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How to Address Firearm Safety with the Rural Suicidal Patient

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Objectives

1. Increase understanding of the epidemiology of suicide and why primary care providers are an important resource in suicide prevention.
2. Increase skills and knowledge for identifying and managing suicidal patients within the primary care setting.
3. Increase understanding of rural firearm culture and implications for collaborating with patients on firearm safety.

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Some Facts

Suicide ranks as the 8th leading cause of death across all ages in Oregon.

White, middle aged males (aged 25-64) historically have the highest rate of completed suicide.

Use of firearms is the most frequently used method (60% of all deaths by suicide.)

Behavioral health problems, relationship problems with intimate partners, physical health problems and financial problems/lost a job were the most reported factors surrounding suicide incidents.

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SUICIDE: OREGON 2017 FACTS & FIGURES

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Oregon	762	17.77	13
Nationally	44,193	13.26	

On average, one person dies by suicide **every 12 hours** in the state.

Based on most recent 2015 data from CDC. Learn more at afsp.org/statistics.

$ Suicide cost Oregon a total of **$740,356,000** of combined lifetime medical and work loss cost in 2010, or an average of **$1,080,811** per suicide death.

IN OREGON, SUICIDE IS THE...

- **2nd leading** cause of death for ages 15-34
- **3rd leading** cause of death for ages 10-14
- **3rd leading** cause of death for ages 35-44
- **5th leading** cause of death for ages 45-54
- **7th leading** cause of death for ages 55-64
- **14th leading** cause of death for ages 65 & older

More than five times as many people in Oregon die by suicide than by homicide; the total deaths to suicide reflect a total of **14,044** years of potential life lost (YPLL) before age 65.

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30 YEARS STRONG

AMERICAN FOUNDATION FOR Suicide Prevention

afsp.org

Risk Factors

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of behavioral health disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local incidents of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing behavioral health treatment
- Loss (relational, social, work, or financial)
- Physical illness, chronic pain
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental illness and substance use disorders

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Warning Signs

- Talking, thinking, writing or drawing about death
- Deep sadness, depression
- Impulsivity, acting reckless or engaging in risky activities, seemingly without thinking
- Loss of interest in things one used to care about or activities that used to bring enjoyment
- Insomnia or sleep disturbance
- Making comments about being hopeless, helpless, or worthless
- Putting affairs in order, tying up loose ends, changing a will, giving belongings away
- Saying things like "It would be better if I wasn't here" or "I want out"
- Dramatic mood changes, including seeming happier after a period of depression
- Withdrawing from friends, family and society
- Visiting or calling people to say goodbye
- A positive answer to the last question on the PHQ-9 or high PHQ-9 Score (Thoughts that you would be better off dead or of hurting yourself in some way.)

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Why Primary Care?

- Persons who die by suicide are more likely to have seen their primary care provider in the days before their death than any other health care provider.
- 64% of those who die by suicide have seen their primary care provider within one year of death (Ahmedani et al., 2014);
- **45% have had contact within one month** (Luomo, Martin & Pearson, 2002).

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Why Primary Care?

- **Primary Care Providers can:**
  - Identify warning signs
  - Engage patients in life-saving treatments
  - Provide referrals to behavioral health
  - Connect patients with emergency services
  - Provide continuity of care for patients with suicide risk

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The problem of the suicidal patient in Primary Care

- Short appointments, pace of Primary Care
- Hand on the doorknob comment
- Very little, if any, training on how to assess risk and develop a safety plan
  - Who can go home with a safety plan?
  - Who needs to be hospitalized
- Asking the question/screening for suicidal ideation/plan, then not knowing what to do if the answer is “yes”

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A moral imperative

- The data indicate that Primary Care providers need to take action
- Preventing suicide is a community responsibility
- The role of the PCP in preventing suicide has been under-emphasized

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How to identify suicidal patients

- Screen for depression, every patient, every visit using PHQ2 with reflex to PHQ9
  - PHQ2: Over the past two weeks, how often have you been bothered by any of the following problems?
    1. Little interest or pleasure in doing things
    2. Feeling down, depressed or hopeless
  - PHQ9: first two questions, plus seven more. Question 9:

    Thoughts you would be better off dead, or of hurting yourself
- Use the Columbia screening tool (there is a primary-care specific tool)

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How to identify suicidal patients

- Ask specifically about suicidal thoughts and plan
- How to ask
- Patient is usually relieved you asked
- Ask about method and means
- Ask about any other method and means, keep asking until there are no more
- If patient denies having a method in mind, ask “If you did have an idea about how you would kill yourself, what would it be?”

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Assess risk

- A continuum
  - Thoughts with no plan
  - Thoughts with vague plan
  - Thoughts with plan but no means (careful with this one)
  - Thoughts with plan and means
- Assess risk factors
- Assess protective factors

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Protective factors

- Social support
- Cultural and religious beliefs that discourage suicide
- Having children
- Problem solving skills
- Restricted access to lethal means
- Responsibilities towards others

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What to do with the hot potato: keep the patient safe

- Leverage protective factors
- Remove access to lethal means, if possible
  - Particularly firearms – 60% of suicides
  - This can be a tricky conversation, be careful how you bring it up (more on this later)
- Elicit the help of family/friends that patient identifies
- Full safety plan
- Crisis team/911 if patient is in imminent danger of dying by suicide

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Primary Care Toolkit

- Role of Primary Care
- Office Protocols/Roles and Responsibilities
- Assessing Risk/Safety Planning/Follow up
- Referral/Community Collaborations
- Training

http://oregonsuicideprevention.org/zerosuicide/primarycare/toolkit-centraloregon/

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Research on limiting access to lethal means in suicidal patients

- Not a pro-gun or anti-gun issue.
- Important to temporarily limit access to guns when individuals are in crisis.
- Need to make it socially acceptable for friends and family members to hold onto a potentially suicidal gun owner's weapon until the crisis has passed.
- Discourse about limiting access to firearms gives rise to constitutional concerns and political polarization (Caine, 2013), often accentuated in rural areas.
- The **"culture gap"** is that which may emerge between a firearm owner and the perceived ideologically different system of power that one encounters in a primary care setting – often tied to the idea of "big" and more "liberal" (and hence anti-gun) government.

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Research hypothesis

- Discussions that occur in primary care settings about patients voluntarily limiting access to firearms during periods of suicidal ideation will achieve successful outcomes **if culturally appropriate messaging about firearm safety is identified and implemented**.

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Methods

- Interviews with 39 adult owners of firearms
- 22 men 17 women
- 5 focus groups and 4 key informant interviews
- Questions designed to understand the culture of gun ownership in rural communities
- Conducted in La Pine and Prineville, Oregon

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Findings

- ***Guns are Pervasive:*** members of this demographic own multiple firearms, many loaded at all times, often not locked or not stored in secure locations.
- ***Firearm Safety:*** most frequently cited basis of firearm safety has been explicit training of children and young adults, primarily through instruction from family members, and secondarily through formal firearms safety courses.

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Findings, cont'd

- ***Firearm Taboo:*** highly inappropriate to ask someone where they keep their guns, how many guns they have, and other details of firearm ownership and safety in the home.
- The above suggests that traditional, public health driven, firearm safety discourses (e.g. store ammunition separately from weapons, use a gun safe, impersonal physician in-take forms) may be ineffective for at least some portion of the gun-owning population.
- ***Crisis Situations:*** in discussions of actual and hypothetical mental health crises with the potential for suicide, trust in the person asking the individual to relinquish their firearm is deemed fundamental. A trusted friend or family member can successfully breach the ***Firearm Taboo***.

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Findings, cont'd

- ***Trust in Primary Care:*** *extremely important*; point blank questions about firearm ownership (including intake checklists) or means restriction from someone who has not established trust are often perceived as threatening and antagonistic; fear of reporting to a government registry, especially among veterans.

- ***Suicide Prevention as an Expression of Cultural Values:*** optimism about efficacy of making culturally-appropriate resources available in a primary care setting; means restriction would be treated as a basic extension of cultural values that emphasize firearm safety (rather than "loss of access") and care for friends and family.

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Message testing for patient education material

- Three messages tested:
  1. Standard public health message
  2. Culturally informed message (some of the language suggested by focus group participants)
  3. Combination of standard public health message and culturally informed message
- 817 respondents

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Findings

- Standard message + culturally informed message resulted in the greatest likelihood of temporarily removing guns for family member, friends or self if contemplating suicide.
- Standard message + culturally informed message resulted in the greatest likelihood of the person speaking about firearm ownership with their physician.
- Results strongest for those who were politically conservative, living in rural areas, and those in favor of gun rights.

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Implications

- Culturally informed messaging about limiting access to firearms is more impactful on gun owners than a message that ignores cultural norms.
- The effect was greater on individuals who more strongly identified as conservatives and who more strongly advocated for gun rights – suggesting that a targeted approach to this messaging intervention may be most effective.
- Information can influence people's decisions – if information comes from a trusted source.
- Trust can be established when values are affirmed and culturally appropriate language is used.

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Links to Firearm Safety Toolkit

For Patients

http://oregonfirearmsafety.org/firearm-safety/

For Providers

http://oregonfirearmsafety.org/addressing-firearm-safety/

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Case #1 - Mary

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Case #2 - Jim

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Questions?

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