EXTREME RISK PROTECTIVE ORDERS:

A Health Intervention to Reduce Gun Violence

Extreme Risk Protection Orders:
A Health Intervention for Preventing Firearm Suicide

Co-Hosted by the Maryland Suicide Prevention Program and Educational Fund to Stop Gun Violence

May 14, 2020

EXTREME RISK PROTECTIVE ORDERS:

Today's Training

- This presentation is being recorded.
- Viewers are in view only mode.
- Please use the Q&A feature if you have questions for today's presenters.
- Please use the chat box if you have any comments.
- You must attend the full training to receive a CEU certificate – stay through the end for online CEU explanation.

Today's Presenters

Moderator:

Jen Pauliukonis

Presenters:

Josh Horwitz, JD

Shannon Frattaroli, PhD

Amy Miller, LCSW-C

THE EDUCATIONAL FUND TO STOP GUN VIOLENCE

EXTREME RISK LAWS

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EXECUTIVE DIRECTOR | EDUCATIONAL FUND TO STOP GUN VIOLENCE

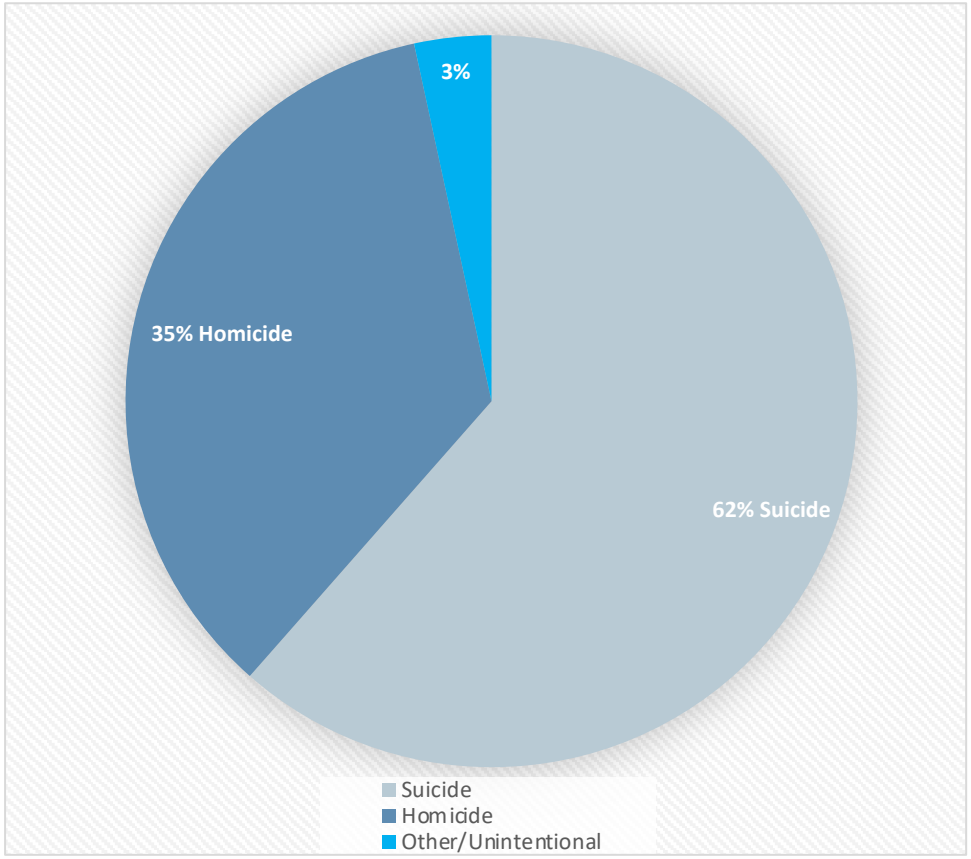
MAY 2020

The Educational Fund to Stop Gun Violence's vision is to make gun violence rare and abnormal. We are a public health think tank that produces evidence-based solutions and advocates for laws and policies that will reduce gun injury and death in all of its forms.

The Numbers

US Firearms Deaths 2018

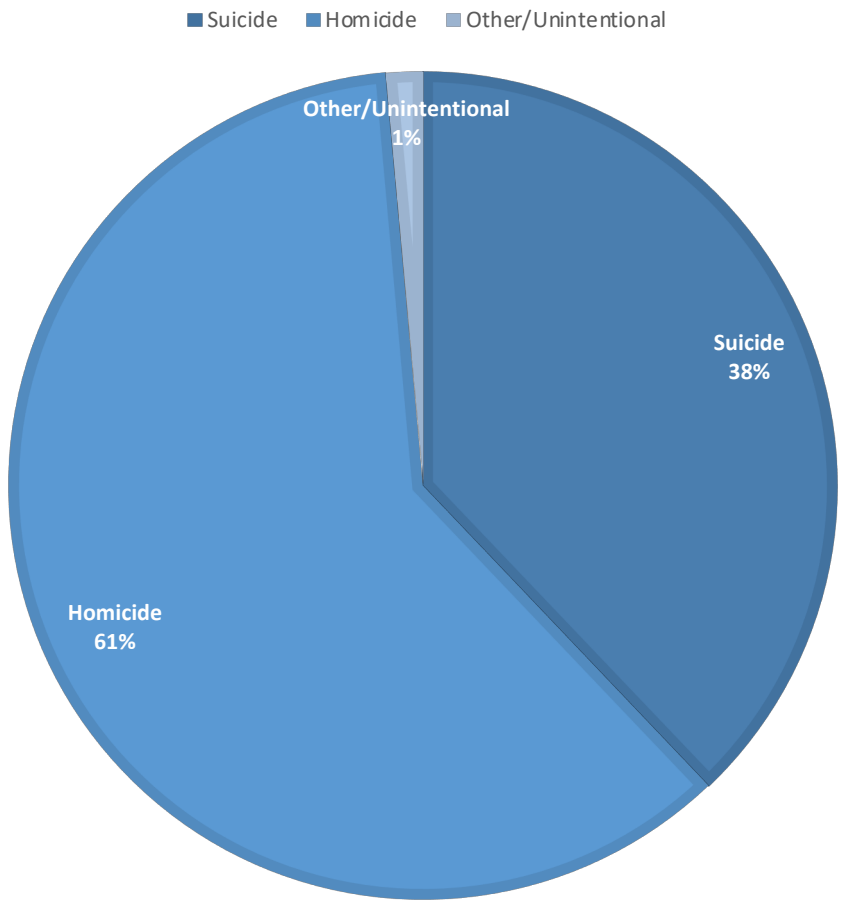
Nearly **40,000** gun deaths in 2018 and more than **71,000** non fatal gunshot injuries on average



Source: Centers for Disease Control and Prevention, National Center for Health Statistics.Underlying Cause of Death 1999-2018 on CDC WONDER Online Database.
Based on a three year average (2012-2014) of NEDS data obtained from: Gani F, Sakran JV, Canner JK. (2017). Emergency department visits for firearm-related injuries in the United States, 2006–14. *Health Affairs*.

MARYLAND FIREARM DEATHS, 2018

MARYLAND FIREARMS DEATHS IN 2018



707

total firearm deaths

Suicides: 266
Homicides: 426
Unintentional/Other: 10

Source: Centers for Disease Control and Prevention, National Center for Health Statistics.Underlying Cause of Death 1999-2018 on CDC WONDER Online Database.

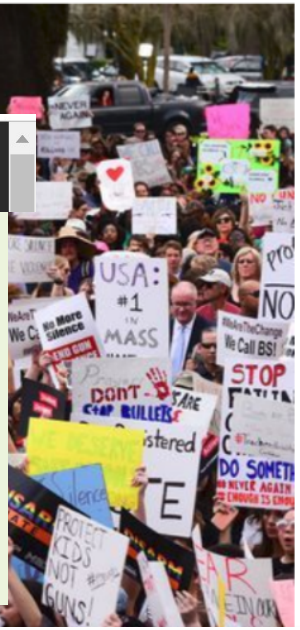
Is mental illness the cause of gun violence?

FLORIDA POLITICS / **THE BUZZ**

On gun violence, Ron DeSantis stresses mental health, internet

After Parkland, Paul Ryan cites law on mentally ill and guns, but it has limited reach

By Tom Kertscher on Monday, February 26th, 2018 at 6:00 a.m.



GALLUP What We Do Who We Are Locations Careers Store

Mass Shootings

Sorted by August 2019 results

	January 2011	September 2013	August 2019	Change since 2013
	%	%	%	pct. pts.
Failure of the mental health system to identify individuals who are a danger to others	78	80	83	+3

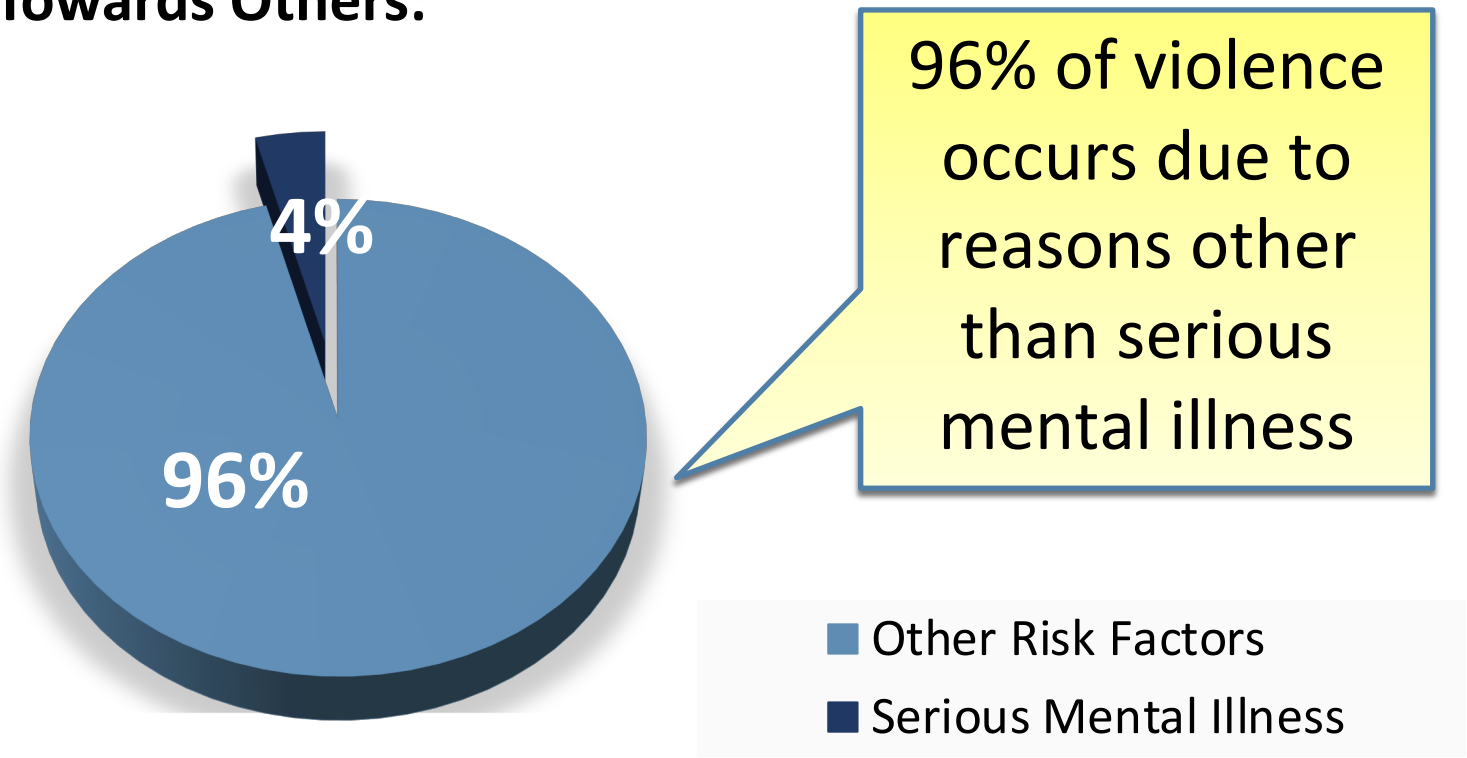
I TURNED TO THE EXPERTS…

March 2013: Convened at Johns Hopkins Bloomberg School of Public Health, Baltimore MD

- ✓ Public Health Researchers
- ✓ Mental Health Providers
- ✓ Medical Professionals
- ✓ Gun Violence Prevention Advocates
- ✓ Policy Experts
- ✓ Law Enforcement

Serious mental illness, on its own, contributes very little to overall violence towards others

Attributable Risk of Minor or Serious Violent Behavior Towards Others:



Source: Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2014). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of epidemiology*.

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SIGNIFICANT RISK FACTORS FOR INTERPERSONAL VIOLENCE

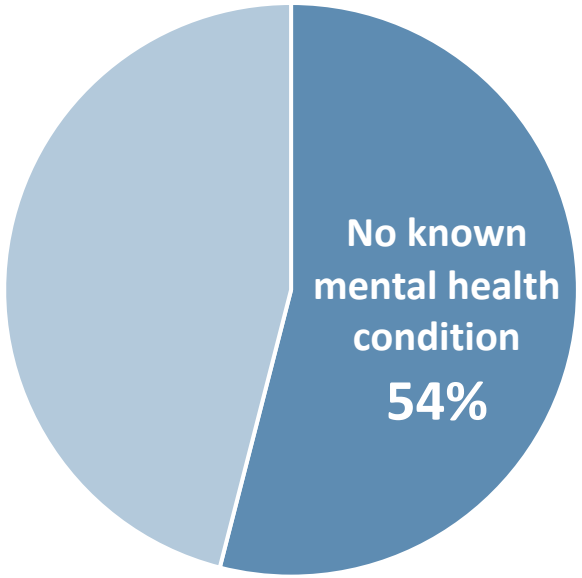
- Age (Young)
- Male
- History of violence
- Threats of violence
- Exposure to violence
- Low socioeconomic status
- Risky alcohol or drug use
- Illegal use of controlled substances

RISK FACTORS FOR SUICIDE

- Mental illness (i.e. clinical depression)
- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- Risky alcohol or substance use
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Local epidemics of suicide
- Feelings of isolation
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of stigma

MENTAL ILLNESS & SUICIDE: RECENT CDC ANALYSIS

Less than half of all suicide decedents were known to have a mental health condition.



The New York Times

OP-ED CONTRIBUTOR

The Mental Health System Can't Stop Mass Shooters

"Even if all potential mass shooters did get psychiatric care, there is no reliable cure for angry young men who harbor violent fantasies."

CONSORTIUM FOR
RISK-BASED FIREARM POLICY

Restricting firearm access on the basis of certain dangerous behaviors is **supported by the evidence**; restricting access on the basis of mental illness diagnoses alone **is not**.

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EXTREME RISK LAWS

- Extreme risk laws **temporarily prohibit access to firearms (purchase or possession) among individuals demonstrating behavioral risk factors for harming themselves or others**
  - Also known as Gun Violence Restraining Order, Lethal Violence Protective Order, Gun Violence Protection Order, etc.
- Enables law enforcement and families to proactively intervene and remove firearms from individuals who are suicidal or behaving dangerously
- Usually 2 types of orders:
  - Temporary (Ex Parte): usually 14 days
  - Final: up to 1 year

KEY FEATURES OF GVRO

- **Evidence based**: focus on behavioral risk factors, not mental illness
- **Civil procedure**, not criminal
- Creates **safer circumstances** for the individual to seek treatment, services, or otherwise access resources to address the underlying causes of their dangerous behaviors.
- Orders are **temporary** and have built-in due process protections.
  - Based on domestic violence protection orders
- Opportunity for subject of order to contest or petition to terminate early

FACTORS FOR CONSIDERATION

- Recent acts or threats of violence towards self or others.
- History of threatening or dangerous behavior.
- History of or current misuse of controlled substances and/or alcohol.
- Unlawful or reckless use, display, or brandishing of a firearm.
- Recent acquisition of firearms, ammunition, or other deadly weapons.
- *Strongly recommend **against** using psychiatric diagnoses in consideration of an order.* Not only is this stigmatizing, but mental illness is not a reliable predictor of violence.

americanhealth.jhu.edu/erpo-state/maryland

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EXTREME RISK PROTECTION ORDERS

MARYLAND

Maryland is the first state to include health professionals as authorized ERPO petitioners, in addition to law enforcement and family members. Under Maryland law, physicians, psychologists, clinical social workers, licensed clinical professional counselors, clinical nurse specialists in psychiatric and mental health nursing, psychiatric nurse practitioners, licensed clinical marriage or family therapists, and health officers or designees of health officers who have examined a patient who may be the subject of an ERPO petition, are eligible to petition for an ERPO.

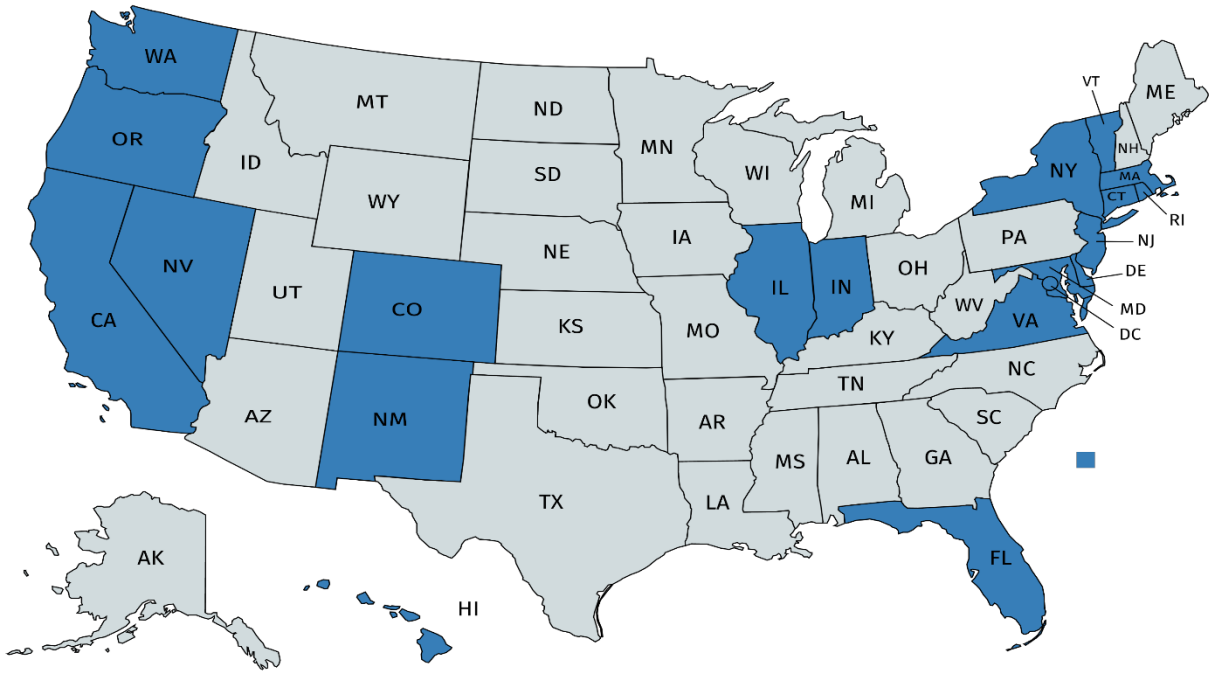
Marylanders may petition for an ERPO 24 hours a day, 7 days a week. District Court provides access when the court is open; judicial commissioners are available when the court is closed to hear petitions for an interim ERPO order. If issued, an interim ERPO is in place until the court is open to hear a temporary ERPO petition.

Explore the following resources to learn more about Maryland's ERPO law:

- Extreme Risk Protective Order Process in Maryland
- Extreme Risk Protective Order & Involuntary Patient Admission: How do they differ?
- Extreme Risk Protective Order & Domestic Violence Protective Order: How do they differ?
- District Court of Maryland Resources

Background: With Gov. Larry Hogan's signature in April 2018, House Bill 1302 created an Extreme Risk Protective Order law, effective Oct. 1, 2018. The District Court has developed ERPO forms for petitioners and informational materials about the new law. In addition, four law enforcement trainings took place around the state to provide police and sheriffs with critical details about how the law would work and ways to incorporate ERPO into their service.

19 STATES AND THE DISTRICT OF COLUMBIA HAVE ERPO LAWS



KEY FINDINGS: CONNECTICUT

- Typical subject: 47 year old married male with **suicidal ideation**
- Police found **firearms in 99% of instances** when an order was issued, removing an average of **7 guns** per subject.
- People in Connecticut subject to orders had an **annual suicide rate 40 times higher than the general population**, showing the increased risk among this population.
- Nearly one-third of all subjects received mental health and substance misuse treatment after an order was issued.
- **For every 10-20 gun removal actions– at least 1 life is saved.**

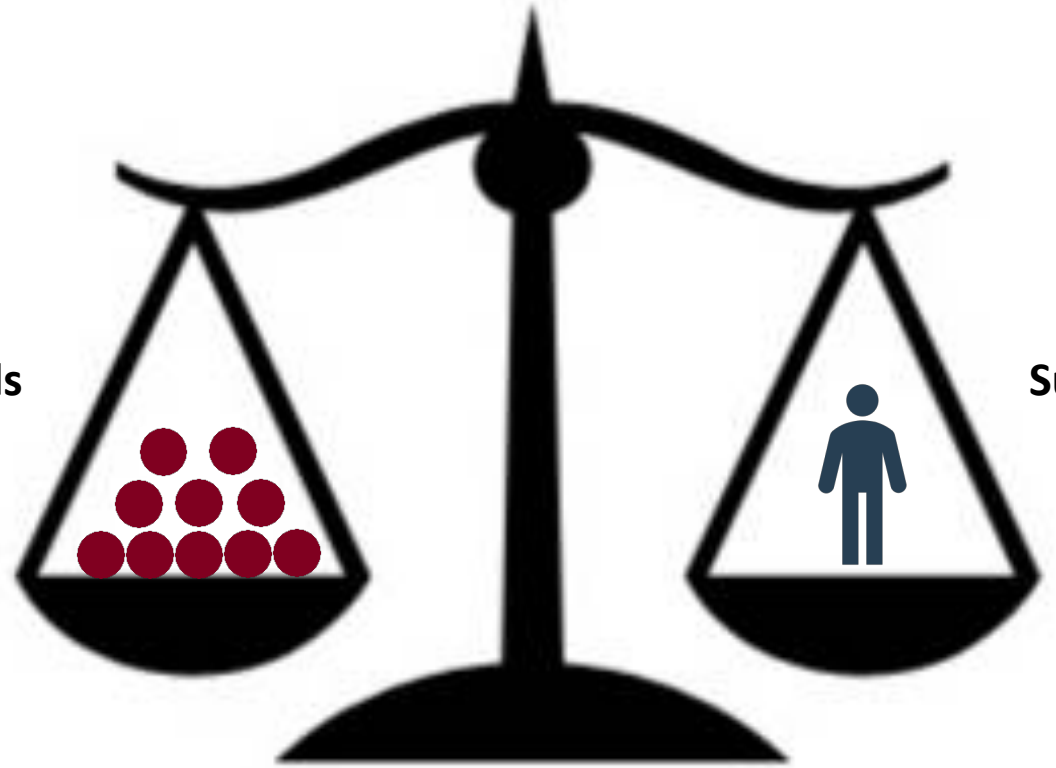
Source: Swanson et al. 2017. Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does it Prevent Suicides? Available: https://scholarship.law.duke.edu/lcp/vol80/iss2/8/

KEY FINDINGS: INDIANA

- Typical subject: 43 year old White male with **suicidal ideation**
- Police removed an average of **3** guns per subject.
- People in Indiana subject to orders had an annual suicide rate **31 times higher** than the general population, showing the increased risk among this population.
- **For every 10 gun removal actions– 1 life was saved.**

Source: Swanson et al. 2019. Criminal Justice and Suicide Outcomes with Indiana's Risk-Based Gun Seizure Law. Available: http://jaapl.org/content/early/2019/04/15/JAAPL.003835-19/tab-article-info

10-20
Firearm Removals



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Suicide Prevented

Slide courtesy of Jeffrey Swanson, PhD
Duke University School of Medicine

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KEY FINDINGS: CALIFORNIA

- Researchers studied California's extreme risk law by examining the court records of 159 orders issued from 2016 to 2018.
- In 21 orders, the subject showed clear signs that they intended to commit a mass shooting.
  - Orders were used as a tool by law enforcement to help prevent school, workplace, and politically motivated mass shootings.
- No mass shootings, suicides, or homicides associated with order subjects were identified to have occurred after the orders were issued.
- The authors concluded that extreme risk laws may play a role in efforts to prevent mass shootings

Source: Wintemute GJ, Pear VA, Schleimer JP, Pallin R, Sohl S, Kravitz-Wirtz N, et al. (2019). Extreme Risk Protection Orders Intended to Prevent Mass Shootings: A Case Series. Annals of Internal Medicine.

CASE EXAMPLES

A 24-year-old man with a history of excessive alcohol and marijuana use threatened to kill employees of the family business, his family, and himself the following day by shooting or bombing. He had threatened employees twice previously and had a prior conviction for a separate weapons offense. The subject's mother petitioned for a GVRO and the surrendered 26 firearms (1 shotgun, 4 rifles, 2 assault-type rifles, 18 semiautomatic pistols, and 1 of unspecified type).

Source: Wintemute GJ, Pear VA, Schleimer JP, Pallin R, Sohl S, Kravitz-Wirtz N, et al. (2019). Extreme Risk Protection Orders Intended to Prevent Mass Shootings: A Case Series. Annals of Internal Medicine.

CASE EXAMPLES

A girlfriend filed an Extreme Risk Protection Order against her boyfriend as he recently attempted suicide and wanted to purchase a firearm. At the Extreme Risk Protection Order hearing, the couple came to court together (holding hands). The respondent had no objection to the Extreme Risk Protection Order. The respondent expressed gratitude that someone cared enough to make sure that he did not have access to a gun.

Source: Written Testimony of Kimberly Wyatt
Senior Deputy Prosecuting Attorney, King County Prosecuting Attorney's Office
for Hearing before the United States Senate Committee on the Judiciary
https://www.judiciary.senate.gov/imo/media/doc/Wyatt%20Testimony.pdf.

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THANK YOU!

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MAY 2020

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Maryland's Extreme Risk Protective Order Law: A Survey of Clinician Petitioners' Knowledge, Use, and Needs

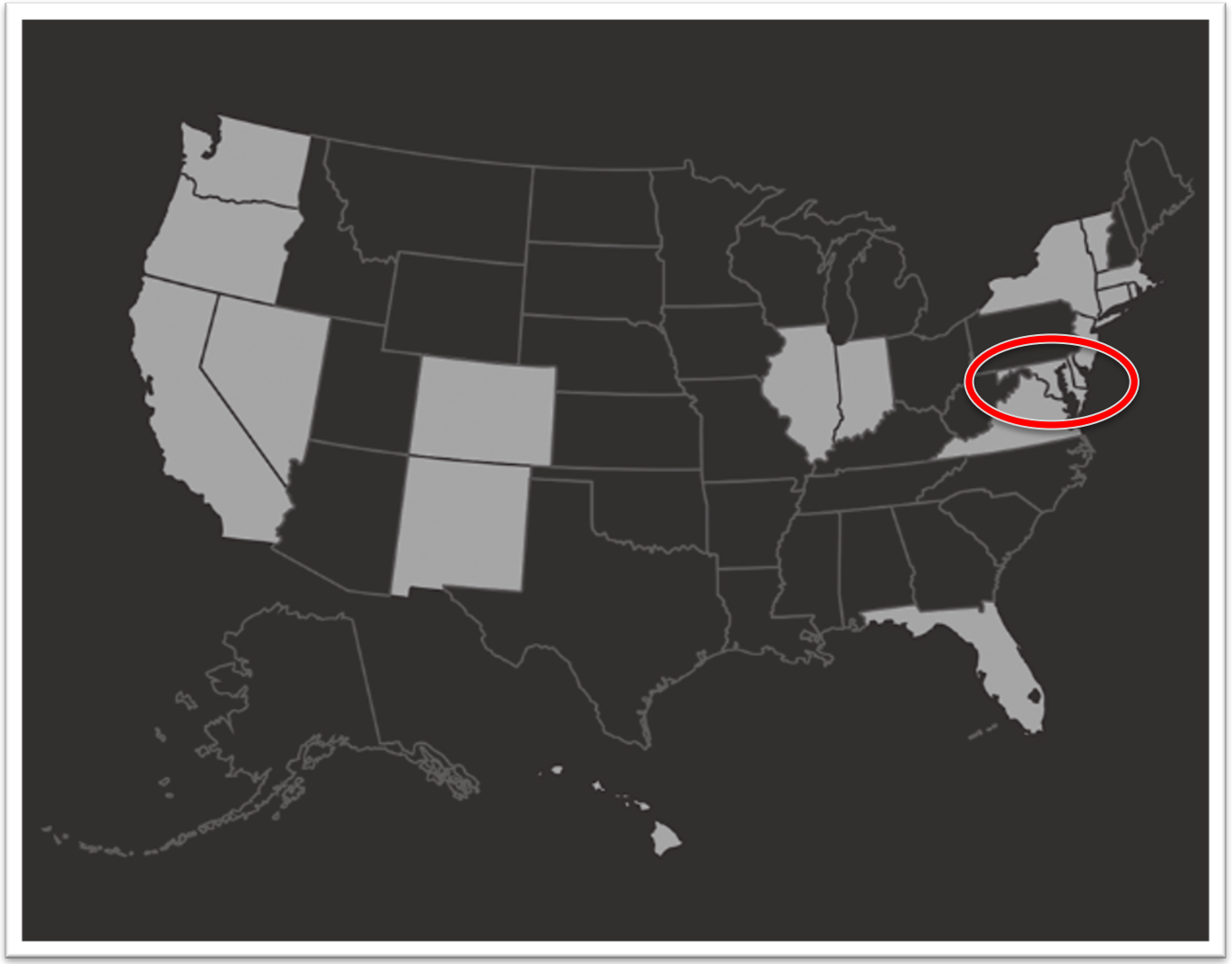
Frattaroli S, Hoops K, Irvin NA, McCourt AD, Nestadt PS, Omaki EP, Shields WC, Wilcox HC. Maryland's extreme risk protective order law: A survey of physician knowledge, use, and needs. JAMA Network Open, 2019;2(12). E1918037.

Where We are Now

19 states and DC have enacted Extreme Risk Protection Order (ERPO) style laws

- clinicians as eligible petitioners: MD, DC, Hawaii

At least 43 states have introduced ERPO style bills since 2014



Who is Authorized to Petition for an ERPO in Maryland?

Law Enforcement Officer

Family or Household Member

Current Dating or Intimate Partner

Medical Professional

- physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage or family therapist, or health officer or designee of a health officer who has examined the individual

Clinician Use of ERPO

- Some numbers
- What we're hearing
- What we want to know

Survey Overview

- Johns Hopkins Hospital physicians
  - Emergency medicine
  - Pediatrics
  - Psychiatry

- 15 questions
  - Knowledge of ERPO
  - Contact with patients who may be eligible
  - Willingness to use ERPO
  - Barriers to ERPO use

Survey Findings

- 92 responded of 353 invited (26% response rate)
- One respondent reported filing an ERPO
- Low knowledge of ERPO
- Frequent encounters with potentially eligible patients
- More than half expressed a willingness to use ERPO

Table 1. Respondents' Familiarity With Maryland's ERPO Law and Their Opportunity and Likelihood of Use, by Specialty

Question	Respondents, No. (%)			
	Emergency Medicine (n = 26)	Pediatrics (n = 16)	Psychiatry (n = 50)	Total (N = 92)
How familiar are you with ERPOs?				
Very familiar	2 (7.7)	0	2 (4.0)	4 (4.3)
Somewhat familiar	1 (3.8)	0	5 (10.0)	6 (6.5)
A little familiar	3 (11.5)	3 (18.8)	10 (20.0)	16 (17.4)
Not at all familiar	20 (76.9)	13 (81.3)	33 (66.0)	66 (71.7)
How often do you estimate you encounter a patient at extreme risk of violence or suicide who you would consider for an ERPO?				
Daily	3 (11.5)	0	0	3 (3.3)
Weekly	9 (34.6)	0	2 (4.0)	11 (12.0)
Monthly	6 (23.1)	2 (12.5)	10 (20.0)	18 (19.6)
A few times per year	8 (30.8)	11 (68.8)	34 (68.0)	53 (57.6)
Never	0	3 (18.8)	4 (8.0)	7 (7.6)
How likely would you be to file a petition against a patient at extreme risk of violence or suicide?				
Very likely	4 (15.4)	1 (6.3)	10 (20.0)	15 (16.3)
Somewhat likely	13 (50.0)	6 (37.5)	21 (42.0)	40 (43.5)
Somewhat unlikely	5 (19.2)	6 (37.5)	14 (28.0)	25 (27.2)
Very unlikely	4 (15.4)	3 (18.8)	5 (10.0)	12 (13.0)

Survey Findings

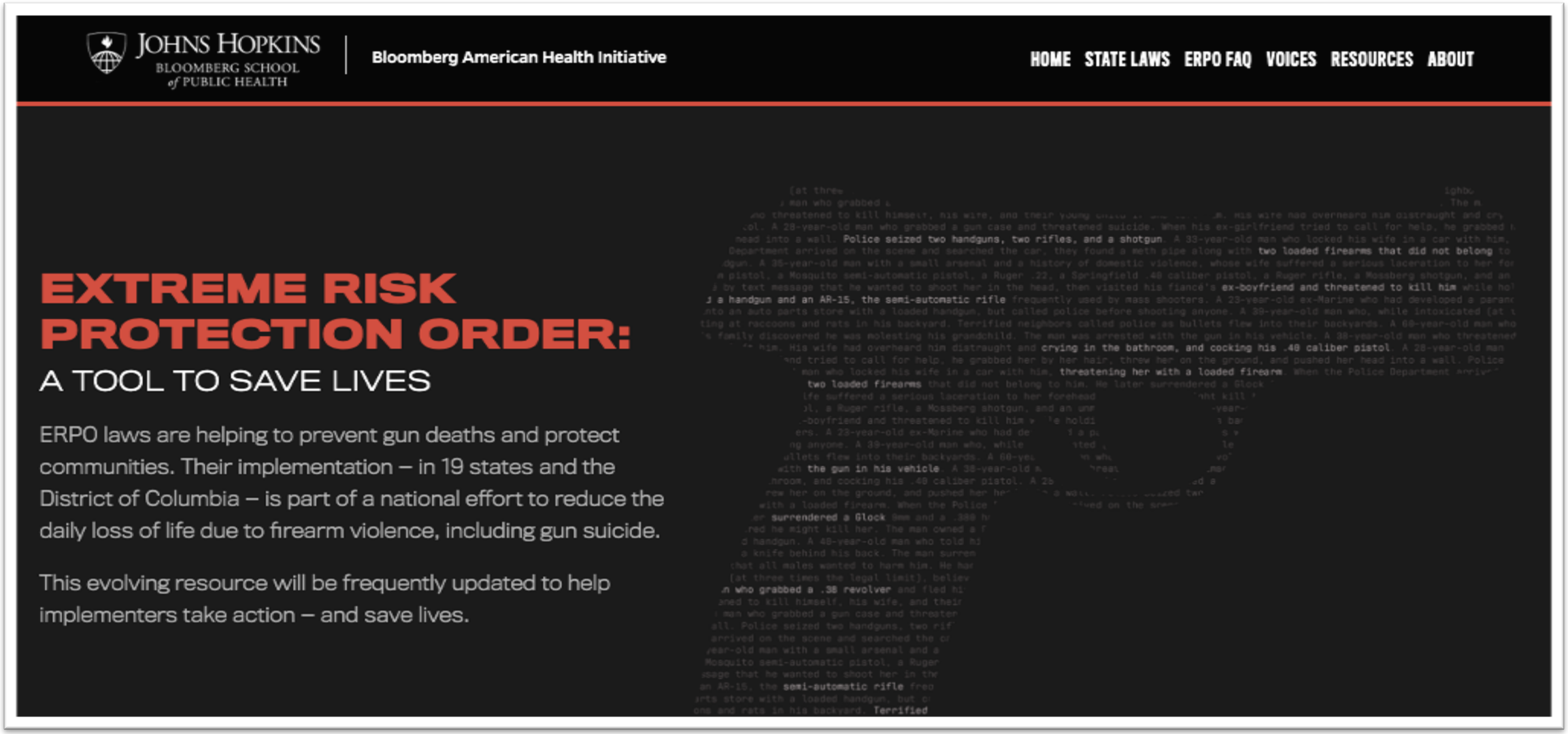
Table 2. Barriers and Facilitators to Physicians' ERPO Use

Question	Respondents, No. (%)			
	Emergency Medicine (n = 26)	Pediatrics (n = 16)	Psychiatry (n = 50)	Total (N = 92)
What barrier(s) prevent you from being able to file an ERPO petition? Check all that apply.[a]				
Not enough time to complete paperwork	20 (76.9)	11 (68.8)	26 (53.1)	57 (62.6)
Not enough time to attend hearing at courthouse	23 (88.5)	11 (68.8)	30 (61.2)	64 (70.3)
Not a billable service	3 (11.5)	1 (6.3)	6 (12.2)	9 (9.9)
It may negatively affect my relationship with the patient	3 (11.5)	7 (43.8)	26 (53.1)	36 (39.6)
I don't think clinical providers should file ERPO petitions	1 (3.8)	3 (18.8)	2 (4.1)	6 (6.6)
Other	9 (34.6)	6 (37.5)	17 (34.7)	32 (35.2)
What tool(s) would help you file an ERPO petition? Check all that apply.				
Training on ERPO	22 (84.6)	16 (100.0)	41 (82.0)	79 (85.9)
Consultation with legal expert	19 (73.1)	10 (62.5)	30 (60.0)	59 (64.1)
A trained coordinator to complete and follow through the petition	25 (96.2)	15 (93.8)	40 (80.0)	80 (87.0)
Remote court hearings (ie, can join by phone)	21 (80.8)	8 (50.0)	39 (78.0)	68 (73.9)
Other	3 (11.5)	1 (6.3)	2 (4.0)	6 (6.5)

- Time cited as the major barrier to ERPO use; some concerns about impact on relationship with patients
- Strategies for addressing barriers identified
  - A designated clinical coordinator to file petitions and testify in court
  - ERPO training
  - Legal consult
  - Remote testimony option

Next Steps

Additional Information



https://americanhealth.jhu.edu/implementERPO

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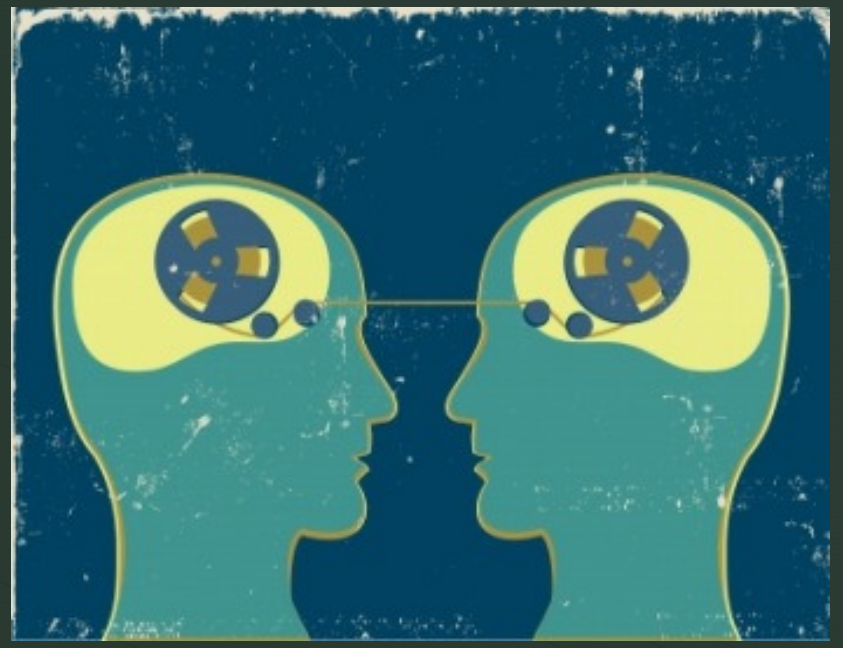
Grassroots Crisis Intervention Center

Mobile Crisis Team Program Manager

Clinical Considerations & ERPO Vignette

Clinical/Ethical Considerations

- In order for therapists/clinicians to have an impact they must build a THERAPEUTIC RELATIONSHIP
  - The purpose of a therapeutic relationship is to assist the individual in therapy to change his or her life for the better.
  - Trust, Respect, Congruence, Time, Empathy, Genuineness



Impact of Informed Consent on the Therapeutic Relationship

- **Pros of Informed Consent**
- Gives the client Autonomy
- Empowers Clients
- Helps clinician set boundaries at the beginning of the relationship – instills trust.
- Ethical Responsibility!

- **Cons of Informed Consent**
- Some argue that clients are less likely to discuss issues such as abuse, DV, Suicidal Ideation, Homicidal Ideation and firearm ownership.
- Clinicians worry about damage to the relationship when they have to act on a disclosure.

Other Clinical/Ethical Considerations

- **Commitment to Clients**
  - Primary responsibility is to promote the well-being of the client; however our obligation to the larger society or legal obligations may supersede the loyalty owed to clients.
  - We need to advise our clients of these limitations.
  - When we need to make decisions for those who can not make decisions for themselves, we should take reasonable steps to safeguard the interests and rights of those clients.
- **Self-Determination**
  - Clients have the rights to identify their own goals, which may not be what we as professionals, or personally think is best.
  - We can limit self-determination if the client's actions or potential actions pose a serious, foreseeable and imminent risk to themselves or others and there is a mental health concern.

More Considerations…

- **Privacy & Confidentiality**
  - We should respect a client's right to privacy and should not solicit private information except for compelling professional reasons.
  - When a client presents with safety concerns, we need to ask further details about thoughts, plans, means, etc.

ERPO Case Study

(Done in November of 2018 (only 1.5 months after the Bill was passed in Maryland).

- Client mentioned having thoughts of wanting to die by suicide. Also said they are “always suicidal.”
- Interested in receiving treatment for SUD with an LGSW SUD Counselor.
- Disclosed they have access to firearms, but would “NEVER” use a gun to die by suicide.
- Worked with Counselor and developed a safety plan:
  - Gave permission to contact partner
  - Agreed to daily calls from Hotline counselors on duty
  - Knew they could walk in any time over the weekend to speak with someone
- Called partner and spoke with them about safety risk. They agreed to secure the guns.

Case Study Continued…

- Learned that client took themselves to ED – Was admitted but signed 72 as soon as they got there. Hospital did not seek commitment.
- Counselor learned after they were D/C charged that the reason they took themselves to the hospital was because of a serious suicide attempt involving putting a firearm in their mouth and pulling the trigger.
- Counselor confirmed this did happen by speaking to both the client and their partner.
- Client was currently in Hospital for ***medical*** detox – not psychiatric.
- Partner stated he was selling the guns and would provide any documentation we needed to prove it. They were advised about ERPO. Also advised about HCPD holding guns voluntarily – the partner declined at that time.

Case Study Continued…

- Counselor learned that client was going to be medically discharged and returning home to wait for SUD treatment.
- Client denied current SI, however, had previously stated that there is “always” some SI present.
- Counselor called partner and requested receipts for gun sales, etc. and they stated the did not receive and receipts because they were given cash and they would not be able to provide and documentation until the weekend because they were working.
- Client’s partner was angry and annoyed. Made a statement about “Do whatever you need to do.”

Resolution to the Case

- Made the decision to file ERPO
- Went to district court at 3pm – left court room at 5:30pm
- Went back a week later to testify
  - Client and partner were there – At the defendant table across the courtroom.
  - Counselor had to testify again and client had the opportunity to provide information. Client's partner also testified.
- Judge believed counselor had provided enough information and the ERPO was extended for 6 months.

What did we Learn?

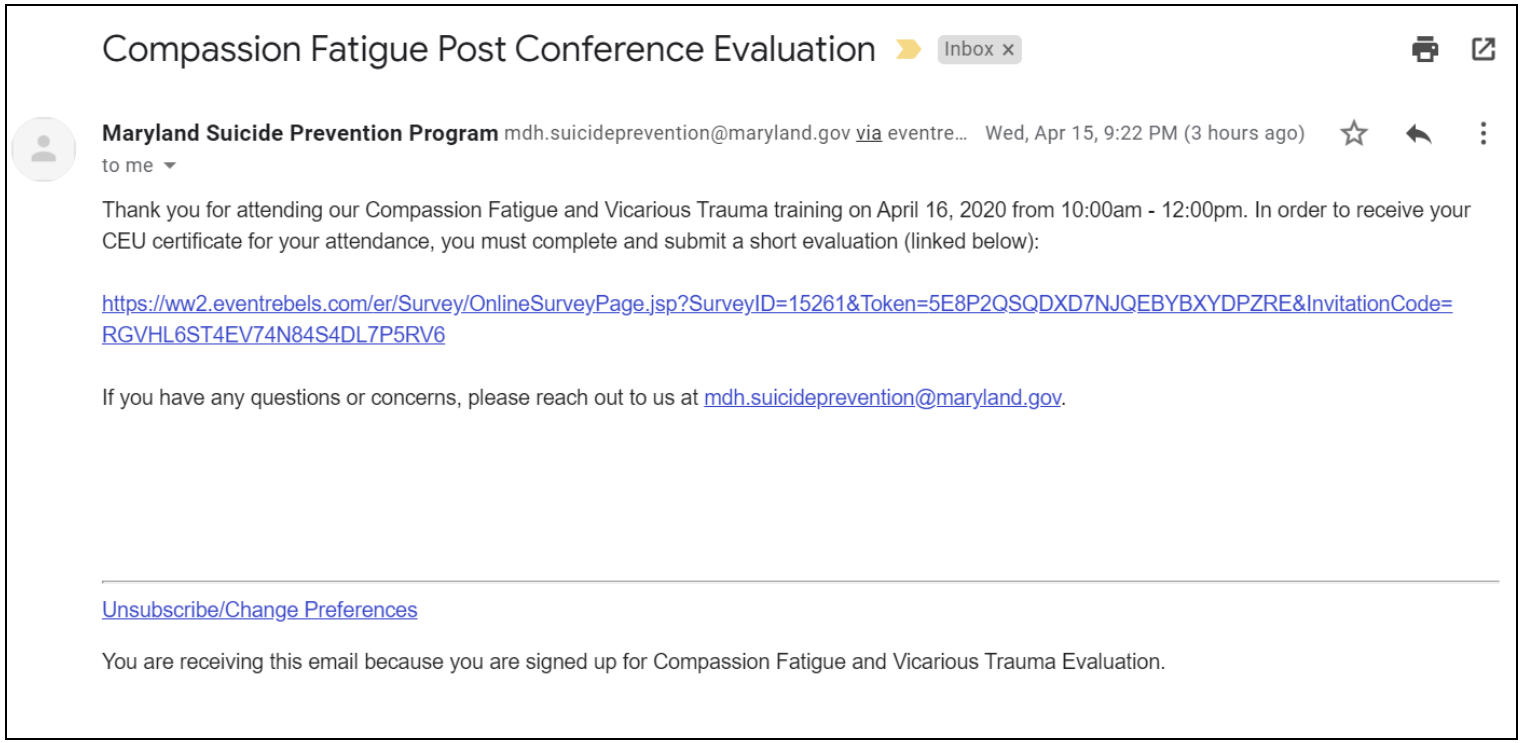
- It's easy to say this is a police issue and they should be the ones to do the ERPO, but we were likely granted the 6 months because the SUD counselor was the one to testify to all the clinical information.
- According to PD, working with them prior to serving the ERPO made the situation much more smooth – the Police had the backstory they needed to work with the clients.
- It helped me to look at ERPO as a tool rather than something we ***HAVE*** to do simply because some is having SI and has firearms.
- Highlights the importance of talking with clients about SI, crisis plans/safety plans etc. prior to the crisis occurring.

CEU Certificate Process

- Receive an email from Maryland Suicide Prevention with a survey link
- Complete and submit the survey
- Receive an email that will contain a link to your electronic certificate
- Check JUNK/SPAM inboxes

Maryland
DEPARTMENT OF HEALTH

Survey Link Email



Compassion Fatigue Post Conference Evaluation Inbox ×

Maryland Suicide Prevention Program mdh.suicideprevention@maryland.gov via eventre… Wed, Apr 15, 9:22 PM (3 hours ago)

to me

Thank you for attending our Compassion Fatigue and Vicarious Trauma training on April 16, 2020 from 10:00am - 12:00pm. In order to receive your CEU certificate for your attendance, you must complete and submit a short evaluation (linked below):

https://ww2.eventrebels.com/er/Survey/OnlineSurveyPage.jsp?SurveyID=15261&Token=5E8P2QSQDXD7NJQEBYBXYDPZRE&InvitationCode=RGVHL6ST4EV74N84S4DL7P5RV6

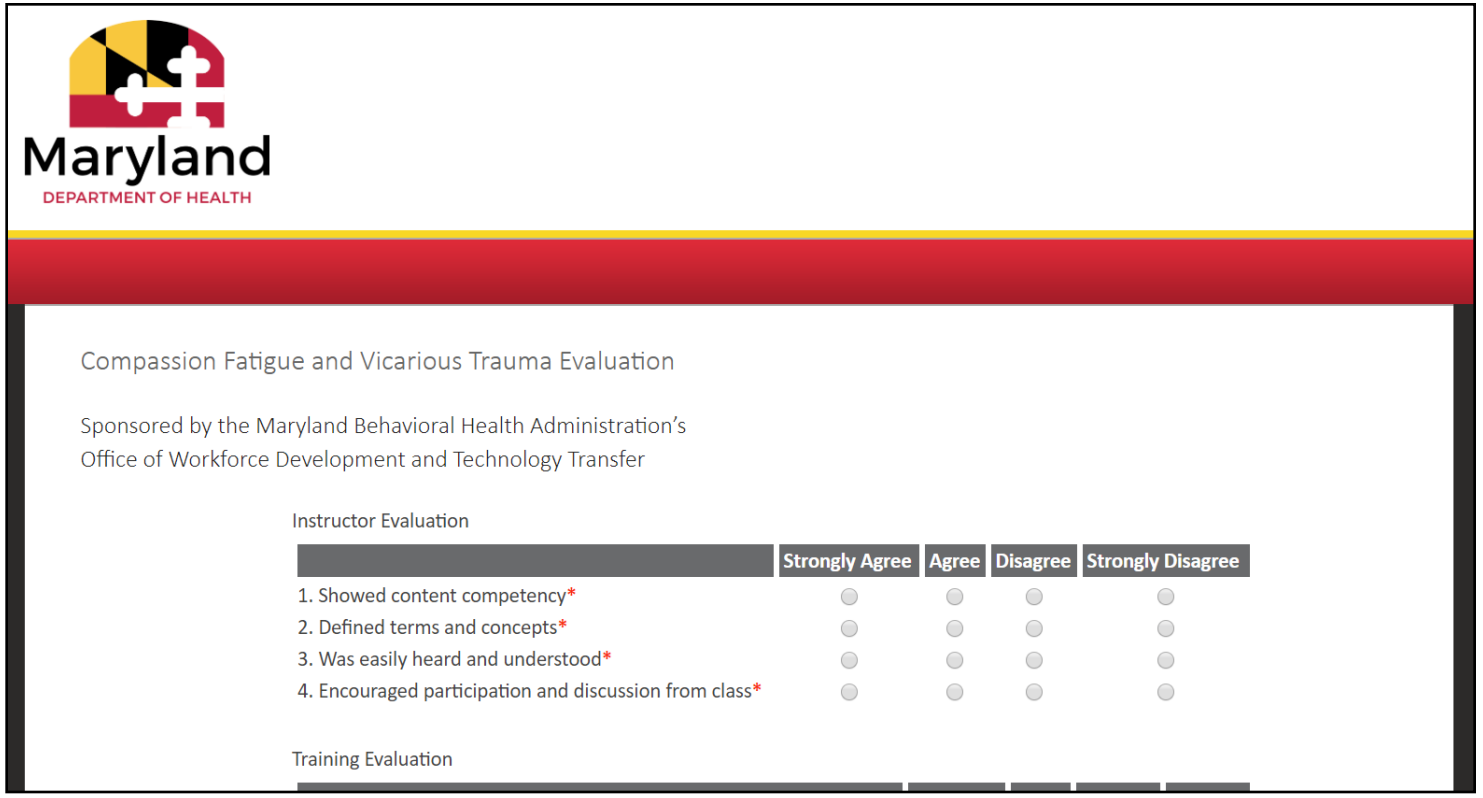
If you have any questions or concerns, please reach out to us at mdh.suicideprevention@maryland.gov.

Unsubscribe/Change Preferences

You are receiving this email because you are signed up for Compassion Fatigue and Vicarious Trauma Evaluation.

Maryland DEPARTMENT OF HEALTH

Survey Page



Maryland
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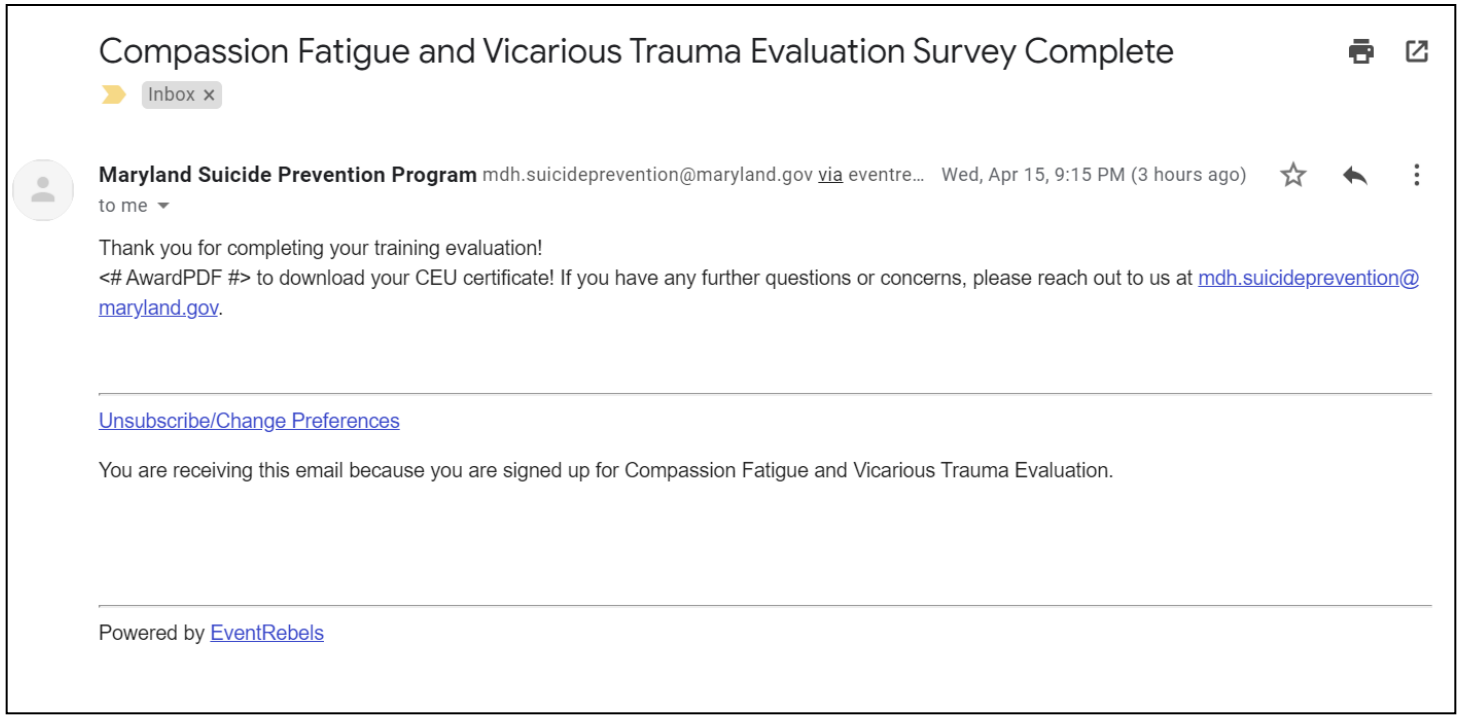
Certificate Email



Compassion Fatigue and Vicarious Trauma Evaluation Survey Complete

Inbox ×

Maryland Suicide Prevention Program mdh.suicideprevention@maryland.gov via eventre… Wed, Apr 15, 9:15 PM (3 hours ago)

to me

Thank you for completing your training evaluation!
<# AwardPDF #> to download your CEU certificate! If you have any further questions or concerns, please reach out to us at mdh.suicideprevention@maryland.gov.

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