Duty to Warn and Protect:
Considerations for New Jersey Psychologists

Gianni Pirelli, Ph.D., ABPP
Board Certified in Forensic Psychology, Lic. NJ & NY

PIRELLI
CLINICAL AND FORENSIC PSYCHOLOGY
A Limited Liability Company

CRT
The Center for Research & Training at Pirelli Clinical and Forensic Psychology, LLC

2019 MCPA Meeting: 1.0 CE

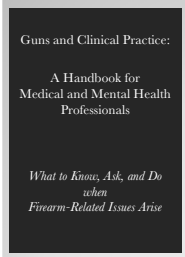
Disclaimer

This seminar is designed to provide the audience with education and information on mental health-related issues associated with firearms, particularly as such relates to NJ's duty to warn and protect standard.

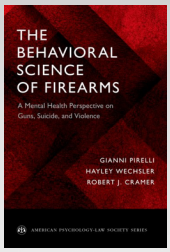
The primary goals of this course are to provide mental health and related professionals who conduct evaluations and provide (therapeutic) services with a framework from which to work in the context of this law and its intersection with firearm-related issues.

Information presented and discussed does not represent legal or psychological advice. Such should be sought from an attorney and/or mental health professional specifically retained to assist you.

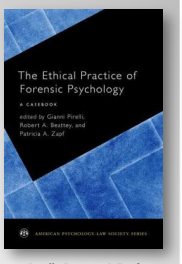
2



Pirelli & Gold
(in progress, under contract)



Pirelli, Wechsler, & Cramer
(2019)



Pirelli, Beattey, & Zapf
(2017)

Disclosure Statement: Please note - this talk is consistent with these books, from which Dr. Pirelli and colleagues may receive royalties through ***Oxford University Press***.

Course Outline

I. Duty to Warn and Protect in NJ:
A General Overview of 2A:62A-16

II. Amendment E to 2A:62A-16

III. Risk Assessment Concepts and Approaches

IV. The Intersection of Firearms and Mental Health
Emerging Roles and Responsibilities for NJ Psychologists

V. Q & A

4

Duty to Warn & Protect in NJ…

5

NJ 2A: 62A-16

Medical or counseling practitioner's immunity from civil liability.

1. a. Any person who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling, whether or not compensation is received or expected, is immune from any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth in subsection b. of this section and fails to discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following conditions exist:

(1)The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2)The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself.

6

NJ 2A: 62A-16

c. A licensed practitioner of psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling shall discharge the duty to warn and protect as set forth in subsection b. of this section by doing any one or more of the following:

(1) Arranging for the patient to be admitted voluntarily to a psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(2) Initiating procedures for involuntary commitment to treatment of the patient to an outpatient treatment provider, a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(3) Advising a local law enforcement authority of the patient's threat and the identity of the intended victim;

(4) Warning the intended victim of the threat, or, in the case of an intended victim who is under the age of 18, warning the parent or guardian of the intended victim; or

(5) If the patient is under the age of 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient.

d. A practitioner who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling who, in complying with subsection c. of this section, discloses a privileged communication, is immune from civil liability in regard to that disclosure.

L.1991, c.270, s.1; amended 2009, c.112, s.21.

7

Amended Law (firearm-related)…

8

A1181 Health Professionals

-amended our existing duty to warn requirement:

e. In addition to complying with subsection c. of this section, a licensed practitioner shall notify the chief law enforcement officer of the municipality in which the patient resides or the Superintendent of State Police if the patient resides in a municipality that does not have a full-time police department that a duty to warn and protect has been incurred with respect to the patient and shall provide to the chief law enforcement officer or superintendent, as appropriate, the patient's name and other non-clinical identifying information. The chief law enforcement officer or superintendent, as appropriate, shall use that information to ascertain whether the patient has been issued a firearms purchaser identification card, permit to purchase a handgun, or any other permit or license authorizing possession of a firearm.

www.njleg.state.nj.us/2018/Bills/A1500/1181_I1.PDF

A law enforcement officer or agency shall not be held liable in any civil action brought by any person for failing to learn of, locate, or seize a firearm pursuant to this subsection.

A patient who is determined to be subject to any of the disabilities established in paragraph (3) of subsection c. of N.J.S.2C:58-3 and submits a certificate of a medical doctor or psychiatrist licensed in New Jersey, or other satisfactory proof in accordance with that paragraph shall be entitled to the reinstatement of any firearms purchaser identification cards, permits to purchase a handgun, and any other permit or license authorizing possession of a firearm seized pursuant to this subsection.

A1181

Concerns?

11

American Psychiatric Association

"Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, **laws designed to limit firearm possession that mandate reporting to law enforcement officials by psychiatrists and other mental health professionals of all patients who raise concerns about danger to themselves or others are likely to be counterproductive and should not be adopted.** In contrast to long-standing rules allowing mental health professionals flexibility inacting to protect identifiable potential victims of patient violence, these statutes intrude into the clinical relationship and are unlikely to be effective in reducing rates of violence." (p. 198, Pinals et al., 2015, emphasis added)

Mental Health & Firearm Laws

- concerns with practicality, reporting and:

  STIGMATIZATION

- people less likely to seek help
  - think: military, law enforcement, corrections…

13

RUTGERS

Tough Cops

Ask For Help

Don't remain silent

Don't let stigma stand in your way

Depression, Anxiety, Substance Abuse, Post-Traumatic Stress Disorder, and other Mental Health Care Needs

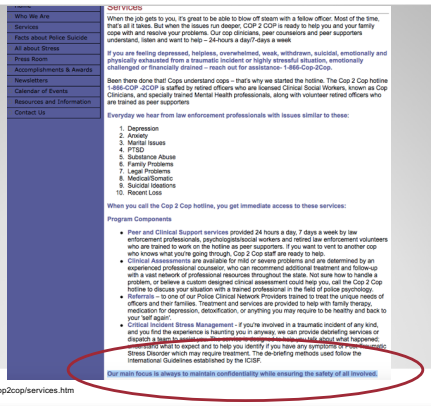
Help is available for you and your loved ones

1-866-COP 2 COP
1-866-267-2267

Cops helping Cops – confidential, 24/7, free

Created by the NJ Police Suicide Task Force

14



Who We Are
Services
Facts about Police Suicide
All about Stress
Press Room
Accomplishments & Awards
Newsletters
Calendar of Events
Resources and Information
Contact Us

Services

When the job gets to you, it's great to be able to blow off steam with a fellow officer. Most of the time, that's all it takes. But when the issues run deeper, COP 2 COP is ready to help you and your family cope with and resolve your problems. Our cop clinicians, peer counselors and peer supporters understand, listen and want to help – 24-hours a day/7-days a week.

If you are feeling depressed, helpless, overwhelmed, weak, withdrawn, suicidal, emotionally and physically exhausted from a traumatic incident or highly stressful situation, emotionally challenged or financially drained – reach out for assistance- 1-866-Cop-2Cop.

Been there done that! Cops understand cops – that's why we started the hotline. The Cop 2 Cop hotline 1-866-COP -2COP is staffed by retired officers who are licensed Clinical Social Workers, known as Cop Clinicians, and specially trained Mental Health professionals, along with volunteer retired officers who are trained as peer supporters

Everyday we hear from law enforcement professionals with issues similar to these:

1. Depression
2. Anxiety
3. Marital Issues
4. PTSD
5. Substance Abuse
6. Family Problems
7. Legal Problems
8. Medical/Somatic
9. Suicidal Ideations
10. Recent Loss

When you call the Cop 2 Cop hotline, you get immediate access to these services:

Program Components

- Peer and Clinical Support services provided 24 hours a day, 7 days a week by law enforcement professionals, psychologists/social workers and retired law enforcement volunteers who are trained to work on the hotline as peer supporters. If you want to vent to another cop who knows what you're going through, Cop 2 Cop staff are ready to help.
- Clinical Assessments are available for mild or severe problems and are determined by an experienced professional counselor, who can recommend additional treatment and follow-up with a vast network of professional resources throughout the state. Not sure how to handle a problem, or believe a custom designed clinical assessment could help you, call the Cop 2 Cop hotline to discuss your situation with a trained professional in the field of police psychology.
- Referrals – to one of our Police Clinical Network Providers trained to treat the unique needs of officers and their families. Treatment and services are provided to help with family therapy, medication for depression, detoxification, or anything you may require to be healthy and back to your 'self again'.
- Critical Incident Stress Management - if you're involved in a traumatic incident of any kind, and you find the experience is haunting you in anyway, we can provide debriefing services or dispatch a team to assist you. The team members are trained to help you talk about what happened; explaining what to expect and to help you identify if you have any symptoms of Post-Traumatic Stress Disorder which may require treatment. The de-briefing methods used follow the International Guidelines established by the ICISF.

Our main focus is always to maintain confidentiality while ensuring the safety of all involved.

http://ubhc.rutgers.edu/cop2cop/services.htm

15

Risk Assessment Concepts and Approaches…

16

Remember…

(good) Clinical Decision-Making

is grounded in

Professional Competence

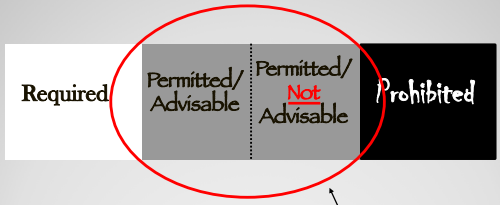
Practice and Legal Standards and Guidelines
Ethics
Cultural Competence
Data- and Empirically-Driven ***(to the extent possible)***

17

Summary of
Ethical Models

STOP…
THINK…
CONSULT…
ANTICIPATE…
DECIDE…
ACT…
FIX…

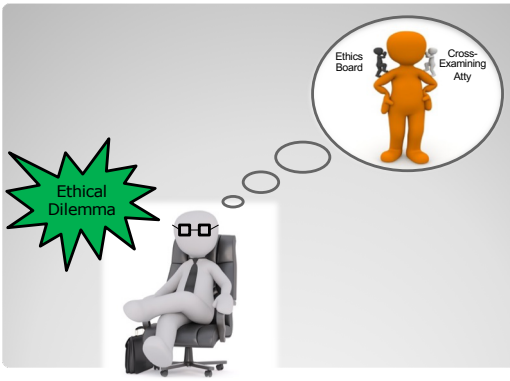
R. K. Otto (2015)



i.e., why we are here…
(the core of decision-making)

"Ethics is knowing the difference between what you have a right to do and what is right to do."

-SCOTUS Justice Potter Stewart



The

Know (K), Ask (A), Do (D)

Framework

(see Appendix)

Pirelli & Gold (2019) 22

KAD: How to Assess Risk

General Violence & Suicide Risk Assessment Models & Principles

When applicable:

- assess violence and/or suicide risk using questions from a step-wise, semi-structured, prevention-based framework
  - (avoid prediction-based approaches)
- include questions related to nomothetic and idiographic (case-specific) factors

23

***Work from a Prevention-Based Framework to Assess Risk…**

(not prediction)

24

APA Press Release (2016)

After Decades of Research, Science is No Better Able to Predict Suicidal Behaviors

"Experts' ability to predict if someone will attempt to take his or her own life is no better than chance and has not significantly improved over the last 50 years…"

*per Franklin et al. (2017)

25

****Risk is context-specific and risk levels can fluctuate (static vs. dynamic risk factors)**

26

PROACTIVE

vs.

reactive or over-reactive

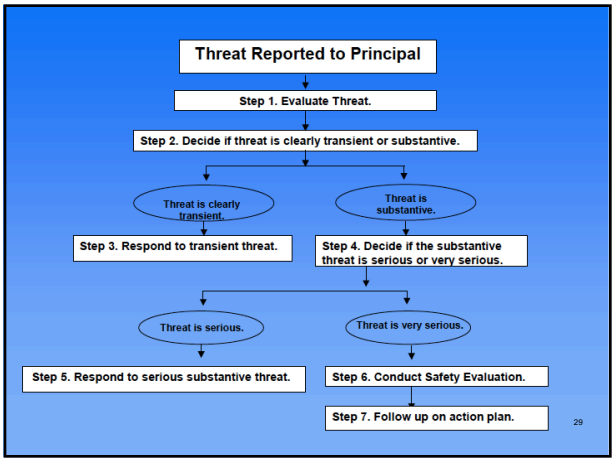
*analysis of behavior, not demographics, etc.
*poses a threat vs. made a threat
*thresholds have bidirectional liability implications

27

The Virginia Model

(Cornell & Sheras, 2006)

28



29

TRANSIENT

- Often rhetorical, not genuine with intent
- Temporary expression of feelings (e.g., anger, frustration)
- Often resolved immediately, threat dissipates
- Apology

SUBSTANTIVE

- Intent to harm beyond immediate situation
- Risk that student will carry it out
- Requires protective action
  - (e.g., warning victims, others)
- Legal violations?
  - Police intervention?

****When in doubt, treat threats as Substantive**

Guidelines for Responding to Student Threats of Violence (D. Cornell)
https://curry.virginia.edu/uploads/resourceLibrary/8-2003-apa-guidelines-for-responding-to-student-threats-of-violence.pdf

30

GUNSITTERS
SECURE FIREARM STORAGE SOLUTIONS

831-B Route 10 East
Whippany, NJ 07981
973-610-8600
storage@gunsitters.com

Disabled Combat Veteran-Owned Business
WEAPONS GUARD
SERVICE MEMBER FIREARM STORAGE FOUNDATION
501(C)(3) NON-PROFIT ORGANIZATION

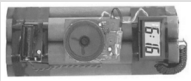
Weapons Guard™ is a 501(c)(3) Non- Profit Organization designed specifically for members of the Armed Forces to store their firearms. We will ensure the safe storage of your firearms in any situation. Our Mission is to ensure safe storage of personally owned firearms for members of the Armed Services and some cases, FREE of Charge!

31

The Intersection of Firearms and Mental Health…

32

A



explosive bomb

explosive grenade

B

18 U.S.C. § 921(a)(3) defines a "firearm" as:

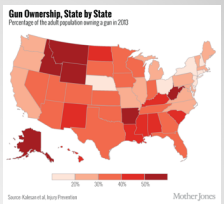
A. any weapon (including a starter gun) which will or is designed to or may readily be converted to expel a projectile by the action of an explosive;
B. the frame or receiver of any such weapon;
C. any firearm muffler or firearm silencer; or
D. any destructive device. Such term does not include an antique firearm.

*manufactured in or before 1898 that is not designed or redesigned for using rimfire or conventional center fire ignition with fixed ammunition is an antique firearm

NJ Ownership Stats

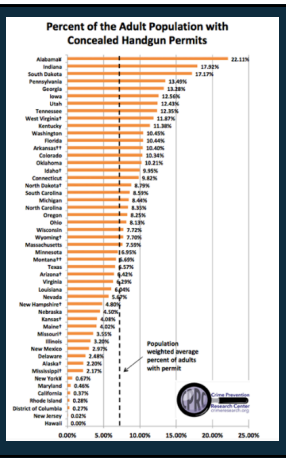
Estimated:

- 11-12%(somewhere in the bottom 4/51*)
- ~1 million+



USAcarry.com via www.thoughtco.com/gun-owners-percentage-of-state-populations-3325153
www.cbsnews.com/pictures/gun-ownership-rates-by-state/4/

35



17.25m

https://crimeresearch.org/2018/08/new-study-17-25-million-concealed-handgun-permits-biggest-increases-for-women-and-minorities/

Rod & Gun and Hunting Clubs, and Shooting Ranges

- ~500 rod & gun/hunting clubs in USA*
- 600+ shooting ranges±
- ~70 clubs and ranges in NJ+

*rodandgunclub.com ±usacarry.com/directory/category/gun-ranges/
+rangelistings.com/shooting-ranges/NJ.html

37

"Gun Violence"

-and-

The mentally ill mass shooter with an "assault weapon"

38

'mentally ill'

39

The Role of Mental Illness in Firearm-Related Violence

- weak predictor … *(dx- and symptom-dependent)
- SMI -> 3-5% of violence, not all of which is firearm-related
- leads to further stigmatization

- Dxs. of Potential Relevance:
  SUDs, Disruptive, Impulse Ctl, Conduct + ASPD

Gold (2013); Gold & Simon (2015)

40

American Psychiatric Association

- vast majority of gun viol. Not attributable to severe mental illness
- bans should be due to risk, not diagnosis
- restoration process
- improved tx access is important, but likely limited impact on violence rates

Pinals et al. (2015)

41

Mental Health & Firearm Laws

- +prohibitors in place, but shifting tide in the professions?

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

(The Consortium for Risk- Based Firearms Policy McGinty et al., 2014, p. e22)

42

'mass shooter'

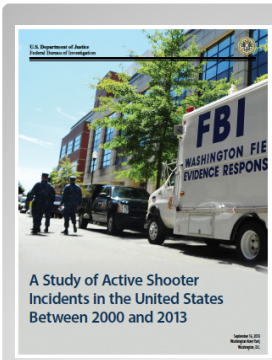
43

U.S. Firearm Statistics

CDC (2010, 2013)

- per year:
  - 31,000 firearm-related deaths *(2/3 suicide)
  - 78,000 nonfatal injuries
  - ~600 unintentional
  - Homicides: 35% of firearm-related deaths
  - Suicides: 61% of firearm-related deaths

44



160 incidents occurred between 2000 and 2013

486 were killed in 160 incidents

U.S. Commercial Airline Fatalities (2000-2013)…?

669

https://www.airfleets.net/crash/crash_country_USA.htm

What about the 30,000 annual deaths from "Gun Violence?"

EXECUTIVE ORDER NO. 21

WHEREAS, every New Jersey resident deserves to live in a community that is safe, secure, and free from gun violence; and

WHEREAS, gun violence takes a devastating toll on its victims, their families, and the communities in which it occurs; and

WHEREAS, an average of 96 people in America die from gun violence every day; and

WHEREAS, according to the most recent data, there were nearly 500 gun deaths in the State of New Jersey in 2016; and

CRIME INDEX FOR THE STATE - 2016

OFFENSES	NUMBER OF INDEX OFFENSES	RATE PER 1,000 INHABITANTS	PERCENT DISTRIBUTION	NUMBER OF OFFENSES CLEARED	PERCENT OF OFFENSES CLEARED
MURDER	378	*	0.2	203	53.7

https://nj.gov/infobank/eo/056murphy/pdf/EO-21.pdf

N.J. Stats: Firearm-Related…

Homicides: 0.3% of deaths
- 69% of homicides with firearm

Suicides: 0.2% of deaths
- 27% of suicides with firearm

Unintentional : 7…<0.01% of deaths
- 0.3% of unintentional deaths

2 firearm deaths from legal intervention

New Jersey Department of Health's State Health Assessment Data (NJSHAD) System: 2009

49

NJ Stats: Geography

384 homicides in 2012
- Essex 121 (31%)
- Camden 71 (18%)
- Passaic 29 (7.5%)
- Union 28 (7.2%)
- Mercer 26 (6.7%)

49%

71% (274) involved a firearm

New Jersey Uniform Crime Report: 2012

50

NJ Stats: Geography

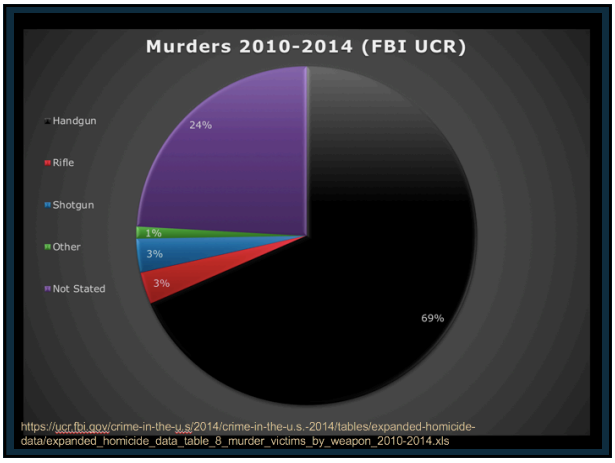
1,784 suicides 2004-2006

27.7% (495) with firearm
- Salem 7/14 (50%)
- Sussex 18/40 (45%)
- Warren 11/28 (39%)

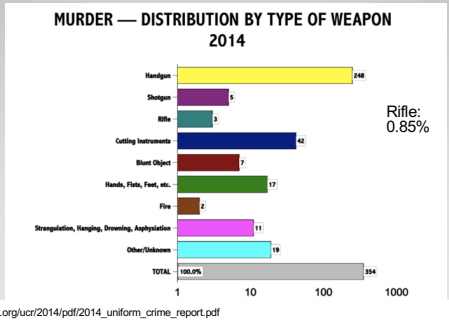
New Jersey Office of Injury Surveillance and Prevention Brief : 2008

'assault weapon'

52



NJ UCR 2014



www.njsp.org/ucr/2014/pdf/2014_uniform_crime_report.pdf

Think: 1, 2, 3, 2/3

<1% gun deaths from active shooters

2% murders with rifles

3 to 5% violence attributable to severe mental illness

2/3 gun deaths are suicides

'To Begin to Understand Gun Deaths in Context…'
-Gianni Pirelli, Ph.D, ABPP (2019)

55

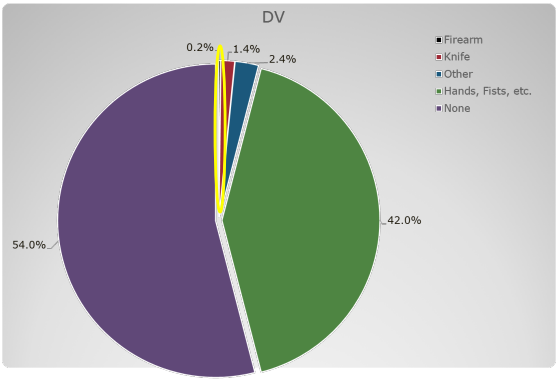
NJ DV Stats 2015: Weapon

62k incidents per year

- 33,088 None
- 26,104 Hands, Fists, Feet, etc.
- 1,449 Other Dangerous Weapon
- 885 knife
- 133 firearm

www.njsp.org/ucr/pdf/domesticviolence/2015_domestic_violence.pdf

56



57

Homicides

- 49
- How many with a firearm?
- ⩽23 (or < ½)*

"Aggravated Serious"

58

KAD: How to Assess Firearm-Specific Risk

When applicable:

- inquire about the nature and extent of likely (or "easy") gun access
- assess for the presence of firearm-specific risk factors to distinguish patients who are likely to engage in firearm-involved violence and suicide from those who are not

59

Firearm-Specific Risk

- not solely or simply "access"
  - focus on moderation, rather than assuming risk
- *Must distinguish btw risk levels among those with access

*prevention…
-when other risk factors and/or warning signs present
-***moderating*** *risk factor?*

- Means-restriction counseling?

60

KAD: Intervention Options

- Remember: if the case extends beyond one's professional competence, seek consultation and/or refer out for further evaluation and/or treatment
- Develop an emergency plan in advance, to include options for peer consultation as well as awareness of local firearm storage options and emergency care, or crisis, services
- Be prepared to provide general counseling in matters that do not reach a higher risk threshold, which may include psychoeducational materials regarding risk factors, warning signs, and preventive and emergency response measures
- When a concerning risk threshold is reached, attempt to collaborate on a risk management plan with patient unless it is a crisis or a duty to warn and/or protect duty is prompted
  - updated inquiries about family support and assistance in this regard and/or other storage options for firearms
  - Is an emergency risk protection order or red flag order an option for the clinician or family?
- Document relevant information, assessment, and procedural data
- Recognize when no particular action is clinically warranted

61

Interventions

- Informed, semi-structured inquiries and/or formal evaluation (clinical or forensic? In-house or out?)
- Preparedness regardless of incoming data/information
- Securing consents (in advance, when applicable) to include other professionals, family, collaterals
- *Focus on process and document/consult
- Ensure wrap-around services (avoid clearances & "waiting for a call mentality")

62

Thank You!

GIANNI PIRELLI, PH.D., ABPP
BOARD CERTIFIED IN FORENSIC PSYCHOLOGY
LICENSED PSYCHOLOGIST
NJ #4975 NY #019418

WWW.GPIRELLI.COM
PIRELLI@GPIRELLI.COM

80 POMPTON AVENUE, STE. 204
VERONA, NJ 07044

Appendix

Additional Information and Further Reading

64

NJ Firearm Purchase Law

2C: 58-3, section c

- prohibits the issue of permits to certain people, including but not limited to:

(1) those who have been convicted of any crime or disorderly persons offense involving an act of domestic violence;

(2) any drug dependent person who is confined for a mental disorder to a hospital or institution, or to any person who is presently an habitual drunkard;

65

2C: 58-3, section c (cont.)

(3) any person who suffers from a physical defect or disease which would make it unsafe for him to handle firearms, to any person who has ever been confined for a mental disorder, or to any alcoholic unless any of the foregoing persons produces a certificate of a medical doctor or psychiatrist licensed in New Jersey, or other satisfactory proof, that he is no longer suffering from that particular disability in such a manner that would interfere with or handicap him in the handling of firearms.

(5)To any person where the issuance would not be in the interest of the public health, safety or welfare;

66

STATE OF NEW JERSEY

Application for Firearms Purchaser Identification Card and/or Handgun Purchase Permit

This form is prescribed by the Superintendent for use by applicants for Firearms Purchaser I.D. Cards & Handgun Purchase Permits. Any alteration to this form is expressly forbidden.

Check Appropriate Block(s)

- ☐ Initial Firearms Purchaser Identification Card
- ☐ Lost or Stolen Identification Card
- ☐ Mutilated Identification Card
- ☐ Change of Address on Identification Card
- ☐ Change of Sex on Identification Card
- ☐ Change of name on Identification Card — *List former name and attach copy of marriage license or court order*
- ☐ Application to Purchase a Handgun — Quantity of Permits: _____

(16) *Have you ever been convicted of any domestic violence offense in any jurisdiction which involved the elements of (1) striking, kicking, shoving, or (2) purposely or attempting to or knowingly or recklessly causing bodily injury, or (3) negligently causing bodily injury to another with a deadly weapon? If yes, explain.* ☐ Yes ☐ No

(17) *Are you subject to any court order issued pursuant to Domestic Violence? If yes, explain.* ☐ Yes ☐ No

(23) *Are you an alcoholic?*	☐ Yes ☐ No	(24) *Have you ever been confined or committed to a mental institution or hospital for treatment or observation of a mental or psychiatric condition on a temporary, interim, or permanent basis? If yes, give the name and location of the institution or hospital and the date(s) of such confinement or commitment.*	
(25) *Are you dependent upon the use of a narcotic(s) or other controlled dangerous substance(s)?*	☐ Yes ☐ No	(26) *Have you ever been attended, treated or observed by any doctor or psychiatrist or at any hospital or mental institution on an inpatient or outpatient basis for any mental or psychiatric condition? If yes, give the name and location of the doctor, psychiatrist, hospital or institution and the date(s) of such occurrence.*	

Note: same question(s) for:

Initial Application For a Retired Law Enforcement Officer Permit to Carry a Handgun

www.njsp.org/firearms/pdf/ids-033.pdf

67

Firearm-Specific Education & Training

Traylor et al. (2009): n = 339 clinical psychs.

- 79% = firearm issues greater w/ mh pts
- 78% = no charting on firearms
- ½ = likely to provide guidance
- ½ = no firearm safety education
  - 20% of the other half → from the media
  - 13% graduate training, 7% prof. journals

68

cont.

Price et al. (2010): n = 213 college counsel.

- 6% = likely to provide guidance
- 17% = asked or charted on firearms
- ½ = no firearm safety education
  - 15% of the other half → from the media
  - 14% graduate training, <10% CEs, journals

- HOWEVER

69

Price et al. (2010)

nearly all *at least* moderately confident in ability to:

- *ask* clients about the presence of firearms in their residence (97%)
- *advise* clients to remove the firearms from their residence (94%)
- *assess* the willingness of clients to remove firearms within the next 30 days (89%)

-AND MANY:

- *assist* clients in what to do with firearms removed from residences (59%)
- *arrange* follow-up contact within four weeks to assess firearm removal (83%)

70

Pirelli's KAD Model (2019)

Know (K), Ask (A), Do (D)

1. *What do medical and mental health professionals first need to know?*
2. *What might they ask?*
3. *What might they do at that point?*

71

Know (K), Ask (A), Do (D)

- Gun Culture, Safety, and Laws
- When & How to Ask about Guns
- How to Assess Risk
  - Firearm-Specific Risk Assessment
- Intervention Options

72

KAD: Cultural Competence

Develop an awareness of:

- gun-related language, terms, and definitions
- clinicians' own potential biases related to patients' views on guns and ownership status
- firearm-related subgroups and identify which, if any, patients belong to include patients' gun ownership status and/or level of access, including any changes to either
- local norms (e.g., rates of gun ownership, public sentiment and practices, violence and suicide rates – with and without guns, legal regulations)

73

Gun Subcultures

- Second Amendment (2A) Groups
- Shooting Sport Groups
- Rod & Gun/Hunting Clubs, Shooting Ranges
- Gun Control and Gun Violence Prevention
- Military, Law Enforcement, Corrections
- Gangs, Organized Crime & Other Crim.
- Victims of Firearm-Related Suicide, Violence, DV/IPV

Pirelli & Witt (2017)

74

KAD: Gun Safety Principles

Gain an Understanding of:

- clinicians' and patients' knowledge of and adherence to gun safety principles, including patients' storage, transportation, handling, and gun use practices

75

KAD: Gun-Related Laws

- Identify clinicians' and patients knowledge of:
  - state laws on confidentiality and reporting (i.e., duty to warn and/or protect)
- federal and state laws generally related to:
  - prohibited persons, firearms, ammunition, and magazine capacity, background checks, Castle Doctrine ("Stand Your Ground"), Right to Carry (RTC), transportation and storage (incl. child access prevention; CAP), transportation, and hunting

76

KAD: When & How to Ask about Guns

Local Laws and Policies

- Develop knowledge and a process for:
  - clinicians' state- and institutional-level requirements regarding asking or counseling patients about guns
  - clinicians' options when patients do not want to discuss/report guns or gun access
  - in non-crisis situations, providing patients with the option to discuss/report their gun ownership status and/or level of access; maintain an open-stance and invitation
  - for patients who decline, seek clarification as to why
- for those who are agreeable, inquire about family support and assistance and/or other storage options for firearms should a risk management plan be needed in the future

77

GUNSITTERS
SECURE FIREARM STORAGE SOLUTIONS

831-B Route 10 East
Whippany, NJ 07981
973-610-8600
storage@gunsitters.com

Disabled Combat Veteran-Owned Business
WEAPONS GUARD
SERVICE MEMBER FIREARM STORAGE FOUNDATION
501(C)(3) NON-PROFIT ORGANIZATION

Weapons Guard™ is a 501(c)(3) Non- Profit Organization designed specifically for members of the Armed Forces to store their firearms. We will ensure the safe storage of your firearms in any situation. Our Mission is to ensure safe storage of personally owned firearms for members of the Armed Services and some cases, FREE of Charge!

78

KAD: When & How to Ask about Guns

Professional Ethics and Standards of Practice

- ensure patients understand the limits of confidentiality
- exhibit a professional and cultural competence-based approach to prioritize and facilitate rapport-building, and to ensure the highest quality of care to include consistency in procedures across patients and services versus arbitrary or casual inquiries; avoiding confirmation bias and knee-jerk reactions
- ask questions that seek to gain a clinical appreciation of both the patients' group-levels of acculturation and their individual differences
- knowing limits of professional competence and when to refer out, especially understanding therapeutic versus forensic roles

79

KAD: How to Assess Risk

General Violence & Suicide Risk Assessment Models & Principles

When applicable:

- assess violence and/or suicide risk using questions from a step-wise, semi-structured, prevention-based framework (avoid predication-based approaches)
- include questions related to nomothetic and idiographic (case-specific) factors

80

KAD: How to Assess Risk

Firearm-Specific Risk

When applicable:

- inquire about the nature and extent of likely (or "easy") gun access
- assess for the presence of firearm-specific risk factors to distinguish patients who are likely to engage in firearm-involved violence and suicide from those who are not

81

KAD: Intervention Options

- Remember: if the case extends beyond one's professional competence, seek consultation and/or refer out for further evaluation and/or treatment
- Develop an emergency plan in advance, to include options for peer consultation as well as awareness of local firearm storage options and emergency care, or crisis, services
- Be prepared to provide general counseling in matters that do not reach a higher risk threshold, which may include psychoeducational materials regarding risk factors, warning signs, and preventive and emergency response measures
- When a concerning risk threshold is reached, attempt to collaborate on a risk management plan with patient unless it is a crisis or a duty to warn and/or protect duty is prompted
  - updated inquiries about family support and assistance in this regard and/or other storage options for firearms
  - Is an emergency risk protection order or red flag order an option for the clinician or family?
- Document relevant information, assessment, and procedural data
- Recognize when no particular action is clinically warranted

82

Gun Evaluations

- Formal Firearm Evaluations
  - Civilian
    - Applicants
    - Reinstatement (incl. but not limited to 'Red Flag')
    - Pirelli Firearm-10 (PF-10) SPJ framework
  - Considerations for Law Enforcement and Related Professions

83

Pirelli Firearm-10 (PF-10)

	Domain
1	Reason(s) for Seeking Licensure/Reinstatement
2	Exposure to Firearms
3	Knowledge of and Perspectives on Firearm Safety Precautions and Relevant Firearm Regulations
4	Experience, Intent for Use, Storage, and Continued Education
5	Response Style
6	Violence Risk
7	Domestic and Intimate Partner Violence Risk
8	Suicide Risk
9	Mental Health
10	Substance Use

Pirelli et al. (2014-2019, + in progress)

84

Firearm Basics

AR-15:
ArmaLite Rifle. A semi- automatic firearm that is gas operated.

Assault Weapon:
An automatic firearm with a detachable magazine and a pistol grip often a type of rifle typically for military use.

Automatic: A firearm which continues to fire as long as the trigger remains depressed (e.g., machine gun).

Concealed Carry: To carry a firearm on one's person that cannot be seen by the public.

Constitutional Carry: To carry a firearm in public without a government permit that does not need to be concealed.

Firearms Identification Card (FID): A permit issued by a state or local government allowing the sale, purchase, or ownership of a firearm.

85

Full Metal Jacket: A round of ammo where each bullet is encased in a stronger/ harder metal.

Magazine: A container, either fixed to a pistol's frame or detachable, which holds cartridges under spring pressure to be fed into the gun's chamber.

Open Carry: To carry a firearm that is not concealed to the public.

Pistol: Refers generally to any handgun that is not a revolver.

Plinking: Shooting at inanimate objects typically to practice shooting.

Round: A unit of ammunition consisting of the primer, casing, propellant and bullet. A cartridge.

Safety: A mechanical device built into a weapon intended to prevent accidental discharge. It may be either manually operated or automatic.

Semi-Automatic: A pistol that is loaded manually for the first round. Upon pulling the trigger, the gun fires. Energy from the discharging bullet is used to eject the fired round, cock the firing mechanism and feed a fresh round from the magazine. The trigger must be released after each shot and pulled again to fire the next round.

86

Firearm Safety

National Shooting Sports Foundation (NSSF)

1. Always Keep The Muzzle Pointed In A Safe Direction
2. Firearms Should Be Unloaded When Not Actually In Use
3. Don't Rely On Your Gun's "Safety"
4. Be Sure Of Your Target And What's Beyond It
5. Use Correct Ammunition
6. If Your Gun Fails To Fire When The Trigger Is Pulled, Handle With Care!
7. Always Wear Eye And Ear Protection When Shooting
8. Be Sure The Barrel Is Clear Of Obstructions Before Shooting
9. Don't Alter Or Modify Your Gun, And Have Guns Serviced Regularly
10. Learn The Mechanical And Handling Characteristics Of The Firearm You Are Using

*consistent with the NRA's fundamental rules as well, plus two rules: (a) never use alcohol or over-the-counter, prescription, or other drugs before or while shooting, and (b) be aware that certain types of guns and many shooting activities require additional safety precautions

87

Firearms & Suicide

**the "real" link between guns & MI

- firearms = most common suicide method
- 90%+ suicides = mental illness
- 60%+ of annual 31,000 firearm-deaths

- and…NJ Police Suicide Task Force (2009): officers 30% higher than peers 25-64

88

New Jersey Police Suicide Task Force Report 2009

Table 1. Suicide Rates of Law Enforcement Officers versus Males 25-64 years, New Jersey, 2003-2007

Crude rates	Annual Suicides*	Population***	Crude Rate (per 100,000)	Ratio LE:Male
Current LE	7.4	40,000	18.5	1.3
Corrections only	2.4	6,900	34.8	2.5
Police only	5	33,200	15.1	1.1
New Jersey**				
Total population	536	8,700,000	6.2	
Males 25-64 years	322	2,300,770	14.0	

*Average 2003-2007; excludes retired officers and officers on disability.
***Law enforcement population data from 2006 UCR

89

Table 2. Reported Circumstances of Law Enforcement and Other Suicides Males, New Jersey, 2003-2007

	Percent with circumstance reported					
	All suicides			Gun suicides		
	Total	Law Enforcement	p	Total	Law Enforcement	p
Crisis in last two weeks	24.9	32.6		27.8	38.5	
Depressed mood	35.8	28.3		42.4	25.6	0.04
Death of family or friend	5.7	10.9		7.2	10.3	
Financial problem	9.2	13		8.2	10.3	
Physical health problem	21.8	34.8	0.03	31.2	38.5	
History of mental health treatment	32.1	15	0.01	21.4	10.3	0.09
Intimate partner problem	25.2	39.1	0.03	27.9	35.9	
Job problem	11.5	6.7		10.5	7.9	
Legal problem	3.4	2.2		2.8	2.6	
Mental health problem	37.6	19.6	0.01	26.1	18	
Perpetrator of intimate partner violence	5.2	13.3	0.09	9.7	12.8	
Left a suicide note	32.1	34.88		33.3	30.1	
Substance abuse	16.1	6.5	0.07	10.5	5.1	
History of attempts	15.5	6.5	0.07	7.7	5.1	
Disclosed intent	20.1	8.7	0.06	24.1	5.1	0.009
Current mental health treatment	26.8	13	0.04	18.2	10.3	
Alcohol problem	16.87	6.5	0.06	14.6	5.1	

Source: New Jersey Violent Death Reporting System, New Jersey Department of Health and Senior Services
Note: p-value shown when less than .10; indicates significant difference at 90% or greater.

90

Firearm-Involved Suicide

2/3+ of military suicides
(Anglemyer, Miller, Buttrey, & Whitaker, 2016; McCarten, Hoffmire, & Boassarte, 2015)

91% of law enforcement
(Violanti, Mnastakanova, Hartley, Andrew, & Burchfiel, 2012)

91

Substance Abuse and Mental Health Services Administration SAMHSA

23.4 million veterans; 2.2 mil. Active and 3.1 immed. fam

18.5% from Iraq/Afghan → PTSD and 19.5% TBI

only 50% seek treatment, half of those adeq. care

2004-2006: 7.1% SUDs

2009: MH and SUDs → more hospitalizations than any other cause

Army suicide all time high in 2012

2005-2009: 1,100+ suicides in Armed Forces, 1 every 36 hours

https://www.samhsa.gov/veterans-military-families 92

VA's DV Task Force (2013)

"Currently the VA does not have a comprehensive national program to address IPV" (p. 11)

-research synthesis: active (n = 88,568), retired (25,497)

Findings: 12-month IPV perpetration among active duty:

22 % perpetration F 29% versus M 18%

30% victimization F 26% vs. M 31%

Gierisch JM, Shapiro A, Grant NN, King HA, McDuffie JR, Williams JW. Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches. VA-ESP Project #09-010; 2013. 93

Law Enforcement DV

20-40% (Neidig, Rusell, & Seng, 1992), but largely unknown:

"The lack of information may result in part from the distinctive culture of law enforcement. A conspicuous feature of that culture is the tendency of officers to think of themselves as separate and apart from the citizens whom they serve"
(p. 85, Oehme et al., 2011)

94

Relevant Citations – Pirelli et al.

BOOKS

Pirelli, G., & Gold, L. H. (in progress). *Guns and clinical practice: A handbook for medical and mental health professionals. What to know, ask, and do when firearm-related issues arise.* Oxford U. Press.

Pirelli, G., Wechsler, H., & Cramer, R. (2019). *The behavioral science of firearms: A mental health perspective on guns, suicide, and violence.* Oxford University Press.

Pirelli, G., Beattey, R. A., & Zapf, P. A. (2017). *The ethical practice of forensic psychology: A casebook.* Oxford University Press.

BOOK CHAPTERS

Pirelli, G., Wechsler, H., & Schrantz, K. (in progress, invited). The emerging role in shaping U.S. gun policy. *In:* M.K. Miller and B.H. Bornstein (Eds.), *Advances in psychology and law.* Springer.

PROFESSIONAL JOURNAL ARTICLES

Pirelli, G., & Gold, L. H. (2019). Leaving Lake Wobegon: Firearm-related education and training for medical and mental health professionals is an essential competence. *Journal of Aggression, Conflict and Peace Research, 11*(2), 78-87.

Pirelli, G., & Witt, P. H. (2018). Firearms and cultrual competence: Considerations for mental health practitioners. *Journal of Aggression, Conflict and Peace Research, 10*(1), 61-70.

Pirelli, G., Wechsler, H., & Cramer, R. (2015). Psychological evaluations for firearm ownership: Legal foundations, practice considerations, and a conceptual framework. *Professional Psychology: Research and Practice, 46*(4), 250-257.

Pirelli, G., & Witt, P. (2015). Psychological evaluations for civilian firearm ownership in New Jersey. *New Jersey Psychologist, 65*(1), 7-9.

95

Further Reading

American Psychological Association. (2013a). Gun violence: Prediction, prevention, and policy. www.apa.org/pubs/info/reports/gun-violence-prevention.aspx

Consortium for Risk-Based Firearm Policy. 2013a. Guns, Public Health, and Mental Illness: An Evidence-Based Approach for Federal Policy: Consortium for Risk-Based Firearm Policy.
—— 2013b. Guns, Public Health, and Mental Illness: An Evidence-Based Approach for State Policy.

Cornell, D. (2007). The Virginia model for student threat assessment. Public Entity Risk Institute (PERI) online conference. www.riskinstitute.org/peri

Gold, L. H., & Simon, R. I. (2016). Gun violence and mental illness. Arlington, VA: American Psychiatric Association.

McGinty, E. E., Frattaroli, S., Appelbaum, P. S., Bonnie, R. J., Grilley, A., Horwitz, J., Swanson, J. W., & Webster, D. W. (2014). Using research evidence to reframe the policy debate around mental illness and guns: Process and recommendations. American Journal of Public Health, 104(11), e22-e26.

Pinals D. A., Appelbaum, P. S., Bonnie, R., Fisher, C. E., Gold, L. H., & Lee, L. (2015a). American Psychiatric Association: Position statement on firearm access, acts of violence and the relationship to mental illness and mental health services. Behavioral Sciences & The Law, 33(2/3), 195-198.

Pinals, D. A., Appelbaum, P. S., Bonnie, R. J., Fisher, C. E., Gold, L. H., & Lee, L. (2015b). Resource document on access to firearms by people with mental disorders. Behavioral Sciences & The Law, 33(2/3), 186-194.

96

Further Reading cont.

Price J. H., Kinnison A., Dake J. A., et al. (2007). Psychiatrists' practices and perceptions regarding anticipatory guidance on firearms. *Am J Prev Med. 33*, 370–373.

Price, J., Mrdjenovich, A. J., Thompson, A., & Dake, J. A. (2009). College counselors' perceptions and practices regarding anticipatory guidance on firearms. *Journal of American College Health*, *58*(2), 133-139.

Price J. H., Thompson A. J., Khubchandani J., et al. (2010). Firearm anticipatory guidance training in psychiatric residency programs. *Acad Psychiatry, 34*, 417–423.

Slovak, K., Brewer, T.W., & Carlson, K. (2008). Client firearm assessment and safety counseling: The role of social workers. Social Work, 53(4), 358-366.

Traylor, A., Price, J. H., Telljohann, S. K., King, K., & Thompson, A. (2010). Clinical psychologists' firearm risk management perceptions and practices. *Journal of Community Health: The Publication for Health Promotion and Disease Prevention*, *35*(1), 60-67.

Yip, P. S., E. Caine, S. Yousef, S. S. Chang, K. C. C. Wu, and Y. Y. Chen. 2012. "Means Restriction for Suicide Prevention." *Lancet* 379: 2393-2399.

97

DV/IPV-Related Reading

Banks, L., Crandall, C., Sklar, D., & Bauer, M. (2008). A comparison of intimate partner homicide to intimate partner homicide-suicide: One hundred and twenty-four New Mexico cases. *Violence Against Women*, *14*(9), 1065-1078.

Bureau of Justice Statistics, U.S. Department of Justice. Homicide trends in the U.S.: Intimate homicide (2007). Retrieved from http://bjs.ojp.usdoj.gov/content/homicide/intimates.cfm.

Bridges, F. S., Tatum, K. M., & Kunselman, J. C. (2008). Domestic Violence Statutes and Rates of Intimate Partner and Family Homicide. *Criminal Justice Policy Review*, *19*(1), 117-130.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study. *American Journal of Public Health*, *93*(7), 1089–1097.

Campbell, J., Webster, D., Koziol-McLain, J., Block, C., et al., (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*, 1089-1092.

Colpitts, J., & Niemczyk, K. (2012). Marital Rape, Strangulation, Bail, Firearms, and Risk. *Domestic Violence Report*, *18*(2), 17-30.

Davis, R. L. (2010). Domestic violence-related deaths. *Journal of Aggression, Conflict & Peace Research*, *2*(2), 44-52.

DeJong, C., Pizarro, J., & McGarrell, E. (2011). Can Situational and Structural Factors Differentiate Between Intimate Partner and 'Other' Homicide?. *Journal Of Family Violence*, *26*(5), 365-376.

Farr, K. A. (2002). Battered women who were 'being killed and survived it': Straight talk from survivors. *Violence and Victims*, *17*(3), 267-281.

Folkes, S. F., Hilton, N. Z., & Harris, G. T. (2013). Weapon use increases the severity of domestic violence but neither weapon use nor firearm access increases the risk or severity of recidivism. *Journal of Interpersonal Violence*, *28*(6), 1143-1156.

98

DV/IPV-Related Reading cont.

Frattaroli, S., & Vernick, J. S. (2006). Separating Batterers and Guns: A Review and Analysis of Gun Removal Laws in 50 States. *Evaluation Review*, *30*(3), 296-312.

Islam, T. (2010). The fourth circuit's rejection of legislative history: Placing guns in the hands of domestic violence perpetrators. *American University Journal of Gender, Social Policy & The Law*, *18*(2), 341-366.

Saunders, D. G., Prost, S. G., & Oehme, K. (2016). Responses of police officers to cases of officer domestic violence: Effects of demographic and professional factors. *Journal of Family Violence*, *31*(6), 771-784.

Sorenson, S.B. (2006). Firearm use in intimate partner violence: A brief overview. *Journal of Applied Social Research, Special Issue: Intimate Partner Violence and Firearms, 229*, 232-33.

Sorenson, S.B. & Wiebe, D.J. (2004). Weapons in the lives of battered women. *American Journal of Public Health, 94*, 1412-1413.

Vigdor, E. R. & Mercy, J.A., (2006). Do laws restricting access to firearms by domestic violence offenders prevent intimate partner homicide? *Evaluation Review, 30*, 313-332.

Vittes, K. A., Webster, D. W., Frattaroli, S., Claire, B. E., & Wintemute, G. J. (2013). Removing guns from batterers: Findings from a pilot survey of domestic violence restraining order recipients in California. *Violence Against Women*, *19*(5), 602-616.

99