National VA Mental Health Wellness & Recovery Webinar Series:
Firearms and Suicide: How to Use Tools from Dialectical Behavior Therapy in Lethal Means Safety Counseling

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Dr. Samantha Hack: Welcome. This is the Mental Health Recovery and Wellness Webinar Series. This series is made possible by the VA Office of Mental Health and Suicide Prevention, Psychosocial Rehabilitation and Recovery Section. The VISN 5 Mental Illness Research, Education and Clinical Center, or MIRECC, and in Partnership with the Employee Education System. The planning committee members for this Webinar series include Daniel Bradford, Valerie Fox, Spencer Glipa, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, my co-host Ralf Schneider, and myself, Samantha Hack. Today's Webinar is entitled, "Firearms and Suicide: Using Dialectical Behavioral Therapy Tools in Lethal Means Safety Counseling". Our presenters for today's Webinar are Drs. Lauren Lovato Jackson and Meredith Sears. Dr. Lovato Jackson is a staff psychologist in the Reach Vet Coordinator at the Long Beach VA Healthcare System. She is also the former program manager for the Long Beach VA DBT program. In addition to her DBT work within VA, she also currently trains providers in the Los Angeles Department of Mental Health System as a consultant with the Treatment Implementation Collaborative. Dr. Sears is a staff psychologist on the Suicide Prevention Team at the San Francisco VA Healthcare System and the Associate Director of the SS VA Dialectical Behavioral Therapy Program. She is also a health scientist assistant clinical professor at the University of California, San Francisco. Her areas of teaching and research are in lethal means safety counseling and DBT. At this time I'm happy to turn the Webinar over to our presenters.

Dr. Meredith Sears: Thank you so much Samantha. All right, so today we're going to be talking about the connection between firearms and suicide, and specifically how to use skills drawn from Dialectical Behavior Therapy, or DBT, to have hopefully, a

fruitful and collaborative discussion with a Veteran who is at elevated risk for suicide. I am Meredith Sears. I am going to start us off today talking about why it's important to talk to patients about access to firearms, especially when there is a concern for suicide, and what your goals will be when you engage in those lethal means safety counseling conversations. And then I will hand it off to Dr. Lovato-Jackson who is going to tell you about storage options for firearms, and specific DBT strategies like dialectics, validation and pros and cons, to help make lethal means safety counseling less contentious and more effective. And as was already mentioned, if you want to go ahead and put questions in the chat, Lauren is going to keep an eye on those as I present, and I will do the same for her. So we will be answering some of those in the chat and then we will reserve the majority of the questions that are easier to answer verbally for the end of the presentation. So, first off, I want to start us off with a discussion of the rationale for the whole concept of lethal means safety counseling. Um, so why should we providers talk to Veterans about firearms and suicide. The first reason is that firearms are responsible for the majority of Veteran suicide death. So as you can see here, um, completed suicide in the US among males, male adults, firearms were responsible for about 54% of the suicide deaths. Among male Veterans, firearms were responsible for a whopping 70% of firearm suicide deaths. And in females, the pattern, although the number of firearms used, or the rate of firearms used is lower among females, you can see that the pattern is similar, where female Veterans are more likely to die by firearms suicide than by alternative means. Not only are firearms responsible for a really big proportion of Veteran suicide deaths, and as you can image, Veterans are much more likely to own firearms than civilians, um, but suicide is actually 5 times more common among firearm-owning households, than in households where a firearm is not present. And I'll just

mention that that language is very intentional. It's not necessarily that the owner of the firearm is more likely to die by suicide, but just having access seems to increase suicide risk. So this suggests, on the face of it, that if we can reduce access to firearms, especially when people are at elevated risk of suicide, and decrease just that one number that we saw before, that 70%, that 42%, that might be a substantial hit to suicide rates overall. So you might be thinking a couple of things. One, is it really just access to firearms? And two, if we reduce access to firearms when people are at elevated risk for suicide, might people just select another method and still die by suicide, and so do we really want to pay a lot of attention to reducing access to firearms? So I will answer those questions now. Um, first off, let's talk about whether there might be some other reasons, other than simple availability, that increases the risk of suicide in households where firearm is present. So the real question here is correlation versus causation. Are people who have guns at higher risk for suicide for reasons other than simple availability? So, for example, are they more likely to have experienced a mental health problems, seriously considered suicide, or attempted suicide. And the answer to all of these is a resounding no. Simply having access to firearms does seem to increase the likelihood of suicide death, just all on its own. One reason for this is the lethality of firearms. So, according to the CDC, 1.4 million Americans attempt suicide every year. That's a pretty extraordinary number, especially considering that we lose about 46,000 people to suicide. So 46,000 out of 1.4 million attempts are fatal. That's a lot of non-fatal attempts. So when you compare the means used in fatal attempts versus the many attempts that people survive, you can see that firearms are, not surprisingly, way over represented in fatal attempts. So here we have 51% of fatal suicide attempts are by firearms, and only 1% of nonfatal self-injury are by firearms. This is largely because firearms are so lethal.

So, the probability of surviving a firearm suicide attempt is about 5 to 10%, and that's a pretty conservative number, whereas the probability of surviving a suicide attempt by any other means, any other means, that includes overdosing, poisoning, sharps, is about 95%. So, this is why we place a huge emphasis on talking with Veterans about firearm access in particular when they are in a suicidal crisis, because on some level, even if they were to, in a suicidal crisis, if they didn't have access to their firearms, even if they were to replace the firearm with some alternative means, they would still be more likely to survive that suicide attempt. So that's once of the reasons we focus a lot on firearms, is just getting, reducing access to firearms can increase survival rates, whether because someone does not make a suicide attempt, or even if they do make a suicide attempt they are more likely to survive. And I'll just mention, just because I think it's interesting, um, we actually have quite a lot of evidence that people don't tend to substitute means. So, people tend to have preferred means when they've thought about suicide. And when they don't have access to those preferred means, they don't have access to really readily available means, we actually have data that suggests that they don't even make suicide attempts, much less die by a suicide attempt. So I will just mention one of these, which is think is particularly interesting, and that's the Israeli Defense Board. In the early 2000s, they were really struggling with suicide by firearms in their active duty soldiers. And so they implemented a really simple policy, they just asked the soldiers to check their weapons in on base when they left home for weekend leave, and then they would check their weapons back out when they returned on Monday. And they saw a 40% reduction in overall suicide rates. So they didn't really see a change in weekday suicide rates, and they didn't really see a change in weekend non-firearm suicide attempt rates. What they saw was just an overall reduction because the weekend firearm suicide rate

went down. There are similar examples in the UK when they reduced carbon monoxide content in domestic gas, which means basically in ovens. In the 1960's, suicide rates went down similarly because that was a very readily available, very lethal means in everybody's home. Similarly, in Sri Lanka, which is a very agrarian economy, a lot of people had access to toxic pesticides and in the 1990's when they changed pesticide regulations and they reduced access to the most toxic ones, suicide rates halved. So people do tend to have strong preferences for a single method. In the U.S. a lot of our folks have access to firearms, and if people have a preference for that method and if they have access to it, availability really does seem to matter. One of the reasons we think availability matters so much is the duration of suicidal crises. I think in kind of popular imagining often people think of suicide as something that people kind of take a long march towards, and its kind of this inevitable conclusion of a long passive suffering, and that's really not what we see born out of in the data. What we really see is that a lot of suicide attempts, not all of course but a lot of suicide attempts are quite impulsive. They occur in a moment of extreme emotional distress when someone isn't problem-solving well; they encounter a problem and they don't know how to solve it and they don't feel that they can ever solve it because the emotional crisis is so intense in that moment. This research team went into hospitals, into their emergency departments and talked with people who had survived very serious suicide attempts, and they asked them, "How long was it from the moment when you first started thinking about killing yourself, to the moment that you acted on those thoughts?" And not necessarily for the first time ever, but in this episode of crisis – and 48% said it was 10 minutes or less from the moment that they started thinking about it, to the moment that they acted on that thought and made an attempt. I believe, I can't remember the exact number off the top of my head, but I

believe it was over 70% said it was less than 10 minutes from the time that they decided to kill themselves to the action. So, that's a lot of people in a very, very short period of time making this decision. And so access, as you can image, matters enormously. So, the more we can kind of introduce barriers, make it a little bit harder to access a loaded firearm in the case of a crisis, the more likely people may be to sort of resolve that crisis, you know, take a breath, call the crisis line, what ever it is. All right, so, what is our role as, sorry, I'm gonna summarize first. Access to lethal means is an independent risk factor for suicide. Firearms are significantly more lethal than other means of suicide. Most people don't seek out alternative means if they can't access their preferred means, so, if that's a firearm. And then suicidal crises are often brief. So, I'm gonna give you a little bit of a road map for how you might engage in lethal means safety counseling in a session with a Veteran patient, and then we're going to talk a bit about goals of what this conversation, what, what kind of, what the outcomes of this conversation we want are. Um, so let's say you're talking to a Veteran, you've established that this person seems to be at an elevated risk of suicide. They've got something going on, they've got some stressors, they've been in and out of emotional crisis. I think it would be a good idea to talk to them about firearms. So the first thing you're going to do is raise the firearms issue. You're going to talk to them about access. You're going to talk to them about their current storage method. Effective strategies for this are really going to vary depending on a treatment context. So, if you have been, you know, engaged in therapy with someone for six months and you know them really well, and you have a bond and you have trust, that conversation is going to look pretty different than if you're meeting them for the first time in a PCMHI context or in the emergency room, or in an intake. Um, you're going to collaborate on a plan to reduce access to firearms, and potentially

lethal medications, and any other methods that they may be considering. So, I really want to highlight the word collaborate and Lauren is going to be talking about this in a lot more detail in a few minutes. This is not something where we just tell Veterans that firearms are dangerous, you should get rid of them. This is a situation where they get, ultimately, to make the decision about how they want to handle this level of risk, and so your job is to educate and guide and to help them think through what the options are and what the risks are. If it's indicated, you can ask the patient for a release of information for you to contact and work with a friend or family member. So, if their plan for reducing their firearm access, for example, involves giving the key to the gun safe to their spouse, or doing a short-term loan to a family member so that they have the gun out of the house, then that may be a situation where you want to say, um, "I'm really glad that you're engaging in this, I trust you to do this, and I want to verify that you're doing it so that I can help support you in making this choice", because it's not uncommon for people when they're talking to you to kind of say, "Okay, you know what, this sounds like a good idea" and then they get home and they're feeling okay, they're kind of, they've decided they don't plan on going into crisis again any time soon and so it just seems less important to actually execute the plan that they came up with you. So, if there is some accountability that could increase the likelihood of success. You want to agree on roles – this is a smart goal, right? You're actually making a specific plan, so you want to figure out what everybody is going to do, figure out a time table, and then you, as the provider, can briefly document that plan in the suicide prevention safety plan. So, if you've done a safety plan you already know that Step 6 is options for increasing safety in the environment, so you can actually say, specifically, in the safety plan, you know, made a plan with the Veteran to reduce access to firearms. And then you want to follow-up with them as

indicated. So you don't want to just assume that it happened. You want to talk to them about how it went, if they made any changes to the plan, and potentially document that follow-up so it is easily available to future providers. So what are your actual goals with these conversations? Um, one goal or course is to reduce access to improve the likelihood that they might survive the next emotional crisis that they have, and Lauren is going to talk in more detail about what that looks like. Another goal of lethal means safety counseling is just psychoeducation for the community. According to the CDC, suicides account for two-thirds of the total number of firearm related deaths in the U.S. I don't know about you, but I don't hear about that a lot in the media. I hear a lot about homicide. I hear a lot about risks of home invasions and robberies and burglaries and all these things, and it just turns out that we are more at risk to ourselves when we own firearms than we are than anybody else is to us, just statistically speaking. And that's something that I just don't think is widely advertised, and I would like, personally, the entire United States to become more aware of that. Most firearm owners don't believe that firearms ownership and storage practices are related to suicide, and so that is something that we can actually educate the public about. Ultimately what I would love to have, if anybody has a great little tag line that they want to throw out there, I'm still looking for one. Um, you know, ultimately I'd like to have something like *friends don't let friends have access to lethal means when they're in an emotional crisis*. It's a little hard to sew on a pillow, but eventually we're looking for something like this, where we can really educate the public and so that, you know, eventually, I'd like it so that when a Veteran sees a buddy whose struggling they say, "Hey man, you know, it doesn't seem like things are going so well, um, maybe this would be a good time to, you know, store your gun differently. Do you want me to help you get a lock of whatever?" So ultimately your goal is to

develop a flexible approach to means storage that is responsive to fluctuations and levels of risk. Um, so you're not necessarily saying to the Veteran, "Hey, you sometimes get suicidal, you need to just not have firearms in your home." You're ideally looking for something that is going to accommodate both their desire to have firearms and the reason that they have for having firearms, which are valid, and also improve safety. So ideally you have a Veteran who becomes so aware of their own fluctuations and risks that they can kind of anticipate, "Hey this is one of these times when I shouldn't have access to my firearms. Okay, this is one of these times when I'm pretty stable, things are going well and it's okay for me to have the firearm." Um, and so you can imagine that self-assessing those fluctuations and acute risk level requires a lot of skill. So it require mindfulness skills, which is one of the reasons why DBT really focuses on mindfulness skills. It requires the ability to self-monitor. So, in DBT we actually have Veterans fill out diary cards every single day where they rate their suicidal ideations on a scale from 0 to 5. So every single day they're exercising that muscle of being able to self-monitor their risk, and when they start seeing that number climb, they start thinking, okay, it seems like maybe things are maybe getting into a more acute place and I need to change my storage strategies. Another strategy you can use is looking at the warning signs that are listed on Step 1 of the suicide prevention safety plan. So what are the kinds of things that start to pop up when I start getting more acute. And Veterans can use that to assess their own fluctuations in acute risk level. And then you're going to collaboratively identify patient-specific options for increasing security of their firearm storage. The Veteran can then deploy as needed. And again, you want to be really, really specific. Um, you can strive to provide a very clear, very transparent rationale. So, I saw just out of the corner of my eye, someone brought up the 2nd Amendment Rights issue, which is

absolutely one of the biggest issues that we face in having these conversations, is that sometimes the minute you mention the word firearms, the conversation kind of shuts down, and they are not able to listen because they are so worried that you're going to try to take away their guns. And so, you can head that off a little bit by giving them a really clear transparent rationale where you're saying, "Hey, this is not political, I want to talk about your safety. There just happens to be this data that having access to a firearm increases your risk". You can talk to them about impulsivity, talk to them about all the reasons why you're concerned for their safety and why you care about them, and really, really focus the conversation on safety. And join with them around that. I've had some great conversations with Vets where, you know, I'm saying "I'm really worried about your safety from your firearm, and they say "Well I'm worried about my safety from other people", you know, they have PTSD and they want their firearm near them so that they can feel safer, and I can say, "I'm so glad that we're on the same page, that we're both worried about your safety. It's just that I'm a little more worried about your safety from you, and you're more worried about your safety from other people – so how can we get on the same page about this?" But, at the end of the day, hopefully you can kind of align with them about maintaining their safety. Broadly, your goal for lethal means safety counseling is to place more decision points between suicidal impulses and suicide behavior, to interrupt impulsive actions. So that means getting the guns totally out of the house so that they're really inaccessible – that's a pretty big barrier, or it may just mean locking up the gun, putting the key in a different place, putting the ammo in a different place - so it takes them 10 minutes to collect everything that they would need, and that gives them 10 more minutes to calm down, call the crisis line, call a friend, whatever it is. We don't have specific data that shows us that decreasing access, you know, for example using locks

in the home as opposed to getting rid of the gun actually improved, or, um, actually reduces suicide rates, but that's still something that someone really needs to study. But, intuitively, and I certainly talk to Veterans who did experience that to be lifesaving. So I really do recommend that this is one of these times when you want to kind of make the best guess we can ahead of the research. And then you also want to underscore the temporary and flexible nature of what you're proposing. The goal is not to have every Veteran store firearms out of the home at all times. The goal is for them to be able to flexibly assess their own risk and reduce access in a way that makes sense for them. One of the analogies that I really like to use is drinking and driving. So, you can say to the Veteran, um, you know, "If you had a friend who came over and had a few glasses of wine and you didn't want them to drive home, you wouldn't take their keys away for the rest of their life because they got intoxicated once . You just want to hold on to hold onto their keys until they're sober enough to drive home. And it's the same thing with firearms, right?" You don't want to take away firearms forever, we just want to make sure that you don't have them while you're in this really emotional state where you're going in and out of crisis. Let's wait until the crises pass and then let's revisit. All right, so now I'm going to turn things over to Lauren. Lauren is there any question that would be helpful to answer right now, before we move on to storage options, or shall we just plow ahead?

Dr. Lauren Lovato Jackson : I think there's a great question that just came in from Don regarding a threat to self versus threats from others. The question is, "Is there evidence to suggest that reduced access to firearms compromise a person's ability to defend against a threat?" Short answer is yes, but Meredith, do you want to speak to that real quick?

Dr. Meredith Sears: I think you may be more familiar with the data off the top of your head, but I can look up the data while you're talking

Dr. Lauren Lovato Jackson: Sure, um, Don really quickly, and I don't have the numbers off the top of my head, and I hope this is the question you're asking, so let me know if this is, if you had something else in mind. But, yeah, there is actually a number of studies that kind of looked at what is the outcome in terms of increased actual safety when somebody has access to a firearm? And a couple of things that we do know is it actually seems that the number of times in which somebody actually uses a loaded firearm during any kind of altercation or assault is very, very, very rare. So, for example, in a home invasion if they, um, and again, I'm paraphrasing and it's been a little while since I've looked at this research, but um, I can send these resources to you. Um, it actually looks like the number of, the probability of one actually using that firearm in that altercation is really rare, and also there is also, on the flip side, some data to say if somebody does have a loaded firearm, it actually can increase the probability that a transaction will escalate. So, there are some things that we can look at and talk about with regard, and a lot of the times, and we'll talk about this a bit more in a second, is, we need to validate the function that firearms often times play and a sense of increased safety is key for a lot of the Veterans that we work with. So there's a lot of room that we need to validate while also bringing in, as Meredith was talking about, bringing in what we do know from the science. So I hope that gives a little bit, again, I'm paraphrasing some of that, um, and I can send you more specific resources if you're interested. Um, okay, so should we move on forward Meredith? Are you ready?

Dr. Meredith Sears: Yes, please.

Dr. Lauren Lovato Jackson: Okay great . So I'm gonna spend the rest of the time today kind of talking about, um, now that Meredith kind of laid the rationale as to why we really need to be bringing focused attention to firearms, um, I gonna plow into looking at how do we have the conversation. So, tips, tricks, strategies, as many of us probably know, talking about firearms can be really a tricky conversation. A number of people have asked about 2nd amendment issues, um, a lot of our Veterans are very connected to their firearms, so this can be tricky territory. And also, of course, it is really an important territory. So I'm going to go into what we know about how to set ourselves and our clients up for success when we set out to have that conversation. A little caveat here - it's interesting to note that there isn't actually a tremendous amount of guidance out there for clinicians guiding us in how to have this conversation? There is some, but as Meredith kind of mentioned earlier, this is an area where a lot of research is still needed. Um, so what you're gonna hear me do today is bring in what we do know from the research about how to have this conversation, and you're going to see me present it from a DBT perspective. So, for those of you who are doing DBT, comprehensive DBT or DBT informed treatment, our hope is, is that um, being able to bring this content into your existing DBT work will be pretty seamless. So with that, I will dive on in. Um, so probably one of the first things to know about doing this work is just what storage options exist. If you're like me, prior to doing this work, I would have been able to rattle off a couple of different storage options but me, personally, and there is actually research to say a lot of providers are not too familiar with firearms. Um, so I wouldn't have been able to tell you an extensive list of options available to me when working with a client to increase overall safe storage practices. So one of the first things that we as clinicians can do for ourselves is really kind of familiarize ourselves with the hierarchy of storage options that exist. Just like Meredith mentioned,

and the goal isn't to have every Veteran remove permanently their firearms from their homes – that's probably not realistic and it's also probably not necessary. As we will talk about, there are a lot of ways in which firearms can be used in a healthy way in an individual's life. So, it's important for us to know that storing out of the home is definitely an option. It is always probably going to be the safest option. That being said, if we either can't work with the Veteran to get them to remove the firearm completely from their home, or if that's either a willingness issue or there's resource barriers, there are still a number of options available to us that we as clinicians can learn and work to build motivation towards. So, for example, things that we can do in home environmental adjustment that can be made through the course of our work with a client. Things like lock the firearm and giving the key to someone else. Or even, say, if they don't have someone to give the key to, maybe locking that key in a safety deposit box. Um, asking someone who is a trusted friend of family member to change the combination on their gun safe. This is one I regularly do, temporarily disabling a gun and then the client giving a key component of the gun, such as the firing pin to someone else. And then even things like storing ammunition out of the home. It's important to know that you may need to make small approximations with some of these behavioral goals. I can think of one Veteran where, when I first started working with this Veteran he kept his firearm loaded in his bed stand, and what we did over the course of treatment is we slowly worked to remove the ammunition from the gun, and then we worked to store the ammunition, so we got to a point where he was able to store the firearm in a safe and then remove the ammunition and store it in the trunk of his car, and then ultimately we worked towards storing the ammunition out of the home. So you may have to take several passes at this and really think begin shaping this, just like we would shape almost any other target and [inaudible] small

approximations. If those things aren't options, I'll loop back around out of the home storage options in a minute, but if those options aren't possible, it is really important for us as providers to recognize that locked guns poses lower risk, even though Meredith did say we don't currently have any research to show what the change is, but it makes good intuitive sense, and again, what we're trying to do, is we're trying to interrupt impulsively and mood dependence. As Meredith mentioned, the combination of the lethality of the firearm, coupled with the impulsive nature of many suicide attempts, that's what seems to be driving the high degree of complete suicide by firearm in the country. So, really any step that we can implement to create some time and some distance between a lethal firearm is always going to be a step in the right direction. So, a lock imposes a lower suicide risk than an unlocked gun, no matter who holds the key, and similarly, an unloaded gun poses a lower suicide risk than a loaded gun. Again, I think that's worth highlighting for us as clinicians. I've been asked to consult on a couple of pieces here and there where a clinician will be in a difficult or challenging clinical spot with a client who is posing an elevated risk for suicide and they've been doing their best clinically and can't seem to get much movement in terms of removing the firearm completely from the home or implementing a lot of the environmental recommendations that were noted on the previous slide, and so, a lot of clinicians will kind of get into this place where they really struggle and so I think it is really important for us to note that even if the change that we work with our client to implement, using a cable lock, that's an excellent step in the right direction, and that doesn't mean that that's where we need to stop with this target. Again, small approximations may be necessary. And then this last point here, it goes without, it may be obvious, but it's worth really highlighting - one thing we really want emphasized is that hiding a gun in terms of suicide or firearm injury prevention is never

going to be recommended. Unfortunately, it is really interesting diving into this research, one thing that surprised me is that it seems like pediatricians are actually driving a lot of the research in firearm injury prevention and the reason is is they see a high degree of children, you know, stumbling onto firearms in the homes that are “hidden”, and of course we all know that children are curious and I think pediatricians see the catastrophic outcomes of a lot of that. So, we want to just make sure we’re overtly stating that hiding a gun in the home is never going to be the recommended strategy for increasing safety. So anything that increases the time and distance between a suicidal impulse and a gun can reduce risk. And this should be our guiding light. The reason why it is really important, again, for us, as clinicians, is as we’ve kind of already mentioned, having these conversations can be really challenging. It can pull from mood dependence or it can pull a client into emotion mind, it can pull ourselves, as clinicians into emotion mind, um, because there are significant risks. And so being really clear, in our clinical conceptualization, of what progress is, um, is, is really important and this kind of really is, is what’s hitting that home. Okay, so as I mentioned, I want back around to off-site storage options. There are a number of off-site storage options to be aware of. There are also a few legalities to be aware of – I’ll give you some resources and show them, familiarizing yourself with legal, or laws and regulations in your state. But in terms of off-site storage options, here are a couple that are really pretty routinely used in firearms safety and safety counseling. So, one is relative, provided of course that they aren’t prohibited from possessing a firearm, being able to temporarily transfer your firearm to a trusted adult is always a really good strategy. Another is storage facilities. Most storage facilities will require you to store the ammunition separately, so that’s just something to note as you’re helping your Veteran weigh through the pros and cons of these options. Another option that a lot

of people aren't aware of is actually police departments. So some police departments will even store, temporarily, at no charge, a firearm if somebody is concerned about a safety risk. Now, again, might seem obvious, but obviously, if we are working with people who are emotionally dysregulated, maybe we're doing this for [inaudible] DBT where skills may not be on board yet. We have to be prepared for a certain amount of potential cognitive dysregulation and we have to coach it appropriately. So one thing we really want to emphasize to our clients when we are considering police department storage options, is making sure that the client actually calls the police department first to inquire whether storage is an option, as opposed to just showing up with a firearm. Again, it seems like it might be intuitive, that being said we want to make sure we're setting ourselves and our clients up for success. Pawn shops - a lot of pawn shops, for a small very small loan, will be a reliable storage option and then gun stores and gun clubs. And as you can see there are a few of these items that have an asterisk next to it and these asterisks may require a formal transfer order, um, and this is where this slide hopefully will be helpful to direct you all. These are a couple of resources. Most of this resources have a directory by state, where you can look up different laws related to formal transfers and firearms. So, just it's just good to be aware of, what the laws are in your area. Um, I kind of debated whether we wanted to even take this on, and then I figured, you know, what? It's worth us noting. I'm not going to spend too much time on it, but this is something that is really kind of catching more and more momentum. Some of you have maybe heard of an ERPOS, or maybe this is your first-time hearing of an ERPO. It's relatively new legislature. But it's, it's gaining momentum and there is a potential that this can show up on our door. So it's just worth noting. So, an ERPO is an extreme risk protection order and currently 19 states have these in place. What an

ERPO is, it's a piece of legislature modeled off of domestic violence restraining orders, where if a family member or loved one of somebody at risk of suicide is seeing cause for concern, what they can do is they can activate an ERPO, which will then initiate a due process order that that individual will have their firearm temporarily removed from them, and then, of course, there is a follow-up which evaluates the level of threat and then determines what the next best step is for their safety and constitutional right. Now, currently as it stands, only family members, or those close to an individual can activate an ERPO. Mental health providers are not people who can trigger an ERPO yet. There is some of those entities that are lobbying for ERPOs. There is some conversation about looping providers into this so that they themselves can also activate an ERPO, but currently as it stands, providers are not able to activate this legal process. Um, so again, just something worth noting as more and more states adopt ERPOS. Again, it's becoming increasingly more likely that we will have a client who has either already had an ERPO activated on them, or may have an ERPO activated in the future. So worth noting. Okay, for tips and stylistic tricks from DBT incorporating firearm safety counseling. So, again, as Meredith really emphasized, our goal is to make this process as collaborative as possible. It can be challenging when we're talking about firearms. Again, firearms tend to activate a lot of emotions, both for clients and for providers. And so, leaning on DBT is a great way to approach this conversation and I think one of the things that I was really delightfully surprised by when starting to dig into this area, is just how well suited DBT is to have these conversations. There are a number of reasons for this. One is DBT already designed for people at elevated risk for suicide. So, these are our clients, this is the work what we're already doing, we're already having conversations about safety, we're already keenly aware of safety issues, and we're, we're focusing on interrupted

mood dependent behavior, which is what DBT is all about. We're trying to, as clinicians, get somewhere in between verge and action, and that is fundamental to preventing a firearm related suicide as we just talked about. So, what we're trying to do in DBT is [inaudible] up and running, so that we can engage somebody in value driven behavior as opposed to mood dependent behavior. And of course, the whole DBT construct sets us up to hopefully do that successfully. Another piece, in addition to the overall composition of DBT, there are some key elements in DBT that are really important in approaching a conversation about firearms. For example, the use of validation. What we know from the lethal means safety counseling literature is that validation and, in particular, validating the functions of a firearm in a particular patient's life is really, really, really important. And of course, as DBT clinicians we know this. Being able to validate the function of a gun or a firearm, to be able to validate whether it's in terms of their past or present experiences is fundamental to creating change. So, DBT already sets us up really well to do this, and what we know from lethal means safety counseling literature is that there are some key language elements to be really mindful of when we approach this conversation. So drawing from the firearm lethal means safety counseling research. What we know is you want to make sure were using lethal means safety, as opposed to referring to lethal means restriction. Restriction was a word that was much popular, even up to a couple of years ago. You will still hear it, and you really want to move away from the word. That is coming from some research where, I believe it was a N of 270-ish participants were presented with scripts and of those who heard the script lethal means safety, as opposed to lethal means restriction, what we know is that they were much more likely to engage in the conversation, and they were also much more likely to follow through with clinical recommendations when they heard lethal means safety versus lethal means

restriction. So incorporating that language into the conversation is really important. Similarly, we want to use the word firearm over gun. This one, I have to be honest with you, it's hard for me, I tend to be fairly informal. DBT, with it's flattened hierarchy and I get to be irreverent and I get to just kind of own my style, um, I tend to, again, be a little less formal, so this is one that continues to be my work, but we really do want to emphasizes the word firearm over the word gun. And then this final point is interesting. When also considering the language, we really do want to emphasize that there is a difference between firearm safety or what the phrase firearm safety kind of usually connotes, versus what we were trying to [inaudible]. So if you talk to an average Veteran and say, "Hey, let's have a conversation about firearm safety", what that is likely going to prompt in their mind is that you want to talk about safety measures for shooting. While, again, I've already disclosed, I can't tell you that I was really too savvy, in terms of firearm ownership, to have me as a clinician come in and watch someone initiate a conversation about firearm safety to a Veteran who was very savvy and very trained in the operation of a firearm. That, that's probably validating [inaudible]. Instead, what we want to do, is we really want to differentiate what we're trying to do with this conversation – from this idea of having conversation about basic safety measure for shooting because they know that. So we want to make sure we're using phrases like lethal means safety, or even firearm suicide safety as opposed to "Hey, I want to have a conversation about firearm safety." So you really do want to emphasize that this is related to suicide, be pretty direct about, so that was not offending them. Okay, so in addition to the language of relying on overall structure of DBT, one of the most important things as clinicians we can do is really stay balanced in the structural dialect of DBT, which is balancing acceptance and change. So, again, our goal is to make sure that we're not getting into a situation where we find

ourselves in opposition with our client, because then that's just not going to be a very collaborative or effective conversation. We know that when individuals are confronted, it turns, it pulls for them to often time just stick their heels in more, which doesn't facilitate change in the direction we want to go. So we really want to adopt a dialectical stance and you've got an example on your slide, where this might sound something like, "Look temporarily giving up your firearm when you rely on it for self-protection is really scary. And at the same time they're really worried about we are really worried about your safety and we know that having easy access to a firearm may make your next bad day fatal." So we really want to be thinking both and, both and, instead of either / or in the service of promoting behavioral change. And similarly with that, we really want to lean on validation. Um, even though validation is an acceptance-based strategy, it is often times the grease to the wheel. Validation, actually if you ever, if you do find yourself stuck at a crossroads with a client, validation often times is one of the first places that I'll want to go to try to start to see if we can get some movement. So, validation, confirming that which is true, accurate, and understandable given a person's current situation, and / or past history. So, really thinking about those levels of validation that we emphasize in DBT, and all of those are relevant to this conversation about firearm safe storage practices. So, what we really want to do, when validating, is we want to honor the wisdom. We want to honor our client's agenda when it comes to the role that the firearm plays in their lives. For a lot of our clients, firearms are a form of social connection, or may even behavior activation. Um, you know, there's lots of reasons why firearm is similarly safety. Obviously, especially if there is a trauma related background, or anything like that, um, and even just the culture that a lot of our Veterans are coming from, um there's a very special relationship and a lot of learning history to be very mindful of when we approach the

conversation about implementing steps to access a loaded lethal firearm. So the validation is going to be really, really important. It communicates acceptance, and what we know from a tremendous amount of research is that it can reduce negative affects, promote more disclosure of emotional states, improve emotion regulation skills, and even be effective in lowering negative mood and aggressions. If you ever find that you're stuck, again, this can be a tricky conversation to have. So, if you ever find that you're at a stalemate with a client and you want to do validation, you think if this lecture and be like, "Okay, let's try and validate." Um, if you're ever stuck about what to validate, here are some things that usually we can always find a kernel of truth.

END RECORDING