

Preventing Firearm-Related Deaths Among Service Members and Veterans

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Heightened risk of death by suicide among military service members and veterans reflects employment of firearms as a favored means. This commentary offers a practical preventive approach employing lethal means reduction, addressing upstream factors, identifying current and former service members in community settings, and understanding their unique culture and concerns.

Introduction

On February 12, 2015, I made my way to the East Room of the White House for the signing into law of the Clay Hunt Suicide Prevention for American Veterans (SAV) Act. Clay Hunt was a 28-year-old Marine veteran of Operation Enduring Freedom in Afghanistan (OEF) and Operation Iraqi Freedom in Iraq (OIF) who ended his life with a firearm in 2011. As President Obama addressed Senator John McCain, House Speaker Nancy Pelosi, the Secretary of Veterans Affairs (VA), and other assembled stakeholders and advocates for service members and veterans—including Clay Hunt's parents—he poignantly noted: “Today we honor a young man who *isn't* here but who *should* be here” [1]. Later that afternoon, attendees joined a still larger group at the Willard Hotel and cheered speakers as they predicted significant reductions in veteran suicide thanks to the new law. As others rejoiced around me, I was gripped by angst: How could I, as VA's national policy lead for mental health, possibly accomplish that goal within the limited provisions of the Clay Hunt Act? This commentary shares lessons learned and offers a practical approach to reducing suicide risk among service members and veterans.

The Scope of the Problem

In his introduction to a 2021 White House report, President Biden observed that, “In an average day, 17 veterans die by suicide—not in a far-off place, but right here at home. Two service members on average die by suicide every day of the year” [2]. This report cites Department of Defense (DoD) data documenting 580 suicide deaths among the military in 2020. VA's National Veteran Suicide Prevention Annual Report for 2022 reports 6146 veteran suicide deaths among veterans that year [3]. VA data indicate that women veterans die by suicide at almost twice the

rate of non-veteran women, and veterans aged 18–34 die by suicide at almost three times the rate of their non-veteran peers [3]. Another key VA finding is that veterans are more likely to employ firearms in their suicides than are non-veterans (71% versus 50%) [3].

Veterans are also more likely to own firearms than the general population (45% versus 20%, respectively) [4]. Nationwide, firearms account for more than half of all suicide deaths, and suicides account for more than 60% of firearm-related fatalities [5]. When employed for suicide, firearms are lethal 90% of the time. In 2018, the rate at which Americans died by suicide with a firearm was twice that of the next most frequent lethal means and greater than all other lethal means combined [6]. The greater likelihood that a service member or veteran possesses a firearm combines with the greater lethality of firearms to help explain the increased rate of death by suicide among veterans. It may also be that the increased risk of death by suicide among women veterans stems from being more likely to employ a firearm than their non-veteran peers (48.2% versus 33.3%, respectively). Since September 11, 2001, significantly more military women have served in combat areas where they were required to be armed at all times. This coincides with an 11.2% increase in the number of suicide deaths among women veterans attributable to firearms since 2001 [5].

Two key conclusions can be drawn: 1) access to firearms and familiarity with their use may account for the increased suicide risk among service members and veterans, including the significantly increased risk of suicide among female veterans; and 2) lethal means reduction by decreasing access to firearms may be the single most effective means of reducing the rate of suicide among veterans.

Lethal Means Reduction

Lethal means reduction does not require taking away a firearm. Such extreme measures are bound to fail, if only because many service members and veterans prefer to own

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firearms, and they often express concern that talking with clinicians about suicide or admitting to owning firearms might curtail their ability to own a firearm. For service members, losing the ability to carry firearms could be a career-ending move. The National Alliance for Suicide Prevention advises that simply putting time and distance between a firearm and a person in crisis can be sufficient to reduce suicide risk. For example, a 2019 study found that only 6% of veterans agreed with the well-established finding that guns in the home increase suicide risk [7]. A well-designed, culturally sensitive educational initiative that encourages gun owners to store firearms safely could be a highly effective suicide prevention intervention among the 94% of veterans who don't perceive that risk.

Lethal means reduction is an evidence-based intervention. Lubin and colleagues reported a 40% decline in overall suicide rate among soldiers four years after a policy change limited their access to military-issued firearms during weekend leave [8]. This decrease corresponded to a decline in weekend suicides. Reisch and coauthors documented a marked reduction in suicide in Switzerland after that nation cut the size of its army by half, thus reducing the number of service members in possession of military-issued firearms [9]. Research shows that 24% of suicide attempts advance from thought to action within five minutes, and nearly half of suicide attempts advance within 19 minutes [10]. If it requires more than five minutes to access, load, and discharge a firearm, a substantial reduction in completed suicides could be achieved. Simple measures, such as keeping weapons unloaded, storing ammunition separately, and employing gun locks and/or gun safes, are best practices in suicide prevention. VA continues to distribute millions of free gun locks with no questions asked through suicide prevention coordinators at local VA medical facilities. DoD and VA are working with other federal agencies to develop a national plan for lethal means safety awareness, education, training, and program evaluation.

VA policy requires clinicians to evaluate access to lethal means among patients who may be at risk for suicide and, whenever possible, take steps to limit that access [11]. Clinicians are trained to collaborate with patients and families to develop effective, and preferably voluntary, plans for lethal means reduction. Clinical experience demonstrates that people at imminent risk for suicide are often willing to place a firearm in the custody of a relative, friend, or even with local law enforcement staff until they feel safe having access to a firearm. Other means of limiting access to firearms include "red flag laws," which temporarily remove firearms from an individual's possession during periods of potential danger.

Addressing Upstream Risks

The White House and VA reports emphasize that suicide prevention ultimately requires a public health strategy based on understanding and addressing upstream risks and protec-

tive factors in community settings. The National Academies of Sciences, Engineering, and Medicine (NASEM) recently advocated for a seismic shift in American health care from its current biomedical focus to a whole health approach [12]. Whole health care offers an important opportunity to practice far-upstream suicide prevention. Whole health focuses on physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities. This requires focus on the social determinants of health (SDOH), which account for most of the variance in health outcomes [13]. These include health behaviors; social, economic, housing, educational, and vocational needs; and the natural and built environments in which people and communities reside. NASEM proposes that VA's new Solid Start Program, a military-to-civilian transition system through which new veterans have regular contacts with VA during their first year post-separation, could incorporate brief well-being measures to enable early detection and mitigation of upstream suicide risk.

Among the most important findings in VA's Suicide Prevention Annual Report is that veteran suicide is most common among those who are not current users of VA care (60.3% versus 30.7%, respectively, in 2020). Just half of approximately 20 million living veterans used at least one VA benefit or service in FY 2017 [14] and little is known about the nature and severity of health conditions, patterns of health care utilization, or unique risk factors for suicide among the other half.

Even among veteran users of VA health care, a significant percentage seek at least some health services outside VA. This includes a growing number of veterans who receive community care at VA direction and expense through the Mission Act or through VA's recent initiative to cover costs for any veteran in acute suicidal crisis (even those not enrolled in VA) at any VA or non-VA health care facility for emergency care—including inpatient or crisis residential care for up to 30 days and outpatient care for up to 90 days [15]. Recent developments in military health suggest that service members, many of whom are already being followed in the community through TRICARE, will be increasingly routed to community care as part of the development of the Defense Health Agency.

These developments raise a crucial question: What do the community clinicians and health systems know about service members, veterans, and their families, or about DoD and VA health programs and resources? Unfortunately, studies of community clinicians reveal that most feel neither clinically nor culturally competent to work with veterans or VA [16, 17]. Many community clinicians and administrators doubt that such competencies are important because they may mistakenly believe that all veterans are enrolled in VA or because their practice is hundreds of miles from any military base, not considering that veterans live in virtually every county, state, and territory in the nation. For example, the most recent VA data show that more than 730,350 veter-

ans live in North Carolina, comprising more than 9% of the state's adult population; more than 11% of these veterans (nearly 82,600) are women [18].

Veterans are often reticent to self-identify in clinical settings out of concern that civilian doctors won't understand their military experience or might look down upon military service in general. In addition, some service members seek care outside of DoD programs because they fear that their medical problems might derail their military career. Members of the National Guard and Reserves often depend on civilian health systems because they live hundreds of miles from military treatment facilities. Even if a service member or veteran tells front-desk staff that their care is covered by TRICARE or VA, that information may not show up on the clinician's computer. Not knowing that a patient served in the military makes it less likely that clinicians will ask about early hearing loss, muscle and back problems, head injuries, travel history, combat experience, or other health issues that may be associated with military service. Further, significant health resources available to service members and veterans (including but not limited to pharmaceuticals and supplies at low or no cost, neuroimaging, neuropsychological testing, pain management, rehabilitation services, prosthetics, and geriatric services) may not be accessed if military service isn't noted or if the clinician isn't familiar with DoD or VA health benefits. Financial support, housing assistance, caretaker support, and a host of other services available to those who have served in the military might never be tapped. Finally, such patients might not be screened for suicide risk even though their risk is 50% greater than that of non-veterans. Given the actionable information to be gained and the range of health resources that could be leveraged (many of which address SDOH, which may impact suicide risk [19]), simply asking whether the patient or someone close to them served in the military could be a powerful means of reducing the risk of suicide among service members and veterans.

Looking Ahead

At the close of the signing ceremony for the Clay Hunt Act, President Obama suggested that, "The best way to honor this young man who should be here is to make sure that more veterans like him are here for all the years to come" [1]. If fewer than half of all veterans are enrolled in VA and most seek health care through community practices and health systems, suicide prevention for service members and veterans depends to a great degree upon the efforts of the larger medical community. Ensuring that service members and veterans receive appropriate care is the best way that we, as medical professionals, can honor those who have served the nation. NCMJ

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