How Physicians Can Reduce Suicide—Without Changing Anyone’s Mental Health

Suicide is the leading cause of injury death in the US, and its rate has increased in recent years. On an average day, over 115 Americans take their lives. A typical physician’s patient is more likely to die from suicide than from motor vehicle crashes, falls, unintentional overdose, or homicide.

Most people who die by suicide have a mental health problem. Not surprisingly, the main approach to preventing suicide has been to try to improve mental health treatment. Yet many of the major successes in reducing suicide in other countries have had little to do with improving mental health.

In the early 1960s, asphyxiation with domestic gas accounted for nearly half of suicides in England and Wales. The conversion of the British gas supply to North Sea gas, which was free of carbon monoxide, essentially eliminated domestic gas suicides in England and Wales and, moreover, was accompanied by a steep decline in the overall suicide rate (a 30% decline in England and Wales between 1960 and 1971, and a smaller decrease in Scotland), driven by the fall in gas suicides.

In 1995, Sri Lanka had one of the highest rates of suicide in the world, with most suicides resulting from pesticide poisoning. In the mid-1990s, the importation and sale of many of the most lethal of these pesticides were restricted. Between 1995 and 2005, the suicide rate in Sri Lanka fell by half, driven by a decrease in poisonings. While the frequency with which people attempted suicide with pesticides did not change, the lethality of that behavior decreased substantially.

In the US, even though only 1% of all suicide attempts are with firearms, half of all suicide deaths are with firearms. The case fatality rate for self-harm with a gun is about 85%; for the most common methods of suicide attempt—pills and cutting—it is about 2%; other methods fall in the middle.

Large differences in suicide rates across US regions, states, and cities are not associated with differences in rates of mental illness, depression, suicide ideation, or even suicide attempts. Instead, the differences are largely associated with differences in levels of household gun ownership. Areas with more guns have more gun suicides; areas with few guns have fewer gun suicides and roughly the same non-gun suicides, so overall suicide rates are lower.

More than a dozen case-control studies in the US have consistently found that a gun at home is a major risk factor for completed suicide. At risk are the gun owner and the gun owner’s spouse and children. Yet gun owners do not have more serious mental health problems than do non-owners, nor do they have higher rates of suicide ideation or attempts. Rather, compared with non-gun owners, when they do make an attempt it is more often with a gun. Studies suggest that storing guns locked and unloaded can reduce suicide risk in gun-owning households.

Gun availability matters not only because guns are more likely than other methods to prove lethal, but also because: 1) many suicide attempts involve little planning, 2) the risk of suicide is often transitory, and 3) few people who survive an attempt go on to die by suicide thereafter. Individuals seen in a hospital following a suicide attempt were asked in one study when they first started thinking about that attempt; 48% said within 10 minutes of attempting. For this group, especially, the lethality of the method readily at hand plays an important role in whether they survive an attempt. And not just in the short run. Studies that followed suicide-attempt survivors over time—including one that followed subjects who survived jumping in front of a train—report that a minority (3%-11%) go on to later kill themselves.

A ROLE FOR PHYSICIANS

Physicians and other health care providers can help protect at-risk patients by speaking with them and their families about gun safety. Based on feedback from informal focus groups and interviews with veterans and gun owners, we suggest wording like:

Lots of families in my practice keep guns at home. Sometimes when a gun owner is struggling in the ways...
you’ve described and has thoughts of suicide, they’ll temporarily store their guns such that they can’t get to them in a moment of desperation. For example, some people will ask their friends to hold onto their guns, others will store their guns locked up and keep the key in a safe deposit box at the bank until they’ve recovered. Are these strategies you might consider?

The focus is not on questioning a patient on whether they have guns; rather it is on providing useful information in the event they do.

This message is appropriate not only for patients who are clearly suicidal, but also for those who are struggling. A patient suffering from PTSD may not be suicidal today. Two months from now, however, when his anxiety has worsened and he’s on his second drunk-driving arrest, or his wife leaves him, he may rapidly become so. When referring a patient for mental health or substance abuse treatment, consider delivering the firearm safety message and adding, “I mention this because sometimes a crisis hits and people experience strong suicidal feelings; those feelings often go away in a matter of hours or days. If a period like that hits, I want to make sure you stay safe and call for help.”

Providers well positioned to deliver this message include not only internal medicine and family medicine physicians, pediatricians, and mental health clinicians, but others who see individuals in crisis, including social service workers, clergy, and first responders. Those who advocate for firearm access and firearm safety—such as firearm instructors, gun retailers, shooting sports groups—are also well positioned to promote suicide prevention as a basic tenet of firearm safety. Some have recently begun to do so and are valuable messengers.12,14 They are also a valuable source of advice on local firearm storage options that are consistent with state law. For example, in a few states, storing one’s guns with a friend may violate state law.

Thirty years ago no one had heard the phrase “designated driver” or “friends don’t let friends drive drunk.” Today they are part of common parlance and have led to a new social norm. Physicians, media outlets, bar owners, advocacy groups, and the beverage industry all had a role in reducing the social acceptability of drunk driving. Similarly, physicians, firearm advocates, and many others can change social norms by communicating this message: putting time and distance between a suicidal person and a gun can save a life.12 Doing so could substantially reduce suicide in the US—without improving the mental health system (as laudable a goal as that is) and even without changing any gun laws.

References