Chapter 7
Fighting Gun Violence from the Doctor's Office

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Abbreviations

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACP	American College of Physicians
ASK	Asking Saves Kids
CHAM CAREs	Children's Hospital of Montefiore Clinical, Academic, Research and Education
CHAM	Children's Hospital of Montefiore
EHR	Electronic Health Record
HIPAA	Health Insurance Portability and Accountability Act
NRA	National Rifle Association
STAR	Straight Talk about Risks
TIPP	The Injury Prevention Program

Introduction

When we first sat down to work on this chapter we had two competing thoughts about the topic: we are passionate about protecting children from the gun epidemic, but are we best suited to write this as pediatricians working in New York City, where registered gun ownership is low? Practicing in the Bronx for the last 14 years (J.P.) and 3 years (O.M.), we have become acutely aware that violence affects too many of our patients—from bullying to emotional, physical, sexual abuse and domestic

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N. A. Dodson (ed.), *Adolescent Gun Violence Prevention*,
https://doi.org/10.1007/978-3-030-84710-4_7

violence. But over our nearly two decades of combined experience as pediatricians, we have directly cared for very few patients injured by gun violence. More recently, since we have begun to routinely screen for guns in the home, generally the families that report ownership are those that work in law enforcement. However, a study done on our inpatient units revealed that 61% of patients hear gunshots in their community [2], and a teenage patient shared with us how easy it is to access shared guns stored outside of his home. There is no regionality to the dangers of the gun epidemic; in the United States, regardless of where you live, guns affect our youth and their communities. As our nation struggles to figure out how to address this epidemic, we hope to illuminate a few strategies to help empower pediatricians to start the conversation with our patients.

What Do Patients and Families Want?

Parents typically underestimate the likelihood of their children handling a gun. A survey of parents in 2003 showed that, when asked what their children would do if they found a gun, the vast majority of parents predicted that their children could be trusted to act responsibly (i.e., leave the area, tell an adult, or leave the gun alone). Only 13% of parents predicted their child would touch the gun (to bring it to an adult, to remove it, to examine it, or to play with it) [3]. In another study, almost half of all gun owners believed that children 6 years old or younger could distinguish between real and toy guns. However, when groups of school-aged boys were observed in a controlled environment with both a hidden toy gun and a real unloaded gun, over 70% of the groups discovered the real handgun and handled it, and at least one member in half of the groups pulled the trigger. Only half of the boys who found the handgun thought it was a toy or were unsure whether it was real. Almost all of the boys who handled the gun or pulled the trigger reported previous gun safety instruction, and boys who were perceived by their parents as having "little" or "no" interest in guns were just as likely to handle the gun as those who were thought to have more of an interest [4]. This landmark study and its chilling results (in which children pointed a real gun at each other and at themselves, sometimes pulling the trigger) shows that children cannot be entrusted to act responsibly around guns; rather, the responsibility is for parents to ensure that children do not gain access to guns.

Providers also underestimate families' exposures to firearms. When asked to predict the likelihood of gun ownership of specific families, pediatricians incorrectly predicted "no ownership" for one-third of families that disclosed owning a gun. This makes physician estimates of gun ownership only 65% sensitive [5]. Further, adherence to other good safety practices, such as childproofing the home and using car seats, has not been associated with safe firearm storage practices or an absence of handguns from homes [6].

With this in mind, it is important to assess our personal biases as providers, and to recognize that no family or community is immune to gun violence. Counseling

about firearm safety should be as ubiquitous as discussions about safe sleep, child-proofing, and other safety practices. However, the hesitation remains: do parents want this sensitive topic to be addressed by their pediatricians, and are physicians equipped to provide this counseling?

Time and again, parents have answered affirmatively that they want firearm safety information from their pediatrician. A study in Maryland in the 1990s found that a majority of the surveyed gun owners reported they would be likely to follow their pediatrician's advice about gun storage, except for the recommendation to remove guns from the home [7]. A 1993 series of focus groups done in pediatric urban clinics in Seattle again found that parents appreciated safety advice from their pediatricians, especially if the provider combined it with an interest in the family's personal situation [7]. In a related survey given out in the same clinics, only 11% of parents reported having received firearm injury prevention counseling from their pediatrician. Yet almost half would follow the doctor's advice to not have a gun in the home and another third would consider the advice. Only 3% would ignore the doctor's counsel and another 3% would be offended by it [7]. In a much more recent study published in 2016, over a thousand families were surveyed amongst clinics in St. Louis, Missouri and it was similarly found that only 13% of parents had been asked by their pediatrician about household firearms. However, 75% of these parents thought that pediatricians should be talking about safe storage, and only a slightly lower percentage (66%) thought they should also be asking about gun possession [1].

Like parents, adolescents and young adults generally have a favorable view of physician-led violence counseling, particularly with providers with whom they feel comfortable. A study of teen and young adult Black male patients (one of the groups most often victimized by gun violence) found that over 80% who received brief violence counseling felt it was important for physicians to talk to them about gun violence. On post-visit surveys, the discussion about firearms was well received and recalled more than any other preventive medicine issue discussed [8]. A survey of New York City high school students found that, while almost half of all teens thought it was okay for anyone to have a gun, only 12% had felt the need to talk to an adult about guns and even fewer listed their physician as this adult (and only 6% had ever been counseled on the topic by a physician). Interestingly, over 60% of teens would discuss the issue with a physician if asked [9]. Notably, teens in Rhode Island who had personal experiences with, or close contacts affected by violence felt that, while violence played a large role in their lives, few would openly discuss violence and safety with their primary care providers. Common explanations included a perceived lack of interest on the part of the physician and a perceived lack of the physician's ability to effect change. However, participants felt they would be more willing to discuss these issues with empathetic and compassionate providers with whom they had a relationship [10].

These data remind us of the importance of the physician-patient relationship and the unique position that we have as pediatricians. Ours is a field with an inherent continuity of care that allows us to establish strong ties with our families as both invested caregivers and as health experts whom they rely upon for information on a

wide array of topics. This is the foundation upon which we are able to provide anticipatory guidance, and it is to our advantage to use this relationship to advocate for improved safety in our patients' lives. The onus lies with us to identify firearm safety as an important topic for patients and families, and to lead the discussion.

Barriers to Counseling

Despite acknowledging the importance of counseling, few pediatricians routinely provide firearm safety counseling to their families. When surveyed, 75% of pediatricians felt it was their responsibility to counsel patients about firearms, but only 20–30% had ever counseled or screened for firearm access [11–14]. Similar trends are seen amongst our adult colleagues, with over 50% of internists surveyed having ever asked about gun ownership and over 75% having never counseled on the risks, even though most agree that it is their responsibility [15].

One important and commonly cited barrier to counseling is a lack of education on firearm safety. In a national survey of U.S. pediatric residency programs, only one third of programs offered residents formal training on firearm safety counseling. In another survey, over 75% of pediatric residents and 80% of attending practitioners rated their firearm safety training as "inadequate." In that same study, approximately half of surveyed residents believed their clinics lacked educational materials for patients, and those who felt less comfortable and less effective in their counseling skills reported a lower likelihood to routinely counsel their patients. Yet, 99% of the residents surveyed believed that it is a pediatrician's responsibility to counsel families about the safety risks associated with gun ownership [16]. This sentiment is reiterated in more recent resident surveys, where 20–60% of residents reported "never" counseling on firearm safety due to a lack of familiarity with the topic despite its importance to their patients [17, 18]. Other specialties cite a similar lack of training and materials: only 20% of surveyed psychiatric residency programs [19] and 25% of preventive medicine residencies [20] include some form of formal firearm counseling training.

Following, we will address some barriers by reviewing medical associations' published policies and recommendations for firearm counseling; examine the legal issues surrounding gun safety discussions; and offer strategies and resources available to guide practitioners. Our hope is that by doing so, our readers will recognize that firearm safety counseling can be feasibly incorporated into routine clinic visits.

Policies and Laws

The American Academy of Pediatrics' (AAP) policy, "Firearm-Related Injuries Affecting the Pediatric Population" was originally published in 1992 and most recently updated in 2012. Their recommendations are summarized below:

1. The most effective measure to prevent suicide, homicide and unintentional firearm-related injuries is to remove guns from homes and communities.
2. Inform parents: counsel them about the dangers of children and adolescents having access to guns inside and outside the home. Ask about the presence of guns in homes, and counsel on safe storage. Reiterate to parents of teens that the presence of guns in the home increases the risk of fatal suicidal acts and reinforce the removal of guns and restricted access for patients with mood disorders and substance abuse issues. Remind families that the safest home is one without a firearm.
3. Guns should be subject to consumer product regulation regarding child access, safety and design.
4. Funding should be provided for research related to firearm injury prevention.
5. Education should be provided for physicians and other professionals interested in understanding the effects of firearms and how to reduce the morbidity and mortality associated with their use [21].

Despite this policy, controversy ensued in 2011 when the Florida Legislature heard of a pediatrician reportedly asking a mother to find a new doctor for her child after she refused to disclose firearm ownership in her home. Based on this and 5 more anecdotal reports of "unwelcome questions" or "improper comments regarding ownership of firearms", Florida enacted the "Firearm Owners' Privacy Act" (FOPA), colloquially known as the physician gag law. This law was meant to "subject health care practitioners to possible sanctions, including fines and loss of their license, if they discussed or recorded information in a patient's chart about firearm safety that a medical board later determined was not 'relevant' or was 'unnecessarily harassing'" [22]. After multiple appeals, the law was finally found to be unconstitutional in 2017 and was revoked.

In response to the gag laws, seven professional physician societies, including the AAP, American Academy of Family Physicians (AFP), American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians (ACP), American College of Surgeons, and American Psychiatric Association, with the help of the American Public Health Association and the American Bar Association, authored a collaborative policy statement regarding gun violence in 2015 [23]. Their joint position was reaffirmed in their 2019 statement [24]. Amongst their many calls to actions they write: "Conversations about mitigating health risks are a natural part of the patient–physician relationship. Because of this, our organizations oppose state and federal mandates that interfere with physicians' right to free speech and the patient–physician relationship, including laws that forbid physicians from discussing a patient's firearm ownership. Patient education using a public health approach will be required to lower the incidence of firearm injury in the United States" [24].

Since 2011, fourteen other states have tried to pass similar laws, none with success. Dr. Rathore expresses it clearly: "It is of paramount importance that determination of the content of patient-physician conversations remains outside the halls of

politics and legislatures and in physicians' offices. Optimal health care can only be delivered when physicians and patients feel free to discuss relevant issues openly" [25]. Even without becoming law, proposed gag laws may have created a "chilling effect" that will discourage firearm safety counseling. Physicians may incorrectly believe that their state has a gag law, or they may be uncertain whether a gag law exists and decide not to take the chance. It is important for all health providers to know, unequivocally, that as of 2021 their right to ask and counsel about gun safety practices is protected in all 50 states and the District of Columbia.

Although the studies are limited in number, data shows that pediatricians want to discuss gun safety and that the majority of families are ready to listen. Furthermore, the leadership of the largest physician professional societies assert that "[physicians] have a special responsibility and obligation to our patients to speak out on prevention of firearm-related injuries and deaths, just as we have spoken out on other critical public health issues" [24].

Extreme Risk Protection Order Laws ("Red Flag" Laws)

While there are currently no gag laws in any state preventing firearm counseling as it pertains to the health of a patient, there are laws that affect patient-physician confidentiality. As local and state laws vary widely, it is prudent for providers to familiarize themselves with the regulations in their area. Most states maintain the minimum federal levels for reporting persons deemed "medically unfit" to purchase firearms.

The shooter in the 2018 massacre at Marjorie Stoneman Douglas High School in Parkland, Florida, had alarmed many people with his violent words and social media posts; yet, the police had no cause to remove his guns because he had not yet committed a crime. In the wake of this shooting, many states considered and passed Extreme Risk Protection Order (ERPO) laws, or "Red Flag" laws, which allow law enforcement to remove the guns from the home of someone that a judge deems to be a danger to themselves or others. Although physicians typically do not file ERPOs, we can make patients aware of the laws in our state, and help them navigate the filing of an ERPO. For example, pediatricians could counsel a mother who disclosed that their partner was abusive and armed; or the parents of a young adult if they had concerns about suicidality. ERPO laws vary by state [26]; the Giffords Law Center to Prevent Gun Violence provides up-to-date state-specific information on ERPO laws at https://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/extreme-risk-protection-orders/#state. It is important to understand your state's reporting requirements and how they interact with federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules. At our academic medical center, we educated the division of pediatric social workers on ERPO laws so that they would be able to help patients navigate the filing of such an order if the need arose.

Approaches to Gun Violence Counseling

The positive impact of physician-initiated firearm safety counseling on families' gun storage habits is well documented. Results of randomized control trials have shown that brief physician counseling directed at parents, when combined with the distribution of gun storage devices, can be effective in promoting safer storage of firearms in homes with children [27–29]. In one study, over half of families with guns in their households who received verbal and/or written safety information made safe changes in their gun storage practices (and 12% removed the guns altogether) when compared to the control group [30]. In another study, similar changes in gun safety practices were seen among families who received gun safety counseling and a free gun lock in their pediatrician's clinic. And of those who kept guns in their household, 50% of the intervention group showed sustained improvements in gun storage habits on follow-up visits [31].

Although gun avoidance programs (such as the National Rifle Association [NRA]'s Eddie Eagle and the Straight Talk About Risks [STAR] program) have been developed to educate children about the risks of firearms, studies suggest that these programs do not prevent risky behaviors and may even increase gun handling among children [32–34]. Instead, appropriate modeling and reinforcement of safe behaviors by caregivers is important in establishing good safety practices.

Therefore, rather than focusing on child behaviors, providers should direct their counseling towards parents and encourage caregivers to, ideally, remove all firearms from the home, or barring this, store firearms safely. To store firearms safely, families must keep all guns locked up and unloaded, and stored separately from ammunition. A multisite study found that keeping a gun (including handguns, rifles, and shotguns) locked and keeping a gun unloaded reduced the risk of both unintentional injury and suicide in children and teens by 73% and 70%, respectively [35].

Only eight states require safety training as a prerequisite for gun ownership, and there is no federal requirement [36]. While organizations like the NRA and local gun clubs may provide firearm safety training, there is little data available regarding the efficacy of these programs or their popularity among gun owners. Research does show, however, that safety information is rarely provided at the time of most gun purchases [37]. This stands in contrast to the vast majority of adults and children in the U.S. who have contact with a healthcare provider annually (over 80% and 90% respectively), with over 50% being primary care visits [38]. This exposure provides ample opportunity for physician-initiated safety counseling, which might reach individuals who would not otherwise receive training or safety information.

Resources & Strategies for Counseling

Over recent years, the public discussion around gun violence has shifted away from the interpretation of the Second Amendment of the U.S. Constitution and has started to reframe the debate about gun policies to focus on the safety of children and adolescents. This change in rhetoric aligns with our concerns as pediatricians and advocates, and presents a way to engage our patients' families in a dialogue about gun safety. By framing firearm safety as a public and personal health issue, much like car seat use, infant safe sleep, and secondhand smoke exposure, clinicians can create a framework for consistent and unbiased patient screening and counseling.

As pediatricians, we are trained to provide anticipatory guidance and education regarding injury prevention on a multitude of topics as part of our regular clinical work, and firearm safety should be no exception. Familiarity with guns and/or their use should not be seen as a prerequisite to providing effective counseling on gun safety and the associated health risks. Non-gun owning pediatricians should feel just as comfortable as gun-owning pediatricians in discussing this topic with patients. There are many resources available to the general practitioner to help begin the conversation about firearm safety and to provide information for families, including locally and nationally endorsed programs. Developing a clinic workflow by utilizing pre-visit questionnaires or Electronic Health Record (EHR) prompts to document screening results can help create a consistent system for discussing firearm safety with families and help to de-stigmatize the topic.

The Developmental Approach to Firearm Safety Counseling

A developmentally appropriate and age-oriented approach can make firearm safety counseling a routine part of every well-child visit. Rather than risk-stratifying families based on the presence of household guns, diagnoses (e.g., depression, substance use), or individual characteristics of the child, taking a universal approach with every visit helps reinforce to both the provider and the family that this is a routine safety issue meant to be discussed as importantly as safe sleep and emotional health. Parental focus groups have shown that families are receptive to firearm safety counseling when it is presented in a relevant context and in a nonjudgmental manner which supports parents' rights to make informed decisions about the well-being of their children [39].

By tailoring our counseling to the developmental age of our patients, we can provide families with timely and practical recommendations that they can implement to improve their household's safety. It also creates an accessible script for providers during the visit that can be updated as patients mature, and incorporates the topic longitudinally into visits' anticipatory guidance. In our practice, we divide patients into the following categories, based on age and developmental milestones: newborns, infants and toddlers, school-aged children, and teenagers and young adults (Table 7.1).

Table 7.1 Developmentally targeted approaches to firearm safety counseling

Ages & Stages	How to Incorporate Counseling	Helpful Facts for Families
Newborn	Use ACES screening to ask about parent's childhood experiences with guns Ex: "Did your family own a gun while you were growing up? Do you know anyone who has ever been shot?" Focus on the newborn period as a time to create the safest home possible for the future	The presence of a firearm in the home increases the risk of all types of gun violence (including suicide, homicide, and unintentional shootings) [40–43] Children exposed to gun violence have an increased risk of mental health diseases (posttraumatic stress disorder, depression, and anxiety), poor school performance, and an increased risk of substance use and criminal activity as they grow older [44–48]
Infant & Toddler	Include in the baby-proofing and household safety discussion Ex: "Now that your baby is learning to stand and move, it is very important that dangerous items, such as household cleaners and guns, be locked away safely. All guns should be unloaded and locked away, and the ammo should be separate"	A child as young as three years old has enough strength to pull the trigger of a handgun [49] 70% of unintentional shootings happen in a home with a family-owned gun [50, 51]
School-aged	Educate and encourage parents to ask about firearms (and their storage) in others' homes Ex: "Does your child spend time in places outside your home? Do you feel comfortable asking about guns in those places with the rest of your safety questions?"	Up to 75% of children aged 5 and older who live in a home with a gun know where it is stored, even if parents have never shown them, and up to one-third of children have handled a gun at some point [52]
Teenager & Young Adult	Use the confidential history to assess personal and peer behaviors, concerns about safety, and to educate about firearm safety Ex: "Are you ever worried about your safety? Do you ever carry a weapon for protection? Do you know where to get a gun if you wanted one?"	Gun violence often occurs within known social groups, rather than strangers [58] Gun violence is the leading cause of death for children and teens [59]
Parents of teen	Discuss the elevated risk of violence when guns are present in the home, and formulate safety plans for critical moments Ex: "What would you do, or who would you call, if you had thoughts about hurting yourself? What would you do if you were in a situation where you felt worried about your safety?"	The presence of a gun can increase household risk of suicide by 300% [55–57] Gun suicides have an 85% success rate (the highest mortality of any method) [55–57] 85% of child and teen firearm suicides involve a gun belonging to a family member [54] Moments of suicidal thinking happen to teens even if they don't have a history of mental health issues

We find the newborn period a time when parents are very enthusiastic and receptive to safety information. Combined with the frequent visits in the first months of their baby's life, this is an opportune time to begin the conversation about firearm safety. Safe storage practices can be incorporated into the "baby-proofing" discussion about household safety. Parents should be reminded that before they know it, their tiny swaddled newborn will be a toddler constantly on the move.

Parental exposure to gun violence can be incorporated into the Adverse Childhood Events (ACEs) screening or the family medical, psychiatric, or social history. This can give way to a discussion about how the presence of a firearm in the home increases the risk of all types of gun violence (including suicide, homicide, and unintentional shootings) [40–43] and the profound impact exposure to this violence has on a growing child's mental health (including an increased risk of mental health diseases such as posttraumatic stress disorder, depression and anxiety, poor school performance, and an increased risk of substance use and criminal activity) [44–48].

The gross motor developmental milestones of the infant and toddler age groups, such as grasping, crawling, and walking, present a well-known and justifiable parental concern for safety. Capitalizing on this, recommendations for safe firearm storage should be included with other recommendations for securing dangerous household items, such as medications, cleaners, stairs, and pools. We find it helpful to point out the child's developmental milestones, and use it to create a scenario for parents. For example, a toddler who has just started to crawl or walk can now access a cabinet where a gun may be stored. A reminder that abstract thought, and therefore the notion of consequences, is not yet developed, is also helpful for parents to understand that toddlers cannot comprehend rules or dangers, no matter how well-intentioned. The sobering fact that a child as young as 3 years old has enough strength to pull the trigger of a handgun [49], and that 70% of unintentional shootings happen in a home [50, 51], also puts the danger into context.

Addressing firearm safety in the school-aged group requires a shift in counseling as children become more independent. While the focus of our counseling remains safe storage practices, ensuring safety in spaces outside the home now needs to be addressed. Parental modeling of good safety practices is paramount, as up to 75% of children aged 5 and older who live in a home with a gun know where it is stored, even if parents have never shown them, and up to one-third of children have handled a gun at some point [52]. When thinking of safety outside the home, it is fundamental that we encourage parents to ask about the presence of firearms in others' homes in addition to the rest of their safety evaluation (such as supervision, pets, and allergens).

The Asking Saves Kids (ASK) campaign from the AAP and the Brady Campaign to Prevent Gun Violence promotes a universal approach to asking about household gun safety for all ages, regardless of gun ownership status. It provides helpful resources and tips for navigating the conversation with family, friends, household members, and more (Table 7.2). While parents should always ask about the presence of guns in households where their children visit (including family, friends, and neighbors), the ASK Campaign encourages all individuals to ask whenever planning to spend time in another's home. This includes young adults moving into

Table 7.2 Tips for asking about firearms in others' homes

Use text or email because it's easier to ask awkward questions that way Ask as a three-part question Offer information about your own house first Lump the question with other safety questions (supervision, pets, allergies, pools, etc) Acknowledge the awkwardness of the topic. Don't be confrontational Save the question as a "note" in your phone so you can quickly paste it into a text with other parents Sharing statistics when you ask can put the question into context Asking many people, often, helps practice the question. Ask family, friends, neighbors, hosts, and anyone else you visit	"Do you have a gun? Is it secured? Is it stored separately from the ammunition?" "We have a gun at home that's stored in a locked safe away from the ammo. How do you store yours, if you have one?" "This is always awkward, but I took a pledge that I would always ask/tell about unsecured guns whenever my children go to someone else's house. We don't have any guns in our home. Do you have any, and if so, how are they stored?" "Did you know that 46% of gun owners don't lock up their guns? So I always ask about guns in the house when we visit. Do you have one, and how do you store it?"
Visit the asking saves kids (ASK) campaign at https://www.bradyunited.org/program/end-family-fire/asking-saves-kids for more tips	

dorms or group homes, teens taking a babysitting job, and when a new member joins a household (such as elderly family members). One recommendation is to acknowledge the topic as uncomfortable but necessary (e.g., "My child is very curious and I am paranoid about their safety, so I always ask if there are any unlocked guns in the house?") This can avoid a confrontational tone. It can also be easier to ask through text or email. Utilizing the ASK campaign can be an effective way to teach families how to approach the topic. A 2017 study that showed that almost 85% of parents who received verbal and written educational information about ASKing from their pediatrician felt both more comfortable and more willing to ask about the presence of guns in spaces where their children play [53]. The ASK Campaign is a pragmatic resource that pediatricians and families can use to implement firearm safety into their daily living.

As teenagers and young adults become even more independent, we find it helpful to have separate approaches for parents and teens. When discussing firearm safety with parents, the focus is on household and individual safety, specifically as it relates to homicide and suicide. It is helpful to frame the discussion around the socio-emotional development of the teen. During this time, when peer groups and interpersonal relationships are more influential than parents, and impulsivity is common, a moment of emotional vulnerability can quickly become a tragedy when there is a gun in the home, regardless of psychopathology [54]. Highlighting that the presence of a gun can increase household risk of suicide by 300%, and that gun suicides have an 85% success rate (the highest mortality of any method) [55–57], can underscore the danger for parents and teens. Another fact that we find helpful

and eye-opening for parents is that almost all child firearm suicides involve a gun belonging to a family member [54]. Developing safety plans with teens and parents, such as who to contact if suicidal thoughts occur (i.e., crisis hotlines) or how to extract the teen from a potentially violent situation outside the home (i.e., safety words, parent check-ins), can help to mitigate these dangers. Further counseling on the importance of removing guns from the home, or barring this, storing them appropriately, is important for all households with teens, regardless of a history of mood disorders or history of self-harm (although removal becomes paramount when this history is present).

Our approach to counseling teenagers focuses on the confidential interview as a time to assess behaviors and provide education. As always, asking about their friends and peer pressure is a way to open the conversation, as are questions about individual safety. Asking, "Are you ever worried about your safety?" or, "Do you ever carry a weapon for your protection?" can provide insight into the teen's risk for violent situations. Other questions about availability of guns, such as, "Could you get a gun if you wanted to?" can also shed light on the risk of community violence. Screening for intimate partner violence during the sexual history is another opportunity to ask about the availability of firearms. Acknowledging that gun violence often occurs within known social groups, rather than strangers [58], and is the leading cause of death for children and teens [59], can help to identify those at-risk for violence and empower teens to ask about the presence of firearms in the spaces they use.

The AAP has developed multiple resources for the general pediatrician with the aim of reducing unintentional injuries to young children and suicide risk among adolescents by providing developmentally- and age-appropriate counseling. The current AAP policy endorses the use of the *Connected Kids: Safe, Strong, Secure* violence prevention program (available online with an AAP subscription) [21]. It provides a clinical guide, patient information brochures, and supporting training materials regarding a variety of violence-related topics. *The Injury Prevention Program* (TIPP), also developed by the AAP, provides safety counseling guidelines for every age, from newborn through adolescence, and a counseling framework that can be used in conjunction with the *Connected Kids* patient materials. Additional resources provided through TIPP include a package of materials designed for office use, including parent safety handouts, patient safety surveys, and a schedule for recommended counseling for each preventative health visit. This age-oriented approach has also been incorporated into the *Bright Futures Guidelines* violence prevention resources.

Several professional physician societies, including the AAP, AAFP, and ACP, have a devoted section to firearm safety education and advocacy, with websites listing resources for both providers and patients (Table 7.3). The National Physicians Alliance also provides resources for practitioners regarding how to counsel about firearm safety, and legal issues surrounding the topic. Other national organizations and campaigns, such as the Brady Campaign, Project ChildSafe, the Coalition to Stop Gun Violence, and Moms Demand Action for Gun Sense's Be SMART campaign, all have online and community resources available to parents

Table 7.3 Resources for education and advocacy on gun safety and violence

American Academy of Pediatrics (AAP)	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Gun-Violence-Community.aspx
American Academy of family physicians (AAFP), familydoctor.org	https://familydoctor.org/gun-safety/
American College of Physicians (ACP)	https://www.acponline.org/practice-resources/patient-education/online-resources/gun-safety
American public health association	https://www.apha.org/topics-and-issues/gun-violence
Brady campaign to prevent gun violence, asking saves kids (ASK) campaign	https://www.bradyunited.org/ https://www.bradyunited.org/program/end-family-fire/asking-saves-kids
Project ChildSafe	https://projectchildsafe.org/
Be SMART campaign	http://besmartforkids.org/
Moms demand action for gun sense in American	https://momsdemandaction.org/
Everytown for gun safety	https://everytownresearch.org/
The coalition to stop gun violence	https://www.csgv.org/
U.S. National Library of Medicine	https://medlineplus.gov/gunsafety.html
Physician's for the prevention of gun violence	http://ppgv.org/
Massachusetts medical society firearm violence resources	http://www.massmed.org/Patient-Care/Health-Topics/Firearm-Violence-Resources
Harvard School of Public Health means matter suicide prevention campaign	https://www.hsph.harvard.edu/means-matter/

and providers. Their offerings include written information, educational videos, social media campaigns, and local advocacy chapters. Several programs also offer educational presentations, which may be used in clinic waiting rooms. For example, utilizing the *Connected Kids* campaign at community Head Start pre-K programs was well-received by parents in Kansas City, Missouri [60] and suggests that pediatricians may take counseling beyond the walls of their clinics with good success, and vice versa. Be SMART is a non-political gun safety campaign designed by Moms Demand Action for Gun Sense that reviews the basics of safe storage and asking about guns in the home using a simple and memorable framework (Fig. 7.1) [61].

The AAP encourages pediatricians to familiarize themselves with local community resources that can assist families at high risk of firearm injuries. In a 2016 national survey of U.S. gun owners, respondents ranked law enforcement personnel, hunting or outdoors groups, active-duty military, and the NRA as most effective in communicating safe firearm storage practices [62]. While healthcare professional counseling was not included in the survey, these responses indicate potential allies for safe storage campaigns, particularly those who can provide patients with access to safe storage devices. Other local resources include hospital- and

Fig. 7.1 The BeSMART Framework for Firearm Safety

community-based violence reduction groups, which work to identify youth and adults at high-risk for community violence and provide educational interventions and support groups.

In Practice

In ambulatory pediatrics, patient loads are increasing, visit times are shortening, and there is a need to screen for more and more health risks. Screening burnout for both patients and physicians is real. It is important to make gun ownership and safety questions practical and impactful.

We have made some simple changes in our own clinical setting to increase firearm safety counseling. Our hospital, The Children's Hospital at Montefiore (CHAM) formed a committee, CHAM CAREs about Gun Safety and Ending Gun Violence, for physicians and staff concerned about gun safety and eager to promote change in the Clinical, Academic, Research, and Educational (CARE) arenas throughout the hospital. Through this committee we realized that even the pediatricians most

passionate about this topic had not yet figured out how to address gun ownership or safety in a routine office visit. With the committee's support, a group of us worked with our EHR team to have the following questions included:

- Are there ever any guns in any of the homes your child spends time in?

  If the answer is yes, the following cascade of choices appears:

- How are the guns stored? Locked? Unlocked? Loaded? Unloaded? Stored separately from bullets/ammunition? Stored in same place as bullets/ammunition?

  – Locked.
  – Unlocked.
  – Loaded.
  – Unloaded.
  – Stored separately from bullets/ammunition.
  – Stored in same place as bullets/ammunitions.

This is now incorporated in all pediatric patients' charts within the health care maintenance section with the hope that a visual cue will help normalize the question and encourage pediatricians to ask. The question does not need to be completed to proceed in the chart and completion is not monitored. Note that we do not ask about personal gun ownership—rather, we ask about the child's exposure to guns in any setting. The literature varies on whether asking about gun ownership is the best approach to safety counseling, but we believe a cue of any sort is the best first step to increasing counseling.

The script we have adopted is as follows: "Gun violence has become such a big problem in our country that I have started to talk to all my patients about gun safety. Is there a gun in your home or any home your child spends time in?" Regardless of their answer I advise: "The safest home for a child is a home without a gun, but in case you or your child is ever in a home with a gun it's really important for you to know the safe way to store it. Guns should be stored unloaded, locked out of reach of children, and locked separately from bullets. Please be sure anyone you know with a gun is storing theirs safely. Do you have any questions?"

Given how long it took us to incorporate gun safety into our anticipatory guidance, we have been surprised by how well it has been received. Many families are taken aback when we first ask, but they all are attentive and many have expressed gratitude for including the discussion in the visit. On a few occasions where a parent has reported there are no guns in the home, the patient (child) has corrected them by telling them of a family member who has one. Yet another reminder of how important it is to start the discussion.

We are also in the process of creating a system-wide message that succinctly reviews safe gun storage to be included in the after-visit handouts. While these new prompts help as visual cues, many providers still feel uneasy giving anticipatory guidance about safe gun storage. Next we hope to aim our efforts at educating providers to feel better prepared, similar to the way we feel when discussing other pediatric safety concerns.

Conclusion

In this chapter, we have reviewed the literature and professional recommendations for firearm safety screening and counseling. We have offered suggestions and resources to improve current practices. However, evidence-based guidelines and interventions remain scarce as research into this topic is limited. With the recent announcement that Congress hopes to approve more national funding towards gun violence prevention research [63], we must strive to design studies with a rigorous methodology for evaluating interventions and practices. Areas for future research of particular importance to firearm safety counseling include: content and delivery of counseling messages; testing of firearm safety devices; and the preferences of gun owners when using and discussing firearm safety. The development of educational strategies for both practicing providers and physicians-in-training also require further study. Greater insight into these topics will help to design and implement effective and practical counseling practices. But for now, the data is clear: pediatricians should embrace universal gun safety counseling as part of their anticipatory guidance.

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