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Older Adults and Planning for Firearm Safety: A Qualitative Study of Health Care Providers

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Abstract

Purpose/Background: Firearm injury, particularly self-directed, is a major source of preventable morbidity and mortality among older adults. Older adults are at elevated risk of serious illness, cognitive impairment, and depression - all known risk factors for suicide and/or unintentional injury. Health care providers are often the first to identify these conditions and,

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although they commonly deliver safety guidance to such patients, little is known about how they approach firearm safety conversations with older adults.

Methods: We conducted semi-structured interviews with health care providers who care for older adults (November 2020- May 2021). We used inductive and deductive thematic analysis approach to develop themes. We present themes and representative quotes from our analysis.

Results: We interviewed 13 health care providers who regularly care for older adult firearm owners. Emergent themes were: circumstances that prompt firearm safety conversations; strategies for addressing firearm safety in routine and acute circumstances; barriers to addressing firearm safety; and available or desired resources.

Conclusion: Planning for firearm safety should occur "early and often" as part of a longitudinal relationship with older adult patients. Age-related safety issues such as driving are regularly addressed with older adult patients, likely because there are standard processes and established pathways. Establishing processes and provider/ patient resources would help improve provider efficacy to address firearm safety and relinquishment for older adult firearm owners. Integrating firearm safety conversations into routine encounters (e.g., Medicare Annual Wellness Visit, problem focused visits) templates could be a promising initial step but resources for follow up to the firearm screening must be available to both provider and patient.

Keywords

Firearm Safety; Safety Assessment; Dementia; Health Counseling; Suicide Prevention

INTRODUCTION

Nearly half of older adults own a firearm or reside with one.[1] Older adults are more likely than younger adults to be diagnosed with cognitive impairment and age-related sensory, motor and visual changes, putting them at greater risk for suicide and unintentional firearm injuries.[2–4] Clinical settings have very high potential to intervene prior to a suicide attempt; up to 95% of older adults who die from suicide have a medical visit in the preceding year.[5]

Clinicians caring for older adults frequently counsel patients on older adults and their family members regarding safety issues such as driving cessation. These sensitive conversations are challenging to initiate and navigate, prompting the creation of guidance and supportive frameworks.[6–8] Despite studies demonstrating that older adults are generally open to their clinicians counseling them about the safe use of firearms and that firearm assessment may reduce firearm injury,[9,10] firearm safety guidance is lacking and resources directed to the older adult and their family members/care partners are few.

Little is known about healthcare provider perceptions of delivering firearm safety counseling and associated strategies for older adult patients, warranting an initial explorative qualitative study. We examined health care provider (HCP) perceptions on firearm safety conversations, and what might be needed to engage patients and their care partners.

Methods

Data Collection

Data were generated through semi-structured interviews. Eligible participants were healthcare professionals (social worker, psychologist, physician, senior living facility manager) who provide care to older adults. Participants were recruited through social media, institutional email listservs, study team personal networks and major professional networks tailored toward older adult health care providers (e.g., American Geriatrics Society, Alzheimer's Association, local Area Agencies on Aging). Snowball sampling was used to identify and recruit additional participants. Gift cards ($50 value) were provided as compensation.

Interviews (30–60 minutes) were conducted between November 2020 and May 2021 by team members with qualitative research expertise (LP, EP). Interviews explored circumstances surrounding the engagement of patients and/or care partners in firearm safety discussions, barriers and facilitators to initiating conversations and helpful resources for engaging older adults and care partners. Semi-structured interview guides were iteratively developed throughout interviews and are presented in Supplementary Appendix S1.

Data Analysis

For analysis and reporting, we followed recommended Consolidated criteria for Reporting Qualitative Research (COREQ) guidelines for reporting qualitative research (Supplementary Appendix S2).[12] Interviews were recorded, transcribed, and transcripts were cross-checked with recordings for accuracy by a member of the study team (EP).

We primarily used the Qualitative Descriptive approach,[13] focusing on describing perceptions and experiences of our participants. Coding followed an inductive/ deductive approach to facilitate identification of themes. Four members of the research team (EP, LP, KN, TL) participated in coding the interviews using Dedoose.[11] Team members (LP, EP, KN, TL) independently double-coded 92% of all transcripts. Weekly coding meetings facilitated shared agreement between coders in code definition and application. Differences in coding were discussed, deliberated, and subsequently resolved. After each interview, we completed a structured debrief using a standardized set of reflection prompts to identify major themes, new insights that emerged and convergence/divergence from other interviews (Supplementary Appendix S3).[14] Data saturation was reached in our sample when no new themes emerged. Additional details on methods are available in Supplementary Appendix S4.

Results

Health care provider credentials are available in Table 1. Several themes emerged through our interviews, including barriers/ facilitators to addressing firearm safety, circumstances prompting firearm safety conversations, and strategies for addressing firearm safety. Barriers and facilitators are identified and described in Table 1 (visual depiction in Supplementary Figure S1), and include lack of established pathways for triaging firearm concerns (barrier), contentious relationships with caregivers/ family members

(barrier), engagement of caregivers as partners (facilitator), understanding reasons for ownership (facilitator), understanding values (facilitator), tailoring conversations based on the individual (facilitator), and peer-based interventions (facilitator). The remaining themes are described below, with representative quotes.

Circumstances Prompting Firearm Safety Conversations

Participants recognized the need to discuss firearm safety and felt it was within their scope to integrate these discussions into care planning with older adults. Physical illness and disability were highlighted as particularly high-risk circumstances due to their impact on social roles and isolation. While the firearm initially served as a means for social connectedness (e.g. hunting, target shooting), the context of illness shifts toward greater risk of depression and isolation and represents a new era of risk related to firearm access.

> "Disability, dysfunction, illness, chronic pain syndromes [and the] impacts on somebody physically [and] the psychologically symbolic meanings of having an illness. The social implications - social disconnectedness - [that is] isolating people from others around them or from meaningful roles in their lives." INT 3
>
> [Male]

This geriatric psychiatrist noted that it wasn't solely the illness or pain syndrome that was concerning, but instead a combination of those conditions with unrestricted access to a firearm. Several providers emphasized the importance of having the conversation early, and perhaps unprompted by high-risk circumstances, separate from diagnoses of physical and mental health conditions. One geriatric psychiatrist stated:

> "Early intervention and education, bringing up these issues as points of discussion before the person has any risk or crossroads. It's a very different discussion than later on when somebody is confused, cognitively impaired or depressed and suicidal." INT 3
>
> [Male]

The quotes represent two common themes that presented in our interviews: considering the acute risk to the individual, while also normalizing these conversations as part of routine care.

Strategies for Addressing Firearm Safety Counseling

Several potential strategies emerged for addressing firearm safety conversations, both in the context of routine care and in acute circumstances. For routine prevention, providers mentioned primary care appointments as an appropriate venue for firearm safety conversations, emphasizing that this format allows for regular check-ins and assessment of changes in health and safety. For example, one geriatrician stated:

> "I would like to see it be done as part of the Medicare Annual Wellness Visit, which is actually when many of us think inquiries about driving should be done and considered part of a routine safety intervention." INT 5
>
> [Female]

A health care provider working at the Veterans Health Administration mentioned the conversations could occur in many settings, but initiating them in primary care rather than during mental health encounters might serve to normalize and de-stigmatize them:

> "People trust their primary care doctors a lot…even maybe the nurse who's doing their vitals. I think Veterans usually like their nurses and primary care docs, but I really want anyone to do it. I think it fits well in any mental health appointment but would be more impactful if it happened during a non-mental health appointment, so that it doesn't feel like it's attached to their mental health diagnosis." INT 4
>
> [Female]

This same health care provider discussed the logistics of initiating these conversations in a primary care encounter, and suggested normalizing them:

> " Asking as part of a battery of questions 'how many firearms you have access to?' and processing it by saying, 'you know, this is a question that we ask everybody and we recognize that a lot of folks in this area [own firearms], and a lot of veterans have access to firearms. So, I just want to check in about how many you might have access to and see how you're storing them to make sure we have a good plan.'" INT 4
>
> [Female]

Underscoring the importance of proactively addressing firearm safety and access, a social worker caring for older adults with cognitive impairment described competing priorities as a challenge of counseling on firearm safety when an older adult is diagnosed with dementia:

> "Our family conferences are oftentimes over two hours long, there's only so much that we can talk about then. I do worry about the amount of information that we have and choosing which things to talk about. I feel an ideal situation you disclose the information, 'You have this diagnosis. These are things that you can do, we want you to get through this, we're here for you' and then at a follow up appointment say, 'now that you've had some time to adjust, we want to follow up on firearm safety.' I feel that would be ideal, but I also worry that you don't always have a second chance to have that conversation." INT 2
>
> [Female]

In more acute cases or when the firearm owner is more reluctant to discuss firearm safety, the issue of safety for others in the home served as a powerful motivator for patients and their care partners. A focus on others' safety – particularly loved ones – was receptive and leveraged by health care providers to initiate and promote firearm safety planning. A clinical psychologist and policy expert said:

> "We also bring up the fact that for a lot of older adults, they may have grandchildren around as well. So, that's a really easy way of broaching the topic." INT 1
>
> [Female]

The “grandchildren conversation” may be particularly motivating for older adults, as the risk the firearm represents to them in terms of self-harm may be less obvious or concerning.

Discussion

Our study is the first to describe the experiences of health care providers who care for older adults in delivering firearm-related counseling to older adults and their care partners or family members. We found that healthcare providers generally believed it was important to address firearm safety with older adults and were supportive of normalizing and integrating firearm safety into routine clinical care. We identified several barriers and potential facilitators (Table 2) which could be explored to improve delivery of these discussions, including standardized approaches and the development of guidance and other resources for clinicians.

In ideal circumstances, routine primary care appointments were viewed as an appropriate setting for facilitating firearm safety conversations and might help to normalize these discussions. Adding firearm safety into established clinical templates, including those used in the AWV, was an approach some providers were already using in their clinical practice for safety assessments.[15] In support of this suggestion, adding standardized language into templates has been found to increase the occurrence of conversations on firearm access and other age-related safety concerns such as driving and falls.[16,17]

Focusing interventions solely on routine primary care visits is likely to miss a large portion of older adults in need of firearm safety counseling, as time-limited visits may need to prioritize complex medical problems over safety concerns. Similarly, focusing on establishing firearm safety templates within the context of AWV may be insufficient given the low uptake.[18,19] Interventions to address firearm safety will need to be tailored to settings where older adult firearm owners are most likely to seek care, particularly in the context of medical/mental health comorbidities. There will need to be a multi-prong approach with standardized processes and templates for firearm safety counseling in wellness and problem-focused encounters, specialty care settings and in community settings that serve older adults.

Involving others such as family members, care partners and peers was seen as important by health care providers. Several providers mentioned using models for peer-supported interventions, such as interventions for advance care planning and driving cessation programs[20–22] as a framework to develop firearm safety programs. Involving care partners was seen as critical, but not without carefully considering the underlying tensions that could create counter-productive conversations in the case of contentious relationships.

Finally, recognizing firearm owners’ values should be foundational to any routine approach. Many firearm owners value their firearms as part of their identity, culture, and as a tradition passed down through generations within family.[23–25] Understanding these values helps build rapport, allowing collaborative conversations regarding suitable substitutions and plans for addressing firearm safety.[26] Future directions include larger qualitative studies to assess perceptions of sub-types of health care providers, as well as the development

and testing of clinical interventions and clinical implementation of planning tools (i.e. firearmlifeplan.org[25]) to facilitate firearm safety counseling for older adults.

Our study is limited due to the small sample size, however we captured a diverse range of providers caring for older adult firearm owners. Our secondary analysis of health care providers' perceptions of firearm safety planning is a novel and initial exploration of relevant themes, similar to other studies in the firearm literature.[27–30] Future studies should include larger sample sizes, with adequate representation to allow for thematic saturation by provider type and specialty. Most of our participants were white and two-thirds identified as having a liberal political orientation. Future studies must focus on providers from diverse racial/ethnic groups and capture more firearm-owning providers as well as those who are politically conservative.

Conclusions

Providers in our study expressed that firearm safety counseling is necessary but established resources to address this problem are lacking. Developing clinical workflows to normalize firearm safety conversations is critical, as is ensuring equity through tailoring counseling for diverse settings of care, including those serving medically fragile and/or traditionally underserved older adults. Interventions must consider individual values on firearm ownership to address this complex and deeply engrained personal decision to own and use firearms.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Key Points:

- Many older adults live with firearms in the home and have not considered planning for the future, as they would with other safety concerns (e.g. driving)
- Health care providers caring for older adult patients feel that having firearm safety conversations early and often in primary care is important, but also feel unprepared by the lack of resources available to facilitate these conversations.
- Firearm safety planning tools and educational resources tailored to older adults and care partners could help facilitate conversations with health care providers.

Why does this matter:

This research matters because health care provider perspectives on counseling older adults on firearm safety has not yet been studied.

Table 1 –

Demographics of Healthcare Provider Interviewees (N=13)

Characteristic	n (%)
Gender	
Female	9 (69%)
Male	4 (31%)
Primary race	
White	9 (69%)
Asian	4 (31%)
African American	0 (0%)
American Indian/Alaska Native	0 (%)
Hispanic ethnicity	2 (15%)
Political Stance	
Liberal	8 (62%)
Moderate	3 (23%)
Conservative	1 (7.5%)
No opinion/don’t know	1 (7.5%)
Provider Degree	
Psychologist/ Psychiatrist	4 (31%)
Geriatrician	2 (15%)
Other Physician	4 (31%)
Social Work (MSW)	3 (23%)

Table 2.

Representative Quotes for Barriers & Facilitators of Firearm Safety Counseling

Parent Code	Brief Description	Representative Quote
Barriers	*Lack of established pathways for reporting concerns related to firearm safety.*	*"The other tricky part as a clinician is that even if you know these things, it's not like with driving where you can just report them to the DMV [Department of Motor Vehicles]." INT 6 [Female]*
Barriers	*Caregiver relationship as potentially detrimental to engaging in firearm safety conversations/ planning.*	*"Interesting to think about then the potentially problematic issues that might arise not just because that relationship between the older person [and] the caregiver [is] particularly troubled, or just not facilitating communication about personal things over the long haul [and] then differences with regard to political, social perspectives." INT 3 [Male]*
Facilitators	Engagement of caregivers as potential partners.	"*We probably under engage caregivers. Perhaps if we can engage caregivers earlier, we may have more accurate understanding of firearms in the house and of potential next steps that might work, and then ability to follow through." INT 7 [Female]*
Facilitators	*Understanding reasons for ownership to promote engagement in planning for the firearm.*	*"We need to do a better job of understanding the role and purpose of guns in the past and currently. If the value and the purpose of the gun has changed, then we can tailor resources to the next good they hope that gun can have." INT 7 [Female]*
Facilitators	*Understanding values related to the firearm to promote engagement in planning for the firearm.*	*"I wonder if some see their firearms as legacy, and so transitioning it to the next generation - just like they may have outside work equipment that they want to give to someone - because they value it." INT 7 [Female]*
Facilitators	*Understanding heterogeneity in firearm ownership and tailoring conversations based on the individual.*	*"It seems like there are different classes of firearms owner …if it's someone who sees the firearm as a utilitarian tool, it was something needed to protect [their] cattle when [they were] actively ranging, I think that's a very different discussion than talking with someone who truly sees firearm ownership and second amendment rights as vital to their self-identification. I do think there are folks on that end of the spectrum and we're probably not going to make headway as clinicians by devaluing or coming from a place of misunderstanding. It's that latter group that's going to be more difficult. Making it clear to the patient and to whoever else is involved that you can see why their value is so high and making clear that you're not coming from a completely diametrically opposed viewpoint or at least expressing an understanding of that viewpoint. I think that's the entry way." INT 8 [Male]*
Facilitators	*Peer-based interventions as a potential approach.*	*"… I could imagine an approach that uses peers, much like the folks who are trained in advanced care planning, you could have someone who is trained in talking about firearm retirement." INT 9 [Male]*