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Extreme Risk Protection Orders in Washington State: Understanding the Role of Health Professionals

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Abstract

Objective: Extreme Risk Protection Orders (ERPO) allow a petitioner to file a civil order to temporarily restrict access to firearms among individuals ("respondents") deemed to be at extreme risk of harming themselves, others, or both. Although unable to file ERPOs for their clients in most states, health professionals may play a pivotal role in the ERPO process by recommending an eligible petitioner initiate the process. We describe the process of filing an ERPO when a healthcare, mental health, or social service professional contacted an ERPO petitioner.

Method: Court documents of ERPOs involving health professionals in Washington State between December 8th, 2016 and May 10th, 2019 were qualitatively analyzed (n=24). We constructed pen portraits from the documents and analyzed them using an inductive qualitative thematic approach.

Results: Themes included factors influencing the *process* by which each professional evaluated respondent behaviors, factors considered during *assessment*, factors influencing *interpretation of respondent behaviors* and subsequent provider *response* during a crisis. These influenced the *outcome* of the crisis event that led to ERPO filing.

Conclusions: Each professional group differed in their approach to risk assessment of respondent behaviors. Strategies to better coordinate and align approaches may improve the ERPO process.

Keywords

Extreme risk protection order; social workers; firearms; mental health; risk assessment

INTRODUCTION

Background

In 2018, there were almost 40,000 fatal firearm injuries in the United States (WISQARS (Web-Based Injury Statistics Query and Reporting System), 2020). The burden of firearm

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injuries and deaths is not distributed evenly in the U.S. Black and American Indian/Alaska Native individuals are 7.5 and 1.9 times more likely to die from firearm homicide than White individuals, respectively. The fatality of a suicide attempt varies, with firearms being the most lethal method (Conner et al., 2019). Because of the brevity of the suicidal moment and frequency of ambivalence in intent, if a more lethal method is unavailable, a delay in suicide attempt might allow suicidal impulses to pass (Hawton, 2007). Based on opportunity-reduction theory (Clarke, 1997), lethal means restriction attempts to reduce an individual's access to the methods for suicide which have the highest fatality rate. Lethal means restriction for firearms has been shown to be a promising intervention to reduce suicide by firearms, both at the policy (Rosengart, 2005) and individual level (Nordentoft et al., 2017). Policies such as mandatory firearm purchasing waiting periods are effective (Luca et al., 2017).

A few individual-level studies have suggested the potential for lethal means counseling and Extreme Risk Protection Orders (ERPOs) to prevent suicides (Swanson, Norko, et al., 2019) and mass shootings (Wintemute et al., 2019). Currently law in 19 states and the District of Columbia (D.C.), ERPOs allow for the temporary restriction of firearm access for individuals at extreme risk of harming themselves or others. As providers of care to individuals at increased risk of firearm death, social workers and other health professionals have been called upon to be allowed to independently file ERPO petitions (ERPOs: New Recommendations for Policy and Implementation, 2020). However, the majority of states with an ERPO law do not currently allow these professionals to file. Further, there are significant gaps in the literature to understand how health professionals should use ERPOs, whether filing independently or with law enforcement or encouraging other parties to file. The goal of this study was to understand the process of filing an ERPO when health care, mental health, or social service professionals cannot independently file an ERPO, but instead contacted an ERPO petitioner for a client at risk of harming themselves and/or others.

Literature Review

Role of Health Professionals and Social Workers in Firearm Injury and Death Prevention—Social workers and other health professionals are often tasked with assessing and intervening in cases of individuals who may pose risk of harm to themselves and/or others (Martin et al., 2020). Individuals may also be referred to health professionals through civil commitment laws that allow for involuntary mental health treatment. Frameworks for evaluating risk of harm to self and harm to others may vary but are conceptually similar. Within criminal justice and mental health literature, risk of harm to self and others is often evaluated through assessing a client's static and dynamic risk factors. Static risk factors refer to immutable events or characteristics of an individual (e.g., history of previous aggressive behavior), while dynamic risk factors refer to those which are changeable through intervention or other influences (e.g., response to a recent loss of a relationship) (Heilbrun, 1997). Similarly, assessment of risk of harm to oneself includes both past behaviors (e.g., previous suicidal behaviors) and current factors (e.g., current suicidal ideation) (Beck et al., 1979; Posner et al., 2011).

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Given the lethality of firearms and the role of many health professionals in evaluating patients or clients for suicidal or homicidal ideation, several professional organizations have called for the providers to assess firearm access. The Substance Abuse and Mental Health Services Administration recommends discharge planning include assessing firearm access for individuals hospitalized for a mental or behavioral health crisis (National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, 2020). Additionally, 44 medical and injury prevention organizations and the American Bar Association have jointly called for health providers to assess clients at risk of harming themselves or others for firearm access (Bulger et al., 2019). Yet studies have shown most health professionals, including social workers, do not regularly assess for firearm access (Betz et al., 2013; Slovak & Brewer, 2010), although those who work with individuals in mental health facilities are more likely to do so.

ERPOs as a Strategy to Reduce Firearm Injuries and Deaths—Federal law does not address the removal of firearms from individuals at risk of harming themselves or others unless they have been formally and involuntarily committed to a mental health facility or a court has found them to "lack the mental capacity to contract or manage [their] own affairs" due to mental illness (18 USC 922(g)(4)). Federal law also does not prohibit firearm access for those who have harmed others unless they are a respondent of a domestic violence restraining order or have been convicted of a felony or domestic violence misdemeanor (18 USC 922(d)(9)). Extreme Risk Protection Orders (ERPO) allow a petitioner (e.g., family member or law enforcement officer) to file a civil order to temporarily restrict access to firearms for individuals ("respondents") who engage in behaviors that are deemed by the petitioner to indicate they are at extreme risk of harming themselves or others. Restricted access involves removing any presently owned firearms and preventing their purchase. ERPOs can be a powerful tool for prevention of firearm-related injury or death when an individual exhibits behaviors signaling they are at extreme risk of harming themselves and/or others.

As of January 2021, this civil law has been passed in 19 states and D.C., although who may petition for an order to be issued varies. Law enforcement may file a petition in all 19 states and D.C., family members, intimate partners, or housemates can file in 12 of these states, and employers can file in California (Supplemental Table 1). Because 17 of the 19 states and D.C. have passed their ERPO law since 2016, thorough evaluations of the laws are still underway. Preliminary evidence has shown they are a promising intervention to prevent mass shootings and suicide. A case study of California's ERPO law found at least 21 cases in which ERPOs were used to remove a firearm from individuals who threatened a mass shooting (Wintemute et al., 2019). ERPO laws in Connecticut and Indiana, the first states to pass such laws, were associated with a 13.7% and 7.5%, respectively, reduction in firearm suicides in the 10 years after passage (Kivisto & Phalen, 2018).

Study Purpose: Role of Health Professionals in ERPOs

Health professionals may be ethically and legally required to intervene in cases where their clients are at significant risk of harming themselves or others (Gorshkalova & Munakomi, 2020). These professionals may observe behaviors that fall under "duty to warn" laws,

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which require specific categories of professionals to warn a targeted victim of a violent act by their client; in many states, they must also notify law enforcement (Henderson, 2015). As ERPOs are non-criminalizing, they may be an additional tool health professionals seek for their clients who have access to firearms and are deemed to be at extreme risk of harm to themselves and/or others. Thus, health professionals may play a pivotal role in the ERPO process.

Only two states and D.C. allow a health professional to file an ERPO themselves: Maryland and D.C. allow physicians, psychologists, clinical social workers, and other therapists; and Hawaii allows medical professionals to file. Additionally, New York allows school administrators or their designee, which may include school nurses or social workers, to file. In other states, if a respondent exhibits or describes a behavior to a social service, mental health, or health professional, and the behavior falls under “duty to warn” laws, the professional must break confidentiality to report the behavior to law enforcement. If knowledgeable about the ERPO process, the professional may recommend to law enforcement that an EPRO should be filed, although law enforcement would make the judgement whether the information provided by the health professional met the definition of “extreme risk.” Alternatively, a professional and client may collaboratively choose to contact law enforcement or a family member to pursue an ERPO as part of establishing a safety plan with a client exhibiting suicidal or homicidal ideation.

Prior calls have been made to include health professionals as independent filers for ERPOs (ERPOs: New Recommendations for Policy and Implementation, 2020), but little research has been conducted to assess their role in filing an ERPO or contacting law enforcement to file an ERPO. One study of clinicians in Maryland—where physicians can independently file—found limited knowledge about ERPOs, but high willingness to file if appropriate (Frattaroli et al., 2019). Efforts have been made by health professionals and law enforcement to jointly assist individuals experiencing an acute mental health crisis (Hnatow, 2015; MSW@USC, 2018; van Dijk et al., 2019). It is therefore important to understand how health professionals are interfacing with law enforcement when health professionals cannot file themselves. The results of this qualitative study will inform continuing discussions of the role of health professionals in the ERPO process.

METHOD

We sought to understand the process of filing an ERPO when health care, mental health, or social service professionals contact an ERPO petitioner. We used the pen portrait method (Sheard & Marsh, 2019) to construct narratives by summarizing ERPO documents and used qualitative thematic analysis to identify themes and sub-themes relevant to the research question. The University Institutional Review Board approved all study procedures.

Reflexivity Statement

Our interdisciplinary team includes researchers who have practiced clinical social work and mental health care, experts in qualitative methods, and injury prevention and public health researchers with expertise in firearms, violence, and ERPOs. All authors are primarily affiliated with academic institutions, range in career stage from graduate students to mid-

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and senior-career faculty, and are affiliated with Schools of Social Work, Public Health, and Medicine. None of the authors were directly involved with developing or advocating for the passing of Washington State's ERPO law. As law enforcement officers filed the majority of ERPO petitions in this sample, we felt it was also crucial to include their perspective. We therefore conducted member checking (Creswell & Miller, 2000) with a law enforcement officer with a great deal of experience filing ERPOs and advocating to others for their use.

ERPO Law in Washington State

The ERPO law went into effect on December 8th, 2016 (House Office of Program Research, 2016). As of September 30th, 2020, an ERPO had been filed for 510 respondents in Washington State; however, for this study, petitions were only available from December 8th, 2016 until May 10th, 2019. Of the petitions filed for 237 respondents during this period, 81% were granted (Rowhani-Rahbar et al., 2020). In Washington State, only law enforcement, family, and household members may file an ERPO petition. Details on the process of filing an ERPO in Washington State is described in a previous study (Rowhani-Rahbar et al., 2020; Rooney et al. 2021).

An ERPO petition details the reasons for filing and may be accompanied by addenda such as police or jail incident reports, search warrants, law enforcement declarations, affidavits, and correspondence or images offered as evidence. A judge reviews these documents and determines if a temporary, ex parte, order should be issued. If issued, law enforcement will then seek to remove firearms from a respondent's possession. A follow-up hearing must be scheduled within 14 days, at which point a judge determines if a one-year order is warranted. In this study, we only reviewed cases for which an ex parte order was granted, regardless of whether the one-year order was granted. All ERPO documents are public record unless sealed.

ERPO Documents for Analysis

For this study, court documents of ERPOs were obtained through central databases maintained by courts in each county. Documents were available from between December 8th, 2016 (day law was enacted) and May 10th, 2019 (end of data collection). The research team gathered copies via a public access terminal, clerks' desks, or remote access and abstracted records verbatim into Research Electronic Capture Database (REDCap) (Harris et al., 2009). The project manager and two research assistants summarized relevant domains summarizing characteristics of ERPOs, such as reason for ERPO filing and respondent and petitioner characteristics; more detailed information on this process is detailed in a prior publication (Rowhani-Rahbar et al., 2020). Long addenda to petitions were summarized in the database and scans of originals were available as separate files. The research team analyzed scans where available, and otherwise relied on verbatim abstracted versions.

Case Definition and Sample

As health care, mental health, and social service professionals are not able to file ERPOs for their clients or patients in Washington State, we included cases in which one of these officials contacted a family member of a respondent or law enforcement officer and the incident during which this contact was made led to the petitioner filing an ERPO. These

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cases were identified by reviewing the variable, "Who made contact with the petitioner to initiate the ERPO?" This variable was completed during the abstraction process by reviewing the entirety of the petition.

Of the 237 individuals who had an ERPO filed for them during the study period, 24 ERPOs met the case definition. As is typical for ERPOs in Washington State and other states, 23 of the 24 petitions were filed by law enforcement. All respondents were reported in the petition as white, and one respondent was also reported to be Hispanic. However, it is important to note these reported races/ethnicities may not be accurate or may not reflect respondent self-identified race; one respondent reported as white in the petition was identified as Native American, American Indian, and white in prior incident reports. Compared to the population of all ERPO respondents available in this study (237), women were overrepresented in this sample (37.5% in this sample vs. 17.9% of the 237 respondents) (Rowhani-Rahbar et al., 2020). ERPOs were filed because the petitioner assessed that the respondent was at risk of harming themselves (n=10; 41.7%), others (n=5; 20.8%), or both (n=9; 37.5%).

Pen Portrait Procedure

Designed as a solution to substantial quantities and complexity of longitudinal data, the pen portrait method serves to generate a linear narrative that documents the story or trajectory of a phenomenon or other study focus (Sheard & Marsh, 2019). The heterogeneity in quantity (up to 900 pages in some cases), quality (e.g., availability of detailed incident reports), and structure (discrete fields or open-ended questions) of available court documents rendered line-by-line content analysis inappropriate and unfeasible. We therefore chose to use the pen portrait method to address these issues in addition to the longitudinal nature of some data, such as respondents with numerous experiences with law enforcement and health professionals over time. Using the pen portrait method allowed us to re-construct the case chronologically in narrative form to better understand the sequence and influence of events leading to ERPO filing. This synthesized unit of analysis also allows for review of both structured and unstructured portions of court documents.

The method consists of four steps, also used in this study: 1) understand and define focus of inquiry, 2) design a basic structure relevant to the dataset, 3) populate the content, and 4) interpret (Sheard & Marsh, 2019). The pen portraits included four primary sections (Figure 1 details source documents). *Reported respondent demographics* included demographics such as age, county, and reported race. Because the ERPOs were filed by the petitioner, most documents were from their perspective; as such, we refer to characteristics and events as "reported by" the petitioner. The second section summarized the petition using a *chronologically re-constructed timeline* of the incident during which the ERPO was filed, as well as descriptions of any other incidents leading up to the ERPO. Where available, these also included summaries of statements or affidavits provided by witnesses to the event, including those provided by the health care, mental health, or social service professional who initially reported the event. The third section, *outcome*, detailed whether the one-year ERPOs were granted by the presiding judge. If the order was not granted, this section also detailed the reasons provided. Finally, data on the respondent's *criminal charges and arrests* were obtained from the Administrative Office of the Courts (AOC) and Washington State

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Patrol (WSP), respectively. These data were only considered after all other segments of the pen portrait were constructed to minimize bias these data may have on construction. The research team chose to use the charge and arrest data to clarify ambiguous reports of respondents' involvement in the criminal legal system by the petitioner.

To populate the pen portraits, the entirety of the 24 petitions and all addenda were reviewed by the first and third authors. Next, individual pen portraits were constructed chronologically and deidentified for each respondent by the first author by reviewing the following documents (where available) in order: petition, law enforcement incident reports, affidavits from officers or health professionals, respondent motion to terminate ERPO, and court orders granting or dismissing an ERPO. The first author then clarified any ambiguities in arrest or criminal charges using the AOC and WSP data. The third author, who also had read all documents for all 237 respondents in our study population, then read and edited the 24 pen portraits for clarity or additions while reviewing the same documents. The final pen portraits ranged from one to three single-spaced pages depending on the quantity of data available. Throughout, researcher memos were written (Berger, 2015).

Data analysis

Pen portraits were analyzed using an inductive qualitative thematic approach (Braun & Clarke, 2006). In the first stage of analysis, the first and third authors identified as many themes as possible that emerged (no themes were defined in advance). The second author also reviewed pen portraits to identify themes specific to the ethical and legal considerations for mental health and social work practitioners relating to "duty to warn" requirements and resulting procedures (Gorshkalova & Munakomi, 2020). The themes from each pen portrait were then compared in entirety to others to elicit patterns by reported respondent characteristics, intent for ERPO filing (e.g., to prevent harm to self or others), and health professionals involved (Sheard & Marsh, 2019). During this phase, interpretations and classifications of themes were constantly revised using the constant comparison method, and negative cases where dissenting patterns of themes were observed. Throughout analysis, all themes, codes, and interpretations were discussed in weekly meetings. Differences in opinion were discussed until consensus was reached among all authors. Finally, pen portraits were reviewed again with the revised coding scheme.

RESULTS

Four themes surfaced and are presented chronologically through the professionals' perspective: 1) factors influencing the *process* by which each professional evaluated a behavior; 2) factors considered during *risk assessment*; 3) factors influencing *interpretation of and response to behaviors* of the respondent during a crisis moment; and 4) these in turn influenced the *outcome* of the crisis event that led to an ERPO being filed (Figure 2). Patterns in the first three themes are presented by first comparing health professionals to law enforcement. Within the health professionals group, we noted further patterns in these themes. Rather than by credentials (e.g., physician, social worker), patterns arose by the health professional's relationship with the respondent or their practice setting. The relevant relational or setting-based categories identified were *respondents' established mental health*

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providers with an ongoing therapeutic relationship with a respondent (11 cases), *crisis line workers* primarily speaking virtually with a respondent (7 cases), and *medical staff* working in an emergency department (6 cases). *Law enforcement officers* also play a crucial role in the ERPO process, as they were often called to the scene of crisis moments, filed petitions in all but one case in this sample, and dispossessed firearms where appropriate. We draw parallels and illuminate differences between the health professionals and law enforcement officers in ethical and professional guidelines, process of risk assessment, and interpretation and response to behaviors.

Theme 1: Factors Influencing Process of Risk Evaluation

All health professional groups and law enforcement officers sought to reduce risk of harm to the respondent and/or those they were threatening or attempting to harm when addressing a crisis and considering an ERPO. However, we found patterns in how these professional groups differ in their approach to achieve that goal, influenced by differing professional roles and responsibilities as outlined in ethical guidelines and protocols and behavioral health service gaps or connections (Table 1).

Sub-theme: Influence of Professional Ethics and Guidelines—While the professional ethics of both health professionals and law enforcement were focused on de-escalation, professional guidelines sometimes resulted in detrimental effects for respondents. For health professionals, “duty to warn” requirements often led to established mental health providers, crisis line workers, and medical staff in an emergency setting being required to breach the respondent’s confidentiality. In Washington State, public or private mental health providers and designated crisis responders are required to notify potential victims and/or law enforcement when a client communicates a threat of physical violence or to die by suicide (Edwards, 2010; Emergency Detention of Persons with Behavioral Health Disorders, n.d.). Additionally, health professionals are bound by codes of ethics and procedures that outline the protocol for breaching confidentiality, reporting and managing risk of harm, and informing clients about the disclosure of confidential information (National Association of Social Workers (NASW), n.d.). These laws and procedures are intended to protect lives, but can damage therapist/client relationships and complicate client mental health care. In one case, when a respondent’s providers at a large behavioral health facility were required to report threats to law enforcement, the respondent no longer felt comfortable seeking care at that center, so began seeing a clinician at a smaller facility. However, given the complexity of the respondent’s needs, the new clinician referred the respondent back to the original facility.

When law enforcement responded to these reports from “duty to warn” laws, their own protocols may also have unintentional negative consequences for respondents. In two cases where a respondent was having a suicidal crisis and was in possession of a firearm, officers called in a hostage negotiation and Special Weapons and Tactics (SWAT) team. This response reflects standard police protocol in the jurisdiction where these incidents took place; however, these responses did have consequences for the respondent in some cases. In one case, increased tension over the need to maintain officer safety led to law enforcement physically restraining a respondent. The respondent resisted, and this incident was described

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as assaulting an officer in the dispatch notes, which may be viewed by law enforcement officers and influence future responses.

Sub-theme: Behavioral Health Service Connections and Gaps—The variation in the mental health, case management, substance use treatment, and other behavioral health services being received by or available to respondents influenced the process of risk evaluation. The most common behavioral health service connection described was involuntary admission to inpatient mental health treatment arising from the Involuntary Treatment Act (ITA). Washington State's ITA allows for individuals to be admitted by a court order to a mental health treatment facility for 72 hours to 180 days if they have a mental health or substance use disorder that either "gravely disables" them or results in them posing a danger to themselves or others (Emergency Detention of Persons with Behavioral Health Disorders, n.d.) as deemed by a state-certified mental health professional. Several respondents had been transported to the hospital by law enforcement under the ITA one or more times prior to the crisis moment that led to ERPO filing. Alternatively, behavioral health service gaps limited the respondent's ability to receive help they sought, sometimes exacerbating the crisis moment. One respondent who threatened to harm their established mental health provider reported they did so because of repeated unsuccessful attempts to receive intensive mental health treatment.

Overall, respondents with established outpatient providers were reported to be connected with more mental health, health care, and social services than those interacting with crisis line workers or medical staff in an emergency setting. Nonetheless, two key gaps were present in this sample. First, integrated crisis services were not reported to be utilized (or were potentially unavailable) by established mental health providers. For example, in one case, a respondent emailed their therapist statements that involved suicidal and homicidal statements towards a specific individual, but without clear plan or intent. Given limitations of existing protocols to address this in their role, the mental health provider relied on police to further assess the risk the individual posed rather than responding in real time or utilizing integrated crisis services. However, in most jurisdictions, the only help that law enforcement officers could provide involved transporting the respondent to a hospital for treatment. One jurisdiction includes a Crisis Response Team consisting of both specially trained officers and mental health professionals to connect individuals to resources.

Second, gaps in service connections were highlighted when clinicians were the target of threats by the respondent. In these cases, there was not a documented plan in the petition to ensure the individual received a higher level of care or continuous care. In one case a clinician felt that they could not safely manage the client and suggested they return to a previous provider. However, at the time of the petition, no specific plan was reported to be in place to achieve this continuity.

A lack of behavioral health service connections was described in all but one of these cases. Most respondents in these cases were also transported by law enforcement to a hospital under the ITA. All but one of the respondents treated by emergency medical staff were admitted for mental health evaluation either voluntarily or involuntarily, although health professionals in different roles (e.g., social worker, nurse, and physician) sometimes came

to different conclusions about whether referral to outpatient mental health services would adequately meet a respondent's needs.

Theme 2: Factors Considered During Risk Assessment

Each professional group had access to different information about the respondents to inform their risk assessment due to differing relationships (established vs. emergent) and care settings (in person vs. virtual). These factors include static and dynamic risk factors and setting of assessment (Table 2).

Sub-theme: Static and Dynamic Risk Factors—Mental health providers with an established relationship with a respondent often had the most time and information to evaluate static (immutable event or characteristic) and dynamic (changeable through intervention) risk factors. For example, in one case where a respondent threatened harm to another individual, their therapist was able to consider their long-standing history of depression and homicidal thoughts (static) with their angered response after a recent altercation with the individual they threatened (dynamic). While the threat fell under "duty to warn" laws, the therapist was able to discuss with law enforcement officers a nuanced assessment of the respondent's risk of harm, including describing the respondent's plentiful protective factors (e.g., recent job interview and supportive family).

Conversely, the crisis line workers and medical staff in emergency settings were limited in the information they had to assess risk to only what the respondent offered, likely limiting their access to static risk factors. In some cases, medical staff in emergency settings had access to medical records that provided context to the static and/or dynamic risk factors. When this was the case, a more nuanced approach was taken to contextualize the crisis. For example, after a respondent had a suicidal crisis on the medical facility property, the medical staff informed officers of medications the respondent had been taking known to cause extreme anxiety. Additionally, the initial risk assessment by law enforcement officers responding to the scene of the crisis was influenced by information provided by the reporting party. For example, one officer reported in his incident report, "While enroute [sic] to the residence, dispatch updated officers that [the respondent] was now armed with a gun," suggesting the situation was high risk without additional contextual factors. Example contextual factors that may influence law enforcement response are respondent's intent (self-harm or harm to others), recent trauma such as sexual assault, serious mental illness, or protective factors such as family support. In rare cases, officers responding to the scene of a crisis moment had a brief history of prior law enforcement involvement with the respondent, which was only possible if a respondent's prior interaction was in the same jurisdiction. For example, one officer responding to a call from a crisis line worker about a respondent with suicidal intent explained in his incident report, "It should be known, I am very familiar with [the respondent's] prior [police department] incident that occurred [two years ago]. I was one of the Officers who responded to the scene, where [the respondent] was armed…" When the respondent expressed similar comments and feelings as they did several years before, the responding officer had the context needed to understand and fully evaluate the respondent's risk of harm.

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Sub-theme: Setting (Remote versus In-person)—In all but one case, crisis workers were only able to evaluate a respondent's risk of harm to themselves or others via phone; in one case, the crisis line workers were able to respond in person with law enforcement. In all cases, they determined the information provided to them by the respondent met their agency's threshold for law enforcement involvement. In these cases, the crisis worker contacted law enforcement, who were dispatched to the respondent's location to remove the firearm from their possession and facilitate transport to treatment. Sometimes this limitation led to initial assessment of situation as high risk, when law enforcement (who were able to respond in person) determined it to be less so. In one case, when law enforcement arrived at a crisis scene, they determined that the threat disclosed to the crisis line worker was not imminent because the respondent did not have access to a firearm. They then allowed the respondent time for their substance intoxication to decrease and returned several hours later to transport the respondent to a treatment facility.

Theme 3: Interpretation of and Response to Respondent Behaviors During Crisis Moment

Washington State mandates that petitioners must describe behaviors, threats of violence, or intent to self-harm when applying for an ERPO. The most frequently reported behaviors in the petition at the time of a crisis moment alone or in combination were substance use or intoxication, engaging in preparatory acts while expressing intent to die by suicide, threats or attempted acts to harm others, behavior with a firearm that was deemed reckless, and "erratic behavior" or cooperation with law enforcement instructions. However, it is important to note that most cases described more than one of these behaviors in addition to other historical or contextual factors. Further, as responders to the physical location of a crisis moment, law enforcement officers were more able to directly observe and interpret behaviors such as intoxication, "erratic behavior," and firearm behaviors deemed reckless (Table 3).

Alcohol and substance use were frequently discussed in the petition. As crisis line workers were only able to evaluate a respondents' risk of harm via phone, intoxication was one of the most reported behaviors to law enforcement. In contrast, law enforcement officers were able to observe behaviors and physical signs suggesting intoxication, such as slurring words or smelling alcohol. Petitioners frequently attributed other dangerous behaviors, such as attempts or threats of self-harm or reckless behavior with firearms, to intoxication or other substance use.

Several petitions cited preparation and planning as evidence of intent to engage in suicidal behavior or self-harm and subsequently rationale for filing an ERPO. Example of these preparatory acts included engaging in steps to obtain a firearm, actually obtaining a firearm, or saying goodbye to family members. In one case, a respondent was reported to be attempting to persuade their family to leave their home to provide the respondent sufficient privacy to follow through with their plan to die by suicide.

Many of the cases where the petition was filed over concerns the respondent was at risk of harming others involved thwarted attempts to do so. For example, law enforcement officers were called in many cases to respond after a respondent disclosed to a crisis line worker they had a firearm in their possession and were on their way to harm a specific individual. In one

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such case, the respondent called a crisis line to express their frustration at the treatment they had experienced at a local hospital. They notified the crisis line worker they had retrieved their firearm and were returning to the hospital to shoot the staff. The worker notified law enforcement, who removed the firearm and facilitated admission for mental health treatment.

As they were able to physically observe respondents, law enforcement officers sometimes described behaviors with firearms as unsafe. These concerns were especially prevalent in cases where the respondent was exhibiting behaviors that could signal mental illness or dementia. Behaviors described included discharging firearms illegally and leaving firearms unsecured.

Law enforcement often described the behaviors of respondents at the scene of a crisis as "erratic." Respondent cooperation, or lack of cooperation, with law enforcement was also frequently discussed in the ERPO filings. For example, law enforcement arrived at one respondent's home after they reported suicidal intent, but they refused to leave their apartment as they requested time to prepare themselves to leave. Law enforcement described them as "uncooperative," "stalling," and "erratic" as they struggled to convince the respondent to come with them to seek help. Conversely, in another case involving a similar threat reported to a crisis line worker, the respondent was described as "cooperative" and "forthcoming" about their suicidal ideations, and law enforcement allowed them time to shower and change before transporting them to a treatment facility.

Theme 4: Outcomes of the Crisis Moment

All respondents in this sample received at least a temporary, 14-day ERPO; additionally, for many respondents, this outcome was co-occurrent with other outcomes. In many cases, the professional guidelines/ethics/protocols, factors considered during threat assessment, and interpretation of respondent behaviors and response influenced the outcome of a crisis moment.

Clinical safety planning is often used to establish a strategy for how an individual will respond during a suicidal or homicidal crisis; for example, an individual may voluntarily remove access to lethal means, such as a firearm. Safety planning was not explicitly described in all cases, but when included was focused on participants who threatened harm to themselves. In these cases, we found ERPOs were filed in relation to safety planning in one of two ways: a) ERPOs filed by a family member or law enforcement as part of a safety plan developed between a health professional and a respondent and b) ERPO filing determined by the petitioner (sometimes at the recommendation of the health professional) to be necessary because other attempts at safety planning were unsuccessful. For example, in two cases, emergency medical staff or a therapist worked collaboratively with a respondent to establish a safety plan that included an ERPO. In these cases, the ERPO would restrict access to firearms in the near future, and was a part of a more comprehensive, agreed-upon safety plan to reduce imminence of future suicidal ideation. Conversely, another respondent had engaged in safety planning over several months to reduce their ability to act on their frequent homicidal ideations, such as removing themselves from situations when those feelings arose. However, both their therapist and law enforcement officers agreed additional

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steps were needed to restrict the respondent's access to firearms because their safety plan was not sufficiently minimizing risk of harm.

While ERPOs are designed to be a non-criminalizing means to remove firearms, the results of a crisis moment did lead to respondent arrest in three cases. In these cases, the respondent was charged and convicted with felony harassment for the threats they made against others. Further, two respondents were arrested for violating their ERPO terms.

Sixteen of the 24 respondents in this study had at least 1 firearm dispossessed (55 firearms total were dispossessed). ERPOs for the remaining 8 respondents were filed to prevent access to firearms. Of the 10 respondents whose ERPOs were filed because the petitioner believed that the respondents were at risk of harm to themselves, 9 had at least one firearm dispossessed (22 firearms dispossessed). Of the 5 filed for risk of harm to others, only one respondent had a firearm dispossessed (4 firearms dispossessed). Among the 9 filed for risk of harm to both self and others, 6 had at least one firearm dispossessed (29 firearms dispossessed).

DISCUSSION

Amid calls for health professionals to be included as ERPO petitioners (ERPOs: New Recommendations for Policy and Implementation, 2020) and calls for research on their role in ERPO implementation (Martin et al., 2020), it is crucial to also understand the process of ERPO filing when health professionals are involved but cannot file independently. This study illuminates details of ERPO filing when a mental health, healthcare, or social service professional contacts an ERPO petitioner—law enforcement in most cases. We found this process centers on an individual's risk assessment and describe the process of assessment, factors considered during assessment, interpretation and response to behaviors that inform assessment, and outcomes of the assessment. Previous research on professionals' roles have focused exclusively on physicians (Frattaroli et al., 2019). Additionally, this study illuminates the similar or enhanced role other professionals, including social workers and crisis line workers, can play in the ERPO petitioning process. These results should not be interpreted as conclusive evidence that health professionals should be included as independent petitioners under ERPO laws, as we highlight the benefit of a multi-disciplinary approach. However, these results may inform future efforts to further understand the role of these professionals in the ERPO petition process.

We found differences in how health professionals and law enforcement evaluate an individual's extreme risk of harm to themselves, others, or both. Many of these differences arise from the laws, protocols, and professional standards applicable to each group. For example, the health professionals described in this study are bound by "duty to warn" laws, confidentiality requirements, and professional codes of ethics, while law enforcement officers are bound by their own procedural regulations and codes of ethics to take precautionary measures for their own safety and safety of others (Arrests and Investigatory Stops, 2019).

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This study also reveals important patterns in service connections and gaps among respondents in the type of professional from whom they sought help. Involuntary admission was the most described service for those without an established mental health provider. Ideally, ongoing service connections may avert many respondent crises altogether; however, the ERPO process may also serve as an opportunity for resource referral or intervention. Literature from Critical Time Interventions, which are a focused time-limited intervention to build community connections to needed resources, may provide lessons into modifications in the ERPO process to support respondents in seeking social services (Draine & Herman, 2007; Lyons et al., 2020). In Washington State, if an individual is threatened by a respondent, and law enforcement petition for an ERPO, officers must contact the threatened individual and provide referrals to resources such as domestic violence counseling (Extreme Risk Protection Order Act, 2016). However, law enforcement agencies are not required to provide similar referrals to respondents. As we identified several gaps in services, further research is needed to assess how service connections at the time of serving an ERPO to the respondent may be protective against order violations, subsequent need for orders, and respondent well-being.

Health professionals considering an individual's risk of harm may rely on static and dynamic risk factors to determine that an individual poses a significant danger. As respondents' established mental health providers had the most access to static and dynamic risk factors, as well as protective factors, including these professionals in the ERPO process is crucial.

While we did find differences in factors considered during evaluation of risk, as well as service connections/gaps by professional group, it is also important to examine how these roles may overlap. We differentiate between crisis workers, mental health professionals, and emergency medical staff, but in actual practice professionals may serve many roles in a client's care. For example, mental health professionals who are part of an individual's established care-team may provide long-term, regular outpatient support. However, mental health practice may also entail that these professionals step into a crisis-worker role when a client experiences an acute mental health crisis. Further, emergency medical staff traditionally either refer individuals to mental health services or provide very brief intervention/stabilization (Zeller, 2010). However, many individuals may not follow-up on referrals or other supports and may continue to use emergency medical systems as their primary mental health providers. Emergency medical staff may indeed develop long-term therapeutic relationships with clients, even if this is not their intended role (Moore et al., 2019). These overlaps are also evident in our finding that differences in patterns did not emerge among professional lines (e.g., social workers and psychiatrists), but in the relationship of the professional to the respondent and the setting in which they practice.

Safety planning is critical to harm reduction, especially in removing lethal means from respondents exhibiting suicidal or homicidal ideations. Consistent with other studies (Swanson et al., 2019; Wintemute et al., 2019), we found ERPOs to be a crucial tool to remove firearms from individuals at extreme risk of harm to self or others. ERPOs are typically discussed in terms of an intervention a petitioner provides the respondent, especially when other interventions fail. We found cases in this sample to be reflective

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of this context; however, we also noted several cases where a decision to approach a law enforcement officer to file an ERPO was agreed upon during the safety planning process with a professional and respondent. This different approach warrants further investigation as to how a collaborative approach to filing an ERPO that involves a respondent as a decision-maker influences the success of the intervention. Further, this method may only be successful if service providers are knowledgeable about the ERPO process.

ERPOs are civil rather than criminal orders. However, in three of the 24 cases in this study, the respondent was charged and convicted of felony harassment during the same incident that let to ERPO filing. Two other respondents were charged with violations of their ERPO. Risk of implicit racial bias compounded with systemic racism may lead to disproportionate consequences (e.g., arrest) for people of color (Swanson, 2020), and exploring strategies to prevent discrimination will be critical for future research.

The findings from this study signal new areas for further research. First, while one study has surveyed physicians in a state that allows them to file ERPOs (Frattaroli et al., 2019), interviewing other professionals, both in states that allow them to file and those that do not, is a crucial next step. These studies should assess providers' knowledge about ERPOs, willingness to file, and preferred role in the process. Future research should also interview respondents and civilian petitioners to understand their preferences for how their health providers should be involved in the ERPO process. Attention to discrimination and equity should be a priority.

Limitations

This study's findings must be interpreted within the context of several limitations. First, the sample was racially and ethnically homogenous. There are several possible reasons for this. For one, respondent race and ethnicity was reported by the petitioner, and therefore may not reflect respondent self-identified race and ethnicity. One respondent was identified as Native American and American Indian in police reports attached as addenda, but as white in the petition itself, signaling potential misclassification, which is common in several racial groups (Rockett et al., 2010). Another explanation relates to the demographics of individuals who seek assistance from the mental health care system (Barksdale & Molock, 2008; K. M. Harris et al., 2005). Rooted in racism, historical and contemporary mistreatment of persons of color by health and mental health care systems cause inequitable provider care in addition to inequitable access to health care (Boyd, 2019); in this sample, it is possible that white respondents were more able to access mental health providers and emergency medical staff (e.g., due to insurance coverage of mental health services). Further, compared to the overall population of ERPO respondents in Washington State within the study time period, women were overrepresented in this analysis, which likely reflects women's increased willingness to seek mental health care compared to men or trans individuals (Addis & Mahalik, 2003; Chandra & Minkovitz, 2006; Steele et al., 2017). While the homogeneity of this sample limits generalizability to more diverse respondents, it also provides insight into gaps in the ERPO process when a health professional is involved that need to be addressed, namely ensuring the process is equitably accessible to all individuals.

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Second, the text analyzed was almost exclusively from the petitioner's perspective; in this sample, all but one petitioner was law enforcement. We were only able to gain unfiltered insight into other perspectives in the four cases in which a professional provided an affidavit and one case in which the respondent provided an affidavit. Further, within each category of professional (respondents' established mental health providers, crisis line workers, and medical staff working in emergency settings), the small sample limited further subgroup analysis (e.g., by gender or whether the respondent intended to harm themselves or another individual). Finally, we did not have access to data on health care or social service utilization before or after the ERPO, except in the rare cases where it was described in the petition.

Implications for Social Work Research, Practice, and Policy

Social workers provide mental health and case management services and are often charged with intervening in cases of individuals who may pose extreme risk of harm to themselves or others. They are therefore likely to encounter individuals who may benefit from an ERPO. This paper provides insight into the process and factors considered during risk assessment. Additionally, social workers practice in a variety of professional settings and practice with other professionals who may differ in training, professional ethics standards, and theoretical foundations of their practice approach. We therefore compare approaches across four groups of professionals: respondents' established mental health providers, crisis line workers, medical staff working in an emergency setting, and law enforcement officers. We highlight the benefit of a multi-disciplinary approach to ERPO filing. This research showed that providers differed in their approach to risk assessment. Social work agencies should develop clear policies and procedures regarding the use of ERPOs. Additional research is needed to determine whether social workers and other mental health and healthcare providers should be able to serve as independent petitioners for their clients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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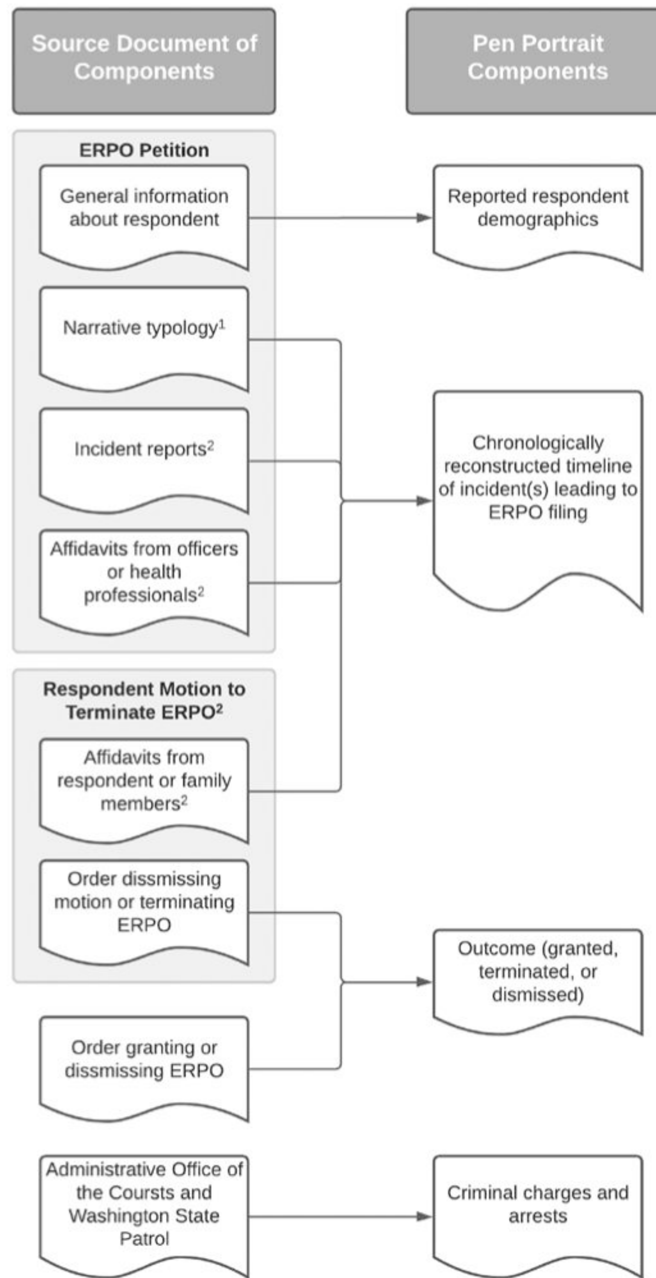

Figure 1. Source documents used to construct four components of the pen portrait for each case.

[1] The Narrative Typology included open-ended questions about the incident(s) leading to ERPO filing and any context the petitioner believed was relevant (e.g. previous mental illness diagnosis)

[2] Not included in all petitions

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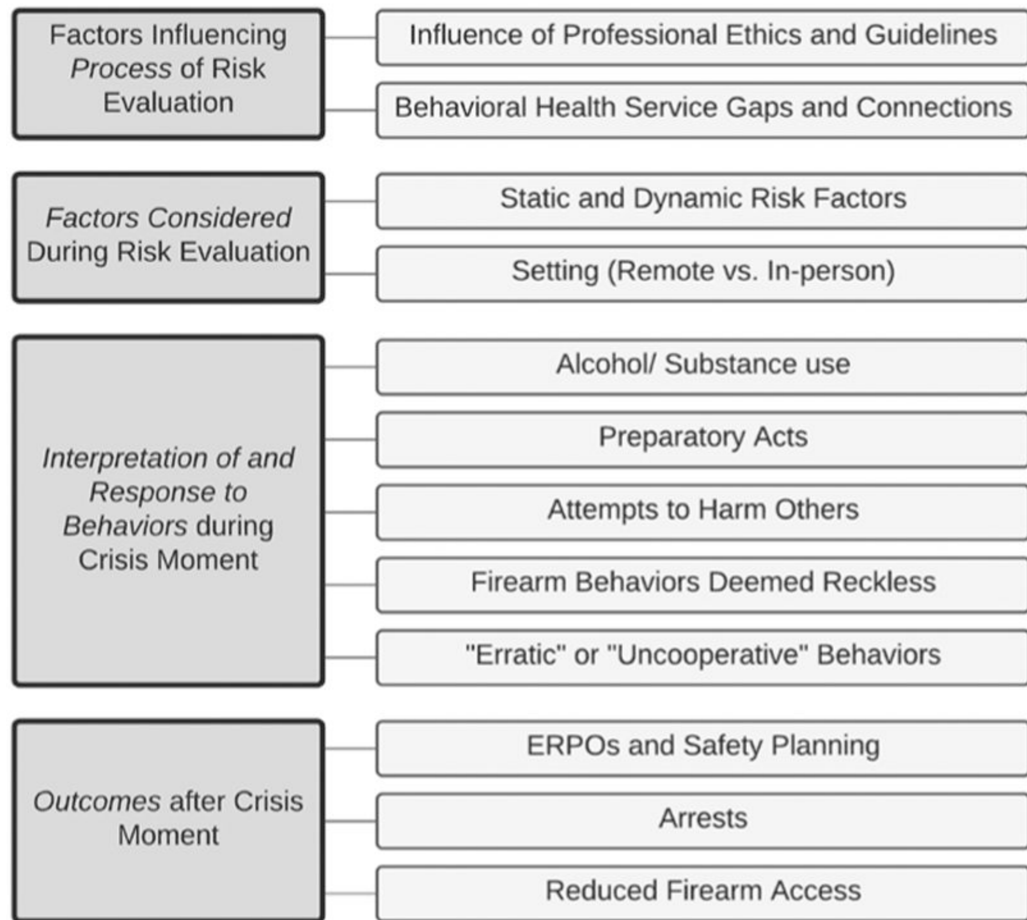

Figure 2.

Conceptual model of themes related to risk assessment of an ERPO respondent

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Table 1.

Factors influencing the process of risk evaluation

	Health Professionals			
	Respondents' established mental health providers	**Crisis line workers**	**Medical staff in emergency setting**	**Law enforcement officers**
Influence of professional ethics and guidelines	"Duty to warn" requirements Breach confidentiality to manage risk Can damage therapeutic bond			Standard protocols in extreme risk cases led to negative consequences for respondent
Behavioral health service gaps and connections	Respondent more connected Lack of integrated crisis services	Lack of services Primary service connection was ITA[1]	Disagreement over best service connection (inpatient or outpatient)	ITA only option for service connection

[1]ITA=Involuntary Treatment Act

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Table 2.

Factors considered during risk assessment

Health Professionals				
	Respondents' established mental health providers	**Crisis line workers**	**Medical staff in Emergency Setting**	**Law enforcement officers**
Static and dynamic risk factors	Most time and information to evaluate risk	Limited to what factors respondent offered in the moment	Limited to what factors respondent offered in the moment	Limited to what factors respondent offered in the moment
Setting (remote vs. in-person)	Assess in-person or remotely	Assess via phone	Assess in-person	Assess in-person

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Table 3.

Interpretation of and Response to behaviors during crisis moment

	Health Professionals			
	Respondents' established mental health providers	**Crisis line workers**	**Medical staff in Emergency Setting**	**Law enforcement officers**
Alcohol and substance use	Relay respondent's history with alcohol or substance use to law enforcement	Commonly reported to law enforcement as "slurring words" or respondent-reported use	Observe physical manifestations of alcohol or substance use	Observe physical manifestations of alcohol or substance use
Preparatory acts	Relay preparatory acts to law enforcement	Relay preparatory acts to law enforcement	No discussion of preparatory acts	Consider preparatory acts in response to crisis moment
Firearm behaviors deemed reckless	Relay concerning firearm behaviors to law enforcement			Observe behaviors with firearm and deem unsafe
Attempted harm to others	No discussion of attempted harm to others	Called law enforcement after respondent disclosed intent or attempt	No discussion of attempted harm to others	Responded to crisis of attempted harm to others
"Erratic" or "uncooperative" behaviors	No discussion of "erratic" or "uncooperative" behaviors			Respondent cooperation or lack of cooperation with orders commonly discussed