Firearms, Suicide, and Approaches for Prevention

Suicide is a leading cause of death in the US, and firearm injuries continue to account for most suicides.

Like other types of gun violence, firearm suicide is preventable. Fewer than 1 in 10 individuals who present to health care services for deliberate self-harm later die by suicide, meaning that suicide death among those with elevated risk is not inevitable.

Lethal means safety (LMS)—in which access to firearms and other lethal methods is reduced—is an evidence-based approach to reducing suicide risk. For firearms, this means removing firearms from the home or changing home storage so the individual with suicide risk does not have access to these weapons. Ideally, such reductions are voluntary and engage the at-risk person in short-term changes, which allows for the individual at risk to take ownership of their own health while still reducing risk. In this model, LMS is analogous to the concept of a “designated driver” to prevent motor vehicle injuries during a period when a driver is at increased risk of crash. LMS does not negate the need for other aspects of suicide prevention, such as assessment and mitigation of other physical, mental, or social risk factors. Rather, it reduces the odds that someone with suicidal intent or in crisis can lethally harm themselves.

In clinical settings, LMS is an essential element of evidence-based suicide prevention programs because (1) clinicians are already charged with assessing and mitigating suicide risk across varied patient populations and settings; (2) an estimated 80% of individuals who die by suicide engage with the health care system in the year prior to death; and (3) clinician-delivered interventions are effective in motivating secure firearm storage practices.

In recent years, LMS training and resources for clinicians across a variety of clinical specialties have expanded, including consensus statements on clinician education, system initiatives like in the Veterans Health Administration, and state-funded training programs like the BulletPoints Project in California.

Despite expanded training, resources, and focus on firearm injury prevention in clinical settings, significant challenges remain. First, although an estimated more than 40% of US residents live in a home with a gun, few firearm owners report ever having discussed firearm injury prevention with a clinician. The reach of LMS efforts in clinical settings may improve with expansions in general suicide risk screening efforts, introduction of firearm-specific clinical prompts and templates in electronic health records, and engagement of a broader representation of clinical specialties that encounter patients with elevated suicide risk (eg, geriatrics, obstetrics, trauma surgery).

Second, although patients are generally accepting of health care–based firearm interventions, some are reluctant to discuss firearms with clinicians, and some clinicians may harbor (and some may display) biases against firearm ownership that negatively affect these discussions. These complex issues might be alleviated through training and resources to foster a clinical workforce capable of delivering counseling that is both acceptable and culturally informed. Engagement of firearm-owning clinicians, as exemplified in ongoing work by the American College of Surgeons, may help refine the language, content, and tone of these patient-facing efforts and potentially decrease distrust of clinician involvement in firearm injury prevention.

Most clinician-delivered LMS interventions focus on individuals with active or elevated suicide risk (“indicated” interventions, Figure) or to groups of patients with specific suicide risk factors (“selective” interventions). Yet these approaches alone are probably inadequate to reduce population-level suicide rates. Among people in the US who die by suicide, approximately one-half have no diagnosed mental illness, yet many clinic-based suicide prevention interventions are focused on those with diagnoses. Furthermore, many individuals who die by
American medicine has its own set of ethical obligations when it comes to suicide prevention. The profession is divided on whether to engage patients directly in conversations about suicide. The opinions vary widely. There is a road forward, and it is one that everyone—clinicians and nonclinicians, gun owners and nonowners—should travel together. However, accelerating efforts over recent years offer hope. Recent national partnerships between the firearm industry and medical and public health organizations are disseminating training, resources, and messages widely, while local programs across the country are finding creative ways to connect with and educate firearm owners about suicide prevention. There is a road forward, and it is one that everyone—clinicians and nonclinicians, gun owners and nonowners—should travel together.