

## BEST PRACTICES

# FIREARMS AND SUICIDE: A LETHAL COMBINATION

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This month's theme issue is on gun violence, its devastation, and the imperatives to study and prevent it. Unfortunately, there are yet more tragedies that we don't see as internists—those who die not only violently but also with intent to cause fatal self-harm: firearm suicides. Not an easy topic to read or talk about.

Internists routinely screen for and coordinate initial management of suicidal ideation in the outpatient setting when patients endorse depressed mood, or provide medical care to patients who survive a suicide attempt in an inpatient setting. Each of us distinctly remembers encountering inpatient cases for suicide attempt survivors. Of outpatient experiences, one of us, as a prior primary care physician (TL), encountered far fewer cases of suicidal behavior management, although in rare instances grappled with concerns about contacting police for well checks of patients in their homes or struggled with the ethical considerations and therapeutic consequences of initiating involuntary commitment of a patient to a hospital (this never happened, fortunately).

For most general internists, this pattern probably holds: patients who survive suicide attempts are seen most often in the inpatient setting and could be critically ill both psychiatrically and physically; those who are severely mentally ill in the outpatient setting are more likely to be under the care of a psychiatrist, or have no affordable access to care altogether. But notably, no patients with suicide attempts that we have encountered involved *firearms*. It's rare, if not impossible for an internist—or any other physician aside from a pathologist or medical examiner—to encounter a patient who presents after a firearm suicide attempt. Even emergency doctors likely don't see such patients. They won't survive to make it that far.

In this article, we explore essential considerations when thinking about and, more importantly, talking about firearm suicide prevention.

### Language Matters

Before continuing, it's helpful to know some basic concepts when talking about suicide prevention in general.

First, there are best practice recommendations from *reportingonsuicide.org* to avoid describing methods of suicide death in reporting to minimize risk of sensationalization and, consequently, the risk of suicide contagion, a phenomenon involving the occurrence of multiple suicides in close proximity typically in time and geography.

Second, recommendations suggest moving away from saying that a person “committed suicide,” as though they have analogously “committed” a crime. Instead, it would be better to say a person “died by/of suicide,” which better acknowledges the complex biopsychosocial context in which suicide death occurs. Talking and writing about suicide prevention can become *very difficult* because of the need for sensitivity to these issues, but the intentional ending of a life, even if its one's own, is almost always controversial. But the need for this dialogue is desperately overdue, as American suicide rates are on the rise. In our view, whatever the language, as long as we talk about it openly and with respect towards the living and the dead, then we should.

### Means Matter

In 2016, firearm suicides accounted for 51% of all suicide deaths in the United States, or 22,936 deaths per year. Overall, the Centers for Disease Control and Prevention reported a disturbing trend that suicide deaths increased by more than >30% in 25 states between 1999 and 2016.<sup>1</sup> Viewed another way, of all the Americans who die due to firearms, 22,274 (61%) are suicides.<sup>2</sup> Regarding gender, men and women are equally at increased suicide risk given access to firearms; state firearm ownership rates range from 12.2% of the state's population (Hawaii) to 72.8% (Wyoming) with an average nationwide of 41%, and there is strong correlation between state firearm ownership and firearm suicides.<sup>3</sup>

Considering best practices on reporting about suicide, discussing firearm suicide is a place where talking about the means, or method, matters. It aligns with what

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we observe: surviving a firearm suicide attempt is virtually impossible. Firearm suicide is quick *and* lethal, forming a deadly combination with contextual factors that lead to death. One theory of suicidal behavior posits that three necessary and sufficient contextual factors are present in predisposing an individual to suicidal behavior: 1) *thwarted belongingness*, or feeling disconnected from others, 2) *perceived burdensomeness*, or believing that one's death would relieve burdens on others, and 3) *acquired capability*, or a loss of fear response to, for example, death.

In an acute, short-term crisis, these three precursors can appear together, and when combined with access to lethal methods, the tragic outcome of suicide follows. Short-term crises that trigger suicidal ideations, if overcome, can potentially mean survival and prevention of suicide. This is where outpatient internists can be influential.

**Firearm Suicide Prevention**

Because of the deadly nature of firearms, prevention involves all the usual best practices for managing suicide risks and behaviors *plus* sensible firearm policies and outpatient harm reduction. The CDC report found that 54% of those who died by suicide had no previously diagnosed mental health condition.<sup>1</sup> Is this due to missed opportunities for mental health and suicide risk factor screening? Or inadequate access to mental health services or insurance to cover them? Or an insufficient supply of such services? What about missed opportunities for gun safety screening and education? Yes, to all the above, with emphasis on the last one. Naturally, suicide prevention involves a multi-tiered approach, including individual, social, institutional, and health policy interventions. The largest impact is likely the development and implementation of evidence-based policy on gun violence prevention and firearm injury

prevention.<sup>4</sup> Screening and education about safe gun storage may need to go hand-in-hand with routine screening for suicidal ideation; this includes advising about the relocation or safe storage of firearms in times of acute crises and high suicide risk, according to the American Public Health Association.

Unfortunately, some special subpopulations are disproportionately at higher risk for firearm suicide. They may have a higher risk of developing the three contextual precursors for suicidal behavior, easier access to lethal methods, or other unique population characteristics. For one of us (SP), this hits close to home, having lost a resident colleague to firearm suicide. Physicians and health professionals may be more likely to experience short-term crises, one of the risk factors for suicide. Additionally, they may have more specialized knowledge of and access to more lethal means of self-harm,<sup>5</sup> which could include the use of firearms. Other occupations may have more ready access to firearms, such as farmers and police officers, who may be at increased risk of firearm suicide.<sup>6</sup>

Those who die by firearm suicide will never re-present to our routine outpatient or inpatient medicine practices as internists. Last month was National Suicide Prevention Awareness month, where September 17th was the second annual National Physician Suicide Awareness Day. Our powerful clinical voices can advocate for gun violence prevention to improve our population's health, including our peers as current and future patients. But we can also intervene to help individual patients, helping them manage key moments during acute crisis to reduce suicide risk. After all, gun violence prevention is (firearm) suicide prevention.

*If you are in crisis and need emergency help, call 911 immediately or the National Suicide Prevention Lifeline (1-800-273-TALK or 1-800-273-8255) if in the United*

*States. If you are in another country, find a 24/7 hotline at [www.iasp.info/resources/Crises\\_Centres](http://www.iasp.info/resources/Crises_Centres).*

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