Massachusetts Suicide Prevention Course

A ROLE FOR EMERGENCY DEPARTMENT PROVIDERS

Introduction

This 60 minute training prepares Emergency Department (ED) providers to:

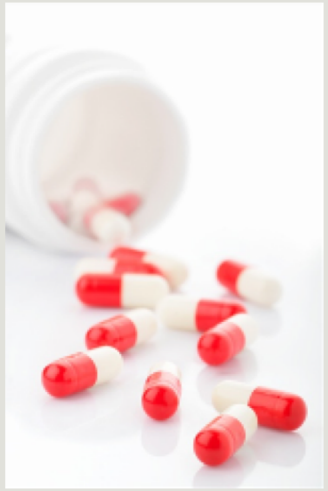
- Module 1 – Understand Why “MEANS Mater”
- Module 2 – Educate Families on Reducing Lethal Means

AND PROVIDES:

- Module 3 – Examples of how to prevent suicide attempts among At-Risk Patients
- Module 4 – Sample Patient Scenarios

MODULE 1

Why Means Matter?



Traditionally suicide prevention has focused on who takes their life when, where, and especially ***why***

We are beginning to understand that ***how*** people attempt suicide plays a crucial role in whether they live or die

A Suicide…

Lauren came home from school with a detention slip, and her parents grounded her. They forbade her from seeing her boyfriend whom they were concerned was having a bad influence. They were considering pressing charges against him for statutory rape.

Lauren went to her father's study, retrieved the hidden key, and opened the gun cabinet, intent on killing herself.

**This case is drawn from an actual suicide death of a young teen; some details changed to protect confidentiality.*

…or a Life Saved?

Lauren came home from school with a detention slip, and her parents grounded her. They forbade her from seeing her boyfriend whom they were concerned was having a bad influence. They were considering pressing charges against him for statutory rape.

Lauren went to her father's study, retrieved the hidden key, and opened the gun cabinet, intent on killing herself. The guns were missing. She slashed her wrists with an exacto blade but survived and was taken to the ED by her mother.

What made the difference?

A month ago when Lauren was in the ED with alcohol poisoning, a social worker heard her parents' concerns that she was spinning out of control. The social worker conducted a psych evaluation; Lauren told her that sometimes thought about suicide but would never do it. The social worker referred her to outpatient counseling and recommended that Lauren's parents store any household firearms outside the home until the situation improved.

Does Reducing a Suicidal Person's Access to Lethal Means Save Lives?

1. Sri Lanka
Pesticides

2. United Kingdom
Domestic Gas

3. Israeli Military
Firearms

1. Sri Lanka & Pesticides

- Pesticides are the leading method of suicide in Sri Lanka.
- The most highly human Toxic pesticides were banned in the mid to late 1990s.
- ***Suicide rates dropped 50%*** from 1996 to 2005.
- Suicide by other methods, did not drop. The decline was driven by a drop in poisonings.
- Nonfatal pesticide attempts did not drop. The ***behavior*** wasn't changing, but the ***lethality*** of the behavior was.

2. United Kingdom & Domestic Gas

- Before 1960, domestic gas was the leading method of suicide in the United Kingdom.
- By 1970, almost all domestic gas in the UK was non-toxic (a cheaper, non-toxic source was discovered.
- ***Suicide rates dropped by nearly a third*** over the decade.
- The decline was driven by a drop in gas suicides; non-gas increased slightly.

Kreitman, 1976

3. Israeli Military & Firearms

- The Israeli Defense Force (IDF) is a population-based army with mandatory draft for 18-21 year-olds in Israel.
- In the early 2000s, IDF leadership focused on preventing suicide – most of which were by firearm, with many occurring on weekends while soldiers were on leave.
- In 2006, IDF required soldiers to leave their weapons on base during weekend leaves.
- ***The suicide rate decreased by 40%***
- Weekend suicides dropped significantly.
- Weekday suicides did not.

Lubin, 2010

Why does it Work?

- How is it possible that such simple changes could save lives?
- How could one person's decision in Sri Lanka save 20,000 lives?
- After all, nothing changed to reduce suicidal people's pain.
- And, as every one knows, if you're intent on suicide you can always eventually find a way to take your life?

So why does *means* restriction work?

The acute phase of suicidal crisis is *often* (not always) brief.

Suicidal Thoughts Among Students

Among college/university students who seriously considered suicide in past 12 months (n=1,321)	
Number of suicidal periods	
1	33%
2	26%
3	15%
4 or more	24%
Missing data	2%
Average length of suicidal period	
1 hour or less	31%
2-24 hrs	25%
2-7 days	27%
>1 week	16%

N+26,451 students surveyed
Drum, 2016

Quick Decisions

When teenagers and young adults (ages 13-34) who nearly died in a suicide attempt were asked how much time passed between the moment they decided on suicide and the attempt, about how many said less than 5 minutes? The correct answer is C.

A. 1-2%

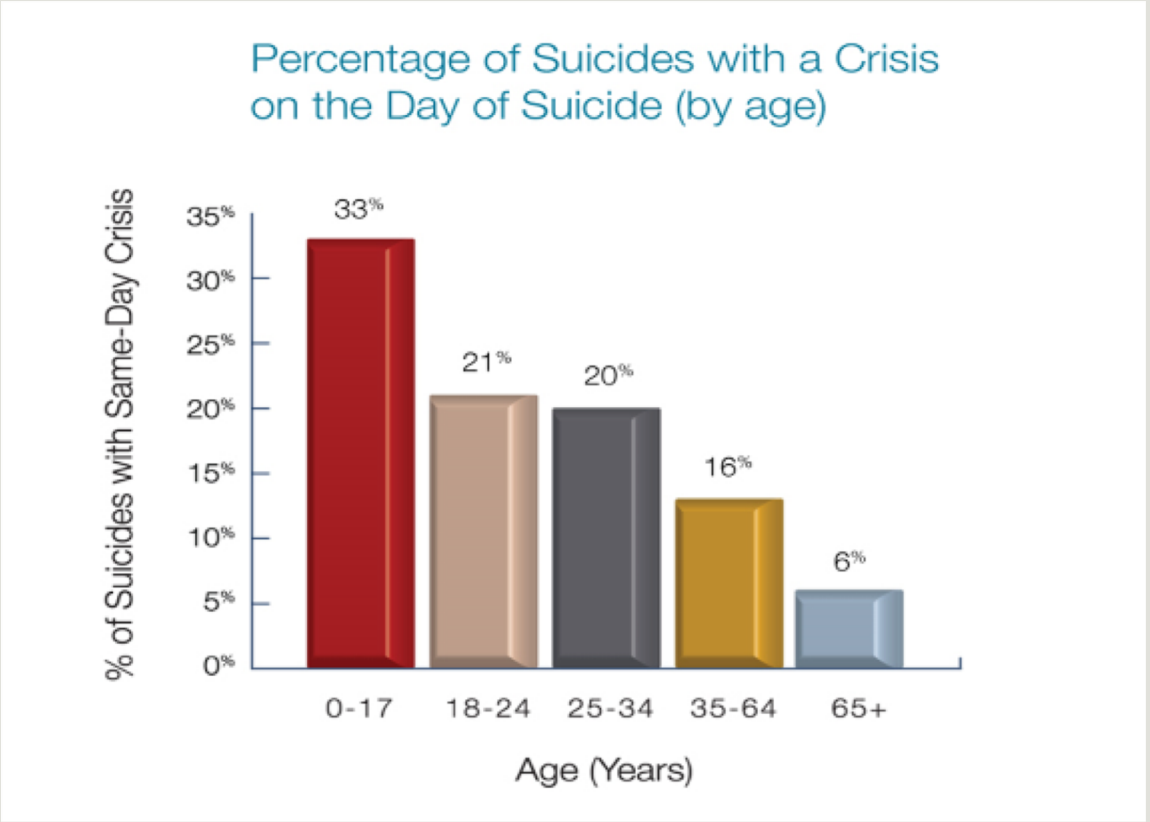
B. 9%

C. 24%

D. 48%

Youth Response to Crisis

Date are based on police reports and coroner/medical examiner reports for 6 states and counties participating in the pilot for the National Violent Death Reporting System.



Putting time and distance between a suicidal person and a highly lethal method can save a life.

Some methods are far more lethal than others.

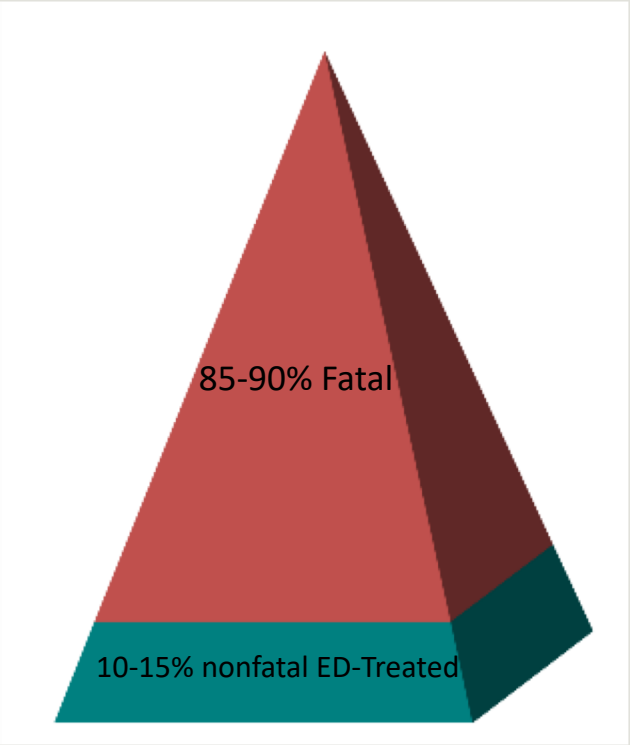
The lethality of the method easily accessible during a suicidal crisis plays a role in whether the person lives or dies.

Intent matters, but means also matter.

Self-Harm Case Fatality Rates, U.S.

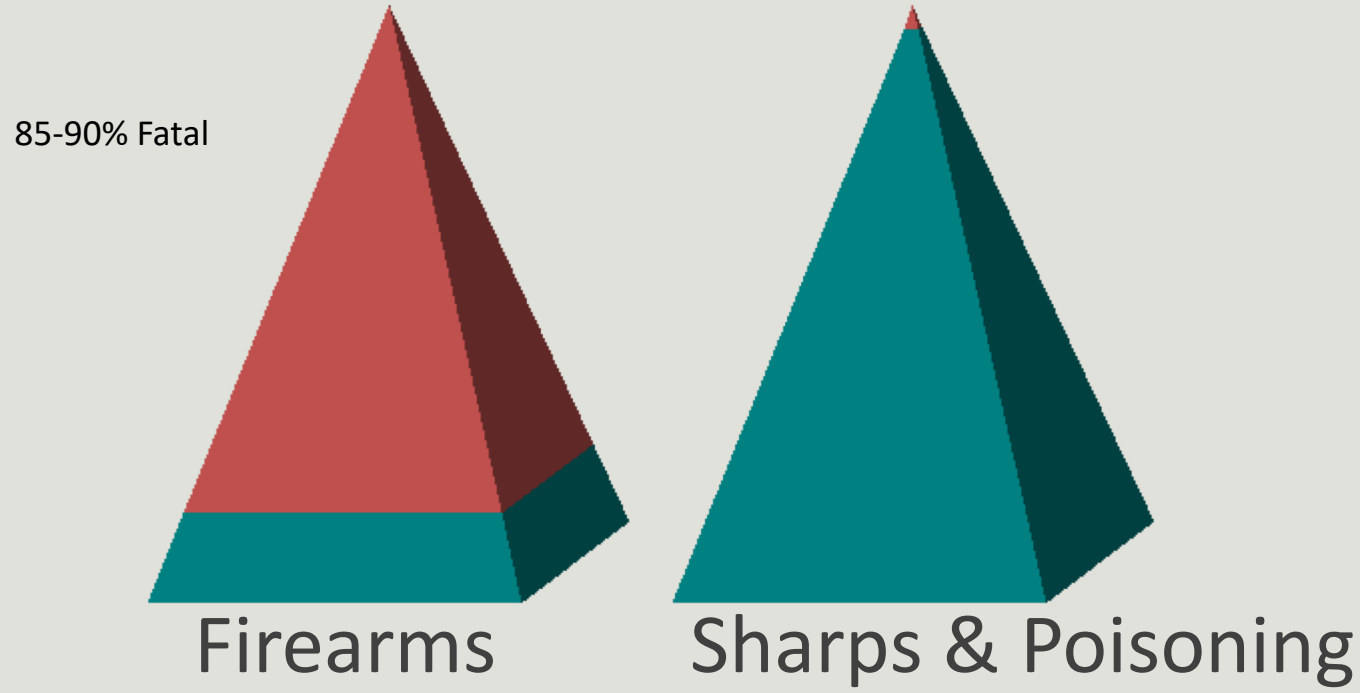
If Lauren had used a gun, the odds of her dying would have been 9 out of 10.

What are the odds of her dying using a blade or pills?



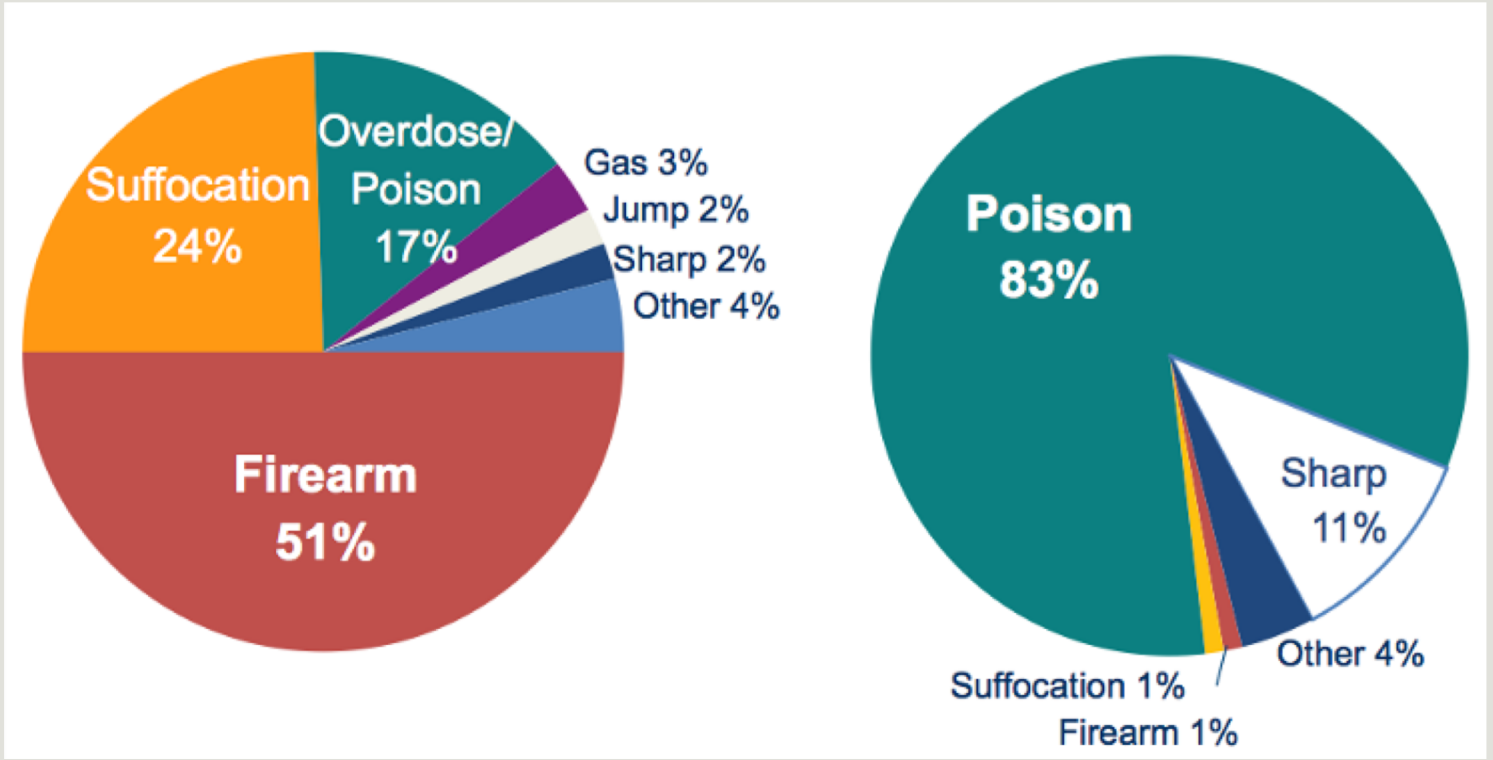
CDC WISQARS Based on data from emergency departments and death certificates.
Case Fatality = the percent of self-harm attempts with a method that end in death.

Self-Harm Case Fatality Rates, U.S.



CDC WISQARS NOTE: This information should not be broadly disseminated to the general public. People's perception that overdose and cutting are more lethal than they usually are probably saves many lives

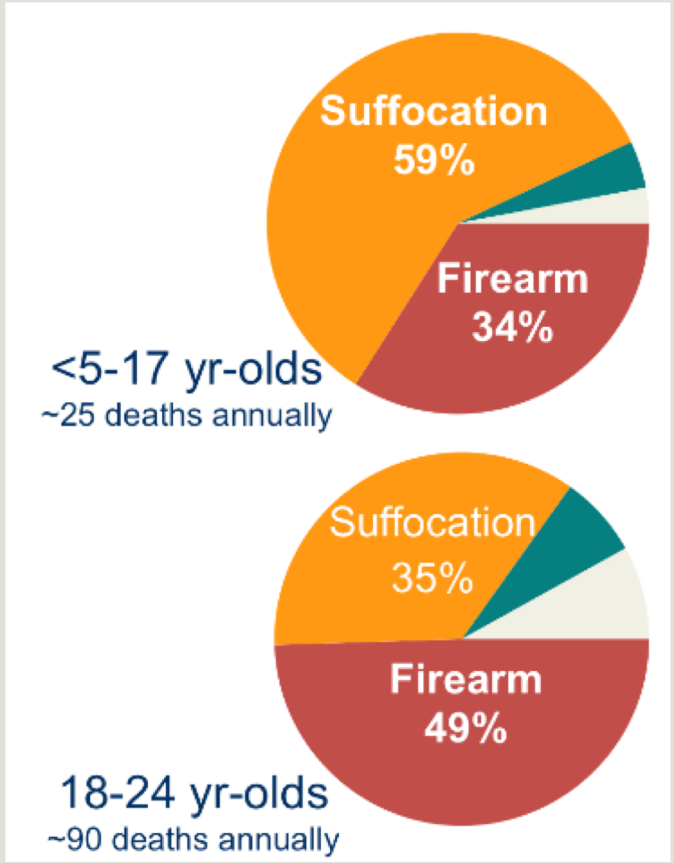
Methods of Self-Harm, U.S. (All Ages)



FATAL (Suicide) **Nonfatal**

Inpatient: HCUP-NIA 2015

Massachusetts Suicide Deaths



CDC WONDER All Ages, 2015 Youth

But Did We Truly Save Lauren's Life?

- History of suicide attempt is a risk factor for suicide.
- What proportion of serious attempters eventually die by suicide?

75%	45%	25%	10%

90% of those who attempt and survive do not go on to die by suicide

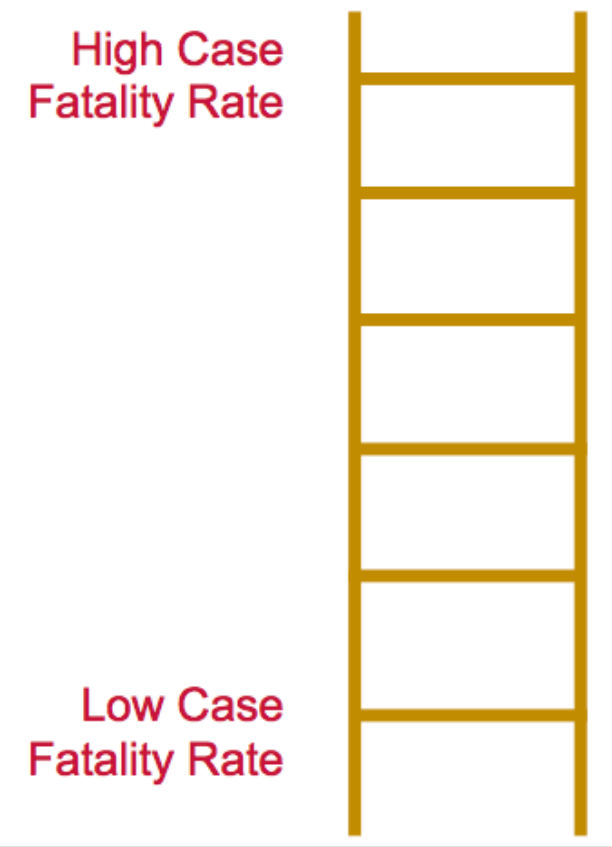
Summary: Why "*Means Matter*"

1. The acute phase of a suicidal crisis is often (not always) brief.
2. Some methods are far more lethal than others. Method choice is influenced by many things including availability.
3. 90% of those who attempt and survive do not go on to die by suicide.

What if Lauren Was Different?

- What if she wasn't an angry, impulsive teenager?
- What if she were very deliberative and had devoted a lot of research to her method?
- Reducing her access to lethal means might not help (although it would likely do no harm).
- In public health, if we do not have a "magic bullet" like a vaccine, we work incrementally, finding different strategies for different groups, chipping away at the problem.

Moving Attempters Down the Ladder



Why Focus on Firearms?

Leading Method

Accessible

Fast Irreversible

Risk Factor

Highly Lethal

Culturally "Acceptable"

Variation in State Suicide Rates

	High Gun States*	Low Gun States**
Population	31.5 million	31.3 million
% households with firearms	50%	15%
Suicides 2008-2009		
Firearm suicides	7,492	1,697
Non-firearm suicides	4,397	4,341
Total suicides	11,889	6,038
Suicide attempts 2008-2009	246,024	303,435

Miller, In press.

Maybe it's not the guns…

Perhaps the higher suicide risk has nothing to do with gun access. Maybe people who have guns are at higher risk for suicide for another reason, like living in a rural area.

Are people who live in homes with guns more likely to have…		
…experienced a mental health problem?	Yes	No
…seriously considered suicide?	Yes	No
…attempted suicide?	Yes	No

Sorenson, 2014; Ilgen, 2014; Miller, 2015

Gun owners aren’t more suicidal.

They’re just more likely to die if they make an attempt USING A GUN.

Thinking Outside the Gun Politics Box

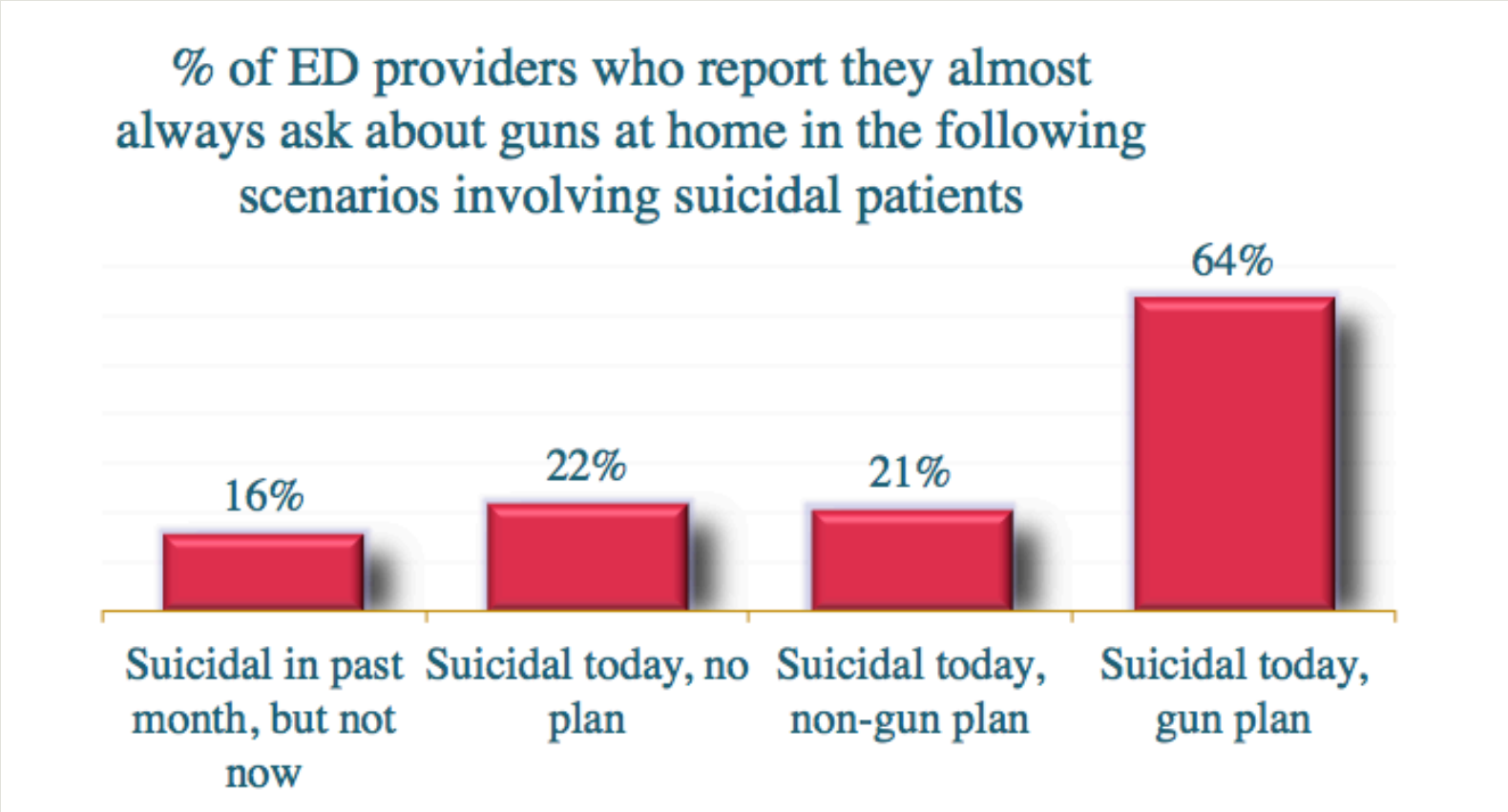
No matter your politics, everyone agrees that giving a suicidal youth access to a gun is unwise.

ED Providers

ED Providers have a significant role to pay in this effort.

- We see families when their child has attempted suicide or disclosed suicidal thoughts.
- This is a crisis, and families are motivated to act.
- ED visits are powerful teachable moments.

ED Providers and Gun Access Counseling



Betz, 2013

Suicidal Plans Among Attempters

Had a Suicide Plan?	People who attempted suicide in past 12 months
No plan	43%
Plan	57%

Not all people who make a suicide attempt planned it in advance.

Borges, 2016

Evidence-based

Reducing a suicidal person's access to lethal means is recommended by:

- The National Strategy for Suicide Prevention (Goal 6)
- Suicide Prevention Resource Center's Evidence-Based Registry
- International review of evidence-based suicide interventions published in JAMA (Joffee et al, 2016)

Lethal Means Counseling Changes Behavior

Advising families of suicidal youth to reduce their access to lethal means is:

Quick

Acceptable to families

Effective

MODULE 2

Conducting Lethal Means Counseling

Where Lethal Means Counseling Fits into the ED Visit

Suicidal Pediatric Patient in ED

After a suicide attempt (SA) or suicidal ideation (SI), or SI revealed during visit.

Risk Assessment by Behavioral Health

After medically stable, assess recent & current SI, lifetime SA, access to firearms, suicide plans (if any), access to methods considered, risk and protective factors

Lethal Means Counseling with Parents

While waiting for admission, Behavioral Health or other ED clinician meets with parents (alone, not with patient) to explain what to expect on admission and for brief lethal means counseling

Overview of Lethal Means

1. Meet with the parents alone (not with the patient)
2. Explain that the patient is at risk for suicide and that suicidal feelings can come and go.
3. Explain that reducing the patient's access to things at home that could kill them – especially firearms – will reduce (but not eliminate) risk.
4. Collaborate on a plan to immediately reduce access to lethal medications and firearms (and other methods if indicated); assign roles and timetable.
5. Document the plan.

Firearms: Raising the Issue

Which option is the more effective way to raise the issue with families?

A. “Lots of families have firearms at home. The research indicates that a suicidal youth is safer if they don’t have access to a gun at home. One option families use is asking a friend or relative to hold onto their guns until the situation improves. Let’s talk over some options that you think would work for you.”

B. “Do you have any guns at home? They’re very dangerous and need to be removed for your child’s safety”

Firearms: Making a Plan

For those with guns at home…

- Explore options for offsite storage
- Second-best option is in-home locking
- Make plans for all homes the youth spends a lot of time in.
- Ideally speak with the gun owner as they will have more control over storage options.
- Look for options that can be enacted quickly. The ED visit is a teachable moment. Things that aren't done immediately on returning home are less likely to be done.

Firearms: Off-site Storage

Safest option is storing all household firearms away from home while the patient is at risk.

- Friend or relative
- Gun stores or gun clubs
- Police departments
- Storage facility
- Pawn shops

Firearms: Locking

If off-site storage isn't an option, the second best option is locking.

- Store guns unloaded and locked in a gun safe or other locking unit, with a cable lock or trigger lock also in place.
- Change the combination and locks if there is any risk the patient has access. Roughly 20% of patients who think their kids haven't handled their guns are wrong (Baxley 2013).
- Keep ammunition out of the home or locked separately.
- See Lock-it-Up and Project ChildSafe for locking options.
- Or remove a key component of the guns.
- Since kids usually know about the hiding places, hiding guns is not recommended.

Language & Collaboration

- Use language such as:
  - "Let's think about a friend or relative who could hold onto your guns temporarily," or
  - "Let's go through some options for storing your guns off-site until the situation improves."
- Do NOT use language such as:
  - "Give up your guns," "dispose of your guns", "the guns must be removed", "relinquished."
- Focus on the temporary nature of the relocation of the guns and of the suicidality.
- Collaborate to find solutions.
- The family should not feel dictated to or interrogated.

Why Firearms?

If parents ask why you're focusing on firearms, explain…

- They're the leading suicide method in Massachusetts (and the second leading method for youth under 18).
- They're the most lethal method.
- Kids have a better chance of surviving an attempt by any other method.

Medications

- Medication overdose is the most common method of suicide attempt.
- Overdose infrequently ends in death; however some medications are more dangerous than others, especially in combination. Such as opioids, benzodiazepines (like Valium and Xanax), and alcohol.
- To reduce the chance of serious harm, recommend reducing the youth's access to medications.




Medications, continued

Recommendations to families:

- Safely dispose of unused, expired, and unwanted meds.
- Store medications the family uses in a locked container. This includes over-the-counter medications and prescriptions.
- If the patient takes medications, suggest that the parents dispense them while the patient remains at risk of suicide.

The best solutions are those that will work for the family and can be readily carried out.

Other methods

- If the patient's ideation focuses on a method other than medications or firearms, work with the family to reduce access.
- Alcohol alone is rarely a lethal suicide method. However, in combination with certain drugs it can prove damaging. Consider not keeping alcohol at home, keeping only small quantities, or locking the alcohol.

Closer Supervision

- It’s impossible to reduce access to all methods, especially hanging and suffocation.
- “That’s where you come in. Especially over the next few weeks, and while your child continues to have suicidal thoughts, avoid leaving him/her alone for other than short periods. We’re releasing him from the hospital because we don’t believe he needs constant supervision, but it’s wise to keep an eye on his moods, to show you care, and to ask him how he’s feeling.”

Module 3 –Video on how to prevent suicides among At-Risk Patients

Module 4

Sample Patient Scenarios

Jason

Shanice

Linda

Jason

Jason, 16, arrived at the ED with his parents. He has previously been diagnosed with Oppositional Defiant Disorder. After being suspended from school for fighting earlier today, he told his guidance counselor that he was “seriously thinking about ending it all.” Later, when his father came home from work, he and Jason got into an argument. Jason said that if his parents grounded him, he would use his hunting rifle to kill himself. When he began to scream and started to punch himself in the face, his parents called 911. In the ED Jason was calm and stated that he no longer wanted to kill himself.

Jason’s Parents

When you meet with **Jason’s parents** and discuss his suicide threat, they say they were alarmed by his violence, but they suspect the suicide threat was “his usual manipulation to avoid facing consequences when he gets in trouble.” Later in the session when you suggest storing the firearms away from home while Jason may be at risk for suicide, Jason’s father says that this is hunting season and “I’ll be damned if I’m going to let him ruin things for the rest of us by playing these games of his.”

Which approach will be more effective?

A. If you really care about Jason and want to keep him safe, you will get rid of your guns.

B. I know you care about Jason and want to keep him safe. I also know that your guns are important to you. Let's work on a plan that'll keep Jason safe and work well for your family.

Which would you say:

When his father says: “I have always taught my kids to respect guns; they’d never use them irresponsibly, even Jason,”

A. You’ve worked hard to pass your values down to your kids. But when a person starts feeling suicidal, even the best training can fly out the window.

B. Maybe you don’t know Jason as well as you think you do. Your inability to face reality is putting your kid’s life in danger.

Which would you say:

When his father says, “This is just what he does when he knows he’s in trouble; it’s just a ploy to distract us,” which would you say?

A. Your son says he’s suicidal, you say it’s just manipulation; am I going to believe you or him?

B. I know it’s disturbing to think your son might be suicidal, and, believe me, I know teenagers in trouble can be manipulative. But in this case, after speaking with Jason, both my gut and my training tell me we need to take these suicidal feelings seriously.

Which would you say:

When his father says, “Jason’s dramatics are always interfering with the family. I don’t want to shortchange my younger son by canceling our hunting plans,” which would you say?

A. You want to hunt and you want to keep Jason safe. So let’s see how we can do that. Are there shooting ranges in the area that offer secure storage? What about a friend or a relative not too far away who could hold onto the guns between hunting trips?

B. Which is more important to you: hunting or saving Jason’s life?

Shanice

Shanice is a 15 year old sophomore who has always done OK in school. Her parents have been fighting more and more since her father was laid off from his job, and he has been drinking more. Recently, Shanice's grades have been dropping, she is spending less time with her friends, and she has stopped going to the after-school art program. Tonight, her mother heard her crying in her room and went in to see what was wrong. She wouldn't say anything but just kept sobbing. When she saw the cuts on her daughter's forearms she brought her in to the ED.

When you talk with her, she says that the cutting is no longer relieving her mental pain and she has been thinking about taking all the pills in the medicine cabinet.

Which would you say:

You assess Shanice for depression and for suicide risk, and Shanice agrees to try cognitive behavioral therapy. Shanice's ideation centers on pills. When talking with her family about reducing access to lethal means, what should you do?

A. Focus on the pills only, since this is the method she is considering.

B. Focus on the pills primarily, but also ask her parents about firearm access.

What happens next?

Your assessment finds that there are no firearms at home. Regarding overdose prevention, which action plan are the parents more likely to carry out?

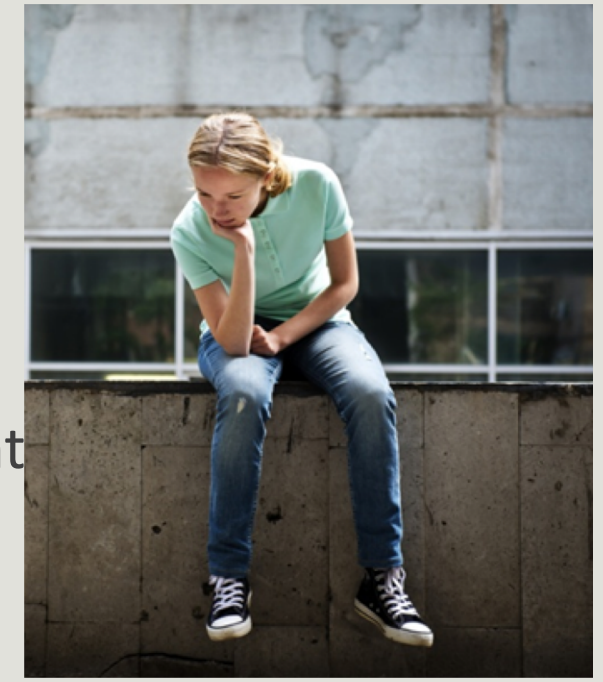
A. The mother will get rid of all pills.

B. The father will install a new locking medicine cabinet.

C. The parents will dispose of all expired and unused medications and move the medications they do not use to a lock box she already has in her closet.

Linda

Linda presented at the ED with what she and her mother feared was a heart problem; it was diagnosed as an acute anxiety reaction. During her psychiatric assessment, Linda revealed that she had thought about suicide at the start of the school year, but not in the past few months. She is receptive to outpatient therapy.



When you meet with her mother, you review the treatment plan and state your concern that Linda's suicidal thoughts might return. You go on to state, "I'd like to talk over ways to make your home safer while she's still struggling with mental health issues.

What's your next step?

Linda's mother says, "I know my husband would do anything to protect Linda, but I just can't see how we'd get the guns out of the house. How do you respond?

A. "Can you fill me in on what the barriers are?"

B. "You're going to have to figure out a way, because that's the safest option for your daughter."

What's your next move?

Linda's mother says "My husband's a gun collector. He must have 75 guns – all kinds, lots of antiques. His gun safe fills up a whole room. We could never ask someone to store that many guns, and it'd take a moving truck to move the safe. I just can't picture making that work."

You ask how the guns are stored. She explains, "My husband is old school. They're all stored unloaded in the safe, and the ammunition is in its own safe. Linda does not know the combinations or have her own gun.

A. Work out a locking plan with the mother.

B. Ask the mother to call the father on her cell phone so the three of you can work out a locking plan.

What's your next step?

Her dad confirms that all of his guns are stored in the safe and explains that Linda's never been given the combinations.

A. Move on to discuss medication safety.

B. Mention that studies have indicated kids often know how to get into their parent's guns even when their parents think they don't. Explore whether changing the combination to the locks is an option, then move on to discuss medication safety.

Congratulations!

You've completed the training. Click here for Course Transcription.

In Summary:

- Means Matter – reducing a suicidal person's access to firearms and other lethal means can save lives.
- You can save lives by education parents of at-risk youth to reduce access at home. The ED visit is a teachable moment!
- Collaboration with and respect for parents is crucial.

National Resources

- National Strategy for Suicide Prevention (Goal 6)
- Suicide Prevention Resource Center's Discussion Guide
- Safety Plan Quick Guide for Clinicians Example
- National Shooting Sports Foundation Firearm Safety
- FDA Guidance on Safe Disposal of Medications
- Project ChildSafe

Massachusetts Resources

- MCPAP
- Massachusetts Strategic Plan for Suicide Prevention
- Data Brief: Suicides and self-inflicted Injuries in Massachusetts
- Emergency Services Program/Mobile Crisis Intervention
- Prevention program information and resources

References

1. Betz ME, Barber C, Miller M. Suicidal behavior and firearm access: results from the second injury control and risk survey. Suicide Life Threat Behav. Aug 2011;41(4):384-391. 2. Betz ME, Miller M, Barber C, et al. Lethal Means Restriction for Suicide Prevention: Beliefs and Behaviors of Emergency Department Providers. Depress Anxiety. Mar 14 2013. 3. Borges et al. Risk factors for twelve-month suicide attempts in the National Comorbidity Survey Replication (NCS-R). Psychol Med. 2006 4. Brent DA, Perper JA, Allman CJ, Moritz GM, Wartella ME, Zelenak JP. The presence and accessibility of firearms in the homes of adolescent suicides: a case-control study. JAMA. 1991;266(21):2989-2995. 5. Brent DA. Firearms and suicide. Ann N Y Acad Sci. Apr 2001;932:225-239; discussion; 239-240. 6. Conwell Y, Duberstein PR, Connor K, Eberly S, Cox C, Caine ED. Access to firearms and risk for suicide in middle-aged and older adults. Am J Geriatr Psychiatry. Jul-Aug 2002;10(4):407-416. 7. Dahlberg LL, Ikeda RM, Kresnow MJ. Guns in the home and risk of a violent death in the home: findings from a national study. Am J Epidemiol. Nov 15 2004;160(10):929-936. 8. Drum DJB, Chris; Burton Denmark, Adryon; Smith, Shanna E. . New data on the nature of suicidal crises in college students: Shifting the paradigm. . Professional Psychology: Research and Practice. 2009;40(3):213-222. 9. Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. Jama. Feb 9 2005;293(6):707-714. 10. Gunnell D, Fernando R, Hewagama M, Priyangika WD, Konradsen F, Eddleston M. The impact of pesticide regulations on suicide in Sri Lanka. Int J Epidemiol. Dec 2007;36(6):1235-1242. 11. Ilgen MA, Zivin K, McCammon RJ, Valenstein M. Mental illness, previous suicidality, and access to guns in the United States. Psychiatr Serv. Feb 2008;59(2):198-200. 12. Kellermann AL, Rivara FP, Somes G, et al. Suicide in the home in relation to gun ownership. N Engl J Med. Aug 13 1992;327(7):467-472. 13. Kreitman N. The coal gas story. United Kingdom suicide rates, 1960-71. Br J Prev Soc Med. Jun 1976;30(2):86-93. 14. Kruesi MJ, Grossman J, Pennington JM, Woodward PJ, Duda D, Hirsch JG. Suicide and violence prevention: parent education in the emergency department. J Am Acad Child Adolesc Psychiatry. Mar 1999;38(3):250-255. 15. Kung HC, Pearson JL, Liu X. Risk factors for male and female suicide decedents ages 15-64 in the United States. Results from the 1993 National Mortality Followback Survey. Soc Psychiatry Psychiatr Epidemiol. Aug 2003;38(8):419-426. 16. Lubin G, Werbeloff N, Halperin D, Shmushkevitch M, Weiser M, Knobler HY. Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. Suicide Life Threat Behav. Oct;40(5):421-424. 17. Mann JJ, Apter A, Bertolote J, Beautrais A, et al. Suicide prevention strategies: a systematic review. JAMA. 2005;294(16):2064-74. Review. 18. Miller M, Azrael D, Barber C. Suicide mortality in the United States: the importance of attending to method in understanding population-level disparities in the burden of suicide. Annu Rev Public Health. 2012;33:393- 408. 19. Miller M, Barber C, Azrael D, Hemenway D, Molnar BE. Recent psychopathology, suicidal thoughts and suicide attempts in households with and without firearms: findings from the National Comorbidity Study Replication. Inj Prev. Jun 2009;15(3):183-187. 20. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. Br J Psychiatry. Sep 2002;181:193-199. 21. Simon TR, Swann AC, Powell KE, Potter LB, Kresnow MJ, O'Carroll PW. Characteristics of impulsive suicide attempts and attempters. Suicide Life Threat Behav. 2001;32(1 Suppl):49-59. (And personal communication from Simon for full distribution of intervals from decision to action.) 22. Sorenson SB, Vittes KA. Mental health and firearms in community-based surveys: implications for suicide prevention. Eval Rev. Jun 2008;32(3):239- 256.

Post-test

1. What is the leading method of suicide death in the U.S.?

A. Suffocation/hanging

B. Motor Vehicle crash

C. Firearm

D. Overdose

E. Cutting

F. Carbon monoxide inhalation

2. What is the leading method of suicide attempt in the U.S.?

A. Suffocation/hanging

B. Motor Vehicle crash

C. Firearm

D. Overdose

Post-test

3. Approximately what proportion of people who attempt suicide go on to eventually kill themselves?

A. 1-2%

B. 10%

C. 25%

D. 50%

4. Approximately what proportion of people who swallow pills in an intentional overdose die from the poisoning (based on emergency department and death certificate data)?

A. 1-2%

B. 10%

C. 25%

D. 50%

Post-test

5. The firearms used by youth under 18 in a suicide most often belong to:

A. Friend

B. Their parents

C. Friend's home

D. The youth (e.g. bought at a gun show, internet, etc.)

6. Please choose the answer that best describes the circumstances under which you should assess a suicidal youth's access to firearms.

A. Only if the patient is suicidal, has a plan, and the plan involves a firearm.

B. Only if the patient is suicidal and has a plan

C. If the patient is suicidal or at risk for suicide

D. Under no circumstances; removing access to some methods, when others are available, will only give the patient and his/her family a false sense of security.

Post-test

7. When young adults (13-34) who nearly died in a suicide attempt were asked how long an interval passed between the time they decided on suicide and the time they made the attempt, about how many said less than 5 minutes?

A. 0.8-1%

B. 10%

C. 24%

D. 50%

8. Which statement is true:

A. Most police departments will temporarily store firearms for families who request the service as a suicide prevention measure.

B. Most police departments will not store firearms for families because of liability issues.

C. Some police departments will store firearms for families and others will not.

Thank you!

Thank you for completing the Suicide Prevention Reducing access to Firearms and Other Lethal Means Course.

Massachusetts College of Emergency Physicians