Equipping Social Workers to Prevent Firearm-related Harm: Examining the Role of Discretion and Structural Racism

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Abstract

Equipping Social Workers to Prevent Firearm-related Harm: Examining the Role of Discretion and Structural Racism

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This four-paper dissertation examines the critical role of social workers in addressing the burden of firearm-related harm, particularly when serving clients at highest risk for disparities due to structural racism. Grounded in the theory of situated bureaucrats, it offers a nuanced understanding of social workers' decision-making processes related to reducing firearm access for clients in crisis, along with the challenges they face in navigating complex social, medical, and legal systems. Chapter One frames firearm-related harm as an urgent social justice issue, delineates the role of social workers in addressing this challenge, and underscores equity considerations in interventions social workers may use to reduce firearm access for clients in crisis. The first paper, Chapter Two, employs qualitative narrative inquiry to identify equity considerations for implementing Extreme Risk Protection Orders by drawing insights from the historical context of Domestic Violence Protection Orders. The second paper, Chapter Three, analyzes qualitative data from ten focus groups with twenty-nine social workers to understand

the ethical dilemmas they face when weighing the benefits and potential harms of referring clients to medical and legal system services based on their social identities (e.g., race and ethnicity, immigration status). In Chapter Four, the third paper draws on survey data from 1,306 social workers to investigate potential racial biases in their decision-making regarding care plan options for clients of different races, with social worker race as a moderator. The fourth paper, Chapter Five, revisits qualitative data from ten focus groups to construct an action plan model depicting the complex factors that guide social workers when choosing how to reduce firearm access for clients in crisis. Finally, Chapter Six synthesizes findings from all four papers to offer practice, policy, and training recommendations, discuss social justice implications, suggest directions for future research, and outline efforts to disseminate research findings. This dissertation underscores the pivotal role of social workers in alleviating the burden of firearm-related harm, especially in communities facing disparities, while critically examining potential biases in their discretionary practices and providing actionable policy and practice recommendations.

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List of Abbreviations

BIPOC: Black, Indigenous, and People of Color

CDC: Centers for Disease Control

DV: Domestic violence

DVPO: Domestic Violence Protection Order

ERPO: Extreme Risk Protection Order

HTO: Harm to others

HTS: Harm to self

MSW: Master of Social Work

NASW: National Association of Social Work

OR: Odds ratio

RCW: Revised Code of Washington

Dedication

For Ellie,

With all my love and a heartfelt wish that the work I do can contribute to making your world a safer place to be a child. May your future be filled with hope, love, and a safer tomorrow.

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There are so many individuals who have contributed directly to this dissertation, as well as to my overall growth and development as a scholar and as a person. It has been essential for me throughout this process to work with diverse voices across disciplines and identities, and collaborate closely with clinical social workers, all of whom challenge me to constantly reflect on my scholarship. Over 1400 social workers participated in one of these three studies. I am so incredibly grateful to them for the gift of their time and expertise. I hope that I can show my gratitude by creating resources and helping them feel supported as they work with clients experiencing a crisis.

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I also would like to express my profound gratitude to the co-authors of the papers in this dissertation, who have read more drafts of these papers than any of us likely care to admit. They have all been so patient with me, and in addition to their intellectual contributions, I am grateful for their openness and kindness. Olivia McCollum has been invaluable throughout the data analysis process. She is always eager to learn and contribute her time and knowledge. These studies are undoubtedly richer and more rigorous given her contributions. Thank you to Julie Kafka and Julia Schleimer for the gift of your profound expertise with DVPOs and ERPOs. I cannot imagine straightening out that paper without your guidance.

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years, they have not only been mentors but also invaluable role models. Their commitment to academic excellence and their hands-on approach in answering questions, practicing reflexivity, and guiding me through various methodological challenges have been pivotal in my development as a researcher. Their encouragement to question established norms and to engage in critical reflexivity has profoundly influenced my approach to research. Their wisdom, dedication, and the high standards they uphold serve as an inspiration. I am immensely thankful for their guidance and aspire to emulate their exemplary qualities in my ongoing research journey.

I also express my heartfelt gratitude to my family—my mom, dad, stepmom, and grandparents—for their unwavering love and support throughout my life. Their influence extends far beyond the confines of this dissertation. From a young age, they instilled in me the belief that there are no limits to what I can achieve. This powerful ethos, nurtured by their encouragement and confidence in me, has been a guiding force in my journey. Their unconditional love and the lessons they have imparted have been my constant source of strength and motivation. This achievement is as much a testament to their upbringing as it is to my efforts. For this, and for everything, I am eternally grateful to them.

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Chapter One: Introduction to the Four Article Dissertation

Defining the Problem of Firearm-related Harm

Firearm-related harm as a public health problem

In 2001, then-Surgeon General Dr. David Satcher declared firearms a public health concern in the United States, shifting from the traditional focus of firearms as a criminal justice problem to solutions rooted in public health approaches of harm reduction and prevention (Office of the Surgeon General (US) et al., 2001). Since then, firearm deaths have increased by 63%, now accounting for more than 48,000 deaths annually, including 25,000 suicides, 19,000 homicides, 600 legal interventions, and 500 unintentional deaths (CDC, 2023). Firearms are now the leading cause of death for children aged 1-19 (*WISQARS Fatal and Nonfatal Injury Reports*, 2023). While data on nonfatal firearm injuries are limited, recent estimates suggest firearm injuries account for at least 133,000 emergency department visits annually (Zwald et al., 2022). Survivors of firearm injury often experience long term physical, psychological, social, and emotional consequences (DiScala & Sege, 2004; Greenspan & Kellermann, 2002); they are also at risk of subsequent violence victimization and/or crime perpetration (Rowhani-Rahbar et al., 2015). Moreover, firearm-related harm can manifest even when victims do not sustain an injury, such as via threats from an intimate partner (Adhia et al., 2021), direct and indirect threats of community violence (Smith & Patton, 2016), and experiences with mass shootings (Lowe & Galea, 2017).

In these scenarios, the presence of a firearm significantly increases the risk of harm. For example, suicide attempts with a firearm have a 90% case fatality rate, whereas drowning (the next most lethal method) has a 55% case fatality rate (Conner et al., 2019a). Because crisis moments are often brief, reducing access to the most lethal method of harm can be life-saving,

allowing ideations to pass and for an individual to receive supportive intervention (Hawton, 2007). Yet, the ease of firearm access in the U.S. complicates efforts to reduce access to lethal means. Between January 2019 and April 2021, 7.5 million adults became new firearm owners, with an estimated 81.4 million American adults now owning firearms (Miller et al., 2022). This increase in firearm ownership potentially exposed up to 11 million people, including 5 million children, to household firearms (Miller et al., 2022). Given the substantial rise in firearm ownership and the widespread accessibility of firearms in households, addressing the accessibility of firearms for individuals in crisis at risk of harming themselves or others is an urgent and complex challenge requiring multifaceted approaches to reduce the risk of harm in crisis situations.

Firearm-related harm as a social justice problem

In addition to a public health problem, any discussion of firearm-related harm must also recognize it as a critical social justice problem. The burden of firearm-related harm disproportionately impacts many historically marginalized and minoritized communities. Black children and adolescents experience firearm homicide rates 10-14 times more than those of white peers (Fowler et al., 2015). Additionally, youth living in urban areas are more likely to witness gun violence (21%) and to hear gunshots in public (48%), compared to nonurban youth (Turner et al., 2019). Men represent more than 83 percent of firearm homicide victims and more than 92 percent of offenders (Cooper & Smith, 2011). American Indian and Alaska Native populations experience some of the highest rates of firearm suicide (*WISQARS Fatal and Nonfatal Injury Reports*, 2023).

Structural racism as a determinant. A growing body of research empirically establishes these disparities as consequences of structural racism (Conrick et al., 2022; Houghton

et al., 2021; Jacoby et al., 2018; Jay, 2023; Mesic et al., 2018; Poulson et al., 2021; Unnever et al., 2021; Uzzi et al., 2023; Wong et al., 2020). Structural racism refers to "the historically contingent and persistent ways in which social systems and institutions generate and reinforce inequities in access to power, privilege and other resources among racial and ethnic groups deemed to be superior and those viewed as inferior" (Agénor et al., 2021 p 428). Disparities in firearm-related harm may be influenced by structural racism through several pathways. Historical racist policies and practices, including slavery, Jim Crow laws, immigrant exclusion, and genocide, continue to influence contemporary policies and systems governing social institutions such as welfare, education, voting, criminal justice, healthcare, and immigration (Alexander, 2012; Bell, 2008; Bonilla-Silva, 1997; Jones, 2001; Pager & Shepherd, 2008). The pervasive presence of structural racism within these systems, which are responsible for the allocation of political, social, and economic resources, perpetuates inequalities (Alexander, 2012; Bell, 2008; Bonilla-Silva, 1997; Pager & Shepherd, 2008). For instance, racially discriminatory housing policies like redlining have fostered residential segregation, concentrating people of color in under-resourced communities (Brown University Center for the Study of Race and Ethnicity in America, 2020). This segregation influences crime rates (Light & Thomas, 2019) by limiting employment opportunities (Bonilla-Silva, 1997), reducing educational resources (Pager & Shepherd, 2008), diminishing public investments (Brown University Center for the Study of Race and Ethnicity in America, 2020), and perpetuating stigmatization of neighborhoods as "hazardous and deleterious" (Woods et al., 2014). Studies have identified a correlation between levels of residential segregation and disparities in firearm-related harm, such as homicide rates, at both the state and city levels (Beard et al., 2017; Benns et al., 2020; Jacoby et al., 2018; Light & Ulmer, 2016; Poulson et al., 2021; Ulmer et al., 2012; B. Wong et al., 2020). Additionally,

consequences of structural racism, such as over policing of and police violence against Black individuals is associated with increases in suicide attempts (DeVylder et al., 2017).

Settler colonialism as a determinant. The implications of the settler colonial project (Elkins & Pedersen, 2005; Wolfe, 2006) on firearm-related harm are profound, yet often overlooked in empirical research. Settler colonialism, which demands the erasure of Indigenous Peoples, has manifested in various forms: physical violence such as genocide, confinement to reservations, epistemicide including efforts to control Indigenous identity and the perpetuation of the "vanishing Indian" myth, and forced assimilation exemplified by Indian Residential Schools (Elkins & Pedersen, 2005). These historical and ongoing acts of erasure have led to increased rates of substance abuse, suicidality, anxiety, and posttraumatic stress disorder among Indigenous populations (Evans-Campbell et al., 2012), who also face some of the highest rates of firearm suicide.

Furthermore, settler colonialism has left an indelible mark on the current cultural and legal landscape of the U.S., particularly in the realm of firearms. The Second Amendment, often celebrated today by many Evangelical Christians as a divine right to bear arms for self-defense (Conrick, Smith, et al., 2023; Vegter & Kelley, 2020) is deeply rooted in the settler colonial project. The Second Amendment's history justified the formation of colonial militias, which were sanctioned for the invasion and occupation of Indigenous lands. These militias, glorified in the nation's founding narratives, were tasked with enforcing laws, suppressing insurrections, and repelling invasions, often against Indigenous peoples (Dunbar-Ortiz, 2018). This intersection of settler colonial violence, divine endorsement, and state-sanctioned narratives has fostered a belief system wherein many settlers viewed their actions as not only patriotic but divinely ordained. Their perceived entitlement to land acquired through violence is a key element of the

nation's origin story, often romanticized as a heroic sacrifice for manifest destiny and the spread of Christianity to Indigenous populations (Dunbar-Ortiz, 2018). Today, this ideology becomes institutionalized in policies and court decisions (e.g., *Heller* and *Bruen* decisions) that prioritize individual rights to own firearms over collective safety. Recognizing this complex historical interplay is essential to framing firearm-related harm as a contemporary social justice issue, highlighting the lasting impact of firearm culture in perpetuating systemic violence.

Social Workers as One Solution to Firearm-related Harm

Social workers serve clients at risk of firearm-related harm

Social workers may play a pivotal role in addressing firearm-related harm as part of a multi-faceted approach to prevention and intervention. Those in direct practice serve clients in a range of settings including private practice, clinical, community, school, social service, and legal settings. These social workers often find themselves at the frontline of identifying individuals at risk of firearm-related harm (Conrick, et al., 2023; Sperlich et al., 2022). Their work ranges from routine clinical settings to high-acuity care situations, where they are equipped to recognize both potential victims and perpetrators of harm, while maintaining cultural sensitivity and awareness (Schriver, 2019). In doing so, they can facilitate evidence-based interventions that address the root causes and risk factors associated with firearm-related harm, such as hospital-based violence intervention programs (Lyons et al., 2021; Webster et al., 2022). In community settings, social workers serve as liaisons between individuals and the resources they need for both prevention and recovery. Their expertise in case management and referral services helps bridge the gap between clinical interventions and broader support networks (Lyons et al., 2021; Rozel & Mulvey, 2017). By linking individuals to pre- and post-intervention resources, social workers contribute to a comprehensive approach that extends beyond the clinical encounter.

Social work perspectives on addressing firearm-related harm

Theoretical foundations. Formal social work training creates a theoretical foundation for understanding firearm-related harm that is unique from other professions. This training emphasizes a comprehensive understanding of person-in-environment, including social determinants of crisis moments and individual, interpersonal, community, structural, and societal contexts in shaping individual experiences and risks (Schriver, 2019). It allows them to identify not only the immediate risk but also the underlying factors that contribute to firearm-related harm from a systems theory perspective, such as lack of resources, experiences with discrimination, and community resilience. With these theoretical frameworks, social workers may also advocate for policies and interventions that address the social determinants of firearm-related harm from strengths-based and empowerment approaches (Schriver, 2019).

Ethical foundations. Social workers bring not only theoretical knowledge but also a strong ethical foundation to their role in addressing firearm-related harm. The profession's core values of social justice, compassion, and client empowerment align seamlessly with the goals of reducing harm and enhancing safety in the context of firearm access (National Association of Social Workers, 2023). Social workers are guided by a commitment to advocating for vulnerable populations and ensuring equitable access to resources. Their ethical principles emphasize the importance of respecting individual autonomy and dignity, making them well-suited to engage in sensitive discussions about firearm access while upholding clients' rights and well-being. By integrating these ethical values with their theoretical and practical expertise, social workers could contribute significantly to the multifaceted approach needed to tackle firearm-related harm effectively. However, research on micro-level social workers' role in preventing firearm-related harm is limited (Sperlich et al., 2019).

Social workers are ill-equipped with practical skills to reduce firearm access for clients in crisis

While social workers possess the theoretical knowledge to address firearm-related harm and are strategically positioned to offer resources for reducing firearm access for clients in crisis, they often find themselves ill-prepared to evaluate clients for access to firearms and intervene effectively (Conrick, et al., 2023). A major challenge is their reluctance to assess firearm access, stemming from discomfort with the subject and uncertainty about effective communication strategies (Conrick, et al., 2023; Slovak et al., 2008; Sperlich et al., 2022). Training can significantly enhance social workers' likelihood of engaging in firearm assessment and counseling (Slovak et al., 2008), highlighting the potential influence of training on increasing self-efficacy in discussing firearms with their clients. However, the availability of such training is limited, partly due to a lack of comprehensive understanding of best practices in working with clients to reduce firearm access.

Equity and Ethical Considerations for Reducing Firearm Access for Individuals in Crisis: Dilemmas Social Workers Face

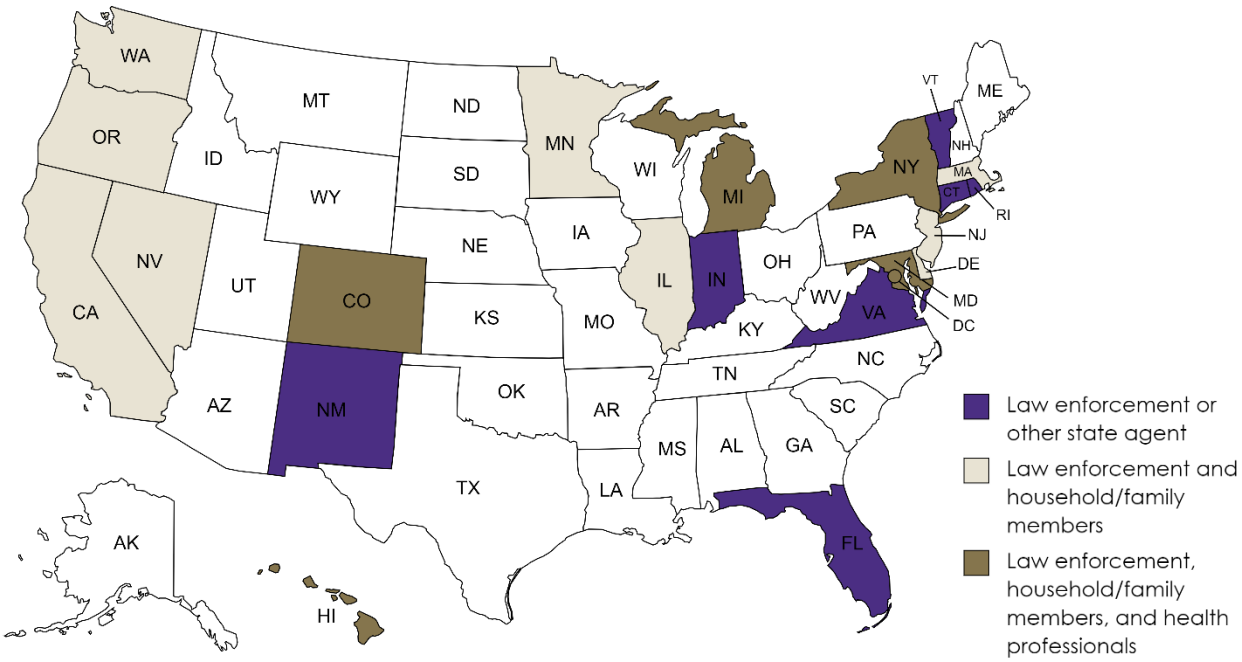
Options for reducing firearm access for individuals in crisis are contingent on their current possession of firearms (including legality of currently accessible firearms), their intent to acquire firearms, available policies and community resources, and intent of harm (self and/or others). These methods also vary in intensity and restrictiveness. The least restrictive option includes increasing security of firearm storage while it remains in the client’s home, such as storing ammunition and firearms locked, unloaded, and separately. If available from their workplace, social workers can provide clients with a locking mechanism such as a lock box or cable lock. Out-of-home storage is another low-intensity option, such as with a family member

or friend or at a community or law enforcement organization. Some states, including Washington, have an interactive map of facilities that are willing to consider temporary, voluntary storage of a firearm for individuals in crisis (https://fiprp.uw.edu/tools-dissemination/resources/). Furthermore, Washington State law allows the transportation of firearms by someone who is not the lawful owner if doing so is to "prevent bodily harm," as long as that individual is not banned from owning firearms (e.g., felony history) and it is intended to be temporary (RCW 9.41.113). The state also offers a Voluntary Waiver of Firearm Rights (VWFR) policy, allowing individuals to restrict immediate access voluntarily and confidentially to firearm purchase by filing a document with the court. The VWFR is one of the only options available to address future firearm acquisition.

The most restrictive option for firearm removal is via an Extreme Risk Protection Order (ERPO). ERPOs are a civil order designed to reduce firearm access for individuals, referred to as respondents, who exhibit behaviors indicating they are at substantial and imminent risk of harming themselves and/or others with a firearm. The petitioner, an individual who observes these behaviors, has the option to complete a petition, requesting a judge to order the removal of any firearms currently in possession and to prohibit the purchase of new firearms. In 21 states and Washington D.C. with existing ERPO laws, law enforcement officers or other state agents can file for an ERPO, and in most states family or household members may also file (Figure 1.1.). A select few states permit health professionals, such as physicians, nurse practitioners, mental health providers, and social workers, to independently file an ERPO petition. Even in states where these professionals cannot independently file, they may still play a critical role in the implementation of ERPOs by recommending law enforcement or family members file them for clients or by assisting clients in navigating the ERPO process if a petition is filed for them

(Conrick, Davis, et al., 2023). Given the relative novelty of these laws, a substantial gap exists in knowledge of the integration of ERPOs into clinical and community settings. Recent scholarship has found ERPOs to be a promising tool for suicide prevention (Kivisto & Phalen, 2018; Swanson et al., 2019). Additionally, ERPOs have been filed by petitioners seeking to prevent respondents from harming another individual with a firearm (Rowhani-Rahbar et al., 2020a; Wintemute et al., 2019).

Figure 1.1. States with Extreme Risk Protection Order (ERPO) Law, by Petitioner



Equity and ethical considerations. Many individuals, including social workers, have expressed concerns regarding involuntary firearm removal options due to ethical and equity considerations. First, while social workers may be ethically and legally required to intervene when their clients exhibit behaviors indicating they are at substantial risk of harming themselves and/or others, involuntary firearm removal options violate client autonomy. Any intervention that removes individual clients' right to determine their own care plan must be carefully weighed.

Additionally, individual implicit biases may influence social workers' choices regarding which clients should be escalated to involuntary measures.

Additionally, involuntary measures for firearm removal rely on the legal system, which is built on a foundation of structural racism and settler colonialism (Agénor, 2021). The same mechanisms through which these forms of systemic oppression drive *disparities* in firearm-related harm also determine which options for firearm removal exist, and furthermore, which options are *safe*. Involuntary measures, though focused on immediate physical safety, can have negative consequences for clients, particularly clients who are Black, Indigenous, and People of Color (BIPOC), undocumented immigrants, trans, or experiencing mental health crises. For example, while ERPOs are a civil (i.e., not criminal) order, their enforcement still necessitates involvement with law enforcement, who are responsible for firearm removal. In addition to the immediate physical dangers associated with firearms, interactions with these systems may also have enduring physical, psychological, and emotional dangers. Consequently, social workers face a nuanced ethical dilemma, balancing immediate safety or service connections against the risk of exposing clients to harm from medical and legal systems.

Theoretical Framework: Situated Bureaucrats

This dissertation consists of four papers, each grounded in the premise that social workers possess discretion in selecting strategies to reduce firearm access. Given that these choices can profoundly impact clients' lives, it is essential to thoroughly understand the decision-making process and the factors influencing these decisions. This insight is crucial to prevent unintended harm, particularly for minoritized and marginalized communities. Thus, my research seeks to equip social workers with knowledge to make informed choices, thereby minimizing negative consequences in their practice. This dissertation is guided by the theory of street-level

bureaucrats (Lipsky, 2010), as well as Watkins-Hayes' adaptation of this theory to define the role of situated bureaucrats (Watkins-Hayes, 2009). Street-level bureaucrats serve as the face of public policies by providing direct social services to individuals (Lipsky, 2010). In this role, they exercise discretionary power to assess the complex context of a client's situation and determine how different facets of a given policy allow them to provide or require them to deny provision of services (e.g., food stamps). This discretionary power also extends to supervision of related stipulations, such as work requirements, within the policies they administer. Watkins-Hayes extends this theory and introduces the concept of situated bureaucrats, which considers the integration of professional and social identities, such as race and class, in shaping the discretion exercised by street-level bureaucrats (Watkins-Hayes, 2009). Situated bureaucrats are defined as, "one's sense of who one is, of one's social location, and of how one is prepared to act and […] how this subjectivity gives rise to a general framework through which each bureaucrat approaches their job." This theory suggests that the variations in the delivery of welfare services, typically attributed to individual workers' discretion, are influenced by the integration of their professional and social identities. In the context of welfare offices, for example, "the focus on advice giving as a key component of welfare casework allows Black and Latino street-level bureaucrats to intervene in the lives of their clients of color in distinct ways, but guards against charges of bias and allows them to adhere to the expectations of the institution."

In the context of social workers assisting clients at risk of firearm-related harm, the integration of their professional expertise and personal identities plays a crucial role in shaping care plans. The interplay between their own subjectivity and the broader institutional expectations and biases could shape the assessments and recommended interventions provided by social workers. Several factors may influence a social worker's decision to refer clients to

pursue an ERPO rather than or in addition to other services, which can have significant implications. For instance, research indicates a disparity in the pursuit of domestic violence protection orders (DVPO), with white survivors or those with higher education and income levels more inclined to utilize them (Durfee, 2009; Macy et al., 2005). These correlations can be attributed, at least in part, to positive experiences with the legal system (Fleury-Steiner et al., 2006) compared to pervasive systemic and structural racism that perpetuates widespread unfair treatment of BIPOC communities (e.g., over policing, discriminatory practices, and lack of access to services). Due to these systemic issues, some individuals, including social workers, are hesitant about involuntary firearm removal methods that necessitate legal system involvement (Conrick, Gause, et al., 2023; Swanson, 2020). This dissertation explores the importance of studying discretion in social work practice regarding preventing firearm-related harm. By exploring how social workers' professional judgments intersect with their personal identities, we can better understand how these factors influence the decision-making process and subsequent outcomes for clients. This study of discretion is vital not only for improving service delivery but also for addressing broader systemic inequalities that impact both clients and social workers.

Researcher Positionality

As a researcher, it is critical for me to acknowledge and reflect on the ways in which my personal perspectives, background, and lived experiences shape my research approach, including the questions I pose, the methods I employ, and how I interpret and frame results. Growing up in rural Alabama, where firearms were a ubiquitous part of life, I was ingrained with a culture that emphasized responsible ownership and the belief that firearm injuries and deaths largely result from irresponsible use. In my community, the responsibility for preventing such incidents was seen as lying with the individual, their family, and their local community, leading to a skepticism

towards policy-level interventions. This upbringing has in part influenced my inclination towards promoting voluntary measures for reducing firearm access, with an understanding that involuntary measures may be necessary for individuals lacking strong support networks.

My educational background in public health brings a perspective focused on population-level interventions. Recognizing the specific focus of my dissertation on the choices made by clinical social workers, I have taken several steps to ensure my work remains relevant and grounded in clinical practice. This includes incorporating multi-level influences that social workers encounter as policy implementers in my PhD coursework, involving clinical social workers in my committee and as co-authors, and consulting practicing social workers for input on survey and interview questions. Furthermore, I engaged in member checking to ensure my findings are representative and collaborate with social workers in dissemination efforts.

As a white woman, I am not part of the demographics most directly impacted by firearm-related harm and do not possess lived experiences of the structural and interpersonal racism discussed in my research. To address this, I engage in reflexivity practices, such as memoing about my identities and their potential influence on my work. I actively seek out and prioritize literature by scholars of color and Indigenous scholars on racism and settler colonialism in social work and their impact on firearm-related harm. Recognizing the academic publication process's undervaluation of the extensive work on racism by scholars of color (Boyd et al., 2020), I make a conscious effort to prioritize citing these scholars in my work. This positionality statement reflects my commitment to conducting research that is both informed by and responsive to the diverse contexts and experiences that shape the field of social work and its approach to addressing firearm-related harm.

Dissertation Study: Structure of the Four Papers

Despite the critical role social workers play in reducing firearm-related harm for clients at risk of harm to self or others, there exists a notable gap in evidence-based trainings and practice guidelines, particularly with a focus on equity. Moreover, limited research has actively worked with social workers to gather their insights on their current approaches when working with clients who may be at risk (Sperlich et al., 2022). Gaining an understanding of this discretion is key to designing, implementing, and evaluating interventions to support them. This dissertation sought to co-create knowledge with social workers that will inform trainings to equip them to prevent firearm-related harm, focusing on two key pieces. First, I sought to understand the factors influences social workers' choices to pursue different care plan options to reduce firearm access for clients in crisis, considering how this discretion may reduce or exacerbate inequities in client care. Second, I examine how social workers consider, navigate, and confront structural racism in options for reducing firearm access.

In Paper One (Chapter Two), I explore the discretionary aspects of integrating ERPOs into social work practice, drawing lessons from the historical integration of DVPOs. Using a narrative inquiry approach, I present findings from interviews with eight community advocates and social workers who were active in the domestic violence advocacy movement during the 1970s-1990s. These interviews seek to understand the intricacies of DVPO implementation into their professional and community settings, with a particular focus on how discretion regarding when to suggest a DVPO for a client may influence equity outcomes. The specific research questions include:

1. What historical contexts influenced the discretionary use of DVPOs in community and social work settings?

2. How did social workers' discretion in implementing DVPOs impact equity for communities affected by domestic violence?
3. How may lessons learned from the implementation of DVPOs inform equity considerations for the implementation of ERPOs?

I extract three key lessons and discuss how these insights can be applied to understand potential equity implications when social workers or community advocates use their discretion to recommend ERPOs for clients at risk of self-harm or harming others.

In Paper Two (Chapter Three), I delve into the approaches social workers adopt when working with clients in crisis who are at risk of harming themselves and/or others with a firearm. I use inductive thematic analysis on 10 focus groups with 29 social workers to understand the ethical challenges social workers face when using their discretion to weigh the benefits of medical or legal system services against potential harms arising from these systems. The specific research questions include:

1. How do social workers use their discretion when serving clients at risk of firearm-related harm who may benefit or be harmed by medical and legal systems?
2. What roles do social workers perceive themselves as holding when working with clients at risk of firearm-related harm?

I identify six roles they assume when serving these clients. These roles reflect the delicate balance they maintain when using their discretion to consider the perceived benefits of medical or legal system services against potential harms arising from these systems, especially when factoring in clients' social identities, such as race, gender, or immigration status. I also identify the specific concerns social workers have regarding pursuing involuntary interventions to reduce

firearm access, highlighting the importance of understanding the contexts in which these decisions are made.

In Paper Three (Chapter Four), I seek to investigate the influence of both social worker and client race on the discretion to pursue voluntary versus involuntary care plans. This study is based on a survey completed by 1,306 social workers in Washington State. In the survey, I employed two case vignettes — one depicting a client at risk of self-harm and the other at risk of harming others. Each vignette was randomized to present the client's race as either Black or white. I applied logistic regression to analyze the relationship between the randomized race of the client and the social workers' choice of voluntary or involuntary methods. Additionally, I explored the role of the social workers' own race as a potential effect modifier in these decisions. The specific research questions are:

1. What is the effect of client race on social worker discretion regarding which approaches to pursue to reduce firearm access, comparing voluntary and involuntary approaches?
2. What is the effect of social worker race on this relationship (i.e., is social worker race a moderator)?

I find social workers differentially pursue involuntary care plans based on client race and intent of harm (i.e., potential harm to self or harm to others).

In Paper Four (Chapter Five), I further explore the insights from the 10 focus groups to examine the decision-making processes social workers use when selecting interventions to reduce firearm access for clients in crisis. The semi-structured interview guide directed participants to discuss experiences with clients at risk of harming themselves and/or others with a firearm and respond to two case examples. The specific research questions include:

1. How do social workers assess clients for risk of harm to self or others with a firearm?
2. What factors influence their choices to pursue voluntary versus involuntary firearm removal options?

I employed grounded theory analysis to construct a detailed action plan model. This model elucidates how social workers use their discretion to navigate various options and ultimately decide on specific interventions to address firearm access in crisis situations.

Finally, in the concluding chapter I synthesize findings from all four papers to provide recommendations for practice, policy, and training. I also identify social justice implications, directions for future research, as well as detail my efforts to disseminate my research findings.

This research will contribute to our understanding of social workers' roles in addressing firearm-related harm, underscoring the urgent need for practices that are both evidence-based and attuned to the nuances of clients from diverse backgrounds who may be at increased risk for harm from medical and legal systems rooted in structural racism. The insights and recommendations presented in this dissertation seek to influence future practices, policies, and training in social work. More than just guiding immediate interventions, these findings offer a foundation for ongoing research and dialogue.

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Chapter Two: Equity Considerations for Implementation of Extreme Risk Protection Orders into Social Work Practice: Lessons Learned from Domestic Violence Protection Orders

Abstract

Extreme Risk Protection Order (ERPO) policies seek to reduce firearm injuries and deaths by restricting firearm access for individuals in crisis. Social workers and community advocates can play a critical role in the implementation of these orders by referring clients to them. In the course of their work, they may also identify unintended consequences or gaps in protection order policies, particularly those that exacerbate inequities. However, the novelty of ERPO laws makes it difficult to understand contemporary implementation into social work and community settings. As most ERPO laws in the United States are based on Domestic Violence Protection Order (DVPO) laws, we sought to understand the history of DVPO implementation, identifying aspects of DVPOs that exacerbated or reduced inequities, then applying those lessons to ERPOs. Semi-structured interviews with eight social workers and advocates involved in DVPO implementation in the 1970's-1990's were conducted. We used narrative inquiry to identify concerns with DVPO implementation with a focus on equity considerations. We then applied lessons learned to potential equity implications for ERPOs. Three "lessons" arose, with corresponding ERPO implications. First, advocates sought to understand individual context before offering options such as protection orders. Participants suggested ERPO advocates should be prepared to offer wraparound services and voluntary firearm removal in addition to or instead of an ERPO. Second, the professionalization of the role of advocates to social workers affected how they served clients. Participants recommended professional development opportunities to be offered to those with lived experience of firearm-related harm. Third, advocates were responsible for identifying and addressing inequities in protection orders. Participants suggested an

evaluation system be developed to monitor for inequities in ERPOs. The insights from participants in this study, situated in a historical context, offer ERPO researchers, implementers, and policymakers a unique opportunity to proactively address and prevent potential unintended consequences of ERPOs.

Key words: domestic violence, protection orders, firearm, extreme risk protection orders, social workers, qualitative, narrative analysis

Introduction

Extreme risk protection orders (ERPO) are civil orders designed to reduce firearm access for individuals, referred to as respondents, who exhibit behaviors indicating they are at imminent risk of harming themselves and/or others with a firearm. Certain individuals, referred to as petitioners, may file an ERPO petition, requesting a judge to order the removal of any firearms currently in possession by the respondent and to prohibit the purchase of new firearms. Preliminary research has shown ERPOs are a promising intervention to reduce suicides (Swanson et al., 2019) and potentially mass shootings (Wintemute et al., 2019). As of December 2023, 21 states and Washington D.C. have ERPO laws. In these states, law enforcement officers or other state agents can file for an ERPO, and in most states family or household members may also file. A select few states permit health professionals and social service workers, such as physicians, nurse practitioners, mental health providers, and social workers, to independently file an ERPO petition. Even in states where these professionals cannot independently file, they may refer clients to the ERPO filing process and play a critical role in helping them navigate this process.

Social workers and advocates may play an important role in ERPO implementation. They often serve clients at risk of harming themselves and/or others with a firearm (Conrick, Gause, et al., 2023), and their unique training equips them to identify the psychosocial context leading to crisis moments for clients that could indicate need for an ERPO. Furthermore, social workers are trained to apply a social justice framework when contextualizing how systems impact individual crises. In addition to social workers, advocates, paraprofessionals, and credible messengers in community and professional (e.g., civil) roles offer dynamic support to individuals in crisis, including informal help, legal support, health care system navigation, and counseling services,

among others (Allen et al., 2004). This positioning equips social workers and advocates to counsel clients on the best approaches to de-escalate crises without re-traumatization by system interactions (Buggs et al., 2022). Additionally, social workers are ethically obligated to train advocates to deliver services in their absence while social workers address more severe cases. The implementation and integration of protection orders into social work practice settings involves equipping social workers with the knowledge and procedures necessary to effectively utilize these tools in their client interventions. This process encompasses training in the legal and practical aspects of the orders, establishing collaborative networks with other professionals and communities for support and advocacy, and ensuring ethical referral processes and application of these orders.

Social workers and advocates can also serve as liaisons between clients and the complex and often challenging medical, social service, and legal systems. When clients discuss their crises with trained professionals who are knowledgeable about available options, these professionals can clarify service choices, provide empathetic support, and facilitate referrals, which can improve service connection and client quality of life. In general, individuals who work with dedicated social workers or advocates experience significant improvements in outcomes related to service connection and quality of life compared to those who do not (Bell & Goodman, 2001; Sullivan & Bybee, 1999). Exploring their involvement in protection orders is imperative to understand how social workers and advocates can effectively connect clients at risk of harming themselves or others with a firearm with supportive services, including possible referrals to ERPOs.

It is important to carefully consider how social workers and other professionals navigate the potential unintended consequences of ERPO utilization and non-utilization, given that ERPO

necessarily involves interaction with law enforcement and the legal system. Petitioners initiate an ERPO through a written request to the court, respondents can respond before a judge, and law enforcement officers serve ERPOs to the respondent and facilitate firearm removal. Historical over-policing and systemic biases against Black, Indigenous, and People of Color (BIPOC) and marginalized communities can deter individuals from these groups from engaging with ERPOs. For example, BIPOC communities have expressed mistrust in the ERPO process (Pear et al., 2022). This skepticism may affect BIPOC community members' willingness to serve as petitioners, as they may hesitate to navigate a legal system with which they have deep-seated mistrust. Yet, there is some evidence they are overrepresented as respondents compared to their share of the population (Rowhani-Rahbar et al., 2020). This hesitancy to engage with ERPOs extends to respondent appearances at ERPO hearings. BIPOC respondents more often fail to appear at ERPO hearings, leading to a higher rate of firearm loss compared to white respondents (Swanson, 2020). Moreover, respondents are sometimes charged and convicted with crimes alongside an ERPO filing (Conrick, Davis, et al., 2023), and ERPO violations are a criminal offense. Given these equity considerations, some social workers have expressed concerns with involving or referring clients to the legal system in the context of ERPOs, arising from conflicting ethical obligations to protect clients and communities from immediate physical harm and potential implications of referring clients to a system known to be racist (Conrick, Gause, et al., 2023).

Social workers and advocates can play a critical role in identifying when and how an ERPO might be a suitable option for a client in crisis. However, the novelty of ERPOs coupled with limited awareness among social workers and advocates hinders a comprehensive understanding of their potential as a tool to reduce firearm-related harm in these settings. Most

ERPO laws were based on the infrastructure of another civil protection order, Domestic Violence Protection Orders (DVPO) (ERPOs: New Recommendations for Policy and Implementation, 2020; Tomsich et al., 2023). Therefore, we can draw insights from the history of how social workers and advocates considered DVPOs as tools to prevent domestic violence (DV). DVPOs allow victim-survivors of DV (the petitioner) to file a petition to request that the court prohibit their abuser (the respondent) from enacting further violence, harm or harassment, potentially including relinquishing their firearms. Similar to ERPOs, social workers and advocates considering whether to refer clients to DVPOs face challenges balancing client autonomy and service needs with potential legal system harms, and disparities have been discussed for decades in this context (Carlson et al., 1999; Coker, 2001; Decker et al., 2019; Durfee & Messing, 2012). We sought to gain insights into the historical context in which DVPOs were implemented into community and professional settings and explore how lessons learned can inform ERPO implementation, with a focus on equity considerations.

This study used structural intersectionality as a guiding paradigm, emphasizing the interconnectedness of hierarchical and oppressive institutional systems and their impact on individuals with intersectional identities (Durfee, 2021). This approach is particularly relevant for examining DVPOs as a historical precedent to ERPOs because it reveals how overlapping systems—such as civil and criminal legal and healthcare systems— shaped responses to DV. Additionally, structural intersectionality centers the perspectives of DV advocates and social workers who have expertise in how macro-level institutional dynamics intersect to shape micro-level individual experiences, thereby revealing the perpetuation of inequalities (Durfee, 2021). These lessons learned may then be used to predict and alter the evolution of ERPOs to ensure they do not perpetuate unintended harm.

Methods

We used a narrative inquiry approach to capture the complex and subjective experiences of DV advocates and social workers who were embedded in the DVPO implementation in their professional and community settings. We conducted interviews with expert key informants (n = 8), who could speak to the evolution of the DVPO implementation over several decades. Participants were recruited via snowball sampling, beginning with the author team's contacts. Eligibility criteria included self-identifying as a social worker or community advocate and having experience serving individuals experiencing DV during early implementation of DVPOs (i.e., between 1975-1995). Participants served in a variety of roles, including as advocates in battered women's shelters with no formal training, as civil legal advocates with legal training, and as social workers. Many participants served in multiple roles, transitioning from community to professional advocates, and they discussed DVPO implementation in each of these settings. Participants also had a diverse range of social identities including by race and ethnicity, sexual orientation, and lived experience. All study procedures were approved by the university Institutional Review Board. Before beginning the interview, all participants were provided with an overview of the study, commitment to confidentiality of their responses, and an opportunity to ask questions. They were then asked to provide verbal informed consent. All interviews were conducted by the lead author (KMC).

Narrative inquiry is "grounded in the study of the particular" (Mishler, 1990); therefore, the semi-structured interview guide (Appendix A) was developed to encourage participants to focus on the details of their stories, allowing for natural divergence as the conversation evolved. The interview guide asked participants to describe their roles and experiences as an advocate and/or social worker, discuss successes and failures with implementation of DVPOs, and explain

their approach to conversations with victim-survivors regarding services they could pursue. Two participants had expertise with ERPOs; these individuals were also asked about the implementation of ERPOs into community and professional settings. For other participants without this experience, the interviewer gave a brief overview of ERPO policies, asked participants to reflect on their impressions, and asked what advice they would give to an advocate who was considering suggesting an ERPO for a client. All interviews were conducted via videoconference, lasted 45-90 minutes, and were transcribed verbatim. Interviews were conducted until saturation was reached, defined as no new insights or themes emerging. Narrative analysis focuses on stories as the coding unit, rather than categorical details of the story (Riessman, 2008). We defined "story" as the individual account of an event. To understand each participant's story of DVPO implementation, the coder (KMC) first worked within each interview individually, ordering each story chronologically. Each story within the interview was tagged with a code representing a significant story component. Once all interviews were ordered and all accounts tagged, we then organized them into a codebook. The codebook was iteratively revised (KMC and MM) to group related codes into categories, and then into themes.

Results

Themes are presented as three "lessons" from DVPO implementation and related "implications" for ERPO implementation. A summary of the lessons and corresponding implications is available in Table 2.1.

Table 2.1. Lessons learned from DVPO implementation and corresponding ERPO implications

DVPO Lesson	ERPO Implication
Lesson 1: Advocates understand individual context before offering options such as protection orders	
Advocates helped victim-survivors navigate a biased legal process, including consideration of possible unintended harms	Become familiar with local options to best utilize or circumvent potentially harmful medical and legal systems

Advocates prioritized understanding survivor's needs and goals and tailored referrals based on unique circumstances	Ensure ERPOs are not the default recommendation for firearm removal; offer wraparound services and voluntary firearm removal in addition to or instead of an ERPO
Lesson 2: The professionalization of advocacy affected service provision	
Shift toward prioritization of social work degrees had substantial impacts on DVPO referral practices. Participants reported a greater perception of advocacy work as a job rather than participation in a social movement; inclusion of social workers expanded pool of knowledgeable staff and therefore resources	Offer professional development opportunities to individuals with lived experience of firearm-related harm so that they can transition to be social workers or system navigators
Theoretical underpinnings of social work influenced victim-blaming within the child welfare system	Incorporate pedagogical methods that prioritize non-judgmental approaches
Changes in funding sources altered operational and evaluation requirements	Be prepared to navigate bureaucratic processes when relying on government funding for ERPO-related work
Lesson 3: Advocates are well-positioned to identify and address inequities in protection orders	
Advocates were responsible for identifying how DVPO implementation helped or harmed the victim-survivors they served, and they changed their referral practices while advocating for change	Seek out potential inequities in ERPOs, then weigh potential harms and benefits while advocating for policy change to mitigate harms
There were inequities in the enforcement of DVPO and mandatory arrest laws	Design an evaluation system to monitor for inequities in filing, granting, and issuing violations of ERPOs
Efforts to collaborate with law enforcement helped promote uptake of DVPOs	Collaborate and educate law enforcement on ERPOs, given their substantial role in filing and enforcement
Women of color and queer women foresaw unintended consequences of certain policies and were therefore hesitant to refer victim-survivors to legal system solutions	Center intersectional voices in policy development, evaluation system design, and implementation

Lesson 1: Advocates understand individual context before offering options such as protection orders

DVPO Lessons

Participants working in legal settings explained their role in helping victim-survivors navigate the legal process, guiding them in crafting narratives that aligned with the legal definition of DV,

> "We really walk people through the process—help them draft their narrative, help them put into words what they experienced. Certainly, with the integrity of what they were communicating, but also knowing that we had people who are engaging in a system that has a lot of bias. And so, we would help people really craft their

> statement in the chronological order that the court wants to hear it in. Highlighting the things that meet the legal definition of domestic violence and trying not to have people lead with things that we know the court would take down a rabbit hole in the wrong direction."

Regardless of their specific roles, all participants shared a common approach when interacting with victim-survivors. They began by listening to the survivor's story and understanding their goals, then proceeded to counsel her on the available options. One participant described the advocate's role,

> "An advocate is like, 'What do you need? What do you need and what can I contribute to that?' And if I can, I will do it. If I can't, I'll try to find someone who can, or try to coach you through it somehow."

Participants emphasized the importance of comprehending the complexities of each survivor's circumstances and offering guidance accordingly,

> "I think an advocate is the one whose job it is to sit down with somebody, take the time to understand all of the complexities within their circumstances, bring in the experience that they have from working with other victims or survivors in that situation, and kinda help guide them through it."

One participant also explained that they began intentionally training other advocates to not start a conversation by offering a list of services because it shaped the interaction. Instead, this participant described the importance of advocating for "things that never would have been on the list."

In navigating conversations related to DVPOs, participants clearly recognized situations where DVPOs might not be suitable. One participant explained that she may not recommend a DVPO for a client dealing with child custody challenges, as additional involvement of the court through the DVPO process might expose the victim-survivor to additional court involvement that could lead her to lose custody of her child,

> "As an advocate, I usually would not necessarily "*recommend"* [a DVPO]—that word is a little stronger. I would say that I would offer it as a suggestion, and sometimes I would urge some people more than others to seriously consider it.

> But sometimes it's a bad idea, you know, sometimes it can be more harm than good."

Concerns were also raised about the potential physical risks associated with DVPOs, and advocates stressed the need for thorough safety planning given the increased risk of intimate partner homicide after a victim-survivor tries to leave an abusive relationship.

ERPO Implications

Participants recommended advocates take an individualized approach to understand the crises at hand before providing wraparound services or referrals. As an example, one advocate likened firearm removal as akin to behavioral control, rather than centering addressing the underlying crisis an individual was experiencing. Additionally, participants called for social workers to proactively educate themselves on intervention options to reduce firearm access and address the underlying crisis.

Participants believed that advocates and social workers could play a pivotal role in mitigating equity concerns associated with ERPOs. Given that law enforcement officers file most ERPOs, participants expressed apprehensions regarding potential biases or unintentional harms ERPO respondents may face within the legal system (e.g., biases in which respondents receive an ERPO or are referred for criminal charges). They saw advocates as potential solutions to reduce law enforcement involvement and assist family members in navigating this complex system.

Participants also voiced concerns about ERPOs becoming the default recommendation, akin to how DVPOs had evolved to become the default over time, emphasizing the importance of individualized assessments for appropriateness of a protection order to address a specific crisis,

> "People think the protection order is gonna solve a problem it's not gonna solve. So, what really is the problem? Is this a piece of the problem that an ERPO could help, you know? And so I think when you're hiring [advocates], instructing them on the work, you want to make sure that you're bringing people in to do the work

> who [are] open to […] actually say to people, 'This might not be enough or the best option for you because if you want it to do this, I don't think it will.'"

Relatedly, some participants expressed worries about current metrics of success in certain jurisdictions, where the focus was on the sheer number of ERPOs sought or obtained, rather than appropriate use,

> "I think that one of the concerns I have is, it was always designed to be of limited use. We should never be measuring success based on how many have been obtained or sought. That is just wrong. […] And I can tell you it's a decision around how they do policing. Whenever they go in, there's some kind of scary case. They find out the person has guns or might have guns, they get [an ERPO]."

Participants also drew parallels between the risks associated for the DVPO petitioner and potential dangers for ERPO civil petitioners, where the protection order may escalate the risk for violence. Additionally, some advocates expressed concern for respondents who may be at increased risk of harm from interactions with the legal system due to their social identities (e.g., higher likelihood of arrest, incarceration, or injury at the hands of law enforcement for BIPOC communities). As a solution, many advocates emphasized first considering voluntary firearm removal options before referring clients to an ERPO. Overall, these insights underscored the need for a thoughtful and individualized approach to ERPO referral practices.

Lesson 2: The professionalization of advocacy affected service provision

DVPO Lessons

Over time, services for victim-survivors of DV became funded primarily by governments, which came with more complicated rules, regulations, and reporting requirements. While some participants saw this shift as legitimizing and financially supportive, others described how this shackled the DV movement to governmental expectations, which could slow down or complicate the movement,

> "And so, what happens in social movements, and what happened in *our* movement, is that we kind of got a lot of stuff. And in order to preserve what we had, we had to kind of abide by the more bureaucratic governmental requirements, and the reliance on governmental funding is still predominant in the movement."

As funding streams shifted towards government sources, governments assumed the authority to define qualifications for individuals in organizations offering services. For example, it became common to require counselors in DV shelters to possess degrees reimbursable by insurance. Some participants noted that government requirements increased the number of professionally trained staff, which contributed to greater accessibility of services. Many advocates initially started as volunteers in informal roles, driven by their passion for assisting victim-survivors or their lived experiences of DV. Over time, some of these individuals chose to pursue formal Master of Social Work (MSW) training. This progression expanded the pool of knowledgeable staff available to deliver services, consequently enhancing overall accessibility to resources.

This change in funding structure also shifted the preferred qualifications of DV advocates, with increasing emphasis on formal training, particularly a social work degree. One participant explained how this change dominated the DV movement,

> "We used to prioritize if you had experience with battering that was an important thing in our hiring. And then it turned into we wanted social work degrees. So the professionalization, the power of that was very strong. And it always is in movements like that, dominant institutions just do what they do."

The de-emphasis of lived experience towards a preference for professional experience shifted the landscape considerably, equating more formalized training of job candidates to less empathy. One participant explained how her organization proactively discouraged hiring social workers,

> "We were so nervous about who social workers were and how they thought about families and how they assigned responsibility for bad things happening to children or to women. And so, we're like, no, let's just stay away from that."

Some advocates also expressed their belief that this shift in preferred qualifications led to a change in how advocates viewed their roles, seeing them more as a job than as part of a larger social movement.

Many participants raised concerns about the theoretical underpinnings of social work and how that framework influenced the field's understanding of DV. In particular, advocates working within the child welfare system were noted as sometimes engaging in victim-blaming. For example, they tended to focus on a mother's perceived failure to protect her child from DV, often overlooking the fact that she was also a victim of violence. This approach led to a misplaced emphasis on the mother's actions rather than prioritizing efforts to address and end the abusive actions of her partner. Others raised concerns regarding how professional training led social workers to perceive themselves as experts positioned over victim-survivors. This hierarchical thinking led them to adopt a prescriptive approach to making recommendations,

> "This professionalization I think has resulted in a kind of lack of sensitivity for the resilience and the wisdom that most survivors have, which is way more than any of us who are service providers. There is a little bit of, I would call it condescension, still towards telling survivors what to do."

Thus, participants noted professionalization can both equip social workers and advocates with critical training for success but can also imperil the respect and understanding that social workers and advocates might hold for lived experience, jeopardizing the quality of their client interactions and recommendations.

ERPO Implications

As government funding played a significant role in shaping the DV advocacy landscape, participants highlighted the importance of being prepared to navigate bureaucratic processes for ERPO-related work. For example, one participant discussed the challenges in serving protection orders given limited resources and administrative constraints,

> "What they found is that the protection order process was flawed orders or inconsistencies. You can never get people served or [the orders] don't get out [to be served] on time. But you can't even think about getting firearms away from people if the court gets an order and they have that the guy's name is Joe Smith and no other identifiers. Like they can't do anything about that […]. It required independent investigation, which is what our unit does."

Participants recommended ERPO advocates and programs should anticipate and advocate to change administrative challenges to ensure that bureaucratic aspects do not hinder the program's overall effectiveness.

Given the lessons learned from the professionalization of the role of DV advocates, participants suggested that it would be important to build a workforce with diverse lived experiences of firearm-related harm for those working with ERPOs. This could be accomplished through offering professional development opportunities to individuals who have experienced or enacted firearm-related harm in the past to help them receive the credentials necessary for social work practice. Alternatively, establishing collaborative work environments where individuals with lived experience work closely with formally trained professionals could augment the effectiveness of ERPO implementation and referrals.

Participants who discussed how the involvement of social workers in DV advocacy increased victim blaming and paternalism raised similar concerns about ERPOs. One participant explained a scenario where a DVPO victim-survivor may be unwilling to file a DVPO due to fears of violence escalation, but an actor from law enforcement may decide to file an ERPO without consideration for the wants or wellbeing of the victim-survivor,

> "The latest version of this [victim-blaming] is in the ERPO context, where it's, if she's not going to get a restraining order, at least we can remove the guns. Because we want to stop mass shootings. So, we're going to go ahead and take the guns away and leave her exposed [to abuse]."

Participants explained these concerns about increased victim blaming and paternalism underscored the imperative of incorporating pedagogical methods that prioritize trauma-

informed, non-judgmental approaches when training those who may refer for an ERPO (i.e., social workers and advocates).

Lesson 3: Advocates are well-positioned to identify and address inequities in protection orders

DVPO Lessons

As advocates interacted daily with the systems involved in the implementation of DVPOs, they were uniquely positioned to detect implementation gaps or unintended consequences. Advocates also bore the responsibility of examining equity concerns, including the carceral consequences of protection orders. Participants highlighted the foresight of women of color in recognizing the unintended consequences of certain policies, as well as how that influenced their referral practices for BIPOC victim-survivors. For example, many participants focused on the racist and heterosexist enforcement of mandatory arrest laws, which compelled law enforcement officers to arrest individuals when there were reasonable grounds to believe that they had assaulted their partner. One participant explained the challenges law enforcement and judges faced in comprehending a non-gendered expression of DV,

> **"**We had a lot of mixed feelings about mandatory arrest for a lot of us who were women of color. Because we saw right away what happened. First of all, men of color were disproportionately arrested. Then women started getting arrested. And that happened fairly quickly. And then in queer relationships, both of them got arrested. Because the police would get there and say, 'Okay, whose fault was it? Who's the man in the relationship? Or who's the woman in the relationship?' And when nobody fit those roles, they said, 'Well okay, then we're gonna have to arrest both of you.'"

By identifying how these practices distinctly harmed people in queer relationships, advocates changed their counseling and referral behaviors to protect their clients' interest and wellbeing, sometimes choosing not to recommend DVPOs. As these issues were identified, advocates and

social workers advocated for policy solutions and judicial and law enforcement education to address implementation gaps and misinterpretations of the law.

These concerns contributed to a more critical view of DV solutions that involved law enforcement or the legal system among many advocates, which elevated preferences for building community solutions. In particular, individuals with intersectional identities were instrumental in identifying service needs specific to marginalized communities. For example, one participant shared an example of a shelter lacking services in various languages to meet the needs of Asian women in the area, highlighting the importance of culturally competent and inclusive services that resonated with diverse populations. To address these concerns and ensure intersectional perspectives were considered, participants emphasized formally embedding women of color in key decisions. Committees were established with intersectional voices at the center, and policy advocacy only advanced when consensus was achieved. As an example, one participant explained how women of color helped forecast and shift the legal intervention model away from mandatory arrest laws, which criminalized DV and exacerbated mass incarceration of BIPOC communities, to the use of DVPOs, which they felt were more appropriate,

> "From the earliest days of the movement we had women of color, Native women at the table, always questioning things, inputting things, framing things from their perspective. [...] It meant that as we considered policies, we were figuring out whether the impact of this policy meant something different for the Queer community, the Indigenous community, Black community. [...] I would say that the way that many women of color and Native women, but not all, did not want domestic violence arrest laws [criminal] to be so dominant in our strategies. In a way protection orders [civil] were much more relevant for women of color, Native women because it kept their community out of the criminal justice system, but it got them what they really needed--their housing arranged, the food, money, childcare, transportation."

Finally, some advocates identified law enforcement officers were not consistently referring victim-survivors to the DVPO process. Participants explained that they felt this lack of referral stemmed from law enforcement's inaccurate perception of DV as "a couple's issue"

rather than as an issue that merited legal response. To address this problem, advocates initiated training programs for law enforcement personnel to enhance their understanding of DV and the utility of DVPOs. Participants explained that these training efforts bridged a critical gap in DVPO implementation by improving law enforcement referrals for victim-survivors.

ERPO Implications

Participants explained that actively identifying implementation gaps is a critical role for social workers and advocates in the ERPO process, with particular attention to practices (or lack thereof) that may lead to inequities or unintended consequences. These individuals would serve as liaisons between policymakers and the community, advocating for policy solutions to rectify identified problems, much like DV advocates did for DVPOs. Participants also suggested collaborative efforts to ensure thorough training and resources for law enforcement to play a constructive and informed role in ERPO referrals. One participant explained their efforts,

> "So much of what we do in our [ERPO] unit is just myth busting. This is about reducing risk in situations where it's predictable and the all the writing's on the wall. That's what we're trying to do. And in those first meetings with law enforcement, in the beginning they're really skeptical, but when you just really connect with people about risk, we have people coming in after the [ERPO] training just saying, 'You know, we've got this guy in our community. We always worry he is gonna be on the 5 o'clock news for doing something really scary.'"

Participants noted social workers and advocates may be uniquely positioned to help get partners across the legal system on board about the goals, appropriateness, and processes for ERPOs. Just as women of color played a vital role in recognizing unintended consequences of DV legal processes, participants explained ERPO referral practices and implementation could benefit significantly from embracing an intersectional perspective. They explained how social workers and advocates were positioned to recognize the potential for disproportionate impacts of ERPOs on different communities, especially those at the intersections of race, gender, and sexual orientation. Similarly, participants explained ERPO programs should prioritize culturally

competent and inclusive services, offering resources and supports that resonate with diverse populations, including language services and cultural awareness training for advocates, law enforcement, and judicial personnel.

Longtime DV advocates with intersectional identities drew parallels with their work on DVPOs, raising concerns that violations of the ERPO as a criminal offense have the potential to render those from marginalized communities and social identities more vulnerable to criminal-legal system entanglements as has been the case with DVPOs,

> "Once the state starts saying, 'You can do this and you can't do this,' it's gonna start leading us down getting people involved in the criminal legal system and to incarceration, to probation...and all kinds of things that are hard to stop. Once that ball starts rolling down that hill...what are you gonna do when there are violations of ERPOs? You violate the protection order, you're gonna go to jail. And then all of a sudden, there are all these brown people and [other] people getting arrested. So, I just think there has to be a little bit of a caution around that."

Learning from inequitable outcomes and unintended harms within the context of DVPOs, participants stressed the importance of tracking key metrics, such as who files ERPOs, who ERPOs are or are not granted for, the reasons behind ERPO violations, and any disparities in violations and punishment. They explained this proactive tracking could help identify trends and inform strategies to address issues promptly, ensuring more equitable and effective referral practices for ERPOs,

> "[For DVPOs,] we weren't really tracking how this was happening, but we started hearing stories. And then we realized, every time somebody got arrested on a mandatory arrest, on the way to the jail, they would get beaten up by the cops in the car. [With ERPOs], you all have the benefit of tracking early on and looking for trends. The best thing you can do is look for trends. And really try to think through what does that mean? How do we do something about it? Is there anything to do about it? Track, track everything you can."

By closely monitoring these trends, participants noted advocates and social workers could advocate for changes to ERPO implementation, ensuring that ERPOs are accessed equitably by all communities and do not cause unintended harm.

Discussion

This study offers valuable insights into the implementation of protection orders into professional and community settings, enriched by a historical perspective from advocates with five decades of experience with DVPOs. These experts provided critical views on the evolving role of advocates and social workers, stressing their importance in delivering tailored services in crisis situations and highlighting the need to address equity issues in ERPO referral practices and implementation. They additionally emphasized the significance of amplifying the voices of individuals with intersectional identities and lived experiences to guide ERPO policy and practice.

It is important to critically examine the substantial discretion social workers and advocates possess when determining whether to refer for a protection order alongside other social service or community resources. Engaging in discussions with a professional about intervention options significantly influences clients' decisions regarding protection orders. For instance, DV victim-survivors who discuss their experiences with medical professionals are 40% more likely to seek a DVPO than those who do not have such discussions (Durfee & Messing, 2012a). However, as participants in this study noted, referrals for protection orders are not always suitable. Specific situations, such as potential violence escalation, risks of child custody loss, and consequences from interactions with the legal system (e.g., arrests due to outstanding warrants), necessitate careful consideration (Durfee, 2021; Goodmark, 2004). Additionally, the identities and experiences of social workers and advocates influence their referral decisions. Structural racism ingrained in systems and implicit biases may sway their choices regarding who receives referrals to legal systems, medical services, or community resources (Conrick, 2024). For example, BIPOC social workers or advocates may be more cautious about referring clients to

legal solutions. Theoretical frameworks such as street-level bureaucrats (Lipsky, 2010), and its adaptation to understand the role of social identities on discretion (Watkins-Hayes, 2009), offer valuable insights into how advocates and social workers, as frontline policy implementers, apply their discretion in client referrals. Evaluating referral processes from these frameworks is key to understanding how ERPO implementation is functioning at the ground level.

In this study, participants emphasized the importance of not defaulting to ERPOs as the first recommendation when reducing a client's firearm access is deemed necessary. Prior research has found that DVPO petitioners often find the process traumatic and difficult, challenging the notion that it is an empowering experience (Durfee, 2015; Herman, 2005). Furthermore, law enforcement and social service providers, such as social workers with Child Protective Services, sometimes compel victim-survivors to pursue a DVPO against their own wishes and safety assessments (Goodmark, 2004). This coercion can further complicate an already challenging situation for those seeking help. Petitioners often encounter significant barriers when filing DVPOs, including costs related to child care, transportation, and lost income due to missed work (Durfee, 2021). These obstacles can make the process daunting and inaccessible. In the context of ERPOs, these findings suggest that advocates should prioritize understanding the unique goals and circumstances of each individual they assist before deciding whether a referral for an ERPO is the most suitable option. Advocates and social workers need to consider a range of factors, including the petitioner's and respondent's personal safety, the potential for further trauma, and practical barriers. Furthermore, it is crucial to expand the support systems and resources available to those considering ERPOs, ensuring that their decision is informed, voluntary, and aligned with their specific needs and circumstances.

The professionalization of the role of DV advocates into social workers paralleled a shift from a grassroots approach, where survivors and activists led efforts, to a more structured system led by trained staff like therapists and caseworkers (Durfee, 2021). This shift, inextricably linked to increased state involvement, expanded service availability, but also led to a conservative shift in the DV movement. This change invisibilized and marginalized certain communities, exacerbating systemic issues like mass incarceration (e.g., from mandatory arrest laws) (Richie, 2012). The study's participants noted that as DV advocacy professionalized, DVPO referrals became more standardized. Learning from the professionalization of DV advocacy can guide ERPO referral practices, suggesting a need for a balanced approach that melds professional expertise with community-driven, culturally resonant solutions. To ensure that ERPO policies do not inadvertently cause harm, it is vital to center voices with intersectional perspectives, including those based on social identities (e.g., race and ethnicity, sexual orientation) and lived experiences (e.g., experiences with suicidality, firearm-related harms, or the legal system). This can be achieved through professional development opportunities and formalizing the involvement of diverse voices in ERPO evaluation, monitoring, and implementation systems.

Participants in this study emphasized the importance of learning from disparities observed in DVPOs and mandatory arrest laws to design an evaluation system for ERPOs that will ensure the effectiveness and fairness of ERPOs. This system should monitor who is receiving ERPOs and granting and violation outcomes in addition to understanding the systemic and procedural barriers different groups face. This approach is particularly relevant for social workers and advocates, as their referral practices play a significant role in determining who accesses ERPOs. Disparities in DVPOs offer critical insights. For example, despite DVPOs being purportedly designed to be “victim-friendly,” those with legal representation are more

likely to have their requests for protection orders granted (Durfee, 2009). Furthermore, evidence suggests state-level provisions in DVPOs, such as requiring firearm relinquishment, reduce the state-level incidence of intimate partner homicide for white, but not Black, victim-survivors (Wallin et al., 2021a), pointing to potential racial disparities in the implementation or effectiveness of these orders. Early evidence from ERPOs indicate white respondents more often have legal representation (Pear et al., 2022), which could lead to ERPOs being disproportionately dismissed or denied for these respondents, meaning they would retain access to their firearms and potentially avoid future criminal legal system consequences of the ERPO (e.g., arrest for violation). Additionally, Black women are less likely to obtain a DVPO compared to white women (Durfee & Messing, 2012a), similar to hesitancies to petition for an ERPO among BIPOC communities (Pear et al., 2022). These decisions to pursue a DVPO are often influenced by their prior experiences with law enforcement (Decker et al., 2019). Considering the variability in the accessibility and provisions of both DVPOs and ERPOs across states (DeJong & Burgess-Proctor, 2006), it is essential for the ERPO evaluation system to also measure disparities at the state level. Such comprehensive evaluation is crucial for social workers and advocates to understand and address the potential inequities in the ERPO system in the specific context in which they are working. By doing so, they can ensure their referral practices are informed, equitable, and effective in serving the diverse needs of those seeking ERPOs.

Utilizing the historical evolution of DVPOs to understand ERPOs may not fully address the unique contemporary challenges of ERPOs. While valuable, this approach could overlook current societal and legal dynamics specific to ERPOs, which have emerged in a different context than early DVPOs. Future research should examine present-day implementation and impact of ERPOs, considering the evolving attitudes and frameworks surrounding DV and

firearm-related harm. Additionally, despite the diversity in social identities, the participants in this study may not have comprehensively captured the breadth of experiences in the field of DV advocacy and social work. Future research should expand the pool of participants to additional contexts and to those from different geographic regions.

The insights from this study offer ERPO researchers, implementers, and policymakers a unique chance to proactively address and prevent potential unintended consequences. Drawing on the rich experiences of long-standing professionals in violence intervention, this study underscores the critical function of advocates in the community-focused implementation of protection orders. It also stresses the significance of incorporating intersectional perspectives and empowers advocates to leverage their expertise in influencing policy and practice. Such informed, proactive engagement is essential for the successful and fair implementation of ERPOs, ensuring they serve as effective tools in violence prevention while being sensitive to the diverse needs of the communities they seek to protect. This approach not only enhances current practices but also paves the way for future advancements in the field, fostering a more inclusive and responsive framework for addressing firearm-related harm.

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Chapter Three: Weighing Medical and Legal Interventions and Potential Harms for Clients at Risk of Firearm Injuries and Deaths

Abstract

Background: We sought to explain how social workers manage the complexities of serving clients at risk of firearm injuries and deaths who may benefit from or be harmed by medical and legal systems.

Methods: We conducted ten focus groups with 29 clinical social workers in Washington state. Participants discussed their experiences with clients and reacted to case scenarios highlighting the risk of harm from medical or legal systems due to social identities (e.g., race). Interviews were recorded, transcribed verbatim, and analyzed via inductive thematic analysis.

Results: Participants described six roles—investigator, collaborator, confidant, facilitator, navigator, and educator—they assume when serving clients at risk of harm to self/others with a firearm, weighing the benefits of medical or legal system services but are also vulnerable to potential harms from these systems.

Conclusions: Social workers serve diverse and crucial roles when working with clients at risk of firearm-related harm. Foundational principles in social work education contextualize individual behavioral health crises within socioecological and social justice frameworks. This uniquely positions social workers to pursue client-centered solutions that maintain safety while accounting for risk of harm from medical and legal systems.

Introduction

Social workers frequently serve clients who may be experiencing a crisis in which they are at risk of harming themselves and/or others. In such contexts, the availability of a firearm can escalate the potential for lethal outcomes. For example, suicide attempts with a firearm have a 90% case fatality, whereas drowning (the next most lethal method) has a 55% case fatality (Conner et al., 2019b). It is therefore imperative for social workers to evaluate whether clients have access to firearms, particularly those who are experiencing a crisis. When deemed necessary, they are responsible for taking steps to mitigate the risk of harm.

Social workers have several interventions available to reduce firearm access for clients experiencing a crisis. Voluntary options may involve improving security of in-home firearm storage or facilitating voluntary out-of-home storage. Involuntary interventions, such as extreme risk protection orders (ERPOs), also exist for clients unable or unwilling to engage in voluntary removal. However, these involuntary measures, despite their focus on immediate safety, can have negative consequences for clients. For example, while ERPOs are a civil (i.e., not criminal) order, their enforcement still necessitates involvement with law enforcement, who are responsible for firearm removal. This engagement may exacerbate risk for structural harm some clients face, such as Black, Indigenous, and People of Color (BIPOC), undocumented immigrants, trans individuals, and those who experience mental health crises. In addition to the immediate physical dangers associated with firearms, interactions with these systems may also have enduring physical, psychological, and emotional dangers. Consequently, social workers face a nuanced ethical dilemma when balancing immediate safety or service connections against the risk of exposing clients to structural harm from medical and legal systems.

Despite the critical role social workers play in this context, there is a dearth of evidence-based trainings and practice guidelines, particularly those focused on equity. Moreover, few studies conducted have directly engaged with social workers to elicit knowledge of their current approaches when working with clients who may be at risk (Sperlich et al., 2022a). Gaining an understanding of these approaches is key to designing, implementing, and evaluating interventions to support them. This study sought to explore clinical social workers' perceptions of the roles they hold when working with clients at risk of harming themselves and/or others with a firearm, particularly clients with social identities that increase their risk of harm if exposed to medical and legal systems.

Methods

Twenty-nine clinical social workers practicing in Washington state participated in 10 focus groups between November 2022 and February 2023. We recruited participants initially from listservs of professional organizations and subsequently through snowball sampling. The email for participant recruitment outlined eligibility criteria (within the last 2 years working with at least one client at risk of harming themselves or someone else), study goals, and logistical and compensation details. Potentially interested participants filled out a short questionnaire that verified eligibility and collected information on the geographical settings of their clients; social workers serving rural clients were prioritized. The lead author, who has experience conducting interviews, conducted all focus groups via Zoom. Focus groups were audio-recorded, transcribed verbatim, and entered into Dedoose (*Dedoose*, n.d.). Each participant received a $50 gift card, and the university institutional review board approved all study procedures.

To create the semi-structured interview guide, we conducted a literature review of interviews with social workers about clients who own firearms. We then pilot tested the

interview guide with four clinical social workers. The interview guide asked social workers to discuss encounters with clients at risk of harm to self or others with a firearm and perceived functions when working with these clients, especially among clients who may benefit from or be harmed by medical and legal systems due to their social identities. Additionally, we provided two hypothetical scenarios that described clients at risk of firearm-related harm as well as differing risk levels for structural harm (e.g., race) and asked participants to outline their steps to reduce risk.

We used an inductive thematic approach to identify the roles social workers perceive themselves as fulfilling when working with clients at risk of harm to themselves or others with a firearm, with particular attention to clients at increased risk for harm from medical and legal systems (Braun & Clarke, 2006). Two study team members (KMC and OM) first reviewed all 10 transcripts to discern as many potential categories of roles as possible, then named and defined each role. Two focus groups were then double coded to identify any disagreements in coding, which were discussed until consensus was reached. The codebook and definitions were refined iteratively. Subsequently one team member coded the remaining focus groups using the finalized codebook, while a second team member conducted a review of the applied codes.

Results

Participants' roles were organized into six categories: *investigator, collaborator, confidant, facilitator, navigator,* and *educator* based on their approaches to addressing risk of harm to self or others with a firearm (Table 3.1). Many participants discussed how their clients' social identities (e.g., race) influenced their approach. For example, they would not recommend a Black client engage with firearm removal options that would involve the legal system for fear of structural racism. Role descriptions did not always fit neatly within a single category; those who

described their roles in dynamic ways often emphasized client-centered strategies for reducing firearm access. These roles developed over the course of collaborative safety planning, with many participants explaining they transitioned roles to best suit their client's needs. However, most participants described a lack of training and limited resources to support them in learning how to address firearm removal for clients at risk of harm to self or others.

Table 3.1 Definitions and exemplary quotes for perceived roles of social workers in reducing access to firearms

Social worker role	**Definition**	**Exemplar Quote**
Investigator	The social worker **investigates the circumstances of the client's life** to find the best route for support.	"I'm listening to them tell me about their firearms that they are using. I'm curious about it. I'm asking all sorts of questions about, "How are you using your firearms? When are you using your firearms?' Trying to figure out the context about it during sobriety and then later, when there is substance use and episodes, and listening to the depression, and what's happening in their depression? Where do they go? Is it going more towards suicide or harm? And are they thinking about firearms and harming themselves?"
Collaborator	The social worker is able to work with client to **identify a shared plan** for firearm removal.	"We see all these things as opportunities to grow in relationship with them and to help to educate them on their circumstance and empower them to make better decisions for themselves on what they choose to do. We obviously don't tell them what they should or shouldn't do, but we just try to leverage the trust that we've built with them to speak life and love into it."
Confidant	The social worker **maintains trust to facilitate client willingness to disclose** firearm access.	"So I think, as far as like what my role is to always try and work with someone to find safety in the situation, however possible, and kind of maintaining that line of contact when they might feel like they don't have anybody else to talk to like if they are in a crisis. I want them to feel like they can tell me that they're having these thoughts, and that they have a firearm, and try to be able to work through that together. Then, having them know that if they were to report X or like they were to say that they have a firearm, thinking that I would have to tell someone, and it would get taken away, and that would prevent them from telling us at all."
Facilitator	The social worker **facilitates conversations with**	"But maybe bringing in the wife to have a conversation around like, 'What's your understanding of what's happening? Like what do you see as the needs? And like, are you going to be a resource or social support for him in actually

	the client's social supports to complete firearm removal.	removing these firearms? Like we're concerned.' With kids you have like a natural collateral in just like parents are typically caregivers and are typically there. But I think, like in adults, whenever I had collateral, it was just like such a better assessment. […] So yeah, I think it would feel important to have collateral and to talk with his social support who is going to help implement this change. I don't think I would feel comfortable being like, 'Yeah, implement this change on your own.'"
Navigator	The social worker **supports their client in finding the best fitting resources** for firearm removal.	"I would think of myself as more of a guide to them. Someone who's with them on this journey, whether it's, you know a positive or negative experience and just offering to connect them with someone who can get them the help they need if they're interested in doing that. Sometimes they're not, in which case, you know, I would do my best to kind of be there as much as possible and then obviously take kind of steps judging from there."
Educator	The social worker **educates other care providers** about assessments and interventions involving firearms.	" I've educated docs and said, "listen, this is as serious as a heart attack, at least in that patient's mind. You may not feel like it's as serious as a heart attack, but that patient is in crisis. If they came in here with a heart attack, you would take that seriously. You gotta take this seriously, too." I try to do education around that trauma informed care, making the point—it took a lot for them to come in. Let's not traumatize them further with our interventions."

Investigator. Many participants explained their role was to investigate the comprehensive circumstances of their client's life that influence their risk of harm when firearms were accessible, including risk of harm from medical and legal systems. This investigative process guided them in determining the most suitable intervention. Investigative strategies included comprehensive questioning regarding intent, plan, and means, as well as standard assessment tools (e.g., Columbia Suicide Severity Rating Scale) to gauge severity and complexity of their clients' risk of harm. Additionally, participants described evaluating the client's socioecological context for additional risk and protective factors. After the investigative phase, many participants noted a shift towards a collaborative role, indicating a dynamic progression in their approach.

Collaborator. The collaborator role focused on identifying a shared plan with the client for firearm removal. Rather than the social worker deciding the best plan of action, they viewed

the client as an equal partner in the decision-making process as they tried to come to an agreement about the firearm removal plan based on the client's unique risk and protective factors, as well as cultural norms.. They prioritized voluntary options such as storing firearms outside of the home, purchasing or being given a lockbox, or voluntarily surrendering firearms.

Confidant. The role of the confidant characterized social workers who valued cultivating and sustaining trust with their clients. This rapport, in turn, facilitated the client's inclination to openly reveal their firearm access. Participants aligning with the confidant role underscored their commitment to fostering strong client relationships and prioritizing a safe, trusting environment to encourage clients to share information about their firearm access.

Facilitator. The role of the facilitator involved guiding conversations with the client's social support network to formalize plans for firearm removal as an alternative to involuntary removal. Participants described this role as particularly relevant for clients at elevated risk of harm from involuntary removal options (e.g., exposure to police violence from officers who remove the firearm). Facilitators created emotionally secure spaces for clients and their loved ones to openly discuss ideas about firearm removal and subsequently take necessary actions, such as physically relocating the firearm from the client's residence or restricting access.

Navigator. Navigators supported their client by guiding them through complex and potentially harmful systems to identify the best fitting resources and plans for firearm removal. These resources often included connections or referrals to community mental health support services or voluntary firearm storage options. Some participants noted the importance of collaborating with fellow healthcare providers within their organization to determine the best fitting resources for their clients' specific needs.

Educator. Educators leveraged their unique expertise to teach other healthcare providers about assessments, interventions, and risks related to firearm removal. Social workers in this role viewed their duties as educating about the potential risks of involuntary interventions, advocating against stigmatizing mental health, and using the strength of interdisciplinary teams to identify resources for their clients.

Discussion

The findings from this study shed light on the multifaceted landscape of social workers' perceived roles and intervention strategies to prevent firearm injuries and deaths. These roles are particularly complex when working with clients at elevated risk of structural harm from involuntary hospitalization or involuntary removal options that involve civil or criminal legal systems. We offer a framework that delineates the dynamic roles social workers adopt when engaging with these clients, demonstrating how these roles synergistically influence their decision-making process based on their clients' unique circumstances. This framework offers valuable insights for designing and improving interventions, training, and policies that are critical of environmental contexts that contribute to disparities in firearm risk.

While many social workers described tools they used to assess clients' risk of harm to self or others such as the Columbia Suicide Severity Rating Scale, there are no standardized tools to support social workers in assessing clients for access to firearms. Social workers do not consistently assess for firearm access (Conrick, Gause, et al., 2023; Slovak et al., 2008; Slovak & Brewer, 2010), likely due to a lack of training and familiarity with firearm removal strategy options. This evidence supports the need for nuanced and intensive training for social workers to learn options and conversational techniques that reflect the diverse needs of firearm safety among different demographics. Training should also include reflexivity and bias recognition

training to support removal strategies that are being employed based on the identities of their clients.

Social work education's focus on social justice and socioecological aspects of health uniquely positions them to address disparities in firearm-related harm by utilizing client-centered care practices to promote safety. Client-centered approaches that many social workers in this study employed included regarding clients as the experts of their own lives, thereby challenging the paternalistic view of expertise innately stemming from the social worker (Bransford, 2011) and providing important opportunities for collaboration currently missing from dominant firearm removal practices. Social workers were also able to take a strengths-based approach to leverage their client's abilities to reduce their own firearm access. Working with clients to identify the least restrictive means creates a therapeutic relationality that centers safety in an understanding environment, which is crucial when supporting an individual in crisis. The pursuit of voluntary firearm removal options also allows social workers to circumvent potential harms from involvement of law enforcement (Swanson, 2020) or iatrogenic harm from involuntary hospitalization (Ward-Ciesielski & Rizvi, 2021).

The focus on collaboration and confidentiality is complicated by legal policies and professional ethics around duty to warn. For example, in Washington state, social workers are mandated to report an individual to a designated crisis responder or law enforcement officer if they "present imminent likelihood of serious harm" to themselves or others (Emergency Detention of Persons with Behavioral Health Disorders, n.d.). Additionally, the National Association of Social Workers outlines procedures and ethical codes for when it may be necessary to breach confidentiality to prevent and manage the risk of harm, including with

firearms. While these procedures seek to protect lives, they threaten client autonomy and may damage the therapeutic relationship, as highlighted by participants in our study.

This study has some limitations. Our sample was restricted to social workers who practice in Washington state, which has policies and resources that may not be available or similar in other states. Further research is needed to assess similarities and differences between roles in states with differing policies. Additionally, the recruitment process via email listservs and snowball sampling may have inadvertently excluded certain perspectives, especially from social workers who are reluctant to address client access to firearms for personal or political reasons.

The roles identified in this study reveal the complex nature of social workers' responsibilities to their work and the importance of client relationships. Participants' descriptions of their roles often defied rigid categorization, emphasizing the dynamic nature of their roles as they adapted to best serve clients' needs. Our findings explain how social workers leverage these roles to address unique client needs and prevent harm from structural discrimination. The roles highlight client-centered strategies that prioritize client engagement, therapeutic alliance, and support networks. These strategies, especially the influence of protective factors, reflect the importance of client-centered approaches to reducing disparities in firearm injuries and deaths.

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Chapter Four: Association of Client and Provider Race with Approaches Pursued by Social Workers for Reducing Firearm Access

Abstract

Social workers assess and intervene to prevent harm among clients at risk of harm to self (HTS) and harm to others (HTO) with a firearm. This study sought to assess the impact of client race on social workers' approaches to reduce firearm access when they weighed voluntary (e.g., store out-of-home) and involuntary (e.g., extreme risk protection order) removal methods. We considered the role of social workers' self-identified race as a moderator of this relationship, comparing white (single race) and Black, Indigenous, and People of Color (BIPOC) social workers. A survey was distributed to Washington State social workers (n=9073) who were presented with two case vignettes, each randomized to view the client's race as Black or white. Logistic regression was used to assess the association between the client's race and the pursuit of voluntary or involuntary methods, stratified by social workers' race. Among the participants (n=1306), 26% pursued at least one involuntary care plan option for the HTS client, and 59% for the HTO client. The Black client at risk of HTS had lower odds of an involuntary care plan option compared to the white client (OR= 0.69, 95% CI 0.54-0.88), while the Black client at risk of HTO had higher odds of an involuntary care plan options (OR= 1.13, 95% CI 1.07-1.66). These associations were not statistically significantly different between white (single race selected) and BIPOC social workers. This study contributes to the growing understanding of potential racial disparities in social workers' decision-making regarding firearm access reduction strategies.

Introduction

Over the past decade, the United States has witnessed a rise in firearm-related injuries and deaths. Age-adjusted firearm death rates have escalated from 10.07 per 100,000 in 2010 to 13.58 per 100,000 in 2020, culminating in approximately 45,000 deaths annually (CDC, 2023). The burden of these firearm-related injuries disproportionately impacts subpopulations. For example, the age-adjusted firearm homicide rate for Black individuals is 25.08 per 100,000, compared to 3.04 per 100,000 for white individuals. Conversely, the age-adjusted firearm suicide rate for white individuals is 7.84 per 100,000, compared to 3.95 per 100,000 for Black individuals (CDC, 2023).

One of the most effective strategies for preventing firearm deaths is lethal means restriction (Mann & Michel, 2016). Reducing access to the most lethal method of harm can delay or interrupt a crisis moment (e.g., suicidal crisis), thereby providing essential time for feelings of harm to subside and/or for supportive interventions to be offered. Imposing restrictions for firearms, which have a 90% case fatality for suicide attempts (Conner et al., 2019b), has been proven effective in reducing firearm-related suicides, at both the policy (Rosengart, 2005) and individual levels (Nordentoft et al., 2017). While research on the impact of restricting firearm access on homicide rates is limited, existing literature suggests that policies prohibiting individuals with a history of domestic violence from possessing firearms significantly reduces state-level intimate partner homicide (Wallin et al., 2021b). Nearly two-thirds of deaths related to intimate partner violence involve a firearm, underscoring the potential impact of these restrictions (Kafka et al., 2023). However, disparities in these protections also exist. While state-level provisions requiring respondents of Domestic Violence Protection Orders (DVPOs) to relinquish their firearms were associated with decreased rates of state-level intimate partner

homicide for white respondents, they were not associated for Black respondents (Wallin et al., 2021b).

Methods for reducing firearm access as a preventive measure may be categorized as voluntary or involuntary. One voluntary removal option includes modifying the way firearms are stored in-home. For example, individuals can increase time between a crisis moment and their ability to harm themselves or someone else by storing firearms and ammunition locked and separately or by creating other physical barriers. Additionally, individuals may voluntarily choose to store their firearms outside of the home, either with a trusted friend or family member, or at community organizations like gun stores or law enforcement agencies (Barnard et al., 2022; Betz et al., 2022; Bongiorno et al., 2021; Cleary et al., 2022; Pallin et al., 2019). Some states have implemented policies, such as the Voluntary Waiver of Firearm Rights (*RCW 9.41.350: Voluntary Waiver of Firearm Rights—Procedure—Penalty—Exemption from Public Disclosure.*, n.d.), to address firearm access for those in crisis. This policy allows individuals to voluntarily place themselves on a list that renders them ineligible to purchase a firearm for a specified duration. Alternatively, law enforcement (often at the recommendation of a clinician) in select states can initiate involuntary firearm removal through civil commitment laws or orders that involve surrendering firearms and being prohibited from new firearm purchases. One such law, extreme risk protection orders (ERPO), can be filed by household/family members, law enforcement officers, and/or clinicians, depending on the state. If a judge determines that an individual poses a substantial risk of harming themselves and/or others with a firearm, law enforcement officers may seize any firearms in their possession and include their name on a list that prohibits firearm purchases for the duration of the order, typically one year.

Social workers practice in a diverse range of clinical and community care settings that serve clients who are at risk of firearm-related harm, providing a unique opportunity to assess for risk and intervene to prevent harm. Direct social work practitioners may identify individuals at risk of harm to self (HTS) or harm to others (HTO) in routine or acute care settings based on the social and/or environmental context of that client (Conrick, Gause, et al., 2023), and are able to implement evidence and/or practice-based interventions accordingly. Moreover, social workers may observe indicative behaviors, such as threats of violence, which fall under "duty to warn" laws, requiring them to report targeted victims and notify law enforcement (Henderson, 2015).

Despite the frequency with which social workers serve clients who may be at risk of HTS and/or HTO with a firearm, research on the role of social workers in the firearm removal process remains limited. One study found that while most social workers do not routinely assess clients for firearm ownership or counsel on firearm safety, they were more likely to do so when their clients expressed suicidal ideation (Slovak et al., 2008). A document review of ERPO petitions found that when health professionals, including social workers, had access to respondents' medical and social history, they assessed the risk of harm differently than crisis workers or law enforcement officers, who did not have access to the same background information (Conrick, Davis, et al., 2023a). Established mental health professionals' thorough understanding of both risk and protective factors influenced their ability to provide a comprehensive assessment when recommending an ERPO to law enforcement or a client's family member. Emerging research has also begun to shed light on the involvement of social workers in intervening with these clients (Sperlich et al., 2019, 2022b). Thoughtfully established therapeutic relationships between social workers and their clients as well as understanding of options for intervention can provide opportunities for social workers to support and advocate on behalf of their clients during an

ERPO process. Additional research has indicated that many social workers are willing to counsel clients about ERPOs or contact law enforcement to recommend such orders (Conrick et al., 2023; Conrick, Gause, et al., 2023). However, they may hesitate to do so for several reasons, including concerns about compromising the therapeutic relationship or concerns for patient and family safety. In particular, some social workers have expressed concerns with potential adverse consequences for engaging their BIPOC clients with the legal system (Conrick et al., 2023).

Social workers are uniquely positioned to interrupt or mitigate acute risk of firearm-related harm among individuals at risk of HTS and/or HTO. Understanding the role of client and provider race in decision making about interventions with firearms is a critically important step towards equitable treatment of clients at risk of HTS or HTO. The purpose of this study was to empirically examine how a client's race can influence the approaches that BIPOC and white social workers pursue for reducing firearm access (involuntarily vs. voluntarily) among individuals at risk of HTS or HTO with a firearm. By investigating this relationship, the study sought to shed light on how a client's race may influence the recommendations and interventions suggested by social workers in this context. The specific research questions included:

1. What are the current firearm access assessment practices for social workers serving clients at risk of HTS and/or HTO?
2. What is the association between client race and intervention options social workers pursue to reduce firearm access for clients at risk of HTS and/or HTO?
3. Is social worker race a moderator of this association?

Theoretical Framework

The approach taken in this study is guided by the theory of street-level bureaucrats (Lipsky, 2010), as well as Watkins-Hayes' adaptation of this theory to define the role of situated

bureaucrats (Watkins-Hayes, 2009). According to the theory of street-level bureaucrats, these individuals serve as the face of public policies by providing direct social services to individuals (Lipsky, 2010). In this role, they exercise discretionary power to assess the complex context of a client's situation and determine how different facets of a given policy allow them to provide or require them to deny provision of services (e.g., food stamps). This discretionary power also extends to supervision of related stipulations, such as work requirements, within the policies they administer. Watkins-Hayes extends this theory and introduces the concept of situated bureaucrats, which considers the integration of professional and social identities, such as race and class, in shaping the discretion exercised by street-level bureaucrats (Watkins-Hayes, 2009). Situated bureaucrats are defined as, "one's sense of who one is, of one's social location, and of how one is prepared to act and […] how this subjectivity gives rise to a general framework through which each bureaucrat approaches their job." This theory suggests that the variations in the delivery of welfare services, typically attributed to individual workers' discretion, are instead influenced by the integration of their professional and social identities. In the context of welfare offices, for example, "the focus on advice giving as a key component of welfare casework allows Black and Latino street-level bureaucrats to intervene in the lives of their clients of color in distinct ways, but guards against charges of bias and allows them to adhere to the expectations of the institution." In the case of social workers serving clients at risk of HTS and/or HTO with a firearm, these professional and social identities may influence the care plans they create for these clients. The interplay between their own subjectivity and the broader institutional expectations and biases could shape the assessments and recommended interventions provided by social workers in the context of this study.

Several factors may influence a social worker's decision to refer clients to pursue a protection order rather than or in addition to other services. These decisions can have significant implications. Domestic violence survivors who are white or have higher education and income levels are more likely to pursue a domestic violence protection order (Durfee & Messing, 2012b; Macy et al., 2005). These correlations can be attributed, at least in part, to positive experiences with the legal system (Fleury-Steiner et al., 2006) compared to pervasive systemic and structural racism that perpetuates widespread unfair treatment of BIPOC communities (e.g., over policing, discriminatory practices, and lack of access to services). Due to these concerns about systemic racism in the legal system, many individuals, including social workers, have reservations regarding involuntary firearm removal options that rely on the involvement of the legal system (Conrick et al., 2023; Conrick, Gause, et al., 2023; Swanson, 2020). Therefore, in addition to examining whether a client's race influenced the care plan pursued by a social worker, we hypothesized that white social workers would be more likely to pursue an involuntary care plan option (e.g., ERPO) compared to BIPOC social workers.

Methods

Overview of Study Design

This study employed a mixed methods design to examine the association between the race of a client and the pursuit of involuntary care plan options, while considering the moderating effect of the social worker's race. First, we conducted ten focus groups with n = 29 social workers to describe the range of care plans social workers suggest to clients at risk of HTS and/or HTO with a firearm (details on focus group data collection and analysis are available in Appendix B). We then administered a statewide survey to social workers across Washington state to assess how a client's race influenced the selection of an involuntary care plan option and

whether the social worker's race influenced this relationship. The University of Washington Institutional Review Board approved all study procedures.

Survey data collection

Contact information for all credentialed social workers in Washington state was obtained through a records request from the state Department of Health. Social workers were included if their credential status was listed as "active," including both associate and full licenses. Social workers with an invalid email address were excluded. An email containing a link to the survey was sent to all social workers who met these initial inclusion criteria. The email outlined the purpose of the study as seeking to understand the services social workers provide to clients at risk of HTS and/or HTO with a firearm, as well as to identify their training needs. Additionally, the email indicated only those who had worked with a client at risk of HTS and/or HTO in the las 5 years were eligible to participate. The survey was available from May 23 to June 23, 2023, and participants received email reminders to complete the survey every 8 days, up to a maximum of 4 emails total.

The survey included 4 domains: 1) practice setting and characteristics; 2) practices for assessing for firearm access; 3) awareness of resources to reduce firearm access for clients in crisis (e.g., map of firearm retailers willing to temporarily store firearms) and policies (e.g., ERPOs), and 4) training received about reducing firearm access. To assess pursuit of care plan components, social workers were asked to respond to two vignettes, one depicting a 29-year-old woman at risk of HTS and the second a 24-year-old man at risk of HTO. The case vignettes were composite cases constructed from examples provided by focus group participants (Appendix B). Social workers who participated in the survey were randomly assigned to view each client's race as either Black or white; all other wording and details of the case vignette were identical. Social

workers were asked which of 10 care plan components they would pursue for each client. The order of the care plan components was also randomized. In an open-ended question, social workers had the opportunity to suggest any additional care plan components they might pursue. To ensure the survey language and care plan components were appropriate, we conducted cognitive interviews with four clinical social workers from diverse practice settings, who provided feedback and helped refine the survey materials. For the purposes of this study, we chose to focus specifically on client and social worker race, as it aligns with our theoretical framework that highlights the influence of a social service provider's social identity on their decision-making. The full survey is available in Appendix C.

Analysis

Counts and frequencies were calculated for each categorical response. Content analysis was conducted to summarize responses to the survey's open-ended questions regarding assessment practices for firearm access, details on trainings received, and care plan components participants would purse that were not initially presented. We categorized each of the 10 care plan components to be voluntary or involuntary. Responses were then dichotomized to be "0" if only voluntary components were selected and "1" if any involuntary component was selected. In the survey, participants could select as many racial subgroups as they identified with (up to 7). For the purposes of analysis, we dichotomized race to be white (single race selected) and BIPOC due to low sample sizes of racial categories. We additionally conducted sensitivity analyses comparing white to Black and Latin(x) participants separately and together; results were similar to the dichotomized results presented below.

To understand the association between care plan pursued and client race, we calculated an Odds Ratio (OR) using binary logistic regression to assess the association of client race

(independent variable) on whether an involuntary or voluntary care plan was pursued (dependent variable). An OR below 1 would indicate a lower odds of having an involuntary care plan option selected, while an OR above 1 would indicate a higher odds of having an involuntary care plan option selected. Analyses were conducted separately for the client at risk of HTS and at risk of HTO. We conducted separate logistic regression analyses stratified by participant's self-identified race (white [single race selected] and BIPOC social workers). To further explore whether the association between care plan pursued and client race significantly differed based on social worker race, we conducted another logistic regression model in the total sample that included an interaction term for client and social worker race.

Results

Table 4.1 presents demographic information including age, race and ethnicity, gender, and years of practice experience in social work. Out of the 9,073 eligible social workers, a total of 1,306 provided complete responses, resulting in a response rate of 14.4%. Most social workers in this study reported encountering a client at risk of HTS at least monthly (63%) and at risk of HTO at least a few times per year (68%). Social workers practiced in diverse settings, with healthcare (27%) and mental health/psychiatric/substance use (56.7%) being the most common. Most social workers reported serving a mixed client population from urban, suburban, and rural areas (59%), and working in large hospitals or organizations (63%). Of all participants, 26.5% (n = 346) were BIPOC, and 73.5% (n = 960) were white (single race selected).

Table 4.1: Characteristics of survey participants (n = 1306)

Characteristic	**All survey participants** (n=1306) *n (%)*	**Randomized condition 1[a]** (n = 657)	**Randomized condition 2[b]** (n = 649)
Age			
18-29	127 (9.7)	64 (9.7)	63 (9.6)
30-39	427 (32.7)	206 (31.4)	221 (33.6)

40-49	301 (23.0)	161 (24.5)	140 (21.3)
50-59	182 (13.9)	92 (14.0)	90 (13.7)
60 or older	112 (9.7)	62 (9.4)	50 (7.6)
Missing	157 (8.6)	72 (11.0)	85 (12.9)
Gender[c]			
Female or Woman	1054 (80.7)	541 (82)	513 (79)
Nonbinary	46 (3.5)	25 (3.8)	21 (3.2)
Male or Man	208 (15.9)	97 (15)	111 (17)
Trans	16 (1.2)	5 (0.8)	11 (1.7)
Race and Ethnicity[c]			
Asian	98 (7.5)	48 (7.3)	50 (5.7)
Black	82 (6.3)	49 (7.5)	33 (5.1)
Latin(x), Hispanic, or Indigenous Mexican, Central, or South American	111 (8.5)	58 (8.8)	53 (8.2)
Native American, American Indian, Alaska Native	40 (3.1)	26 (4.0)	14 (2.2)
Native Hawaiian or Pacific Islander	16 (1.2)	9 (1.4)	7 (1.1)
White	1054 (80.7)	521 (79)	533 (82)
Other	37 (2.8)	16 (2.4)	21 (3.2)
Years Practicing			
0-5	341 (26.1)	171 (26)	170 (26)
6-10	341 (26.1)	164 (25)	177 (27)
11-15	235 (18.0)	115 (18)	120 (19)
16-20	130 (10.0)	75 (11)	55 (8.5)
20 or more	258 (19.8)	132 (20)	126 (19)
Missing	1 (0.1)	0 (0)	1 (0.2)
Personally Owns Firearm			
Yes	244 (18.7)	525 (81)	493 (76)
No	1018 (77.9)	111 (17)	133 (21)
Prefer not to say	38 (2.9)	16 (2.5)	22 (3.4)
Missing	6 (0.5)	5 (0.8)	1 (0.2)

[a]Participants in randomized condition 1 viewed the client at risk of harm to self (HTS) as white and the client at risk of harm to others (HTO) as Black
[b]Participants in randomized condition 2 viewed the client at risk of harm to self (HTS) as Black and the client at risk of harm to others (HTO) as white
[c]Participants could select more than one option

Most social workers reported assessing at least one client for firearm access in the last year (87%). When asked about the timing of assessment, the most common response (82%; Table 4.2) indicated that they inquire about firearms when the client is at risk of harming themselves. About one-quarter of social workers selected the "other" category, stating that assessment for access to firearms is routine for all clients. Regarding workplace policies, most social workers

reported having either a formal (31%) or unofficial (22%) policy for assessing clients for firearm access. Of those who did not report such a policy, 64% expressed a belief that their workplace should establish one.

Table 4.2: Survey participant practice characteristics, firearm assessment practices, policy awareness, and education experiences (n = 1306)

Characteristic	**All survey participants N (%)** N = 1306	**BIPOC participants N (%)** N = 346	**White (single race) participants N (%)** N = 960
Frequency of encountering client at risk of HTS with firearm			
Daily	117 (9.0)	34 (9.9)	83 (8.7)
Weekly	399 (30.6)	96 (27.7)	303 (31.6)
Monthly	303 (23.2)	79 (22.8.)	224 (23.3)
A few times a year	450 (34.5)	130 (37.6)	320 (33.3)
Never	34 (2.6)	6 (1.7)	28 (2.9)
Missing	3 (0.2)	1 (0.3)	2 (0.2)
Frequency of encountering client at risk of HTO with firearm			
Daily	23 (1.8)	8 (2.3)	15 (1.6)
Weekly	128 (9.8)	43 (12.4)	85 (8.9)
Monthly	140 (10.7)	28 (8.1)	112 (11.7)
A few times a year	595 (45.6)	165 (47.7)	430 (44.8)
Never	418 (32.0)	102 (29.5)	316 (33)
Missing	2 (0.2)	0 (0.0)	2 (0.2)
Practice Specialty			
Administration, policy, or research	11 (0.8)	6 (1.7)	5 (0.5)
Child and family welfare	21 (1.6)	7 (2.0)	14 (1.5)
Community social work	19 (1.5)	6 (1.7)	13 (1.4)
Legal system (civil or criminal)	21 (1.6)	7 (2.0)	14 (1.5)
Healthcare	355 (27.2)	95 (27.5)	260 (27.1)
Mental or behavioral health	740 (56.7)	184 (53.2)	556 (57.9)
Military and veterans	48 (3.7)	14 (4.0)	34 (3.5)
Palliative and hospice	21 (1.6)	3 (0.9)	18 (1.9)
School social work	69 (5.3)	24 (6.9)	45 (4.7)
Ages of Clients Served[a]			
Children and adolescents (< 18)	654 (50.1)	183 (52.9)	471 (49.1)
Young adults (18-24)	942 (72.1)	259 (74.9)	683 (71.1)
Adults (24-65)	1099 (84.2)	289 (83.5)	810 (84.4)
Older adults (65+)	800 (61.3)	195 (56.4)	605 (63.0)
Rurality of Clients Served			
Mostly urban/suburban	424 (32.5)	111 (32.1)	313 (33.6)
Mix of urban/suburban and rural	771 (59.0)	208 (60.0)	563 (58.6)
Mostly rural	110 (8.4)	27 (7.8)	83 (8.7)

Missing	1 (0.1)	0 (0.0)	1 (0.1)
Practice Modality[a]			
In person	1067 (81.7)	281 (81.2)	786 (81.9)
Online	875 (67.0)	236 (68.2)	639 (66.6)
Practice Size			
A large hospital or organization (>50 employees)	825 (63.2)	231 (66.8)	594 (61.9)
A small organization (10-49 employees)	162 (12.4)	45 (13.0)	117 (12.2)
A group private practice (2-9 employees)	75 (5.7)	20 (5.8)	55 (5.8)
An individual private practice	233 (17.8)	47 (13.6)	186 (19.4)
Missing	11 (0.8)	3 (0.9)	8 (0.8)
How often do you assess clients for access to a firearm?			
Always	447 (34.2)	131 (37.9)	316 (32.9)
Sometimes	591 (45.3)	135 (39.0)	456 (47.5)
Rarely	234 (17.9)	72 (20.8)	162 (16.9)
Never	32 (2.5)	7 (2.0)	25 (2.6)
Missing	2 (0.2)	1 (0.3)	1 (0.1)
When do you assess clients for access to a firearm?[a]			
When client is at risk of HTS	1068 (81.8)	283 (81.8)	785 (81.8)
When client is at risk of HTO	936 (71.7)	245 (70.8)	691 (72.0)
When a client brings up firearms	796 (60.9)	214 (61.8)	582 (60.6)
Familiarity with community firearm storage map			
Very familiar	23 (1.8)	11 (3.2)	12 (1.3)
Somewhat familiar	154 (11.8)	45 (13.0)	109 (11.4)
Not at all familiar	1125 (86.1)	290 (83.8)	835 (87.0)
Missing	4 (0.3)	0 (0.0)	4 (0.4)
Familiarity with extreme risk protection order			
	112 (8.6)	33 (9.5)	79 (8.2)
Very familiar	522 (40.0)	136 (39.3)	386 (40.2)
Somewhat familiar	670 (51.3)	177 (51.2)	493 (51.4)
Not at all familiar	2 (0.2)	0 (0.0)	2 (0.2)
Missing			
Receipt of education specific to firearm removal			
Yes, in my MSW or BASW program	193 (14.8)	57 (16.5)	136 (14.2)
Yes, in a seminar, for continuing education units	282 (21.6)	57 (16.5)	255 (26.6)
Yes, in a seminar, not for continuing education units	99 (7.6)	26 (7.5)	73 (7.6)
Yes, in another type of training	260 (19.9)	58 (16.8)	202 (21.0)
No	690 (52.8)	196 (56.6)	494 (51.5)

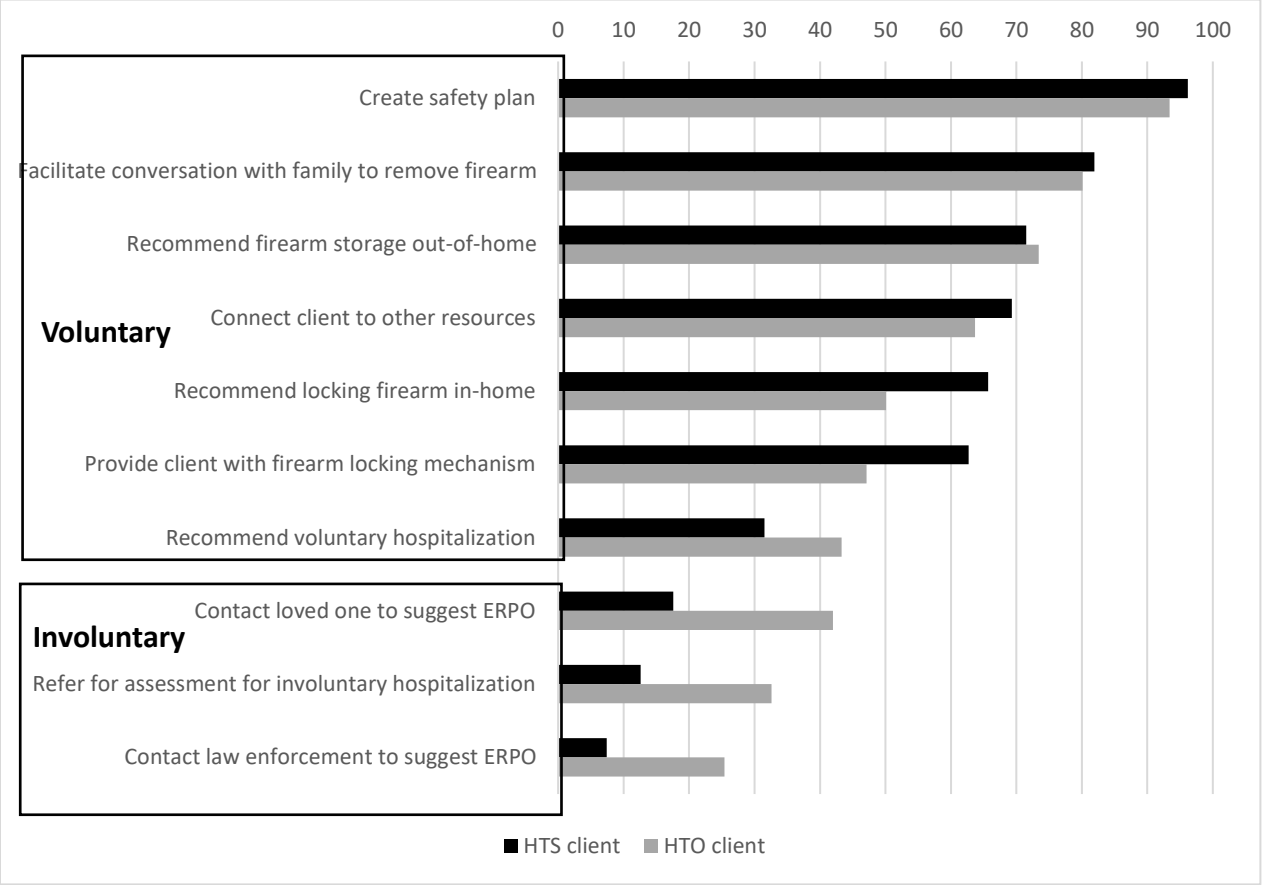
[a]Participants could select more than one option; percentages may not add to 100%

Participants were largely unfamiliar with existing policies and resources related to firearm removal options for their clients (Table 4.2). Specifically, 86% of participants were not at

all familiar with a community firearm storage map, and 51% were not at all familiar with ERPO laws. Regarding available resources, only 13% of social workers reported that their workplace provided firearm locking mechanisms for distribution to clients. However, most (75%) of those who did not have access to such resources expressed a desire to have them available. Additionally, only 47% of participants reported receiving any type of training specific to facilitating firearm removal for their clients. Among those who received training, the most common types were seminars for continuing education units (22%) or other forms of training (20%), such as on-the-job training.

Analysis of focus group data identified ten care plan components social workers pursue when working with a client at risk of HTS or HTO with a firearm (Figure 4.1). When presented with these components as options in each case vignette, survey participants most frequently indicated they would create a safety plan (HTS 96%; HTO 93%) and facilitate a conversation with a client's loved one for firearm removal (HTS 82%; HTO 80%). The three involuntary care plan options were least likely to be selected. In responses to open-ended questions, many social workers clarified they would pursue an involuntary care plan option only if the client was unwilling to pursue the voluntary options. For the client at risk of HTS (who had a history of alcoholism and substance use), social workers additionally suggested substance use disorder treatment services. For the client at risk of HTO (who had stopped taking medication), additional care plan options social workers suggested reinitiating medication and contacting the initial prescriber for ongoing management as well as developing a safety plan in collaboration with trusted members of their family or friends.

Figure 4.1 Care plan component pursed for clients at risk of harm to self (HTS) or harm to others (HTO) with a firearm (n=1306)



For the HTS client, 26% of social workers pursued at least one involuntary care plan option, while 56% pursued an involuntary option for the HTO client. On average, social workers had lower odds of offering an involuntary care plan option to the Black client at risk of HTS compared to the white client (OR = 0.69; 95% CI 0.54, 0.88) (Table 4.3). When looking at the client at risk of HTO, on average, social worker participants had higher odds of offering an involuntary care plan option to the Black client compared to the white client (OR = 1.13, 95% CI 1.07, 1.66). There were no statistically significant differences in the strength of the association between client race and involuntary care plan option by social worker race for either the HTS or HTO client. There were no statistically significant differences in the strength of the association

between client race and involuntary care plan option by social worker race for either the HTS (p = 0.98) or HTO (p = 0.27) client.

Table 4.3 Results of binomial logistic regression of association between client race and selection of at least one involuntary care plan option, stratified by social worker race

Participant race	**All social workers** (n = 1306)	**BIPOC social workers[a]** (n = 346)	**White social workers (single race)[a]** (n = 960)
	OR (95% CI)	OR (95% CI)	OR (95% CI)
HTS[b] client race			
Randomized condition 1 (white client)	*ref*	*ref*	*ref*
Randomized condition 2 (Black client)	0.69 (0.54-0.88)	0.69 (0.44-1.09)	0.70 (0.51-0.94)
HTO[c] client			
Randomized condition 2 (white client)	*ref*	*ref*	*ref*
Randomized condition 1 (Black client)	1.13 (1.07-1.66)	1.07 (0.69-1.66)	1.43 (1.10-1.85)

[a]Analysis using an interaction term in the logistic regression model indicated no statistically significant difference between BIPOC and White (single race) social workers for either client, suggesting the difference between these two groups of social workers is not statistically significant
[b]Harm to self
[c]Harm to others

Discussion

The findings from our study highlight the complex relationship among social workers, their clients, and discussions about firearm access. We identified differences in the care plan options social workers pursue based on the client's race. We found that a Black client at risk of HTO was more likely to experience their provider recommending an involuntary care plan option compared to a white client. However, our findings for the client at risk of HTS revealed a contrasting pattern, with the white client being more likely to have an involuntary care plan option selected compared to the Black client. We did not identify differences in the association between care plan approaches and client race based on the social workers' race. Several explanations exist for these findings. For one, a social worker's unchecked racial biases may influence their determination to refer a BIPOC client to the legal system for involuntary firearm

removal. Additionally, social workers' referral practices may be influenced by interpretation of client risk of firearm suicide or homicide based on their race. These findings underscore the need to further investigate how social workers consider client race when formulating care plans for clients at risk of harm with a firearm.

Social workers face a difficult decision when choosing whether to pursue a voluntary or involuntary care plan, and their comfort with intervening is influenced by their training, perceived understanding of the broader role of social workers, and individual beliefs about firearms (Sperlich et al., 2022b). One central ethical principle of social worker practice includes respecting client autonomy to participate in the development of their care plan (National Association of Social Workers, 2023). Yet, fear of liability due to duty to warn laws or belief that voluntary removal options may not be sufficient to prevent harm may lead social workers to prefer involuntary firearm removal options. Involuntary options, such as ERPOs may benefit clients, including removing access to firearms and facilitating service connections. However, despite the potential benefits of these options, these options may have unintended negative consequences, particularly for BIPOC communities. Engrained systemic racism within the legal system causes negative effects (e.g., disproportionately higher rates of law enforcement-related shooting) and oversurveillance of BIPOC and other minoritized communities [15,16]. Consequently, utilization of firearm removal options that involve the legal system may contribute to these disparities, highlighting the need for careful consideration of the potential adverse impacts of initiating involuntary approaches to firearm access reduction and the negative downstream implications they may have on BIPOC and other marginalized and minoritized communities. Our study revealed differences in the care plans social workers pursue based on the race of the client. Contrary to our initial hypothesis, the white client at risk of harm to self was

more likely to be referred for an involuntary care plan option compared to the Black client. Further research is necessary to better understand the reasons behind this finding. By expanding our understanding of the various factors that shape social workers' discretion, we can strive towards enhancing equity, fairness, and the provision of effective care for clients at risk of harm to themselves or others with a firearm.

Social workers regularly encounter clients who are at risk of HTS and/or HTO. However, consistent with prior studies (Slovak et al., 2008; Slovak & Brewer, 2010), including those assessing other care providers (Roszko et al., 2016), our findings indicate that social workers often do not assess their clients' access to firearms. This finding supports previous research and represents a critical gap in preventing the risk of firearm-related harm. However, increasing assessment of firearm access without offering resource options for practitioners to respond is ineffective. Our study revealed that most social workers lacked access to firearm locking devices they could distribute to their clients. Despite this deficit, three-quarters of participants expressed a desire to have this resource available to them. Counseling about safe storage in addition to providing locking devices has been shown to enhance firearm storage practices (Rowhani-Rahbar et al., 2016; Uspal et al., 2021). Increasing frequency and comfort of social workers counseling about firearm storage and temporary dispossession in combination with provision of locking devices is particularly important considering emerging evidence suggesting that improving the safety of firearm storage can potentially reduce the risk of firearm-related suicides and unintentional firearm injuries (Monuteaux et al., 2019). Therefore, additional strategies and approaches to promote firearm safety are critically needed to reduce the associated risks in vulnerable populations.

This study represents a novel application of the theory of situated bureaucrats (Watkins-Hayes, 2009) to examine the discretion exercised by social workers when developing care plans for clients at risk of HTS and/or HTO involving firearms. This theory offers a valuable framework to explore the complex interplay between organizational structures, professional norms, client social identities, and individual discretion within social work practice. The decision to focus on the race of both the client and social worker was driven by several factors. First, our guiding theoretical framework emphasizes the role of race in social workers' discretionary choices. Given the prominence of race as a social identity and social construct in the US, and the complexities and variations of how race is conceptualized, we anticipated it may have a significant impact on care plan decisions. Additionally, based on sample sizes from other studies with similar populations, we anticipated considering social worker race would ensure sufficient statistical power to detect potential differences between groups (Conrick, Gause, et al., 2023; Conrick, Graves, et al., 2022). It is important to note that our study does not seek to oversimplify the complexity of racial and ethnic identities to a singular factor influencing care plans. There is certainly substantial heterogeneity within the crude racial groups we used for this study, and racial categories in this study were based on the dominant social construct, which is rooted in white supremacy (Roberts, 2012). While we used client and social worker race as our independent variable and moderator, respectively, we are using these metrics as an indicator of racism. Additionally, we recognize that race intersects with multiple dimensions of identity and social context, and our study aims to highlight its potential role in shaping social workers' decisions. By specifically focusing on differential forms of treatment experienced based on the client's race, our study seeks to contribute to the growing body of literature on implicit biases and racism within social work practice. Social workers, like any professional, likely also hold

implicit biases from their training, backgrounds, personal experiences, and social identities. Biases other than race may include client characteristics such as gender, mental illness diagnosis, disability, sexual orientation, gender identity, and housing status, among others. In this study, we did not identify differences among BIPOC and white (single race) social workers in the association between client race and care plan options pursued. This finding could reflect limitations in the study design, such as the dichotomization of social worker and client race, as well as care plan options (involuntary vs voluntary). Future research should continue to explore additional social identities and intersectional factors that may also influence care plan choices to provide a more comprehensive understanding of the complexities at play.

Several limitations should be considered when interpreting the findings of this study. First, there may be response bias as participants who held strong opinions or had personal experiences related to firearms may have been more or less inclined to respond to the survey, as well as selection bias reflected in our response rate (14%). These could have influenced the representation of perspectives within the sample. The list of care plan options provided in the survey may not have included all possible interventions that social workers might consider or have been feasible or allowable in certain practice settings, which could limit the comprehensiveness of our findings or generalizability to other states. Limited voluntary care options available in the mental health crisis care system and variations nationwide may also have been an important factor for social workers when considering up- and/or downstream services for clients at risk of HTS and/or HTO with a firearm. Many social workers stated that their approach to each situation would differ depending on the specific circumstances of each client, suggesting that overall generalizations of care plans and approaches may not be sufficiently representative of real-life events. However, our study design, which incorporated mixed

methods, partially mitigates this limitation by incorporating real insights from social workers themselves. Through focus groups, we engaged with practicing social workers to identify and discuss the care plan components they would pursue when working with clients at risk of HTS and HTO with a firearm. Additionally, the nature of social work practice, which typically involves collaborative discussions and individualized care planning with clients, may not have been fully captured by the survey's format. Finally, the lack of available demographic data for the overall population of social workers prevented us from comparing the characteristics of our study sample with the broader population. This limits our ability to generalize the findings and assess the representativeness of the participants in relation to the larger social work profession.

This study sheds light on the care plan decisions social workers make when working with clients at risk of HTS and/or HTO with a firearm. Specifically, we highlight the potential influence of client race on the pursuit of involuntary or voluntary methods for reducing firearm access. We observed disparities in care plan options based on the race of the client, underscoring the importance of understanding how client race influences care plan decisions. Furthermore, the study reveals a lack of awareness and training among social workers regarding existing policies, resources, and interventions related to firearm removal. This suggests the need for enhanced education and support for social workers to effectively address the risk of firearm-related harm among their clients. It is imperative to develop comprehensive training programs that equip social workers with the knowledge and skills necessary to navigate the complexities of firearm access reduction while ensuring culturally sensitive and equitable care.

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Chapter Five: Preventing Firearm Injuries and Deaths Among Clients: An Action Plan Model for Social Workers

Abstract

Social workers are uniquely positioned to provide resources for reducing firearm access for clients in crisis. However, many social workers have reported need for support in navigating these conversations and awareness of what options are available. We sought to understand the decision-making process social workers use to choose which interventions (e.g., out of home storage) are appropriate to reduce firearm access for clients in crisis. Ten focus groups were conducted with 29 social workers in Washington State. The semi-structured interview guide directed participants to discuss experiences with clients at risk of harming themselves and/or others with a firearm and respond to two case examples. Grounded theory was used to develop an action plan model describing how social workers choose which interventions to pursue. Participants described two categories that influence their decision-making process for reducing firearm access for clients in crisis. The first category, *sociopolitical context*, included structural intersectionality, policies, professional ethics, workplace environment, and values. These influenced the second category, which described the process of *collaborative safety planning intervention for reducing firearm access*. Steps within this safety planning process included considering client factors (client history, engagement, and risk of harm due to structural discrimination), social worker actions, and options for reducing firearm access. This model can be used to develop trainings for social workers to educate them on processes to reduce firearm access and harm for clients in crisis.

Key words: firearms, social workers, firearm removal, risk assessment, grounded theory

Introduction

In the United States, firearms account for nearly 49,000 deaths annually and are the leading cause of death for children ages 1-19. Firearms elevate burden for those at risk of suicide, homicide, being harmed by an intimate partner (Adhia et al., 2021), and direct and indirect threats of community violence (Smith & Patton, 2016). The presence of a firearm in any of these circumstances significantly increases the risk of harm. For example, suicide attempts with a firearm have a 90% case fatality rate, almost twice that of the next most lethal method, drowning (Conner et al., 2019b). Harm reduction intervention strategies such as lethal means restriction may reduce these risks. Limiting access to firearms can allow crisis moments to pass, giving individuals the chance to receive support (Mann & Michel, 2016). Policy-level interventions like mandatory waiting periods for firearm purchases and individual-level interventions, including counseling during crises, are effective in reducing firearm suicides.

Social workers operate in diverse clinical and community care settings and therefore have a unique opportunity to assess for risk and intervene to prevent harm (Sperlich et al., 2019). Direct social work practitioners can identify individuals at high risk of harming themselves and/or others, offer evidence- and practice-based interventions, and connect them to supportive resources (Conrick et al., 2023; Sperlich et al., 2022). Additionally, social workers working in community settings are well-positioned to provide case management and referral services that connect individuals to pre- and post-intervention resources that supplement clinical interventions (Sperlich et al., 2022a). Due to their unique training, these professionals also typically have an awareness of the effects of structural intersectionality, understanding how hierarchical and oppressive institutional systems (e.g., legal, medical, and social services systems) intersect to influence crisis moments that necessitate reducing firearm access (Durfee, 2021).

Several intervention options exist for social workers to pursue to reduce access to firearms for individuals in crisis. Extreme risk protection orders (ERPO) allow a family member or law enforcement officer to petition a judge to temporarily restrict an individual's (known as a respondent) access to firearms using a civil (non-criminal) order. While social workers cannot independently file an ERPO petition for a client in most states, they may counsel clients or their family members about these or suggest law enforcement file an ERPO (Conrick, Davis, et al., 2023). Other options for reducing firearm access include increasing the security of firearm storage in-home or storing the firearm out-of-home.

Social workers often lack awareness of options for reducing access to firearms for clients (Conrick, et al., 2023). Moreover, they frequently refrain from assessing firearm access due to a combination of discomfort with the topic and uncertainty about effective communication (Slovak et al., 2008; Sperlich et al., 2022a). Receiving training increases their likelihood of assessing for and counseling about firearms (Slovak et al., 2008), highlighting the potential influence of training on increasing self-efficacy for social workers to discuss firearms with their clients. However, there are few trainings to support them, due in part to a limited understanding of the best practices when working with clients to reduce firearm access. To bridge these knowledge and practice gaps, we sought to understand the process social workers use to choose which interventions to pursue to reduce firearm access and under what circumstances.

Methods

We conducted 10 focus groups with 29 social workers in direct and community practice settings in Washington State. Participants were recruited via email listservs from professional organizations and then snowball sampling. The recruitment email identified eligibility criteria and explained the content of the focus groups, as well as logistics and remuneration. Eligibility

criteria included those who had recently (within the last two years) worked with a client at risk of harming themselves or someone else. Interested social workers completed a brief interest form which confirmed eligibility and queried the rurality of clients they served. Recruited participants were purposively sampled based on client rurality to increase applicability of findings to social workers serving rural populations. Focus groups were conducted via Zoom by the lead author, who has experience with conducting qualitative semi-structured interviews. Focus groups were conducted between November 2022 and February 2023 and ranged in size from 1-6 participants. Participants were provided with a $50 gift card as remuneration. All study procedures were approved by the university institutional review board.

The semi-structured interview guide was developed based on a literature review and pilot tested with four practicing clinical social workers. The guide included 4 domains: 1) recent experiences with working with a client at risk of harming themselves or someone else with a firearm; 2) familiarity with and opinions of voluntary and involuntary firearm removal options; 3) resources currently used when serving these clients; and 4) gaps in perceived preparedness to serve these clients. Participants additionally were provided with two case vignettes of clients at risk of harming themselves and/or others with a firearm and were asked to describe what actions they would take to support the client.

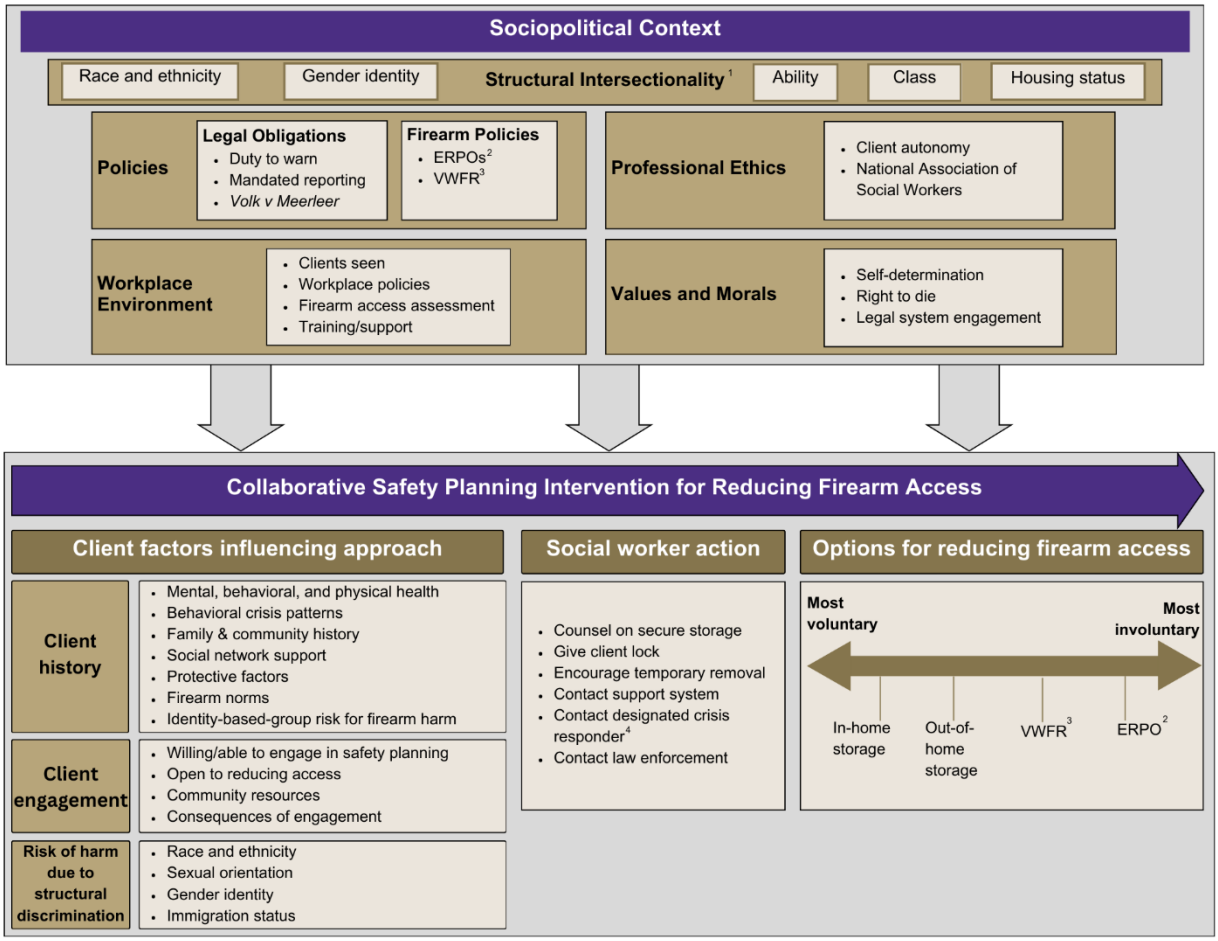
The ten focus groups were transcribed verbatim and entered into Dedoose analytic software (*Dedoose*, n.d.). Our analytic approach was informed by grounded theory methods (Creswell, 2012). Two focus groups were double-coded by two study team members, who separately open-coded through a line-by-line analysis to identify salient categories of information. The study team identified the central phenomenon of interest as the process of assessment and intervention social workers pursue when working with clients at risk of harming

themselves or others with a firearm. The coding team then organized the list of codes as they related to these two open coding categories (axial coding). We then applied the revised codebook to the first two focus groups analyzed, then applied it to another two focus groups, which were also double coded (selective coding). The coders met to discuss suggested modifications to the codebook after coding each focus group and iteratively refined the codebook. Any disagreements in codes were discussed until consensus was reached. One coder then independently coded the remaining six focus groups. The developed model was member checked via individual interviews with three social workers who participated in the original focus groups.

Results

Action plans were often highly influenced by the context of the social worker's role in their clients' care and customized to clients' needs. Participants offered insights into the sociopolitical context that influenced their intervention approach to designing a collaborative safety planning intervention to reduce firearm access for clients exhibiting concerning behaviors such as suicidal ideation, threats of harm to self or others, or cognitive decline. The model in Figure 5.1 assumes that a social worker has already assessed the risk of harm to self or others and has deemed it necessary to limit their access to firearms. Example quotes for all categories and sub-categories are available in Table 5.1.

Figure 5.1. Action plan model of factors influencing social workers' decision-making process to reduce client firearm access



Notes

[1]Structural intersectionality refers to the way hierarchical and oppressive (macro-level) institutional systems intersect to shape micro-level individual experiences, thereby revealing the perpetuation of inequalities (Durfee, 2021).

[2]Extreme Risk Protection Order

[3]Voluntary Waiver of Firearm Rights

[4]Under Washington State's Involuntary Treatment Act, designated crisis responders assess individuals to determine if they meet criteria for involuntary treatment.

Table 5.1. Example quotes from categories of action plan

Category	Sub-category	Quote
Sociopolitical context	Structural intersectionality	“One of our young men was transitioning into housing and had some difficult mental health challenges that he was really working through. But in his new transitional housing situation, he was being threatened by one of the other tenants and ended up purchasing a weapon. And not long after that also became suicidal, and our staff worked with the youth. […] But yeah, just a young man and feeling threatened kind of from all fronts, both by himself and others, and wanting to feel safe and secure. So, we just worked towards that end for him.”
	Policies	"I'm glad that there is due process because I know other states, especially, you know, when we talk about ITA laws [in Washington]. For example, you know I’m licensed in California, and in California their whole process called 5150. In California, if anybody's experiencing an acute psychiatric crisis, they don't go for least restrictive. They go for most restrictive, and everybody is put on that 5150 full, even if they're willing to go in. So, it makes me feel good to know that there is due process behind [ERPOs], because in other states when we're talking about psychiatric crises, there is no due process. Boom you're on a hold, too bad so sad. It doesn't matter if you get better, or you meet with somebody like me, and somebody like me says, no, they can stay, you know they can probably go home. They're gonna stay on that hold regardless. So, I’m glad to hear that there's due process [in Washington]."
	Professional ethics	"I think about autonomy a lot, and us as like a working value. And just for ethics like respecting that, and like essentially taking somebody's rights away right? […] But those are the things that I think about just really making sure that I'm being appropriate. And I'm being—in all areas—so that I’m not doing more harm or just prolonging the underlying issue."
	Workplace environment	"When I worked in family adult medicine, I focused more on families figuring it out themselves and not involving law enforcement. But if I ever had a situation where, like I worked in the ED for example, I think I would very much. And they're coming in manic or hypomanic, I would very much recommend like, you should get this protection order and you know, and screening, oh there are guns in the home and they, they are currently not stable right now, then you should definitely pursue this order."

	Values and morals	"I mean, this just brings a lot about just like even me doing the work on myself. [...] But I think about like how, what are my feelings and attitudes towards the subject, and towards like these sort of situations based on my experiences. And it's not a one size fits all but yeah. So, I guess just our attitudes and our feelings, and how we view things like this."
Client factors influencing approach	Client history	*Social network support.* "I've often discharged people home, but they have a family member willing to take off work for the next couple of days to kind of like support them and, and that person is a supportive person that they're really enjoy spending time with. So, if there's something other big safety nets, then yeah, maybe it's time to talk about, well this is gonna happen if you don't want to." *Identity-based-group risk factor for firearm harm.* "I'd say, like one contributing factor to me is like the fact that, like white men in their fifties are the most likely at this point, and, like this has been a statistically huge rise in white men shooting themselves. And so statistically, that is a contributing factor of like this is a higher risk. I'd say like I would also anticipate or receiving more resistance."
	Client engagement	"And he told me like the first visit he was like, 'I know you're gonna ask about my gun. I'm not gonna give up my gun.' But he's like, I think he told me he was like "a gun person." Like he's just always had a gun. But we were able to talk like we, we check in a lot about his like passive suicidal thoughts, and like really looking at like where those are at, knowing that he's had a time in the past where they were more active. And so, it's like us…it's almost like building up the trust between me and him that if it changes from more kind of passive like, I wish I were dead. You know, all his health stuff, to more like, I want to end my life that he would feel comfortable talking about that. And it's like it feels kind of weird to put the gun issue to the side, but it's like it almost felt, especially at that, like in those initial visits. It felt like if I had like, like harped on the gun like a lot that I would have like lost that like…I wouldn't have built any rapport. "
	Risk of harm due to structural discrimination	"Yeah, I'm just concerned that people of lower income and people that are part of the BIPOC community would receive that type of forceful intervention rather than just stopping and pausing, and kind of have conversation and trying to work together with them. It would be like. Oh, you know. This is what we're gonna do. That's it. And so that was my concern is, how are we partnering with you as a client? How are we supporting them with being able to access these avenues in such a way that it doesn't it continue to disenfranchise them. But yeah, that's my that's my immediate concern. I have work with clients where it is just not safe. And no matter, you know what options that we would try, that they would just

		fail. And so, it is nice to have that [voluntary] option in situations where…that you just don't have another option. But and I also really would love to see if someone would be able to collect data and make sure that there are not patterns of racial discrimination of class discrimination."
Social worker action	Err on the side of most voluntary option	"So, it's part of my role like we have to rule out the sort of voluntary, less restrictive options as we, as we're progressing towards that option of involuntary treatment. So, I really do try to come at it with the person exploring that, and really figuring out, how can we help you not end up in the hospital? Since that's your stated goal. [...] And so if you are really pro-gun, usually, people are gonna do whatever they can to keep their right to keep a firearm, so that can be a very motivating option for them is by verbalizing that. [...] So the person is very aware that if you don't find a voluntary option here, you don't work with me and the supports that you have at your disposal, then you're going to lose this thing that's important to you for a while."

Category 1: Sociopolitical Context

Participants described several sociopolitical contextual considerations that shaped the overarching framework of their planning process for supporting clients in reducing firearm access. These factors included structural intersectionality, policies that influenced their legal obligations (e.g., duty to warn laws) or options available for reducing firearm access (e.g., ERPO), professional ethics, workplace environment, and values and morals. Many participants described how intersecting power structures (i.e., structural intersectionality) influenced their clients, in particular those with intersectional identities. For example, one participant shared a case where a client's experience of homelessness, housing instability, and threats from another tenant led to firearm purchase and a suicidal crisis, necessitating collaborative safety planning.

Participants described the role of policies on the legal obligations they had regarding client risk disclosure (e.g., duty-to-warn laws), options they had available for intervention (e.g., presence of an ERPO law), as well as the implementation of these policies, such as how acceptable their peers and organizations found involuntary interventions. One participant who

was licensed in both Washington and California described the differences in culture of involuntary interventions due to California's 5150 law, which defines circumstances under which individuals may be involuntarily detained for mental health evaluation and treatment. This participant explained their belief that the structure of the 5150 law encouraged over-detainment and decreased social workers' discretion compared to similar policies in Washington State. Additional policies discussed included those related to duty to warn and mandated reporting, as well as court rulings such as *Volk v. Meerleer*, which established that mental health professionals can be held liable for failure to warn even when there is not a specific target named.

Additionally, discussions often included the influence of social work professional ethics on their decision-making process, such as those established regarding client autonomy by the National Association for Social Work (NASW). Participants discussed the delicate balance between the imperative to maintain immediate client and community safety and their commitment to clients' autonomy, rights, and potential harms from medical and legal systems. Some participants who worked in large organizations discussed the influence of their workplace context, such as the clients served and institution-specific policies. These often also influenced social workers' frequency of assessing for firearm access. Many participants worked in multiple settings and compared these experiences. For example, one participant explained when they worked in an adult primary care office, which is a low-acuity setting, there was more flexibility to utilize the client's social network and community supports, whereas in an emergency setting, they may be more likely to pursue an involuntary option due to the high acuity and lack of time to identify another solution. Another participant described their institutions' policies on the specific circumstances under which they were allowed to involve law enforcement. Finally, some

participants described the influences of values and moral stances on their approach to decision-making, for example beliefs concerning individuals' right to die or their views on firearms.

Category 2: Collaborative Safety Planning Intervention for Reducing Firearm Access

The above-described sociopolitical contextual factors influenced the process of collaborative safety planning interventions to reduce client firearm access. The components of this process included considering client factors (client history, engagement, and risk of harm due to structural discrimination), actions social workers could take, and then the range of options for reducing firearm access.

Subcategory 1: Client factors influencing approach

Client factors including the client's history, level of engagement in safety planning, and the risk of harm resulting from structural discrimination in medical and legal systems were key aspects influencing the decision-making process regarding which interventions to pursue to reduce firearm access. In relation to client history, participants highlighted the role of the client's acute and historical mental, behavioral, and physical health as well as familial and recent community history of suicide in shaping their approach to action planning. These factors informed their perception of the imminence associated with the client's potential risk for harm. Additionally, participants observed that behavioral patterns exhibited by clients during prior crises served as indicators of their likely responses in an ongoing crisis scenario. For example, if a client had previously attempted suicide during periods of emotional distress, social workers might lean toward a more assertive approach, potentially involving involuntary measures. Protective factors, especially a supportive and engaged social network, would facilitate a voluntary removal option. These social networks could provide emotional support in times of acute crisis or physically remove the firearm from the client's access. Participants also factored

in firearm-specific elements of the client's history, noting that clients with a lengthy firearm history or a strong identity as a firearm owner often exhibited greater resistance to firearm removal planning. They described higher inclination towards involuntary interventions for groups at highest risk of firearm suicide, like older white men or Indigenous individuals.

Client engagement was also identified as influencing the approach for reducing firearm access. Specifically, social workers outlined instances where clients, particularly those experiencing an acute mental or behavioral health crisis, were unable or unwilling to discuss voluntary removal. They also explained the presence or absence of community resources to support the individual in crisis influenced the clients' willingness and ability to engage in collaborative safety planning to reduce firearm access. Furthermore, social workers faced dilemmas when working with clients in professions like aviation or military reserves, where seeking mental health support could jeopardize their careers. For example, pilots feared losing their licenses if they sought counseling for suicidal thoughts, while reservists were concerned about impacting their chances of receiving a 20-year honorable discharge. This added complexity to social workers' decision-making to pursue involuntary interventions as they navigated the balance between immediate client needs and potential long-term career consequences.

Another client factor included the client's risk of harm due to structural discrimination based on their race and ethnicity, sexual orientation, gender identity, immigration status, or intersection of these or other identities. For example, numerous participants explained their reluctance to suggest BIPOC clients or clients with mental illness surrender their firearms at a police station or expose them to the legal system via an ERPO. Similarly, they hesitated to refer clients who were undocumented for an ERPO due to risk of deportation.

Subcategory 2: Social worker action

Most participants expressed a preference for the most voluntary approach when seeking to reduce firearm access. They viewed voluntary measures as respecting client autonomy, preserving the therapeutic relationship between social workers and their clients, and recognizing the potential dangers associated with involving legal and healthcare systems in the process. Participants described several actions they took to reduce firearm access for clients. If available from their employer, participants also provided firearm locking mechanisms (e.g., cable locks or lockboxes) to clients to increase the security of their in-home firearm storage. They also shared communication techniques, such as calling firearm storage "responsible" instead of safe, which resonated better with firearm owners. Additionally, they explained acknowledging the client's expertise with firearms helped establish trust. One of the most common actions discussed involved facilitating a conversation with the client's support system (e.g., spouse, adult child, parent) to participate in planning to remove the firearm. For example, with client permission, they would call a support person to remove the firearm from the client's home before the client returned home. Finally, participants described pursuing involuntary hospitalization or involving law enforcement as last-resort options when no other options seemed feasible or likely enough to prevent immediate physical harm.

Subcategory 3: Options for reducing firearm access

Participants identified several options for reducing firearm access for clients, including increasing the security of storage in the home (e.g., locking firearm and ammunition separately), storing the firearm out-of-home, and ERPOs. Participants indicated a preference for the most voluntary options possible, describing ERPOs as the least preferred option.

Discussion

The findings from this study offer valuable insights into the complex landscape of intervention strategies social workers employ when working with clients at risk of harming themselves and/or others with a firearm. The presented action plan framework provides a detailed understanding of the sociopolitical context and client factors that influence social workers' approach to collaborative safety planning intervention to reduce firearm access. This model serves as a practical tool that can be used to develop and enhance trainings for social workers. By using this framework, these trainings can effectively educate social workers about the intervention options, approaches, and the multifaceted decision-making factors that guide their efforts to mitigate firearm-related crises among clients.

Effective collaborative safety planning hinges on understanding the complex interplay of sociopolitical contexts and their impact on crisis situations. These contexts not only shape the emergence of crises but also influence the intervention options available to social workers and their clients. Participants in this study underscored the significance of recognizing how intersecting power structures oppress individuals with various social identities, including race, housing status, gender identity, sexual orientation, and ability. Participants acknowledged these as key examples within a broader spectrum of marginalized identities, also including language, immigration status, religion, and gender. This nuanced understanding of intersectionality is pivotal in developing tailored intervention strategies that resonate with the unique needs and experiences of each client, ensuring that safety planning is inclusive and contextually aware.

Values and morals, workplace environment, professional ethics, and policies played significant roles in shaping the decision-making process regarding intervention approaches for reducing client firearm access. While some social workers in our study cited their personal

morals, particularly those related to client autonomy, as factors that decreased their inclination toward involuntary interventions, international research has shown that excessive reliance on individual moral reasoning can inadvertently lead to paternalistic tendencies among social workers (Lerbæk et al., 2015). Relying solely on moral reasoning within the power dynamics of a social worker and client relationship may lead to social workers dismissing the validity of clients' autonomous choices if their values do not align. This is at odds with the core ethical principle of social work practice: respecting client self-determination (Section 1.02 of NASW Code of Ethics). Reflexivity practices can give social workers a framework to be cognizant of their emotional reactions and biases that arise during interactions with clients and influence the recommendations they make (Shaeffer, 2014). Additionally, the relationship between individual morals, professional ethics, and social worker decisions that empower clients is intertwined with the work environment's perceived conduciveness to collaborative decision-making (Levin & Schwartz-Tayri, 2017). The polarizing nature of firearms discourse in the U.S. further complicates discussions about reducing firearm access for clients in crisis. Our participants discussed several strategies they used to approach conversations with clients who were hesitant to discuss firearm removal, such as those from rural areas. These included using clients' own language, such as "responsible" rather than "safe" storage, as well as focusing conversations on reducing access to all lethal means (e.g., medications) rather than only on firearms. Other studies with social workers have also identified challenges social workers face when they perceive their values regarding firearms to differ from their clients (Sperlich, 2022). This intricate interplay among personal values and professional standards underscores the complexity of navigating the delicate balance between safeguarding client autonomy and ensuring physical safety.

Workplace environments, such as clients served and institution-specific policies, also emerged as critical contextual factors affecting the decision-making process for social workers. For example, variations in the acuity of clients served related to differences in factors influencing social workers' approach to reducing firearm access, underscoring the importance of adaptable strategies. In low-acuity settings, flexibility allowed for customized, family-centric planning, whereas social workers in high-acuity situations sometimes felt pulled toward involuntary measures that prioritize immediate physical safety. Recognizing the significance of workplace context in decision-making is imperative when developing training programs. Training materials must be flexible, acknowledging the diverse practice environments social workers navigate.

As social workers play a pivotal role in client safety and well-being, this study's results further emphasize the need for adequate support, training, and resources for effective firearm access interventions. One strategy includes offering free firearm locking mechanisms to clients. Paired with counseling, this approach has been shown to increase security of firearm storage (Rowhani-Rahbar et al., 2016). Of note, allowing clients to select their preferred type of locking mechanisms increases willingness to participate in secure storage practices (Simonetti et al., 2019). While some social workers in this study were aware of workplaces providing these resources, many remained unaware of this option. Having social workers or other healthcare providers provide locking mechanisms through their institutions can alleviate the financial and logistical burden on clients. It is important to note that while these trends have been observed regarding firearm locking mechanisms, no studies have specifically studied lock provision to clients in a social work setting. Additionally, providing locking mechanisms to these clients has great implications for addressing concerns social workers may have about involuntary interactions with medical and legal systems. Further research is needed to determine the

effectiveness of providing locking mechanisms to clients compared to other strategies to reduce firearm access for clients with differing intents (e.g., suicidal or homicidal ideation).

Our study also highlights the concern that social workers have when they consider referring clients to more involuntary strategies to reduce firearm access. Participants discussed the implications of involving law enforcement for involuntary options, specifically for populations at highest risk of police violence such as BIPOC individuals, people experiencing homelessness, and those in the LGBTQ+ community. Significant equity concerns can arise in situations when social workers must weigh the potential benefits that connecting clients with behavioral health, social service, and legal systems may provide with the potential harms they can experience within these systems. For example, ERPOs are a civil order that can reduce immediate firearm access for individuals in crisis and facilitate connections to behavioral health and social services. However, the ERPO process utilizes law enforcement officers to remove firearms from respondents of granted ERPOs. The implications of police response could potentially expose clients and their families to police-related violence and trauma. In contrast, this harm may also reduce benefit of ERPOs' potential to reduce suicide (Swanson et al., 2019) for BIPOC communities, who are hesitant to engage with the legal system (Pear et al., 2022).

Participants in this study were exclusively from Washington State, which has policies and resources that differ or are unavailable in other states. Further research is needed to test the generalizability of the action plan both within and outside of Washington State. Furthermore, the recruitment methods, which relied on snowball sampling and email listservs, may have unintentionally omitted specific viewpoints, particularly those of social workers who may be hesitant to limit client access to firearms due to political context or personal beliefs.

In conclusion, the proposed model action plan offers a framework to understand how social workers serving clients at risk of harm to self or others with a firearm currently conceptualize factors influencing their decisions on how to reduce firearm access. These factors include client history, clients' ability or willingness to engage in safety planning, and clients' risk for harm from medical and legal systems due to structural discrimination; additionally, these factors are situated within the broader contexts of individual morals, professional ethics, state and local policies, and workplace context. This model may serve as the basis for trainings to equip social workers to navigate these nuanced conversations and ethical dilemmas as a complement to efforts to educate social workers on available resources and policies. Moreover, this research highlights the need for ongoing collaboration among social workers, policymakers, and advocacy groups to ensure that the support and resources necessary for effective firearm access interventions are readily available and relevant to social work practitioners.

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Chapter Six: Conclusion

This dissertation sought to understand the discretionary process social workers use when supporting clients at risk of firearm-related harm, as well as how social workers confront, navigate, or reinforce structural racism while working with clients at risk of harm to self and/or others with a firearm. Using four interconnected research studies, I identified recommendations for implementation of ERPOs into social work practice, explored the ethical dilemmas social workers encounter while working with these clients, who may benefit from connections to medical and legal systems but are also vulnerable due to their social identities, and pinpoint recommendations for developing training programs that equip social workers to effectively address disparities in firearm-related harm. The findings from this dissertation have shed light on critical aspects of social work in the context of preventing and addressing firearm-related harm. Findings revealed that social workers often prefer the most voluntary approach to reducing firearm access when dealing with clients in crisis given the individual context of each client. Moreover, many social workers felt unprepared to navigate conversations about firearm removal with their clients and were unaware of available resources to assist in these situations. Social workers prioritize safeguarding their clients from potential harms stemming from interactions with medical and legal systems while guiding them through the crisis. Additionally, findings from this dissertation underscore the importance of centering intersectional voices in discussions about social worker training and policy reforms to avoid unintentional harm and mitigate existing disparities. Collectively, these findings emphasize the need for comprehensive training and policy reform to ensure effective interventions are in place. Table 6.1. summarizes the methods, findings, and implications of all four studies.

Table 6.1. Summary of the four-paper dissertation.

Paper	Objective	Methods	Findings	Implications
Paper One	To explore ERPO implementation in social work by drawing insights from the historical context of discretion regarding DVPOs, with a focus on equity considerations	Narrative inquiry with interviews of community advocates and social workers involved in domestic violence advocacy from 1970-1990	Four lessons learned: Individual context understanding, professionalization impact on advocacy, advocacy responsibilities in addressing issues with protection orders, and centering intersectional voices for policy equity	Provides guidance for equitable ERPO implementation in social work practice.
Paper Two	To understand how social workers use their discretion to navigate complexities when serving clients at risk of firearm-related harm, including benefits and harms of medical and legal systems	Ten focus groups with 29 clinical social workers in Washington state discussing case scenarios related to firearm harm risks	Social workers assume six roles when serving clients at risk of firearm harm, emphasizing the importance of socioecological and social justice frameworks in social work education	Highlights diverse roles social workers play and the relevance of social work education principles
Paper Three	To assess the impact of client race on social workers' discretionary approaches to reduce firearm access, considering voluntary and involuntary methods	Survey distributed to Washington State social workers with case vignettes randomized by client race (Black or white); consider social worker race as moderator	Racial disparities found in social workers' decision-making regarding firearm access reduction strategies. Black clients at risk of harm to self had lower odds of involuntary care options, while Black clients at risk to others had higher odds	Raises awareness of potential racial disparities in social workers' decision-making and highlights the need for equity-focused training and interventions
Paper Four	To understand social workers' decision-making process for choosing interventions to reduce firearm access for clients in crisis	Ten focus groups with 29 social workers in Washington State discussing client scenarios and using grounded theory to develop an action plan model	Three categories influencing decision-making: Social worker context (morals, ethical guidelines, policies, workplace), client factors affecting threshold for action (client history, engagement, structural discrimination), and intervention approach strategies	Offers an action plan model for social workers' decision-making, facilitating the development of tailored training programs.

In Paper One, I sought to address gaps in understanding of ERPO implementation into social work practice by gaining insights into the historical context in which DVPOs were implemented into community and professional settings. Specifically, I considered how social workers and advocates chose when to refer clients to the DVPO process, as well as their broader role in identifying systemic gaps through their expertise and advocating for policy solutions. I explore how these lessons learned may similarly inform ERPO implementation, with a focus on equity considerations. I used a narrative inquiry approach to this study, interviewing eight community advocates and social workers involved in domestic violence advocacy from 1970-1990. Three lessons identified included the importance of understanding individual context before offering options such as protection orders, how the professionalization of social work affected the ways in which advocates served victim-survivors, and the responsibilities of advocates to identify problems with implementation of protection orders that cause inequities. The insights gained from this study shed light on key lessons learned from the historical implementation of protection orders, which can offer valuable guidance for the equitable implementation of ERPOs in social work practice today.

In Paper Two, I sought to explain how social workers use their discretion to manage the complexities of serving clients at risk of firearm injuries and deaths who may benefit from or be harmed by medical and legal systems. I conducted ten focus groups with 29 clinical social workers in Washington state. Participants discussed their experiences with clients and reacted to case scenarios highlighting the risk of harm from medical or legal systems due to social identities (e.g., race). Participants described six roles—investigator, collaborator, confidant, facilitator, navigator, and educator—they assume when serving clients at risk of harm to self/others with a firearm, weighing the benefits of medical or legal system services against potential harms from

these systems. Findings from this paper suggest social workers serve diverse and crucial roles when working with clients at risk of firearm-related harm. Additionally, foundational principles in social work education contextualize individual behavioral health crises within socioecological and social justice frameworks. This uniquely positions social workers to pursue client-centered solutions that maintain safety while accounting for risk of harm from medical and legal systems.

In Paper Three, I sought to assess the impact of client race on social workers' discretionary approaches to reduce firearm access when they weighed voluntary (e.g., store out-of-home) and involuntary (e.g., extreme risk protection order) removal methods. I considered the role of social workers' self-identified race as a moderator of this relationship, comparing white (single race) and BIPOC social workers. I distributed a survey to Washington State social workers who were presented with two case vignettes, each randomized to view the client's race as Black or white. Logistic regression was used to assess the association between the client's race and the pursuit of voluntary or involuntary methods, stratified by social workers' race. The Black client at risk of harm to self had lower odds of an involuntary care plan option compared to the white client, while the Black client at risk of harm to others had higher odds of an involuntary care plan option. This study contributes to the growing understanding of potential racial disparities in social workers' discretion regarding firearm access reduction strategies.

In Paper Four, I sought to understand the decision-making process social workers use to choose which interventions (e.g., out of home storage) are appropriate to reduce firearm access for clients in crisis. Ten focus groups were conducted with 29 social workers in Washington State. The semi-structured interview guide directed participants to discuss experiences with clients at risk of harming themselves and/or others with a firearm and respond to two case examples. Grounded theory was used to develop an action plan model describing how social

workers choose which interventions to pursue. Participants described two categories that influence their decision-making process for reducing firearm access for clients in crisis. The first category, *sociopolitical context*, included structural intersectionality, policies, professional ethics, workplace environment, and values and morals. These influenced the second category, which described the process of *collaborative safety planning intervention for reducing firearm access*. Steps within this safety planning process included considering client factors (client history, engagement, and risk of harm due to structural discrimination), social worker actions, and options for reducing firearm access. This model can be used to develop trainings for social workers to educate them on firearm removal.

Social Justice Implications

The findings from this dissertation can be used by several groups to reduce disparities in firearm-related harm, including currently practicing social work practitioners, social work professional organizations developing trainings, policymakers, and researchers. Any efforts to reduce firearm-related harm must acknowledge disparities faced in many marginalized and minoritized groups, as well as the driving mechanisms (e.g., structural racism, settler colonialism) of these disparities. Consequently, these efforts must also acknowledge the potential harm that may come from interventions that require these communities to interface with medical and legal systems. Conversely, the mistrust of medical and legal systems may cause hesitancy for individuals of these groups to engage with services within these systems that could support them, leading to disparities in beneficial services. A summary of implications and recommendations is available in Table 6.2.

Table 6.2. Summary of social justice implications and recommendations for social work practitioners, social work training developers, policymakers, and researchers.

Group	Implications and Recommendations
Social work practitioners	• Proactively assess clients' firearm access to identify potential risks • Advocate for providing free lockboxes to clients • Offer individualized guidance and support, considering clients' unique contexts and goals • Identify and address policy implementation gaps in firearm policies and educate other providers about changes • Pursue cultural resonance of interventions, acknowledging potential harm in interactions with marginalized communities • Address implicit biases through self-awareness, mindfulness, and ongoing training
Social work training developers	• Develop specialized training programs tailored to social workers' needs • Customize trainings to state-specific contexts, including state policies and available resources • Incorporate equity considerations, addressing biases and challenges in referring clients to medical or legal systems
Policymakers	• Center intersectional voices in policy development to ensure equitable implementation and outcomes • Define qualifications for individuals involved in serving clients affected by firearm-related harm with attention to cultural responsiveness • Consider unique challenges social workers face in implementing policies such as ERPOs • Do not hold social workers liable for not filing ERPOs due to concerns about client well-being within medical and legal systems • Monitor states' experiences with social workers filing ERPOs to inform policy decisions
Researchers	• Conduct further research to generalize findings to different regions and consider disparities in firearm-related harm • Utilize frameworks presented in this dissertation as foundations for similar studies in other states • Explore experiences and insights of social workers who have access to more resources (e.g., free locking mechanisms) and who engage with high acuity clients • Prioritize community-based participatory research with affected communities for inclusive and equitable representation • Use narrative inquiry to capture nuanced perspectives, especially from marginalized populations in firearm-related harm

Implications for Social Work Practitioners

The findings from this dissertation highlight specific recommendations social workers can readily incorporate into their practice. First, they should proactively integrate regular

assessments for clients' firearm access to help identify potential risks and facilitate appropriate interventions (Slovak et al., 2008). Second, they should advocate to their institutions for the provision of free lockboxes for clients; this action aligns with social workers' preferences for voluntary removal options, underpinned by moral, ethical, and equity considerations. Additionally, social workers can better support clients by offering individualized guidance and collaborating to achieve solutions. This process begins with a comprehensive understanding of each client's unique context and goals for support. Social workers then can provide education regarding the risks and benefits associated with each available option and support clients in pursuing them. Social workers should also consider clients' protective factors, such as strong social supports, when determining a plan of action for addressing firearm access.

Additionally, it is imperative for social workers to proactively identify gaps in the implementation of firearm policies, including ERPOs, with a particular focus on issues related to equity. Advocating for policy changes and actively educating other providers about these proposed changes is a crucial step toward promoting safety. Social workers should be mindful of the potential harm that clients from marginalized and minoritized communities may face when interacting with the medical and legal systems, especially in involuntary situations (Borecky et al., 2019; Ward-Ciesielski & Rizvi, 2021). This consideration underscores the importance of cultural competence and sensitivity in social work practice. Moreover, social workers must acknowledge and reflect on potential implicit biases that they may hold when deciding whether to pursue involuntary care plan options. Self-awareness, mindfulness, reflexive practices, and ongoing training can help address these biases and ensure equitable care (Devine et al., 2012; Dupper, 2017; Wong & Vinsky, 2021). These recommendations provide concrete steps that social workers can take to enhance their practice and contribute to reducing firearm-related harm. By

advocating, providing individualized support, addressing policy gaps, promoting cultural competence, addressing biases, and conducting regular assessments, social workers can play a pivotal role in creating safer environments for their clients.

Implications for Social Work Training Developers

Social workers in this dissertation reported a significant gap in formal training on how to address firearm access for clients, and they expressed feeling unprepared to handle such situations. Addressing this gap through the development of specialized training programs is critical. Yet, there is a lack of comprehensive literature on firearm-related trainings tailored to social workers. While one study found a positive association between prior training and a positive attitude toward firearm risk assessment and counseling (Slovak & Brewer, 2010), it's worth noting that only 24% of social workers in that study had received any form of training related to firearms. In contrast, data from this dissertation revealed that approximately 47% of the participating social workers had undergone some training, highlighting a positive trend over the years. However, to the best of our knowledge, no studies have been published specifically evaluating the effectiveness of social work trainings on firearm assessment and interventions. Among the social workers who did receive training, they often found that these programs were primarily designed for physicians, making them less relevant to their specific roles. As a result, future trainings should be customized to meet the unique needs of social workers. These trainings should encompass fundamental education on firearm terminology and locking mechanisms, along with guidance on how to navigate these sensitive conversations with clients. Furthermore, it is crucial for such trainings to be tailored to individual states, enabling social workers to familiarize themselves with state-specific policies, such as ERPOs, and available resources, such as maps indicating temporary firearm storage locations.

Additionally, the findings from this dissertation underscore the necessity for these training programs to incorporate equity considerations. For instance, social workers in paper two discussed the challenges they face when deciding whether to refer clients to medical or legal systems for services, considering the potential harm that these systems may pose to clients, especially those from marginalized communities. However, paper three revealed that many social workers hold implicit biases. This study indicated social workers more often escalated white clients at risk of harm to themselves into involuntary care plan options, while being more likely to escalate Black clients at risk of harm to others into involuntary care plan options. To address these biases, recommendations for social work training programs include the incorporation of strategies like the use of counter-stereotypical exemplars (Fitzgerald et al., 2019) and teaching implicit bias recognition (Gonzalez et al., 2021). Developing specialized firearm-related training programs for social workers is essential to equip them with the necessary skills and knowledge to address firearm access and related risks in their practice. Developers of these trainings should tailor them to the unique needs of social workers, adapted to state-specific contexts, and infused with a strong focus on equity considerations to ensure the provision of equitable and effective services to all clients.

Implications for Policymakers

This dissertation offers valuable insights for policymakers, drawing attention to critical considerations in the development and refinement of firearm-related policies. In paper one, a central theme included emphasizing the necessity of centering intersectional voices within policy frameworks to safeguard against unintended consequences and ensure equitable outcomes. Additionally, this paper underscores the importance of defining the qualifications of individuals, such as community advocates, who may play crucial roles in serving clients affected by or at risk

of firearm-related harm. Striking a balance between ensuring competency and preserving cultural responsiveness, policymakers should carefully evaluate the requirements for these roles, considering potential barriers posed by stringent educational prerequisites. Furthermore, policymakers should consider the unique challenges social workers face when navigating policies such as ERPOs. Social workers often grapple with concerns about potential harm stemming from interactions with medical and legal systems when deciding whether or not to file an ERPO (Wortzel et al., 2023). Therefore, policies should not hold social workers liable for choosing not to file an ERPO due to their apprehensions regarding the well-being of their clients within these systems. To inform future policy decisions, policymakers can closely monitor states like Colorado and New York, which initially did not permit social workers to file ERPOs but later revised their laws to include these professionals as independent filers. This inclusion offers an opportunity to assess how the implementation of ERPO policies evolves with the active involvement of social workers, potentially enhancing the effectiveness of these measures. Lastly, policymakers should not quantify the number of ERPOs filed as a measure of success. Instead, the primary goal should be the reduction of firearm access for individuals in crisis. Acknowledging that voluntary measures can also contribute significantly to this objective, policymakers should adopt a broader perspective in evaluating the impact and effectiveness of ERPO policies. This dissertation provides policymakers with valuable insights and recommendations, emphasizing the need for inclusive, culturally responsive policies, thoughtful qualification requirements for service providers, and a nuanced understanding of the challenges social workers face within the context of ERPOs. By heeding these lessons and adopting a holistic approach to policy assessment, policymakers can contribute to the development of more effective and equitable firearm-related policies.

Implications for Researchers

The findings from this dissertation also highlight several new research avenues and methodological approaches. Further research is needed to generalize findings to other states, with an emphasis on considering the potential disparities in firearm-related harm and access to resources in different regions. Washington state's distinct firearm policies and available resources, which may not be commonly found in most states, could pose unique strengths or challenges in reducing firearm access. This warrants further investigation to understand how these variations impact social work practice.

The frameworks presented in this dissertation can serve as a foundation for conducting similar studies in other states, providing an opportunity to explore the broader applicability of the proposed recommendations and their effectiveness in diverse contexts. Furthermore, while a substantial number of social workers in this study reported a lack of training or felt unprepared to navigate conversations about firearm access with clients, a subset of professionals worked in settings where they routinely engaged with high-acuity clients and had access to resources such as lockboxes or other locking mechanisms that could be distributed free of charge. Research efforts focusing on these social workers' experiences and insights may unveil additional research avenues, particularly regarding the distribution of firearm locking mechanisms and best practices for social work practitioners, thus promoting more equitable care (Uspal et al., 2021).

In addition, this dissertation has methodological implications for researchers in the field. Future research should prioritize community-based participatory research with communities disproportionately affected by disparities in firearm-related harm. This approach will help researchers gain a deeper understanding of these communities' preferences for collaborative support from social workers, ensuring research inclusivity and equitable representation.

Furthermore, the utilization of narrative inquiry, as demonstrated in paper one, is an underutilized approach in the study of firearm-related harm. By eliciting detailed narratives from participants, researchers can enrich their studies with nuanced perspectives, particularly concerning the experiences of marginalized and minoritized populations in firearm-related harm. Moreover, the framework of identifying distinct "roles" introduced in paper two can prove particularly beneficial in future research targeted at the social work audience. This framework, commonly employed in social work education, resonates with social work practitioners and offers an accessible presentation of the dynamic and collaborative approaches employed when working with clients at risk of firearm-related harm (Parris, 2012). Future studies can leverage this framework to delve deeper into social workers' roles and responsibilities in reducing firearm-related harm, with an eye on addressing potential disparities and ensuring equitable care. This dissertation not only uncovers new research directions but also suggests methodological innovations that can advance the field of firearm-related harm research, with a specific focus on promoting equity and inclusivity in research design and practice. By prioritizing diverse contexts, marginalized communities, and innovative methodologies, researchers can contribute to a more comprehensive understanding of firearm-related harm and the role of social work in addressing it.

Dissemination of Research Findings

Throughout the dissertation process, I collaborated closely with social workers to ensure that my dissemination efforts would be both relevant and applicable to their practice. As a result of this collaboration, I have developed and am continuing to create several resources. First, I created a 1-hour training program that has already been delivered to over 100 social workers across various professional organizations, individual institutions, and MSW classes. Feedback

and evaluations for this course have been overwhelmingly positive, with a 100% satisfaction rate among participants, all of whom reported gaining new insights from the training. Additionally, all participants expressed a belief that similar training should be made available to all social workers. I also designed a resource sheet tailored specifically for social workers (Appendix D). This resource provides valuable information on their roles in reducing firearm access, outlines the available options for firearm removal, explains various locking mechanisms, and includes links to relevant resources and training opportunities. This resource sheet has been distributed to every social worker who participated in these studies.

I have also developed badge tags that feature options for reducing firearm access (Appendix D). They include QR codes that link to local resources, such as a map indicating locations for temporary firearm surrender. A second badge tag has been designed to assist social workers in understanding the ERPO process more easily. Finally, I am creating a one-page advocacy document intended to support social workers in advocating to their institutions for the provision of free lockboxes for their clients, aligning with principles of equity and ethical practice. Once all these materials are finalized, I will reach out to the social workers who have consented to offer them digital versions of these resources and extend the option to receive physical copies of the resource sheet, badge tags, advocacy one-pager, and/or ERPO navigation card at no cost. This comprehensive approach seeks to provide practical support to social workers in their roles related to firearm safety.

Conclusion

This dissertation explores the critical roles of social workers in addressing disparities in firearm-related harm. Through four interconnected research studies, it identifies recommendations for policy implementation, navigates ethical dilemmas, delves into the impact

of client race on social workers' decision-making, and dissects the decision-making process for interventions to reduce firearm access. The findings illuminate social workers' preferences for voluntary approaches over involuntary methods, their unpreparedness in addressing firearm removal, and their prioritization of client safety within and from medical and legal systems. Additionally, the importance of centering intersectional voices is emphasized for equitable outcomes. The findings underscore the need for comprehensive training, policy reform, and collaborative efforts to ensure effective interventions. The implications span across social work practice, training development, policymaking, and research, with a strong focus on addressing structural racism and promoting equity. These insights have been disseminated through various resources and training materials, connecting research findings with practical application for social work practitioners. If properly trained and supported, social workers may significantly contribute to reducing the burden of and disparities in firearm-related harm.

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Appendices

Appendix A: Interview Guide for Participants for Paper 1 (Individual Interviews)

Introduction

Thank you for being willing to talk to me today. If it's okay with you, can I tell you a little more about the study and why I'm interested in DVPOs?

I'm interested in how social workers and advocates work with clients at risk of harming themselves or others with a firearm. One policy related to this is Extreme Risk Protection Orders (or ERPOs). You might or might not have heard of them, but basically someone can file a petition—similar to a DVPO or other protection order—that explains why someone should have their access to a firearm temporarily restricted. This person is usually experiencing some kind of acute crisis, like suicidal ideations or is threatening someone, but they have to be deemed to be at substantial and imminent risk of harming themselves or someone else with a firearm. A judge will decide if the order is appropriate, and if so, law enforcement will remove their firearms, and place them on a list so they can't buy a firearm.

A lot of ERPO laws were based off of DVPO laws, so I think a lot of the benefits and criticisms of DVPOs might have some applications to ERPO laws as well. I know there is a lot of research on the benefits and criticisms of DVPOs for survivors and perpetrators of DV. What I'm really interested in for this study is actually the implementation of DVPOs—so how they became integrated into practice after the laws were passed and what the role of social workers and advocates was in that process. I'm curious about what we can learn from your experience with DVPOs that could improve ERPO laws and prevent harm.

Do you have any questions so far?

This interview will take about an hour depending on how much you have to tell me. If it's okay with you, I'll record this conversation just to be sure I'm hearing everything you're telling me. No one will have access to this recording except the research team, and I'll make sure you can't be identified in the transcript of the interview or any reports. You can also decide to stop participating at any time or decide to skip a question if you don't want to answer.

The last thing is for transparency, I'm receiving funding from a grant sponsored by the National Institutes for Health (NIH).

Do you have any questions?

Are you okay moving forward with the interview?

1. Tell me about your earliest work with the DV movement.
2. [If did one-on-one advocacy] I want to know a little bit more about this kind of what I've been calling this menu of options. So, when you were doing this advocacy like one on one work, what we're kind of the things that you would say like this is your list of options. What were the things on that list?

    a. *Prompt:* What were the different types of things you would help her with?
    b. *Prompt:* When you had a woman come to you experiencing DV, how did you decide what things on the list to present or suggest as "I think one of these things is your best option"?
    c. *Prompt:* Organically responding to survivor's needs vs. standardized list of options.
3. [If did bigger level-advocacy] Once the DVPO laws were passed, what do you remember about how advocates were educated about DVPOs?
    a. *Prompt:* What were the different types of things advocates could help survivors with?
    b. *Prompt:* Organically responding to survivor's needs vs. standardized list of options.
4. How do you measure success of DVPOs?
5. What were some of the gaps or problems you think that there were with DVPOs? What about now?
6. Some people have told me their life experiences or identities, like their race or sexual orientation, influence the way they think about DVPOs. Do you feel that's true for you?
7. Now I want to switch gears a little and talk about ERPOs and clients who are at risk of harming themselves or someone else with a firearm specifically. What do you think about ERPOs?
8. There are starting to be efforts made to develop an ERPO navigator or advocator role, similar to how some DV advocates helped file DVPOs. What advice would you give to someone who was going to take on that role?
    a. *Prompt:* What advice would you give to the people trying to create that role and hire for it?

Appendix B: Interview Guide for Participants for Papers 2 and 4 (Focus Groups)

Introduction

Thank you for being willing to talk to me today. First, I would love to tell you a little more about the study and why I'm interested in this topic if that's okay?

I'm interested in how social workers, advocates, counselors work with clients at risk of harming themselves or others with a firearm. Some of my prior work has looked at how social workers are or want to be involved in Extreme Risk Protection Orders or ERPOs, which are a way to remove a firearm involuntarily. And now I'm also broadening that focus to incorporate more ways for these professionals to help advocate for firearm safety that are voluntary. Especially ways that don't necessarily involve the legal system.

Today I'm hoping we can all have a conversation about how you view your role in helping these clients, what kinds of resources you use when working with these folks, and also what kinds of resources you feel currently aren't available but that would be helpful.

Do you have any questions so far?

This interview will take about an hour and a half. I'll record this conversation just to be sure I'm hearing everything you're all telling me. No one will have access to this recording except the research team, and I'll make sure no one can be identified in the transcript of the interview or any reports and also be sure any of the organizations you work for can be identified. You can also decide to stop participating at any time or decide to skip a question if you don't want to answer.

The last thing is for transparency, I'm receiving funding from a grant sponsored by the National Institutes for Health (NIH).

Do you have any questions?

I'm going to start the recording now.

The first thing I'll do is have everyone introduce themselves and talk about what kind of practice they work for. You can use your real name or a pseudonym. I'll assign everyone a pseudonym in the transcript to help with confidentiality, so if you want to choose that now, you can definitely do that. When you introduce yourself, also give us a little information about the setting you practice in. You don't have to give specific names, but just something like "inpatient substance use" or something like that. So whoever wants to start, can you give us a name or pseudonym and what kind of setting you practice in?

1. Can you tell us about a recent time where you were working with a client at risk of harming themselves or someone else who you know had access to or plans to access a firearm?
    a. *Prompt:* How did you find out about their access to a firearm?
    b. *Prompt:* What did you do when you find out they could access a firearm?
2. Now I want to give you a couple of scenarios and have you tell me what you think you would do in this situation. These are examples I've come up with based on some of the

ERPOs I've read and some conversations I've had from social workers, but I'm using pseudonyms and changing some details to be sure things aren't identifiable.

   a. You are a social worker working in the Emergency Department. You're called to a patient's room where you meet James, who is a 32 year old Black man. He tells you that last night he got in an argument with his wife, Lizzie. She left and went to a friend's house to cool off, but he kept getting more and more upset after she left. He sent her some text messages saying things like, "Goodbye, you're going to get your wish," and "What's the point anyways?" Lizzie called the police, who brought James to the ED. You talk with James and he tells you even though he sent those texts, he really regretted sending them and didn't intend to harm himself. He lets you know he is thinking about at least temporarily surrendering the firearms in his home until things are more resolved with Lizzie just in case.
      i. What would you do?
      ii. *Prompt:* Would you contact law enforcement about an ERPO? Recommend Lizzie file an ERPO? Recommend voluntary removal?
   b. You have your own social work practice in a mostly rural area. Your client Jimmy, who is a 66-year old white man, has been coming to see you every other week since he attempted suicide six years ago after his wife died. He's been pretty isolated since his wife died, and pretty much his only social time is going hunting or target shooting with his friend, Stan. The anniversary of Jimmy's wife's death is coming up and he tells you he's been having suicidal thoughts. You ask a couple more probing questions and find out he has a plan (to use a firearm), but only passing ideation and not immediate intent. You ask him what he would think about asking his friend Stan hold on to his firearms for a while until he's feeling better. He doesn't agree because he's worried about what Stan would think if he admitted thinking about suicide. Plus he really likes hunting with Stan and doesn't want to stop that activity.
      i. What would you do?
      ii. *Prompt:* Would you contact law enforcement about an ERPO? Recommend voluntary removal?

3. One policy related to involuntary removal is Extreme Risk Protection Orders (or ERPOs). You all might or might not have heard of them, but basically someone can file a petition—similar to a DVPO or other protection order—that explains why someone should have their access to a firearm temporarily restricted. This person is usually experiencing some kind of acute crisis, like suicidal ideations or is threatening someone, but they have to be deemed to be at substantial and imminent risk of harming themselves or someone else with a firearm. A judge will decide if the order is appropriate, and if so, law enforcement will remove their firearms, and place them on a list so they can't buy a firearm. What are your reactions to this kind of law?
   a. *Prompt:* Would you feel willing to suggest a client file this involuntary removal petition for their loved one?
   b. *Prompt:* Would you feel willing to contact law enforcement for a client?
   c. *Prompt:* Would you fear retaliation from a client?
4. What resources do you use when you're trying to figure out how to work with clients at risk of harming themselves or someone else with a firearm?
5. What resources do you want to help you feel more confident working with these clients?

    a. *Prompt:* What specific components of a training program would be helpful?
6. What form would you want these resources to take?
    a. *Prompt:* A course for continuing education credits? An online toolkit? A website?
7. When I start to work on disseminating whatever resources I develop (e.g., training), who do I talk to? Where would you learn about a training or web page with resources?
8. As a social worker or advocate, what do you think your role is in addressing risk of harm for clients with a firearm who are in crisis?
    a. *Prompt:* In some of the research I've done I've found that a lot of times phyicians and ARNPs will say, "I don't have the expertise" or "I don't have the time" to talk about these firearm safety things. And that they would refer people to social work. What do you think about that?
9. Is there anything that I didn't ask you but that you think is important for me to know?

Appendix C: Survey Instrument for Paper 3

Title: Social Worker Resources to Prevent Firearm Injuries

Thank you for your interest in participating in this survey seeking to develop resources for social workers serving clients at risk of harming themselves or someone else with a firearm. Below is more information to help you decide if you would like to participate in this survey. If you have any questions, please contact the study lead, Kelsey Conrick (kmc621@uw.edu) or faculty adviser, Megan Moore (mm99@uw.edu).

Purpose of the Study

The goal of this study is to support social workers who serve clients at risk of harming themselves or someone else and have access to (or plans to access) a firearm. We are interested in your thoughts because of your clinical expertise with these clients. From your responses and conversations with other social workers, we hope to create educational materials that will support social workers as they work with these clients.

Eligibility

To be eligible for this study, you must:

- Have an active social work license in Washington State
- Serve clients who live in Washington State
- **In the last 5 years**, have worked with at least one client whom you thought may be at risk of **harming themselves or someone else**

Survey Content

This survey will ask about the following things:

- The setting you practice in (e.g., substance use, private practice) and they general types of clients you serve (e.g., children, older adults)
- How often you work with clients at risk of harming themselves or someone else
- If/when you assess clients for access to a firearm
- How you do or would support these clients in reducing access (if needed)
- What resources and policies you would like to be developed to support you in working with these clients

Confidentiality

Your responses to this survey are confidential.

Other Details

- At the end of the survey, you will be asked to provide your email address to be entered into a drawing to win one of five **$50 gift cards**.
- Participation in the survey is voluntary.
- You can decide to stop participating at any time or skip any question.
- You can ask questions before completing this survey by emailing Kelsey Conrick at kmc621@uw.edu

Survey text

KEY

[variable_name]

{survey logic instruction}

(Instruction to participant that will appear at the end of the question)

Page 1

- In the last 5 years, have you worked with at least 1 client who you thought was at risk of harming themselves or someone else? [incl_five_yrs]
    - 1, Yes
    - 0, No {STOP}
- In your social work practice, do you serve clients who live in Washington State? [incl_wa]
    - 1, Yes
    - 0, No {STOP}

Page 2

- In the past **12 months**, how often have you encountered a client who you believed may be at risk of **harming themselves**? [harm_self]
    - 1, Daily
    - 2, Weekly
    - 3, Monthly
    - 4, A few times a year
    - 5, Never
- In the past **12 months**, how often have you encountered a client who you believed may be at risk of **harming someone else**? [harm_other]
    - 1, Daily
    - 2, Weekly
    - 3, Monthly
    - 4, A few times a year
    - 5, Never

Page 3

- In the past **12 months**, have you asked at least one client about their access to a firearm? [access_ask]
    - 1, Yes
    - 0, No

- {If access_ask = 1} **How often** do you ask clients about their **access to a firearm**? *(Check all that apply)* [access_freq]
    - 1, Always
    - 2, Sometimes
    - 3, Rarely
    - 4, Never
- {If access_ask = 1} **When** do you assess a client for their **access to a firearm**? *(check all that apply)* [access_when]
    - 1, When I am worried about a client harming themselves
    - 2, When I am worried about a client harming someone else
    - 3, When a client brings up firearms
    - 4, Other
- {If access_when = 4} Please provide more information about when you assess clients for **access to a firearm**. [access_other]
- {If access_freq = 4} Why do you not ask clients about their **access to a firearm**? *(check all that apply)* [access_no]
    - 1, This is not relevant to my practice setting
    - 2, This is not relevant to the clients I serve
    - 3, I do not believe social workers should ask about firearm access
    - 4, I think my clients may react negatively to asking about their firearm access
    - 5, Another reason not listed here
- {If access_no = 5} If there is another reason you do not ask clients about their **access to a firearm** not listed above, please describe that here. [access_no_o]
- Does your workplace have a policy for **when to assess** clients for **access to firearms**? [access_work]
    - 1, Yes, a formal or written policy
    - 2, Yes, an unofficial policy
    - 0, No
- {If access_work = 0} Do you think your workplace <u>should</u> have a policy for **when to assess** clients for **access to firearms**? [access_should]
    - 1, Yes
    - 0, No

Page 4

- An extreme risk protection order (ERPO) is a civil (not criminal) court order that temporarily restricts access to firearms for an individual who is at substantial risk of harming themselves and/or others. In Washington, a household/family member or law enforcement officer completes a petition explaining to a judge why this individual should have their firearms taken and be prohibited from purchasing for one year. If granted, law enforcement removes firearms. Clinical staff, including social workers, can NOT complete this petition for a client, but you could recommend a client's family member or law enforcement file one. Before taking this survey, how familiar were you with extreme

risk protection orders in Washington State? (For example, what is an ERPO and who qualifies) [erpo_familiar]
    - 1, Very familiar
    - 2, Somewhat familiar
    - 3, Not at all familiar
- One way to reduce access to firearms is increasing the safety of in-home storage . There are many types of locking mechanisms, such as lockboxes, trigger locks, and cable locks. Some workplaces provide these locking devices at no-cost to clients. Does your workplace have access to free or low-cost firearm locking mechanisms (for example, lockboxes or trigger locks) you can provide to your clients? (If you have your own private practice and have never provided a firearm locking mechanism, select 'no') [work_locks]
    - 1, Yes
    - 0, No
    - 2, I'm not sure
- {If work_locks = 0,2} Would you find it helpful if you had access to free or low-cost firearm locking mechanisms you could provide to clients? [locks_help]
    - 1, Yes
    - 0, No
    - 2, I'm not sure
- Another way to reduce access to firearms is to store them out of the home. Below is the Washington Firearm Safe Storage Map, which is an interactive map of businesses (e.g., gun range) and law enforcement agencies who are willing to consider requests for temporary, voluntary firearm storage. Before taking this survey, how familiar were you with the Washington Firearm Safe Storage Map?
    - 1, Very familiar
    - 2, Somewhat familiar
    - 3, Not at all familiar

Page 5

Please read the below scenario and let us know how you would approach helping this client.

You are a case manager in a group behavioral health clinic. Jimmy is a 24-year old [randomized: white/Black] man. You have been working with him for the last 2 years.

History
- Two years ago, he was discharged from an inpatient behavioral health facility.
- He was under an involuntary 14-day hold following an episode of **severe paranoia** where he **threatened to harm a coworker**.
- Jimmy has been doing well since being discharged, has found stable employment and lives with his parents.

Present Day

- He lets you know that because **he stopped taking his medication about a month ago** because he has been doing well and is unhappy with some of the side effects.
- He tells you he thinks people are plotting to hurt him, so **he has been collecting weapons**, including a firearm.
- Jimmy has been having intermittent homicidal ideation, thinking about harming people.
- He does not express intent and does not describe a specific plan or name a specific person

- What would you do to help Jimmy? *(Check all that apply)* [case_1] {random order}
  - 1, Connect Jimmy with other community or mental health resources
  - 2, Contact law enforcement to suggest an Extreme Risk Protection Order
  - 3, Facilitate conversation between Jimmy and his parents to remove the firearm from Jimmy's access
  - 4, Give Jimmy a firearm locking mechanism, such as a trigger lock
  - 5, Recommend Jimmy lock up his firearm in his home
  - 6, Recommend Jimmy seek a place outside of his home to store his firearm, such as a gun range
  - 7, Contact a designated crisis responder to assess for involuntary hospitalization
  - 8, Create a safety plan (for example, who to call or where to go if Jimmy starts to think about harming others)
  - 9, Contact Jimmy's parents to suggest an Extreme Risk Protection Order
  - 10, Recommend voluntary hospitalization

- Please describe any other actions you would take that aren't included in the list above. [case_1_other] {open-ended}

Page 6

Please read the below scenario and let us know how you would approach helping this client.

You are a therapist in a small group private practice. Denise is a 29-year-old [randomized: white/Black] woman.

History

- Denise has a history of depression and alcohol use disorder.
- She lives with her long-term boyfriend of 10 years.
- She has been stable on antidepressants and has been sober for 5 years since she became pregnant with her first child.
- She recently started drinking again and temporarily lost custody of her two children after relapsing.

Present Day

- She tells you she feels shame and guilt for relapsing and for not being there for her children.
- You ask her about whether she has had suicidal ideation, and she says she thinks about it often.
- She says late last night, she started thinking that her kids would be better off without her, and got so upset that her boyfriend suggested calling you.
- You then ask her about means, and she says she has a firearm for protection because she lives in a dangerous neighborhood.
- Denise denies a specific plan or immediate intent.

What would you do to help Denise? *(Check all that apply)* [case_2] {random order}

- 1, Connect Denise with other community or mental health resources
- 2, Contact law enforcement to suggest an Extreme Risk Protection Order
- 3, Facilitate conversation between Denise and her boyfriend to remove the firearm from Denise's access
- 4, Give Denise a firearm locking mechanism, such as a trigger lock
- 5, Recommend Denise lock up his firearm in her home
- 6, Recommend Denise seek a place outside of her home to store his firearm, such as a gun range
- 7, Contact a designated crisis responder to assess for involuntary hospitalization
- 8, Create a safety plan (for example, who to call or where to go if Denise starts to think about harming herself)
- 9, Contact Denise's boyfriend to suggest an Extreme Risk Protection Order
- 10, Recommend voluntary hospitalization

- Please describe any other actions you would take that aren't included in the list above. [case_2_other] {open-ended}

Page 7

- Have you ever received training to work with clients to **reduce access to a firearm** when they are at risk of harming themselves or someone else? *(Check all that apply)* [education]
  - 1, Yes, in my MSW or BASW program
  - 2, Yes, in a seminar that I completed for Continuing Education Units
  - 3, Yes, in a seminar that I attended, but did not receive Continuing Education Units
  - 4, Yes, in another type of training I completed
  - 0, No
- {If education=1,2,3, or 4} Can you provide any details on the training you completed, such as the name, organization that sponsored, or the MSW/BASW class where you received the training? [education_details]

Page 8

- What are the ages of the clients you serve? *(Check all that apply)* [pract_age]
    - 1, Children and adolescents (<18)
    - 2, Young adults (18-24)
    - 3, Adults (25-65)
    - 4, Older adults (65+)
- Do your clients live in… [pract_rural]
    - 1. Mostly urban or suburban areas
    - 2, A mix of urban/suburban and rural areas
    - 3, Mostly rural areas
- Do you provide services… *(Check all that apply)* [pract_tele]
    - 1, In person
    - 2, Online or virtually
- Which of the following best describes your practice setting? [pract_type]
    - 1, Administration, policy, or research
    - 2, Adult protective services
    - 3, Child protective services
    - 4, Grassroots community organization
    - 5, Legal system
    - 6, Healthcare
    - 7, Mental health, psychiatric, and substance use
    - 8, Military and veterans
    - 9, Palliative care and hospice
    - 10, School social work
- Do you work in… [pract_size]
    - 1, A large hospital or organization (>50 employees)
    - 2, A small organization (10-49 employees)
    - 3, A group private practice (2-9 employees)
    - 4, An individual private practice
- How many years have you been practicing social work? [pract_years]
    - 1, 0-5 years
    - 2, 6-10 years
    - 3, 11-15 years
    - 4, 16-20 years
    - 5, 20 or more years

Page 9

- What is your race or ethnicity? [sw_race] *(Check all that apply)* {required}
    - 1, Asian
    - 2, Black, African American, or Afro-Caribbean
    - 3, Latin(x), Hispanic, or Indigenous Mexican, Central, or South American

    - 4, Native American, American Indian, or Alaska Native
    - 5, Native Hawaiian or Pacific Islander
    - 6, White
    - 7, Other
- Which of the following best describes your gender? *(Select one)* [sw_gender]
    - 1, Female or Woman
    - 2, Nonbinary
    - 3, Male or Man
    - 4, Trans
- How old are you? *(years)* [sw_age] {validate to whole integer 18-100}
- Do you personally own a firearm? [sw_own]
    - 1, Yes
    - 0, No
    - 3, Prefer not to answer

Appendix D: Disseminated Resources for Social Workers

Resource 1: Resource Page

FIREARM INJURY & POLICY
RESEARCH PROGRAM

UW Medicine

Resources for Social Workers to Prevent Firearm-Related Harm

Updated October 2023

Intervening to Prevent Firearm-Related Harm

Intervention options that could be included as part of a robust safety plan collaboratively developed with client:

- Recommend more secure storage of firearm in-home (e.g., lock firearm and ammunition separately)
- Give client a firearm locking mechanism (e.g., cable lock or lockbox)
- Work with client's family or friends to facilitate voluntary firearm removal
- Recommend voluntary, out-of-home community storage
- Recommend extreme risk protection order (ERPO)

Factors influencing recommendations

- **Client-specific factors**
  - Social and medical history
  - Ability to engage in collaborative safety planning
  - Values related to firearms
  - Risk for structural harm due to social identities (e.g., racism)
- **Social worker-specific factors**
  - Lived experiences
  - Workplace norms and policies
  - Morals and ethics

Types of Firearm Locking Mechanisms

Cable Lock

Lockbox

Gun Safe

Life Jacket

On the following page are resources, trainings, and more information about how social workers can support clients at risk of firearm-related harm. Links can be accessed via a virtual version of the flyer with this QR code.

SCHOOL OF SOCIAL WORK
UNIVERSITY of WASHINGTON

Encouraging Responsible Firearm Storage

- Lock To Live is an interactive website that helps you and your client build a tailored safety plan
- Washington State firearm safe storage map is an interactive map of gun shops, shooting ranges, and police stations willing to consider requests for temporary firearm storage
- Lock It Up (King County) is designed to educate health professionals on how to facilitate conversations with clients about firearm storage option.
- Children's of Wisconsin has a hand-out for parents on safe firearm storage after their child attempts suicide
- The American Academy of Pediatrics hosts a training on counseling about safe firearm storage

Extreme Risk Protection Orders

- Civil (not criminal) order that **temporarily** restricts the possession and purchase of firearms for an individual (called a respondent) if their behavior indicates they might be at **substantial risk of harming themselves and/or others**
- In Washington, only a **family/household member** or **law enforcement officer** may file an ERPO petition. As a social worker, you cannot file this petition for a client, but you could contact their family/household member or a law enforcement officer to suggest one
- The petition goes before a judge, who determines whether the respondent should have their firearm access temporarily restricted
- If approved, law enforcement enforces the ERPO by removing firearms from the respondent and places their name on a list to prohibit purchase
- This website describes the ERPO process in detail and answers FAQs for both petitioners and respondents

Voluntary Waiver of Firearm Rights (Do-Not-Sell) List

- Lets people voluntarily and confidentially restrict immediate access to firearm purchase
- Stops impulsive firearm purchasing at the time when someone is in crisis, and can be reversed by the individual
- Instructions on filing found here

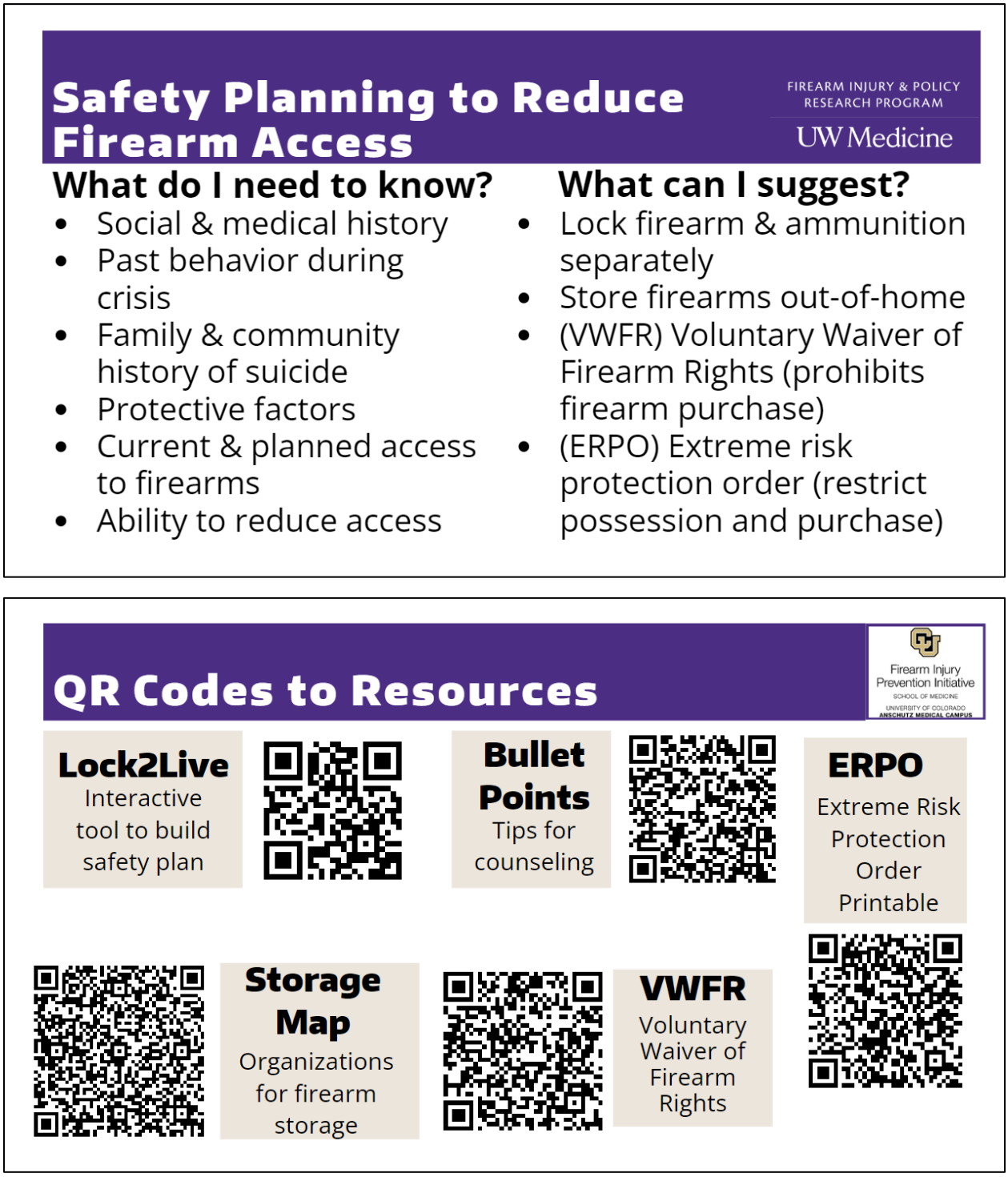
Selected Other Trainings and Resources for Clinicians

- The Joyce Foundation stores recorded webinars on intimate partner violence, equity issues, firearm ownership, and policy trends
- The University of Michigan Institute for Firearm Injury Prevention hosts a course on the science of firearm injury prevention among children and teens
- The BulletPoints Project has several clinical tools for preventing firearm injury

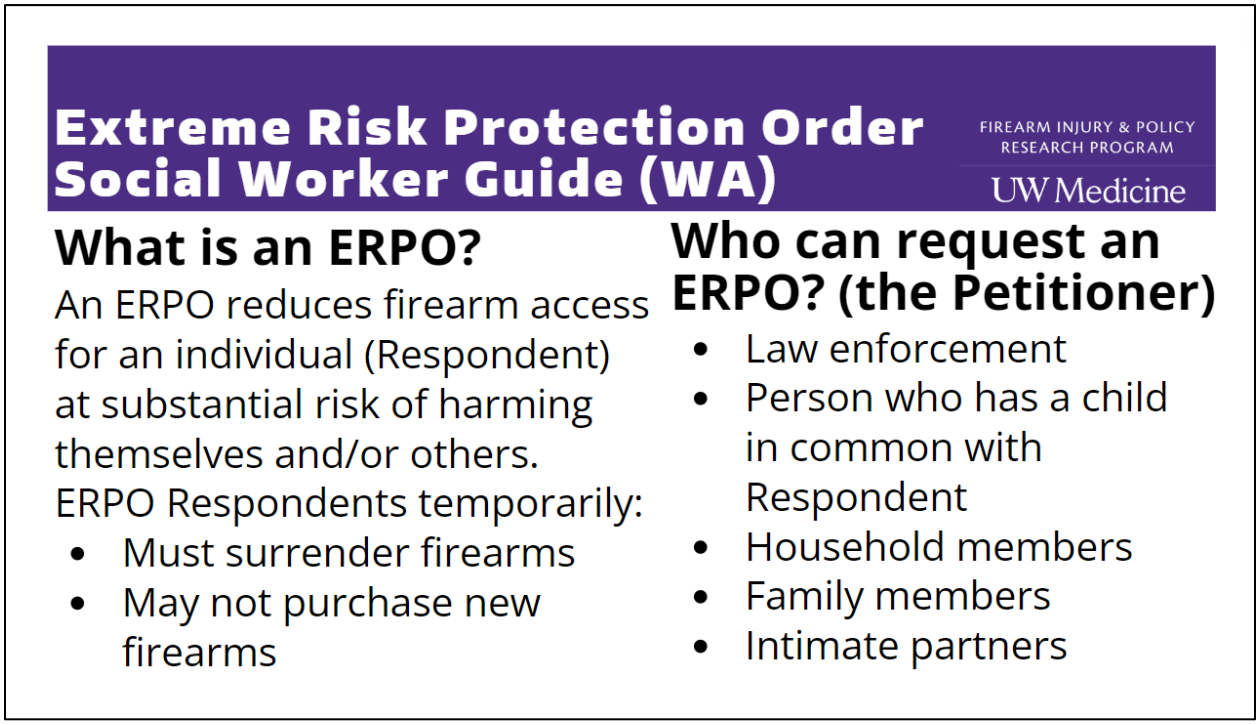
More Information

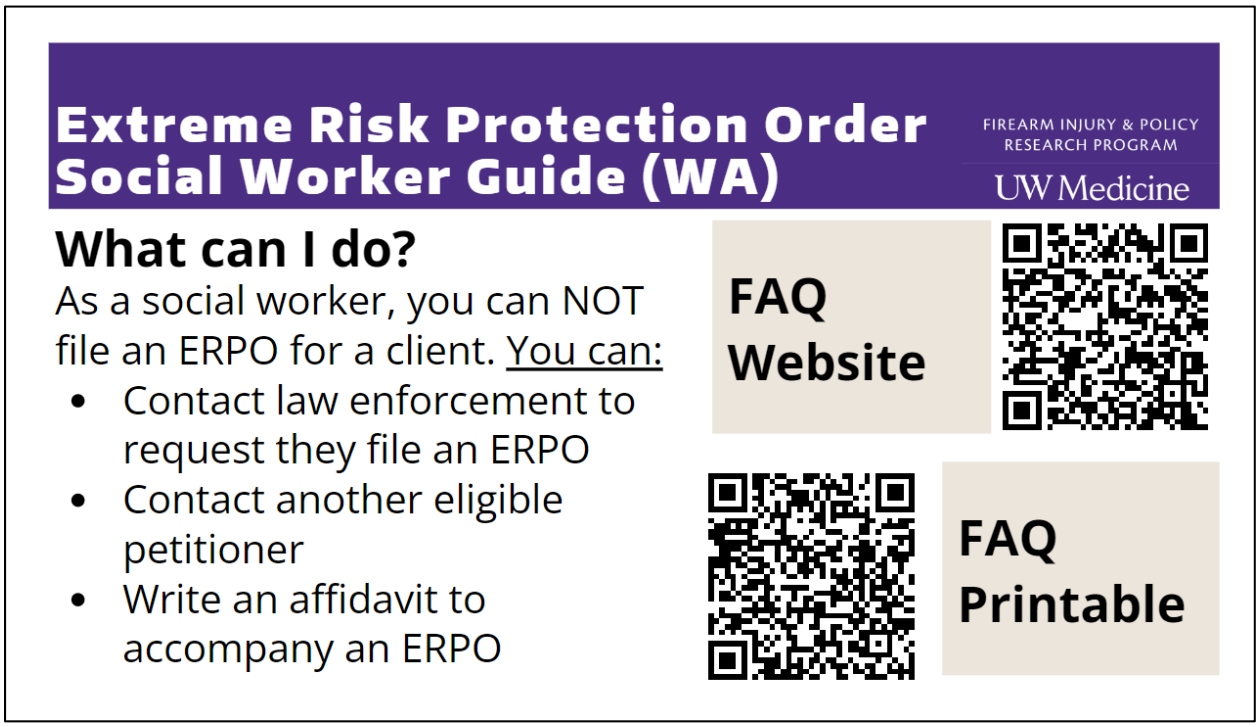
- For more information or to ask any questions, you can contact Kelsey Conrick (kmc621@uw.edu) or visit fiprp.uw.edu

Resource 2: Badge Tag with Resources



Resource 3: ERPO Badge Tag





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Wallin, M. A., Holliday, C. N., & Zeoli, A. M. (2021b). The Association of Federal and State-level Firearm Restriction Policies With Intimate Partner Homicide: A Re-analysis by Race of the Victim. *Journal of Interpersonal Violence*, 08862605211021988. https://doi.org/10.1177/08862605211021988

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Zwald, M. L., Holland, K. M., Bowen, D. A., Simon, T. R., Dahlberg, L. L., Stein, Z., Idaikkadar, N., & Mercy, J. A. (2022). Using the Centers for Disease Control and Prevention's National Syndromic Surveillance Program Data to Monitor Trends in US Emergency Department Visits for Firearm Injuries, 2018 to 2019. *Annals of Emergency Medicine*, *79*(5), 465–473. https://doi.org/10.1016/j.annemergmed.2022.01.016

Curriculum Vitae

Kelsey Conrick
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Email: kmc621@uw.edu
Website: https://sites.google.com/view/kelseyconrick/

EDUCATION

Expected March 2024 **Doctor of Philosophy, Social Welfare**
University of Washington, Seattle, Washington GPA: 3.96
Dissertation: *Equipping Social Workers to Prevent Disparities in Firearm-related Harm*
Committee: Megan Moore, PhD, MSW (Chair), Kalei Kanuha, PhD, MSW, Ali Rowhani-Rahbar, PhD, MD, MPH, Christopher St. Vil, PhD, MSW

2017 **Master of Public Health, Social and Behavioral Sciences**
University of Washington, Seattle, Washington GPA: 3.81
Thesis: *Homeless High Users of the Emergency Department: Understanding the Relationship Between Life Stress and Emergency Department Use*
Committee: Clarence Spigner, DrPH, MPH (Chair), Megan Moore, PhD, MSW

2015 **Bachelor of Arts, Cellular Biology (magna cum laude)**
Minor: Psychology
Huntingdon College, Montgomery, Alabama GPA: 3.85

PEER-REVIEWED PUBLICATIONS

Peer Reviewed Publications

1. **Conrick, K.M.,** McCollum, O., Porter, S.F., St. Vil, C., Kanuha, K., Rowhani-Rahbar, A., Moore, M. Association of Client and Provider Race with Approaches Pursued by Social Workers for Reducing Firearm Access. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-024-01934-0
2. **Conrick, K.M.,** Mills, B., Fuentes, M., Graves, J.M., St. Vil, C., Vavilala, M.S., Bulger, E.M., Arbabi, S., Rowhani-Rahbar, A., Moore, M. Identifying Common Data Elements to achieve injury-related health equity across the lifespan: A consensus-driven approach. *Health Equity. In press.*
3. Moore, M., Kempthorne, L., Fann, J.R., Shulein, O., Dams-O'Connor, K., Kajankova, M., **Conrick, K.M.,** Seeliger, J., Hoffman, J.M. Patient and Caregiver Satisfaction with Brain Injury Rehabilitation: Improving the Transition Experience (BRITE) Intervention. *Journal of Head Trauma Rehabilitation. In press.*
4. **Conrick, K.M.,** Mills, B., St. Vil, C., Dotolo, D., Bulger, E., Arbabi, S., Herrenkohl, M., Vavilala, M.S., Rowhani-Rahbar, A., Moore, M. (2023). Disparities in Misclassification of Race and Ethnicity in Electronic Medical Records among Patients with Traumatic

Injury. *Journal of Racial and Ethnic Health Disparities.* https://doi.org/10.1007/s40615-023-01783-3

5. **Conrick, K.M.,** Porter, S.F., Gause, E., Rowhani-Rahbar, A., Rivara, F.P., Moore, M. (2023) Integration of Extreme Risk Protection Orders into the Clinical Workflow: A Qualitative Comparison of Clinician Opinions. *PLoS ONE.* 18(12): e0288880. https://doi.org/10.1371/journal.pone.0288880
6. **Conrick, K.M.,** Mills, B., Solano, E., St. Vil, C., Dotolo, D., Bulger, E., Arbabi, S., Herrenkohl, M., Vavilala, M.S., Rowhani-Rahbar, A., Moore, M. (2023). Centering Patient Perspectives to Address Injury-related Health Equity in Trauma Registries. *Injury.* doi.org/10.1016/j.injury.2023.110847
7. **Conrick, K.M.,** Davis, A., Gibb, L., Bellenger, M.A., Rivara, F.P., Rowhani-Rahbar, A., Moore, M. (2023). Extreme Risk Protection Orders: Understanding the Role of Health Professionals. *Journal of the Society for Social Work and Research.* 14;2 185-552. doi.org/10.1086/714635
8. **Conrick, K.M.,** Gause, E., Rowhani-Rahbar, A., Rivara, F.P., Moore, M. (2023). Social Workers' Perspectives on Extreme Risk Protection Orders. *Social Work.* doi.org/10.1093/sw/swad012
9. **Conrick, K.M.,** Smith, M.B., Rooney, L., Morgan, E., Rowhani-Rahbar, A., Moore, M. (2023). Openness to Church-based Firearm Safety Interventions Among Protestant Christian Firearm Owners. *Public Health. 216*, 45-20, doi: 10.1016/j.puhe.2022.12.010.
10. Adhia, A., Ellyson, A.M., Mustafa, A., **Conrick, K.M.,** Kroshus, E. (2023). Barriers to Formally Reporting Sexual Violence among Undergraduate Student-Athletes. *Journal of Family Violence.* doi.org/10.1007/s10896-023-00564-0
11. **Conrick, K.M.,** Adhia, A., Ellyson, A., Haviland, M., Lyons, V.H., Mills, B., Rowhani-Rahbar, A. (2022) Race, Structural Racism, and Racial Disparities in Firearm Homicide Victimization. *Injury Prevention.* Published Online First: 23 December 2022. doi: 10.1136/ip-2022-044788
12. **Conrick, K.M.,** Mills, B., Mohamed, K., Bulger, E., Arbabi, S., St. Vil, C., Dotolo, D., Solano, E., Vavilala, M.S., Rowhani-Rahbar, A., Moore, M. (2022). Improving Trauma Data Collection and Abstraction to Assess Health Equity in Trauma Care. *Journal of Medical Systems.* 46, 21. Doi:10.1007/s10916-022-01804-4.
13. Gause, E., **Conrick, K.M.,** Moore, M., Rowhani-Rahbar, A., Rivara, F.P. (2022). Survey of Washington Clinicians' Willingness and Preferences Related to Extreme Risk Protection Orders for their Patients. *Preventive Medicine, 28*, 101883.
14. Prater, L., Rooney, L., Bowen, A.G., **Conrick, K.M.,** Mustafah, A., Bellenger, M.A., Moore, M., Rivara, F.P., Rowhani-Rahbar, A. (2022). Civilian Petitioners and Extreme Risk Protection Orders in the State of Washington. *Psychiatric Services.* Doi:10.1176/appi.ps.202100636
15. Philipson, E.B., Gause, E., **Conrick, K.M.,** Erickson, S., Muma, A., Liu, Z., Ayyagari, R.C., Vavilala, M.S. (2022). Concussion Symptoms & Temporary Accommodations Using a Student-Centered Return to Learn Care Plan. *Neuro Rehabilitation.* 49(4), 655-662. doi: 10.3233/NRE-210182.
16. Stadeli, K.M., Sonett, D., **Conrick, K.M.,** Moore, M., Riesenberg, M., Bulger, E.M., Meishcke, H., Vavilala, M.S. Emergency Medical Services Provider Perceptions of Pre-hospital Care for Patients with Limited English Proficiency. *JAMA Network Open.* 6(1):e2253364. Doi: 10.1001/jamanetworkopen.2022.53364.

17. **Conrick, K.M.**, Graves, J.M., Angell, L., Moore, M. (2021). Assessing Learning and Training Needs for Social Workers Working with Clients with Traumatic Brain Injury. *Journal of Social Work Education.* doi: 10.1080/10437797.2022.2039823
18. Rooney, L., **Conrick, K.M.,** Bellenger, M.A., Moore, M., Haviland, M.J., Rivara, F.P., Rowhani-Rahbar, A. (2021). Understanding the Process, Context, and Characteristics of Extreme Risk Protection Orders: A Statewide Study. *Journal of Health Care for the Poor and Underserved.* 32(4), 2125-2142. doi: 10.1353/hpu.2021.0186
19. Graves, J.M., Moore, M., Kehoe, L., Li, M., Chan, A., **Conrick, K.M.,** Vavilala, M.S. (2020). Family Hardship Following Youth Concussion: Beyond the Medical Bills. *J Ped Nurs.* 51, 15-20.
20. **Conrick, K.M.,** Moore, M., Abbotts, L., Widdice, L., Hoag, S., Kroshus, E., Philipson, E., Chrisman, S., Jinguji, T., Weiner, B., Glang, A., Rivara, F.P., Quitiquit Dickason, C., Vavilala, M.S. (2020). Community-Engaged Approach to the Development and Implementation of a Student-Centered Return to Learn Care Plan after Concussion. *J School Health.* 90(11), 842-848.
21. Stadeli, K.M., Abdullahi, D., Abdifatah, A., **Conrick, K.M.,** Paulsen, M., Bulger, E., Vavilala, M.S., Mohamed, F.B., Ali, A., Ibrahim, A. (2020). Working toward Equity in Emergencies through Stop the Bleed: A Pilot Collaborative Health Program with the Somali Community in Seattle. *Am J Surg*, 219(5), 759-763.
22. Mills, B., **Conrick, K.M.,** Anderson, S., Bailes, J., Boden, B.P., Conway, D., Ellis, J., Feld, F., Grant, M., Hainline, B., Henry, G., Herring, S., Hsu, W., Isakov, A., Lindley, T., McNamara, L., Mihalik, J.P., Neal, T., Parsons, J., Putukian, M., Rivara, F.P., Sills, A., Swartz, E., Vavilala, M.S., Courson, R. (2020). Consensus Recommendations on the Prehospital Care of the Injured Athlete with a Suspected Catastrophic Cervical Spine Injury. *Clin J Sport Med.* 30(4), 296-304. *Published simultaneously in J Athl Train*, 55(6), 563-572.
23. Moore, M., **Conrick, K.M.,** Reddy, A., Allen, A., Jaffe, C. (2019). From Their Perspective: The Connection between Life Stressors and Health Care Service Use Patterns of Homeless Frequent Users of the Emergency Department. *Health & Social Work*. 44(2), 113-122.
24. Moore, M., **Conrick, K.M.,** Fuentes, M., Rowhani-Rahbar, A., Patil, D., Ebel, B., Graves, J.M., Rivara, F.P., Vavilala, M.S. (2019). Research on Injury Disparities: A Scoping Review. *Health Equity.* 3(1), 504-511.

Under Review

1. Scheuer, H., **Conrick, K.M.,** Mills, B., St. Vil, C., Dotolo, D., Bulger, E., Arbabi, S., Solano, E. Vavilala, M.S., Rowhani-Rahbar, A., Moore, M. Utilizing Automated Modalities to Improve Post-Injury Follow-Up Survey Response. *Under review.*

OTHER PUBLICATIONS AND RESEARCH BRIEFS

1. Marts, E., **Conrick, K.M.,** Rowhani-Rahbar, A., Prater, L. (2023). Clinicians' Opinions on Extreme Risk Protection Orders in Washington State. [Research brief]. Available at: https://fiprp.uw.edu/research-briefs/clinicians-opinions-on-extreme-risk-protection-orders-in-washington-state/

2. **Conrick, K.M.,** Caouette, J.D., Steel, B., Rowhani-Rahbar, A., Kuklinski, M. (2023). Communities that Care Reduces Rural Adolescent Handgun Carrying. [Research brief]. Available at: https://depts.washington.edu/sdrg/research/research-briefs-and-issue-papers/
3. **Conrick, K.M.,** Mills, B., Fuentes, M., Graves, J.M., Bourgeois, C., Vavilala, M.S., Rowhani-Rahbar, A., Moore, M. Model of factors contributing to injury-related disparities and solutions to achieving injury-related health equity across the lifespan (iHeal). [Conceptual model]. Available at: https://hiprc.org/iheal-symposium/
4. **Conrick, K.M.,** Walker, L., Chrastil, J. (2016). Training Protocol for Clinic Based Organizing Relational Meetings. Industrial Areas Foundation NorthWest and Sound Alliance. [Unpublished Report].

SELECTED ACADEMIC PRESENTATIONS

1. **Conrick, K.M.,** McCollum, O., Porter, S.F., St. Vil, C., Kanuha, K., Rowhani-Rahbar, A., Moore, M. (2023, November 1-3). Equity Implications for Extreme Risk Protection Orders: Lessons Learned from Domestic Violence Protection Orders. [Conference session]. National Research Conference for the Prevention of Firearm-related Harms.
2. **Conrick, K.M.,** McCollum, O., Porter, S.F., St. Vil, C., Kanuha, K., Rowhani-Rahbar, A., Moore, M. (2023, November 1-3). Preventing Disparities in Firearm-related Harm: Preferred Roles of Clinical Social Workers. [Conference session]. National Research Conference for the Prevention of Firearm-related Harms.
3. **Conrick, K.M.** (2022, February 9). Policies, Resources, and Strategies for Social Workers to Reduce the Burden of Firearm Injuries. [Invited talk]. Washington State Society for Clinical Social Work.
4. **Conrick, K.M.,** Smith, M.B., Rooney, L., Morgan, E., Rowhani-Rahbar, A., Moore, M. (2022, March 30-April 1). Openness to Church-based Firearm Safety Interventions Among Protestant Christian Firearm Owners. [Poster presentation]. Society for the Advancement of Violence and Injury Research.
5. **Conrick, K.M.,** Adhia, A., Ellyson, A., Haviland, M., Lyons, V.H., Mills, B., Rowhani-Rahbar, A. (2022, March 30-April 1). "Race, Structural Racism, and Racial Disparities in Firearm Homicide Victimization." [Conference session]. Society for the Advancement of Violence and Injury Research.
6. **Conrick, K.M.,** Davis, A., Rooney, L., Bellenger, M.A., Rivara, F.P., Rowhani-Rahbar, A., Moore, M. (2021, April 5-9). "Extreme Risk Protection Orders: Understanding the Role of Health Professionals." [Conference session]. Society for the Advancement of Violence and Injury Research.
7. **Conrick, K.M.,** Graves, J.M., Angell, L., Moore, M. (2020, November 12-15). "Assessing Training Needs for Social Workers Serving Clients with Traumatic Brain Injury." [Conference session]. Council on Social Work Education.
8. **Conrick, K.M.**, Moore, M. (2020, September 15). "iHeal: Setting a Research Agenda and Improving Equity Data Collection." [Work in Progress Session]. Harborview Injury Prevention and Research Center.
9. **Conrick, K.M.** (2020, May 20). "Exploring Religiosity and Firearm Safety Behaviors." [Work in Progress Session]. Harborview Injury Prevention and Research Center.
10. **Conrick, K.M.,** Graves, J.G., Mills, B., St. Vil, C., Dotolo, D., Rowhani-Rahbar, A., Moore, M. (2020, April 27-29). "Patient-reported Outcome Measures Following Injury:

Cultural Incongruence with Diverse Populations" [Sub-session as part of symposium: "Developing Innovative Methods and Interdisciplinary Collaborations to Address the Challenges of Achieving Health Equity in the National trauma Healthcare System." [Symposium]. Society for the Advancement of Violence and Injury Research. (Conference canceled due to COVID-19).

11. Mills, B., **Conrick, K.M.,** St. Vil, C., Dotolo, D., Moore, M., Rowhani-Rahbar, A. (2020, April 27-29). "Discordance in Race and Ethnicity between Medical Record and Self-reported Data" [Conference session]. Society for the Advancement of Violence and Injury Research. (Conference canceled due to COVID-19). Published in *Injury Prevention* 26(Suppl 1), A32-A33.
12. **Conrick, K.M.,** Mills, B., Rivara, F.P., Vavilala, M.S. (2020, April 27-29). "Implications for Health Equity and Lessons Learned from a Community-Engaged Modified Delphi Process and Nominal Group Technique." [Conference session]. Society for the Advancement of Violence and Injury Research. (Conference canceled due to COVID-19). Published in *Injury Prevention* 26(Suppl 1), A16.
13. **Conrick, K.M.,** Mills, B., Mohamed, K., St. Vil, C., Rowhani-Rahbar, A., Moore, M. (2020, April 27-29). "Data Collection/Abstraction Process Improvements to Achieve Injury-related Health Equity in the National Trauma Healthcare System" [Conference session]. Society for the Advancement of Violence and Injury Research. (Conference canceled due to COVID-19). Published in *Injury Prevention* 26(Suppl 1), A35.
14. **Conrick, K.M.,** Moore, M., Fuentes, M., Rowhani-Rahbar, A., Patil, D., Ebel, B., Graves, J.M., Rivara, F.P., Vavilala, M.S. (2019, April 1-3). "A Decade of Research on Injury Disparities: A Scoping Review" [Conference session]. Society for the Advancement of Violence and Injury Research, Cincinnati, OH, United States.
15. **Conrick, K.M.,** Moore, M., Reddy, A., Allen, A., Jaffe, C. (2018, January 17-20). "On Death's Doorstep:" The Impact of a Crisis Moment on Service Use Patterns for Homeless Persons. [Conference session]. Society for Social Work and Research, San Francisco, CA, United States.
16. **Conrick, K.M.,** Walker, L., Chrastil, J., Edwards, T. (2017, April 27). "Training Protocol for Clinic Based Organizing Relational Meetings: Ensuring Replicability." Poster Presentation at University of Washington School of Public Health Practicum Symposium.

SELECTED MEDIA

1. Rivara, F.P. (Host). 2024, Feb 7. Integrating Extreme Risk Protection Orders (ERPOs) into Clinical Practice. [Audio podcast episode]. https://fiprp.uw.edu/podcast/.
2. Gomes, M. 2022, Nov 29. Preventing harm with firearm policy: An interview with TL1 trainee Kelsey Conrick. [web blog]. https://www.iths.org/news/an-interview-with-kelsey-conrick/.
3. McClure, R. J. (Host). 2022, June 9. Handguns, structural racism, and an intersectional framework: 3 student papers. [Audio podcast episode]. In *Injury Prevention.* https://podcasts.apple.com/gb/podcast/handguns-structural-racism-and-an/id942473946?i=1000565916369.
4. de Leon, A. (2022, April 5). Health equity in trauma care [web blog]. https://hiprc.org/blog/health-equity-in-trauma-care/.
5. Green, S. J., & O'Sullivan, J. (2021, June 1). Washington voters led much of the nation in saying guns must sometimes be seized to prevent violence. How's the law working?

Seattle Times. https://www.seattletimes.com/seattle-news/washington-was-at-the-forefront-of-a-gun-violence-prevention-law-heres-how-its-played-out/.

6. de Leon, A. (2021, April 19). Study focuses on clinicians' roles in extreme-risk petitions [web blog]. https://hiprc.org/blog/study-focuses-on-clinicians-roles-in-extreme-risk-petitions/.

FUNDING AWARDED

2023 University of Washington Presidential Dissertation Fellowship

2022-2023 TL1, Institute of Translational Health Sciences
"Equipping Social Workers to Prevent Disparities in Firearm-related Harm"

2021 Rivara Endowment Injury Research Grant, Inaugural Recipient
"Exploring Influences on Firearm Safety Behaviors"

PROFESSIONAL EXPERIENCE

2019-2020 **Pre-doctoral Research Assistant**
School of Social Work, Seattle, WA
Achieving Injury-related Health Equity across the Lifespan in the National Trauma Healthcare System

- Develop and oversee all research protocols, meeting agendas, and overall progress
- Train and supervise 7 undergraduate and graduate research assistants to recruit and conduct in-depth, semi-structured interviews with patients.
- Conduct inductive qualitative analysis of 239 patient interviews.
- Design multiple database systems in Excel, Access, and REDCap to maintain patient information.
- Prepare manuscripts for peer-reviewed publication

2018-2019 **Research Coordinator**
Harborview Injury Prevention and Research Center (HIPRC), Seattle, WA
Return to Learn after Concussion for Youth

- Develop evidence-based material to assist school personnel in facilitating Return to Learn for students after concussion
- Develop and refine implementation guide for schools to establish a protocol to assist students returning to the classroom after concussion
- Maintain multi-state network of Return to Learn stakeholders, including school personnel, district administrators, and Washington State Risk Management Pool
- Analyze data and prepare manuscripts for peer-reviewed publication

2018-2019 **Research Coordinator**
Harborview Injury Prevention and Research Center (HIPRC), Seattle, WA
Establishing Pre-Hospital Care Guidelines for the Spine-Injured Athlete

- Coordinate effort to use rigorous methods to develop a protocol for the pre-hospital care of athletes with suspected spine injury
- Conduct systematic review to assess the current state of knowledge of the care of athletes with suspected spine injury
- Conduct a Delphi process to build consensus among national stakeholders regarding athlete care, and present results to 20 national stakeholders in March 2019.
- Adapt guidelines for use across different sports and levels of play, from high school to professional athletes

2017-2019 **Research Coordinator**
Dr. Megan Moore, University of Washington School of Social Work
Various Projects
- Conduct systematic review of literature on disparities in physical injury
- Synthesize results of studies and prepare manuscripts

2017-2018 **Research Editor**
Harborview Injury Prevention and Research Center (HIPRC), Seattle, WA
Grant to Centers for Disease Control: Injury-related Health Equity Across the Lifespan
- Coordinated the design and writing of a large, multi-project grant to fund HIPRC's administrative, outreach, training, education, and research efforts
- Adapted communication style to communicate with more than 30 staff, administrators, and junior and senior faculty
- Coordinated with the UW Administrative Business Center's representative to ensure that all university and federal requirements were met
- Co-wrote and edited 100-page Research Strategy and all supporting documents

2017-2019 **Program Co-Director**
Harborview Injury Prevention and Research Center (HIPRC) , Seattle, WA
INSIGHT Summer Research Internship Program
- Supervised and mentored more than 100 interns over three years, ranging in age from high school to graduate students
- Developed a practice-based, adaptable learning curriculum based on the fundamentals of public health, communications, and outreach, and taught several lessons about these topics.
- Reviewed research work and deliverables of students, troubleshoot concerns, and provide feedback on the presentation of research
- Serve as liaison to faculty mentors and guest speakers, arrange calendars for seminars, plan final research symposium.

2017 **Research Assistant**
Dr. Megan Moore, University of Washington, School of Social Work, Seattle, WA

Injury-related Health Equity across the Lifespan National Symposium

- Researched and wrote extensive scoping review on the current state of injury disparities research and interventions to address these disparities
- Coordinated 25 senior and junior researchers providing guest speeches in injury prevention, acute care, and rehabilitation

2017 **Teaching Assistant for PSYCH 355: Cognitive Psychology (5 credits)**
University of Washington Department of Psychology
Spring Quarter

- Teaching Assistant for 120 undergraduate students
- Taught weekly sections to complete material not covered in lecture
- Graded weekly essay tests

2016 **Graduate Research Assistant (Intern)**
Dr. Megan Moore, Harborview Injury Prevention and Research Center (HIPRC) , Seattle, WA
Homeless High Users of the Emergency Department: Understanding Their Perspectives on Care and Service Access

- Researched and wrote literature review of the population characteristics of high users of the emergency department and interventions successful at reducing use.
- Conducted semi-structured, in-depth interviews with patients part of the Harborview High User Case Management Program
- Analyzed interviews using Dedoose and interpreted the results using grounded theory
- Constructed and finalized manuscript for publication

2016-2017 **Research Coordinator and Project Consultant**
Industrial Areas Foundation Northwest, Seattle, WA
Health Effects of Engaging Patients of Community Health Centers in Clinic-Based Organizing

- Researched and reviewed literature on the history of clinic-based organizing, patient activation measures, provider burnout, and patient/provider trust dynamics
- Formulated hypotheses and evaluation measures to address research question
- Completed IRB Human Subjects review application
- Developed training protocol for the evaluation of Clinic Based Organizing campaign
- Designed and carried out public health campaign on how stress affects the body, how to talk to your physician, and how to use social networks to combat stress

TEACHING EXPERIENCE

2021-2022 **SOC W 505/506: Research Methods for Social Workers (3 credits for 2 quarters)**
Pre-doctoral Sole Instructor, University of Washington School of Social work

- Sole instructor for 21 graduate students
- Created lesson plans
- Created and graded assignments
- Supported students in development and conduct of independent research study

2021 **SOC W 505/506: Research Methods for Social Workers (3 credits for 2 quarters)**
Pre-doctoral Teaching Assistant, University of Washington School of Social Work

- Teaching Assistant for 58 graduate students

2020 **SOC WF 402: Human Behavior and the Social Environment (5 credits)**
Pre-doctoral Teaching Assistant, University of Washington School of Social Work

- Teaching Assistant for 58 undergraduate students
- Graded weekly assignments

2016-2018 **UCONJ 624: Health Equity and Community Organizing (1 credit)**
Instructor, University of Washington Conjoint Courses
Fall (2016, 2017, 2018), Winter (2017) Quarters
Designed and modified curricula, taught major concepts in relational community organizing, recruited students to participate in Health Equity Circle and Sound Alliance campaigns.

2017 **PSYCH 355: Cognitive Psychology (5 credits)**
University of Washington Department of Psychology
Spring Quarter
Teaching Assistant for 120 undergraduate students; taught weekly sections to complete material not covered in lecture; graded weekly essay tests.

SERVICE

2023-	Co-Lead, Methods Team	Firearm Injury & Policy Research Program
2023-	Member, Dissemination Team	Firearm Injury & Policy Research Program
2021-	Students and Early Career Professionals Committee	Society for the Advancement of Violence and Injury Research [Co-chair for 2023-2025]
2021-2022	Elected Representative to Student Advisory Committee	University of Washington School of Social Work PhD Program

2021-2022	Elected Representative to Graduate Library Advisory Council	University of Washington School of Social Work PhD Program
2021-2022	Student Representative on the Board of Directors	Society for the Advancement of Violence and Injury Research
2021	Admissions Committee Application Reviewer	University of Washington School of Social Work Bachelor of Social Work Program
2020-2021	Increasing Equity in Work-In-Progress Sessions Committee	Harborview Injury Prevention & Research Center
2019-	Reviewer	*Journal of Health Care for the Poor and Underserved*
2021-	Reviewer	*JAMA Network Open*
2022-	Reviewer	*Journal for the Society of Social Work Research*
2023-	Reviewer	*Injury Prevention*
2023-	Reviewer	*Journal of Racial and Ethnic Health Disparities*

ACADEMIC AND OTHER HONORS

2023	Finalist, Best Student Science	Society for the Advancement of Violence and Injury Research
2022	Best Student Science Award	Society for the Advancement of Violence and Injury Research
2021	Brooks Webb Student Paper Award	Society for the Advancement of Violence and Injury Research
2020	Marsha S. Glazer Endowed Fellowship	University of Washington
2011-2015	Teague Scholarship	Huntingdon College
2015	Beta Beta Beta Award	Awarded to the most promising senior in Biology
2015	Alpha Beta	Awarded to the top 3% of the graduating class
2015	Sigma Sigma Sigma	Honors outstanding senior leaders
2014	Everrett Bishop Award	Awarded to the most promising junior in Biology
2014	Omicron Delta Kappa Honor Society	Honors outstanding leaders on campus for academics and extracurricular activities
2014	Beta Beta Beta Honor Society	Honors outstanding students of Biology
2014	Psi Chi Honor Society	Honors outstanding students of Psychology
2014	Gamma Sigma Alpha Honor Society	Honors Greek students above the all-Greek GPA
2013	Sigma Tau Delta Honor Society	Honors outstanding students of Psychology
2014-2015	Chief Justice of College Judicial Board	