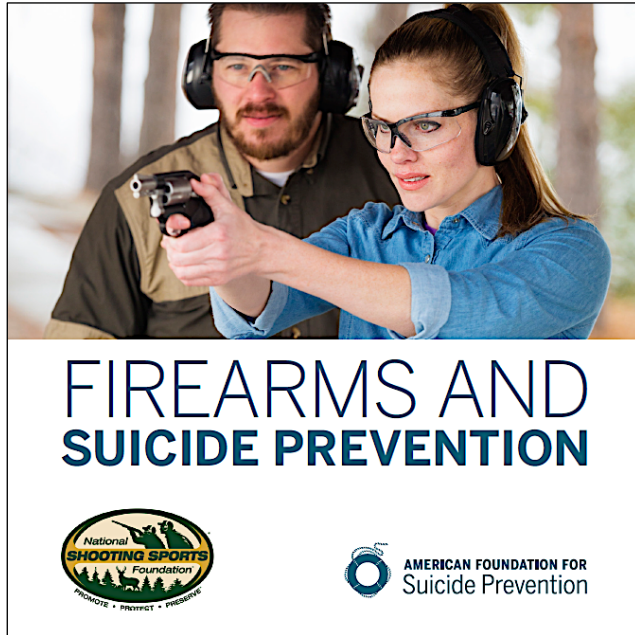
If your concern relates to mental health or substance use, you may want to recommend counseling or treatment. You can also bring your friend or family member to a primary care physician, mental health counseling center, or local emergency department for evaluation.

If you are concerned that someone you know should not have a gun because he or she might be violent, suicidal, or at risk of accidental injury, you can alert the local police.

The police department may revoke a gun license if the person does not meet the licensing requirements or is otherwise unsuitable for gun ownership.



## Appendix 6. Firearms and Suicide Prevention.





## Take Suicide Warning Signs Seriously



### TALK

If a person talks about:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Most people who take their lives exhibit one or more warning signs, either through what they say or what they do.



### BEHAVIOR

Behaviors that may signal risk, especially if related to a painful event, loss, or change:

- Increased use of alcohol or drugs
- Looking for a way to end their lives, such as searching online for materials or means
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too little or too much
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue



### MOOD

People who are considering suicide often display one or more of the following moods:

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation
- Agitation
- Rage

## Reaching Out Can Help Save a Life

**SUICIDE IS A LEADING CAUSE OF DEATH, AND IT'S PREVENTABLE**  
By keeping secure firearm storage in mind, you can help reduce the number of suicides involving firearms.

### LEARN THE RISKS AND WARNING SIGNS OF SUICIDE

If you are worried about a friend or family member, don't wait for them to reach out.

### LET THEM KNOW YOU CARE

Ask them directly about suicide and encourage them to seek help. Asking about suicidal thoughts and showing concern will not put someone at greater risk.

### IF YOU ARE CONCERNED ABOUT A LOVED ONE

Always store firearms securely and consider temporary off-site storage for firearms when not in use.

### IF YOU'RE GOING THROUGH A DIFFICULT TIME

If lawful where you live, consider giving the firearm and gun lock keys to a trusted family member or friend.

**DID YOU KNOW?**

Firearms are used in nearly 50% of all suicides in the United States.

## Firearms Storage For Your Lifestyle

As a gun owner, you can choose from multiple options for safely storing and protecting your firearms when they're not in use.

### CABLE LOCK

Starting at \$10

Requiring either a key or combination to unlock, an inexpensive cable lock runs through the barrel or action of most firearms to prevent it from being loaded and fired.

### GUN CASE

Starting at \$20

A gun case is an affordable storage solution for those looking to secure, conceal, protect or legally transport a firearm. Be sure to lock the case with an external device for added security.

### LOCK BOX

Starting at \$25

With an integrated lock, storage boxes provide reliable protection for firearms. Electronic boxes can be accessed only by using a special code or biometrics.

### FULL SIZE GUN SAFE

Starting at \$200

A gun safe allows you to safely store multiple firearms in one place.



Additional firearm safety resources are available at [ProjectChildSafe.org](http://ProjectChildSafe.org).

## RESOURCES



### Visit

Your Primary Care Provider  
Psychiatric Hospital  
Walk-in Clinic  
Emergency Department  
Urgent Care Center



### Find a mental health provider

[findtreatment.samhsa.gov](http://findtreatment.samhsa.gov)  
[mentalhealthamerica.net/finding-help](http://mentalhealthamerica.net/finding-help)



### Suicide Prevention Lifeline

1-800-273-TALK (8255)  
Veterans: Press 1



### Crisis Text Line

Text HELLO to 741-741



### CrisisChat.org



### Call 911 for emergencies



AMERICAN FOUNDATION FOR  
Suicide Prevention

[afsp.org](http://afsp.org)

Source: National Shooting Sports Foundation and American Foundation for Suicide Prevention. <https://afsp.org/wp-content/flipbooks/firearms/?page=1>



## Appendix 7. Firearm Safer Storage Options

Retaining possession of firearm		
Cable lock	Uses key or combination; usable on most firearms Cost: \$10–\$50	Must install according to directions (not around trigger); must keep key or combination away from at-risk persons; can be cut
Trigger lock	Uses key or combination; blocks trigger but does not prevent loading Cost: \$10–\$50	Never use on a loaded gun (could still fire); not usable on lever-action guns; must keep key or combination away from at-risk persons
Lock box	Uses key, combination, keypad, or biometrics; smaller than safe Cost: \$25–\$350	Firearm can be stored loaded or unloaded; lock box could be stolen; in electronic version, batteries must be replaced; must keep key or combination away from at-risk persons
Safe	Uses key, combination, or biometrics Cost: \$200–\$2500	Most secure option for multiple guns (especially long guns)
Disassembly of gun	Requires gun knowledge but ensures gun cannot be fired	Not always practical; may lose parts; may not be appealing to some patients
Personalized “smart” guns	Various technologies proposed; helps ensure that only authorized users can fire gun	Does not protect against misuse by authorized user; cannot be retrofitted
Transferring possession to others		
To a family member or friend	State laws vary widely; discuss with your practice's legal advisor or local law enforcement	May be the most feasible option for out-of-home storage (especially if stored with family), if allowed by state law
To law enforcement	Allowed in many states; discuss with your practice's legal advisor or local law enforcement	May not be appealing to some patients
To a gun range or store	Allowed in many states; discuss with your practice's legal advisor or local law enforcement	Not all stores or ranges store firearms

Source: Wintemute, G. J., Betz, M. E., & Ranney, M.L. (2016). Yes, you can: Physicians, patients, and firearms. *Annals of Internal Medicine*, 165(3), 205-213.

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