BulletPoints
Stakeholder Symposium

March 16, 2020
Epidemiology of Firearm Injury

Garen Wintemute, MD, MPH
Director, University of California Firearm Violence Research Center
Professor, Dept. of Emergency Medicine, UC Davis School of Medicine
“If it’s not a health problem, then why are all those people dying from it?”

- Dr. David Satcher, 1993
US, 2009-2018:
• 337,957 deaths from firearm violence (homicide, suicide)
• 350,586 total firearm deaths

US, 2018:
• 38,390 deaths from firearm violence
• 74% of homicides, 51% of suicides involved firearms
Death Rates from Motor Vehicle Traffic Events and Firearms, 1950-2018

Deaths/100,000 Population

Year

Data from CDC WISQARS
Death Rates from Firearm Suicide and Homicide, 1981-2018

Data from CDC WISQARS
Death Rates from Firearm Homicide
Males, 2018

Deaths/100,000 Population

Age

White
Black
Hispanic

Data from CDC WISQARS
Death Rates from Firearm Suicide
Males, 2018

Data from CDC WISQARS
Death Rates from Firearm Homicide
Females, 2018

Deaths/100,000 Population

Age

White
Black
Hispanic

Data from CDC WISQARS
Death Rates from Firearm Suicide
Females, 2018

Deaths/100,000 Population

Data from CDC WISQARS
Death Rates from Firearm Violence
Males, 2018

Data from CDC WISQARS
Deaths from Firearm Violence
Males, 2018

Data from CDC WISQARS
Death Rates from Firearms Children, 2018

Suicide
Homicide
Unintentional

Data from CDC WISQARS
Violence, Suicide, and Firearm Policy

Amy Barnhorst, MD
Director, BulletPoints Project
Vice Chair, Department of Psychiatry and Behavioral Science, UC Davis School of Medicine
Assumptions

• People who threaten / commit mass shootings are mentally ill
• People who threaten / complete suicide are mentally ill
• People with mental illness can’t buy / own guns
• Everyone who buys a gun has to go through a background check
• We have a great system! 👍
2018 Firearm Fatalities

- 64% Firearm suicides
- 36% Firearm homicides
- 0.2% Mass shooting deaths

Data from CDC WISQARS & Mother Jones Mass Shooting Database
Second Amendment to the Constitution

“A well regulated Militia being necessary to the security of a free State, the Right of the People to keep and bear Arms shall not be infringed.”
The Gun Control Act of 1968

Regulates firearm industry and owners and prohibits ownership by “prohibited persons” including:

• Felons
• Unlawful users of or people addicted to a controlled substance
• Respondents to DV restraining orders
• Anyone “adjudicated as a mental defective” or who has been “committed to any mental institution”
The Brady Act of 1993 and the NICS System
The Brady Act of 1993 and the NICS System

Established background check system for all FFLs: National Instant Criminal Background Check System (NICS)
State Reporting to Federal NICS Database

By i happy!! from NY, NY (Flickr) [CC BY 2.0 (http://creativecommons.org/licenses/by/2.0)], via Wikimedia Commons
California State-level Prohibitions

• Admission for dangerousness
• Tarasoff (duty to protect) statute
• Violent misdemeanors
Other California Policy

- Universal background checks
- Purchase waiting period
- Minimum age for purchase of 21
- Purchase quantity limitations
Other California Tools

- Extreme Risk Protection Orders (ERPOs)
- Armed Prohibited Persons Program (APPS)
Physicians and Firearms

Rocco Pallin, MPH
Director of Education, BulletPoints Project
Research Data Analyst, Violence Prevention Research Program, UC Davis School of Medicine
What we know

- Preventable deaths from firearms
- Identifiable risk factors
- Physicians feel within clinical responsibilities
- Pts say generally appropriate
- Physicians often report needing more information
Barriers exist

- Legal considerations
- Discrepant policy
- Concern for alienating patients
- Gaps in knowledge (of firearms, risk, recommendations, etc.)
The approach

Physicians have unique potential

Counseling should be
• Risk-based
• Informed
• Individualized
• Evidence-based
• Acceptable
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The message

Reduce access for those at risk
Informed, acceptable, individualized

• Put this in context
• Remember the importance of trust
• Know what safe storage means
• Use appropriate language
• Be aware of policies and tools
• Make reasonable recommendations
• Know your own gaps in knowledge
What facilitates and what impedes talking about firearms? Changing storage behaviors? Limiting access in emergencies?

What makes screening and interventions effective?

How can we engage with families and trusted people to those at risk?

How can providers become more trusted messengers?

How can providers collaborate with owners on preventing firearm injury? Better understand varying backgrounds? Change the conversation around reducing firearm injury?
Cultural Humility in Patient Interactions

Kara Toles, MD
Assistant Clinical Professor, Dept. of Emergency Medicine, UC Davis School of Medicine
Director, Equity and Inclusion
Objectives

Explore concepts of culture, cultural humility, and bias

Improve culturally humble, non-judgmental communication with patients around gun violence
**Big Picture**

How not to alienate patients who come from different backgrounds especially around topic of gun violence?
What constitutes culture?

Race, Body type, Immigration status, Socioeconomic status, Religion, Sex, Gender, Physical ability, Sexual Orientation, Many others, Gun ownership
1. Culture is complicated
2. Cultural “competence” is a fallacy
3. Cultural humility is key
Cultural “competence” vs. humility

Competence
• Mastery of a finite body of knowledge

Humility
• Lifelong commitment to self-evaluation, self-critique, redressing the inherent power imbalances in the patient-physician dynamic, and meaningful partnership with communities (Tervalon and Murray Garcia, J)
• Requires acknowledgement of individual and systemic forces that negatively impact marginalized communities (Fisher-Borne et al)
# Social Identities and Systems of Oppression

## Oppression Matrix

<table>
<thead>
<tr>
<th>Type of Oppression</th>
<th>Privileged Social Group</th>
<th>Border Social Groups</th>
<th>Oppressed Social Groups</th>
<th>Social Identity Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racism</td>
<td>White People</td>
<td>Biracial People</td>
<td>Asian, Black, Latina/o, Native People</td>
<td>Race</td>
</tr>
<tr>
<td>Sexism</td>
<td>Biological Men</td>
<td>Transsexual, Intersex People</td>
<td>Biological Women</td>
<td>Sex</td>
</tr>
<tr>
<td>Transgender Oppression</td>
<td>Gender conforming biological men and women</td>
<td>Gender ambiguous biological men and women</td>
<td>Transgender, Genderqueer, Intersex People</td>
<td>Gender</td>
</tr>
<tr>
<td>Heterosexism</td>
<td>Heterosexuals</td>
<td>Bisexuals</td>
<td>Lesbians, Gay men</td>
<td>Sexual Orientation</td>
</tr>
<tr>
<td>Classism</td>
<td>Rich, Upper Class People</td>
<td>Middle Class People</td>
<td>Working Class, Poor People</td>
<td>Class</td>
</tr>
<tr>
<td>Ableism</td>
<td>Able-bodied People</td>
<td>People with Temporary Disabilities</td>
<td>Disabled People</td>
<td>Ability/Disability</td>
</tr>
<tr>
<td>Religious Oppression</td>
<td>Protestants</td>
<td>Roman Catholic (historically)</td>
<td>Jews, Muslims, Hindus, Sikhs</td>
<td>Religion</td>
</tr>
<tr>
<td>Ageism/Adultism</td>
<td>Adults</td>
<td>Young Adults</td>
<td>Elders, Young People</td>
<td>Age</td>
</tr>
</tbody>
</table>

*National Museum of African American History and Culture*
Bias

Defined
• Positive or negative attitudes that a person holds toward another person, group or thing

Explicit bias
• Conscious

Implicit bias
• Attitudes and beliefs which are **unconscious**
• These are part of our biology and evolution
• They can help us adapt (auto-pilot)
• They can also be irrational, harmful
• **We all have them**
How not to alienate patients who come from different backgrounds, especially around the topic of gun violence?
Summary

- Culture is complicated, especially with regard to guns
- Understanding individual biases (both explicit and implicit) is critical
- Understanding systems of oppression which impact marginalized communities is critical
- Cultural humility is the goal and likely a life-long process which requires meaningful partnership with affected communities
Hospital-Based Violence Intervention Programs (HVIPs)

Nicole Kravitz-Wirtz, PhD, MPH
Assistant Professor, Dept. of Emergency Medicine, UC Davis School of Medicine
Too often, violence is recurrent

Exposure to interpersonal violence is a form of trauma

“Hurt people, hurt people”

Among the strongest predictors of future violent injury is previous violent injury

HVIPs aim to disrupt the cycle of violence
HVIP principles

Life-saving medical care alone is not sufficient

Unique “window of opportunity” following violent injury

Health care providers may not be effective messengers, but can facilitate connections to Violence Intervention Specialists (VIS)

VIS provide relationship-based mentoring and intensive, individualized case management
Admit to Trauma Center
- May make contact with family, next of kin

Visit bedside and establish rapport
- Relationship development may be slow and require multiple visits

HVIP enrollment and consent
- Initial needs assessment

Post-discharge programming/case management (6-12+ months)
- Address evolving needs and support longer-term goals

Transition to natural and community-based supports
Mental health services
Court advocacy
Job training
Employment
Education
Housing
Victim of crime assistance
Substance abuse treatment
Court advocacy
Existing evidence on HVIPs

Evaluations of individual HVIPs have demonstrated success
- Receiving mental health services
- Obtaining employment/returning to school
- Increased self-esteem
- Decreased trauma recidivism
- Hospital cost savings

Need for multi-site studies, over longer time periods, including qualitative assessments
Additional resources

The Health Alliance for Violence Intervention (HAVI)

https://www.thehavi.org/
Research & Evaluation

Amanda Charbonneau, PhD, MPP
Director of Research & Evaluation, BulletPoints Project
Postdoctoral Fellow, Violence Prevention Research Program, UC Davis School of Medicine
NEEDS ASSESSMENT

Identify gaps in education on firearm injury prevention

PROCESS EVALUATION

Reach institutions, organizations, providers

OUTCOME EVALUATION

Increase knowledge among providers
Prevent firearm injuries

RESEARCH

Develop tools for risk prediction and supporting clinical decisions
Does your institution or organization currently provide education for healthcare providers on clinical strategies for firearm injury prevention?

- No
- Yes
- Don't Know
How useful would the following materials be at your institution or organization?

- Tools for risk assessment/intervention
- Case-based learning modules
- Mobile app/decision support tool
- Live, in-person lecture
- Slides and talking points
- Online continuing education
- Library of literature
- Patient handouts
- Media talking points
“It is our role as healthcare providers to be at the center of firearm injury prevention, and to be effective, we need to be educated.”
Thank you

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Clinical tools for preventing firearm injury

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