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Session: Promoting Firearm Safety among Veterans at Risk of Suicide – Challenges and Opportunities

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Molly: We are at the top of the hour now, so at this time I would like to introduce our presenter. Joining us today we have Dr. Joe Simonetti. He is an investigator at the Rocky Mountain MIRECC, an investigator for the Seattle-Denver Center of Innovation for Veteran-centered and value-driven care, and hospitalist with the hospital medicine group at Denver VA Medical Center. We are very grateful for Dr. Simonetti for joining us today. And at this time, Joe, I would like to turn it over to you.

Dr. Joe Simonetti: Okay, thank you. Okay. And are you able to see the screen there?

Molly: We are, thank you.

Dr. Joe Simonetti: Okay. All right, well thank you everybody. I appreciate you joining us today. Today I'm going to be talking about promoting firearm safety among Veterans with a large focus on some findings from the 2015 National Firearms Survey. I want to really start by acknowledging Matt Miller and Deb Azrael who are two investigators who have done a lot of work in this field and initially funded and designed the National Firearms Survey, along with Ali

Rowhani and Emily Cleveland, two colleagues of mine. You have done a lot of work with me on these survey findings including a lot of the stuff I'll be presenting today among Veterans. I don’t have any disclosures, no conflicts of interest that anybody should know about.

The outline is fairly straightforward on my talk. I’m going to give you just a few slides, a little bit of primer on Veteran suicide epidemiology with a real focus on the role of firearms and why firearms are sort of unique when we discuss suicide risk among Veterans. Then we’re going to go over what I think are some of the main findings from the 2015 National Firearms Survey as it relates to Veterans and suicide prevention. And the discussion I want to frame really what are the implications of those findings for the two groups of people who might be on the call today, the clinicians or any of the clinical staff in VA who might be interacting with patients, and second for investigators, going forward how might we think about these findings in terms of future work and in some of the stuff that we’re already doing.

So this is the information I think a lot of us are already familiar with, but I think it’s always worth starting a talk with basic epi about Veteran suicide. So in general, Vet suicide is the 10th leading cause of death in the United States. Claimed the lives of about 44,000 Americans in 2015. And if you looked at the report from the CDC last year, you learned along with me that suicide rate among nearly every age group in the United States has been increasing fairly steadily since about 1999. When you look at the risk of suicide among Veterans in comparison to U.S. adults and you match them based on age and gender, you find that the suicide risk among Veterans is about 20% higher, but that risk for the most part is concentrated in our younger Veterans returning from our most recent wars, that the overall highest suicide rate we see amongst our younger Vets, though in terms of the sheer numbers of Veterans who die by suicide, most actually are occurring in the older age groups, the 50 and 60 and up groups.

So on an average day, the statistic that we see quoted quite frequently and accurately is that about 20 Veterans die by suicide on an average day. Why is it that I want to focus my work on firearms and why are we here learning about firearms today? Well, of those 20, 13 are going to die using a firearm in their suicide. And so not only do most Veteran suicides occur due to firearm injury, Veterans are also more likely to die from a firearm-related suicide than non-Veterans. About two-thirds of Veteran suicides are firearm related, and that’s in comparison to just under 50% among the non-Veteran population. And this comparison holds true when you stratify these findings by both men and women, so males and females are also more likely to die by firearm-related suicide in the Veteran population compared to U.S. adults.

So what is the link between firearm access and suicide risk? There have been at least 15 U.S. case-control and cross-sectional studies that have found that firearm access is an independent risk factor for suicide, and this holds true when you look at the international literatures. Well, this association between firearm access and suicide risk is not explained by differences in other suicide risk factors. What do I mean by that? Well, a number of studies have asked a couple of questions such as, well, if those who own firearms are more likely to die by suicide than those who don’t, is it more likely that they have a higher prevalence of depression? Do they have a higher prevalence of suicidal ideation or a history of suicide attempt? The answer, as far as we can tell, is absolutely not. There’s no difference in other traditionally known risk factors for suicide between these groups other than access to a firearm.

This relationship between firearm ownership and suicide risk holds true across basically the 50 states. So on the left, what you see on this slide is the proportion of individuals at the state level who own a firearm, sorry, on the X axis. And on the Y axis is the firearm suicide rate within that population. And so what does that mean? Well, it’s exactly what I said. Across the 50 states, the higher rate of gun ownership is correlated very tightly with the higher rate of firearm suicide. What you see on the right-hand screen is the prevalence of or the rate of gun ownership in relationship to non-firearm suicides. And what you see is that the higher the gun ownership rate, there’s no association between that and suicides by other mechanisms other than firearms.

So I’ll turn it back to Molly for the first poll question of this presentation.

Molly: Thank you. So for our attendees, as you can see up on your screen, you do have the first poll question. So we’d like to get an idea, what do you think is the percentage of U.S. adults in the U.S. that own a firearm? The answer options are 20%, 25%, 30%, 35%, or 40%, and you can just go ahead and click the circle right there on your screen that corresponds to your response. And we’ll give people just a few more seconds to get their replies in.

Okay, I'm going to go ahead and close out the poll and share those results. So one-fifth of our respondents, 20%, selected 10, oh, I'm sorry. Let me get this one other way. Give me just a second here. Lots of percentages. Okay, so it looks like 10% of our audience think that 20% of adults own firearms, 10% of our audience think that 25% of adults own firearms in the U.S., 22% think that it is 30%, 30% of our audience think that it is 35%, and 27% of our respondents selected 40%. So thank you to those respondents, and I will turn it back over to you, Joe.

Dr. Joe Simonetti: Okay, thank you. So those are, that’s interesting findings. The correct answer is approximately 20% of U.S. adults own a firearm. And so with that information as we go forward you can sort of, I think, understand Veteran firearm ownership in a little bit better context once you understand what the average is nationally.

Moving on, suicide prevention in the VA is, I think, undisputed a population health leader in terms of suicide prevention. And one of the things we’re thinking about and trying to move forward on is how is that we start to talk about firearms with Veterans and what is the evidence base behind doing that? Well, some of the first evidence that popped up in terms of lethal means safety actually came out of the United Kingdom in the ‘50s, ‘60s, and ‘70s, and in those days in England, one of the most common mechanisms for suicide was that individuals had ovens within their home, and in an emotional crisis, they could stuff the oven, fill their dwelling with carbon monoxide, and that would result in death. But through an unrelated reason, these ovens that could emit carbon monoxide actually were phased out quite a bit through England throughout the ’50s and ‘60s. And what you see in terms of those ovens being phased out of England was that carbon monoxide suicides fell substantially in both men and women over those years. And while you see a slight increase in suicide death by other mechanisms in both men and woman, it did not account for the total fall in carbon monoxide deaths. And so what you actually see is a huge fall in suicide in England over those years. And there’s similar evidence when it comes to access to lethal pesticides in Southeast Asia and in firearms in other settings as well.

And so with that, what does that mean for the VA? So as I said, the VA is a leader nationally in terms of suicide prevention, and I think as we already know, suicide prevention is one of the leading clinical priorities within the Veterans Health Administration. However, of all the things that we’re doing and leading the way on, we really don’t have any evidence-based firearm safety interventions for clinicians to address firearm access with our Veterans at risk of suicide. And in this component, access to lethal means and addressing access to lethal means is considered to be an essential element of effective evidence-based suicide prevention programs. And we really have very little epidemiologic data to guide those practices. We don’t know very much about who within our patient population owns firearms, their motivations for doing so. The data that are available come from either the Behavioral Risk Factor Surveillance System Survey that was fielded for the last time with firearm questions back in 2004, or we have a number of small studies that have been published with the VHA population, but small samples of dozens to maybe a couple hundred Veterans, so really no broad-based information in terms of firearm access and related perceptions among Veterans.

So the aims of this study were to use data from the 2015 National Firearms Survey and assess the prevalence of firearm ownership and related behaviors and perceptions among a nationally representative sample of U.S. Veterans and to do so for the first time.

The methods, this was a web-based survey we fielded in 2015. For it, we used a survey firm known as Growth for Knowledge that has a sampling frame they maintain of about 55,000 U.S. adults. And within that sampling frame, individuals are sampled for response based on their address using equal probability sampling techniques. And this was done among the U.S. adult population to answer sort of broader questions about firearm ownership and access among the U.S. adult population, but we oversampled Veterans so that we would have a representative sample of Veterans to which we could address some of the same questions.

In our analyses we applied weights that accounted for both nonresponse and under/over coverage that may have been posed by the study design. All of the baseline data we used to match respondents to what we considered to be a nationally representative sample came from the U.S. Census and Veteran supplements to the U.S. Census.

So overall the National Firearms Survey sample was a nationally representative sample of U.S. adults, excluding those who are actually in active military status. For the purposes of this study we included those who self-reported themselves to be Veterans and reported owning a firearm. There are a couple of findings you’ll find in here in which we make comparisons between the U.S. population and Veterans, and we make a couple of comments about Veterans who don’t own firearms. But for the most part, these are self-reported Veterans who own firearms.

There are a broad number of measures in the survey including firearm ownership, how individuals stored their firearms, some of their risk perceptions in relation to firearm ownership, self-reported use of VHA healthcare services, and self-reported mental health and substance use diagnoses. And before we go to findings, I'm going to leave this back to Molly for our second poll question.

Molly: Thank you. So for our attendees, as you can see, you do have the second poll question up on your screen. So do you agree or disagree with the following statement: Having a gun in the home increases suicide risk among household members. Do you strongly agree, disagree, neither, agree, or strongly agree? Please take just a moment to select your response.

Okay, I'm going to go ahead and close out the poll now and share these results. Six percent strongly disagree with that statement, 11% disagree, 10% neither agree nor disagree, 33% agree, and 40% strongly agree. Thank you again to those respondents, and I'll turn it back to you one last time, Joe.

Dr. Joe Simonetti: Thank you. So that’s really interesting. This is an anonymous survey. For those of you who disagree or strongly disagree, I'd be interested to hear your thoughts on that, so please feel free to reach to me. It looked like, if I added those numbers correctly, about 70 to 77% of you either agreed or strongly agreed with this, so that’s nearly eight in 10 respondents agreed or strongly agreed that a gun in the home increases suicide risk among household members. And so keep that in mind as I go through some of these findings and how your perceptions compare to those among Veteran firearm owners.

So let’s get down to some of the findings here. What I won’t present are the basic sociodemographic characteristics of the sample other than to say then they largely represented what we know as the Veteran and the VHA enrolled Veteran population with the exception that these were firearm owners. And so although the Veteran and VHA population is predominantly male, this population is even more so male, so about 95% of the survey respondents were male.

When we looked at mental health conditions, self-reported mental health conditions between Veterans who did and did not report utilizing VHA services, about 19% of non-utilizing Veterans had a self-reported mental health or substance condition, and that’s compared to about 49% of Veterans receiving VHA services who reported they had a mental health or substance condition, so consistent with what we already know about the VHA versus non-VHA Veteran population. And though we made a lot of comparisons for the manuscripts that will be coming out about this in terms of making VHA and non-VHA comparisons, for the purpose of this presentation I think it’s suffice to say that in general there are almost no differences in these findings between those who did and did not use VHA services.

So what we found was 45% of U.S. Veterans own at least one firearm in the household, and if you recall, that’s in comparison to about 20% of U.S. adults. Forty-seven percent of males own at least one firearm, and about 24% of female Veterans own at least one firearm. And about 4% of respondents overall did not report that they were an owner of a firearm that was in their household but did report a firearm in their household. So whether that’s a spouse or family members or somebody else, they also have a firearm in the home.

Sixty-six percent of them had at least one unlocked firearm in the home, so that’s a gun that’s not stored with a cable lock. That’s a gun that’s not stored in a firearm locking safe or cabinet. And about one in three Veteran firearm owner stores at least one firearm in their house that is both loaded with ammunition and unlocked. So that is the least secure method in which a firearm can be stored, and that applies to about 33% of all Veteran firearm owners. And the third poll question, which I ended up cutting, which is what is the average number of firearms owned by Veterans. Of the Veteran firearm owners, they own about six on average, so quite a few firearms in the household of Veteran firearm owners.

This is the question that I posed to you in poll question number two. So we asked Veteran firearm owners does a firearm in the household increase suicide risk among household members. And if you’ll recall, about 77% of us agreed or strongly agreed that firearm access increases suicide risk. Among Veteran firearm owners, the answer is 6%, so a fairly low proportion of Veteran firearm owners agree with that statement.

However, we also went on to ask the same individuals what would you do in a hypothetical scenario if a household member were suicidal? And interestingly, 82% reported they would make sure he or she couldn’t access a firearm in the home. And we’ll talk a little bit more what that means in the discussion section of this presentation.

We talk a lot, I think, in clinical medicine and suicide prevention about what are the risks of firearm access and ownership, but I think to frame it differently, I think that a lot of individuals who own firearms also believe there is a risk to not owning a firearm. And that’s something we’re going to have to struggle to communicate with in terms of our clinical scenarios. So 66% of the Veterans in this survey reported that one of the primary reasons they keep a firearm home is protection against other people. And that’s relevant because those individuals were more likely to agree that a firearm is not useful for protection if you store it safely, and by safely I mean locking it up and storing it without ammunition inside of it. And in fact, those individuals who kept firearms for protection were less likely to store their firearm safely. Forty-six percent of Veteran firearm owners who keep firearms for protection had a loaded and unlocked gun in their house. Of those who did not say that they kept guns at home for personal protection, only 9% of them kept a firearm at home that was both loaded and unlocked, so a huge difference between those two groups of people based on perceptions.

For the clinicians in the room, this I think is an encouraging finding. We also wanted to know what do individuals think about having discussions about firearms in clinical settings. And so we asked is it at least sometimes appropriate to discuss firearms in a clinical setting, and 50% of gun owners and 68% of non-gun owners who lived in gun households reported that it was least sometimes to have discussions about firearms in clinical settings, so about half of gun owners and a majority of those who don’t own firearms agreed that it was.

So let’s talk about what, at least in my opinion, this means for the clinicians in the room and the investigators in the room. So in summary, Veterans are just more likely to own firearms than those in the U.S. adult population. About 45% report owning a firearm, and another 40% reside in a household with a firearm, though they don’t consider themselves owners of it. That’s in comparison to about 20% of non-Veteran U.S. adults.

We don’t have great comparisons to assess how this has changed over time. As I mentioned, the last time that this question has been asked nationally among Veterans was the 2004 Behavioral Risk Factor Surveillance System. And at that point, 49% of Veteran males reported a gun in the home and 36% of non-Veteran males reported the same, and so a similar proportion among of Veterans. But it appears that ownership among non-Veteran males has actually fallen over time. Similarly in 2004, 31% of Veteran females reported a firearm in the home compared to 26% of non-Veteran females. And so the Veteran proportion that owns firearms does not seem to have changed substantially, but things seem to have fallen among the non-Veteran proportion. And among Veterans at that time in 2004, 18% reported that least one of their firearms was loaded with ammunition and locked, I'm sorry, unlocked at the time of survey response. That’s in comparison to one-third, so a much larger proportion today would report that a gun is both loaded and unlocked at home.

A slight caveat that this not a perfect comparison because we asked individuals who were firearm owners in this study. The Behavioral Risk Factor Surveillance System asked people who had a gun in the home. And we know that there are some reporting differences in terms of discrepancies in reported storage practices between people who live in homes with guns who may or may not consider themselves owners. So long story short, these aren’t perfect comparisons, but I think overall the overall proportion of Veterans who own guns does not appear to have changed substantially over this time period.

So for clinicians, what does this mean for us? Well, it means every second patient we see in the hospital, in the clinic, has a firearm at home, and that’s obviously on average. This is going to vary a little bit based on some sociodemographics, which I didn’t show here, certainly the region of the country we practice in. Every sixth patient we see has a firearm at home that is unsecured and loaded with ammunition, and then again, that’s on average. So this is obviously something that affects a lot of our patients, and as clinicians, all of us are seeing patients with firearms at home.

Fifty to 68% of Veteran firearm owners reported it was at least sometimes appropriate to discuss guns in the clinical setting. And importantly, no study has ever shown that our patients are upset about these discussions. And so I do think we have some leeway to have these conversations in clinical settings when we believe it to be clinically warranted. This a little bit to me feels like the studies 10 years or so ago about screening and brief intervention for unhealthy alcohol use. There’s a lot of hesitancy among clinicians to start screening and counseling about alcohol use because we are afraid about upsetting our patients. And it turned out that those, I think, concerns were valid, but the studies came out and found out that we weren’t really upsetting our patients by having these conservations, and the question, I think we’re probably going to end up seeing the same thing when it comes to firearms.

For researchers, I think there’s a lot of things that, I think, can help guide our work going forward, but here’s the main issue I'm struggling with as a researcher: Six percent of Veteran firearm owners agree that a firearm increases suicide risk. Now I know there’s a little bit of response bias happening here, but 77% of us today agreed that a firearm increases suicide risk. And one thing I think I hit home earlier but I'm just going to reiterate, the empirical evidence suggests that this is absolutely the case, that a firearm access increases suicide risk. And this is a real problem for us if we want to discuss behavioral change in terms of our firearm safety practices within the context of suicide prevention.

The Health Belief Model was proposed as a theoretical framework in the ‘70s to help us understand how individuals go about making decisions on behavior change and what aspects of their thinking might we be able to influence in order to promote different behavior changes. And within the context of firearm suicide prevention, to influence or effect an individual to make changes about their firearm safety behaviors, first they would have to believe that there’s a perceived threat. And that is do they believe that either they’re at risk of suicide and that that firearm is a risk factor for their own suicide. Now on top of that, they have to perceive a benefit to change, and so if I'm suggesting that they lock their firearm more safely or perhaps give it to one of their Veterans while they’re in crisis, do they believe that making that change will actually reduce their suicide risk? And only if you can balance those two in the appropriate way will that actually lead to behavior change, and so this is something that I think we have to do a lot more work to really better understand.

Now 6% said that a firearm in the home increases suicide risk. At the same time, 82% said that if a household member were suicidal, they would limit firearm access for them. So there’s a discrepancy between these two findings that I can’t quite explain. The 6% perhaps people misinterpreted the question stem. Maybe we wrote a bad question. I don’t know. But needless to say, I think more work needs to be done here because it’s really, I think, these perceptions about risk that are going to largely influence individuals’ interest in making changes in firearm safety.

So wrapping up, suicide is the leading clinical priority in VA. And I think as a national and international leader in population health and clinical approaches to suicide prevention, we have a great opportunity here to not only address suicide but further the general knowledge on suicide prevention for others. But to do so the reality is we’re going to have to start addressing firearm access.

Findings from this survey show us that firearm access is common and far more common among Veterans than it is among the general population. One in three Veteran firearm owners has a loaded firearm at home that is unlocked. And I think these findings, if you interpret them within sort of a broader literature about firearm discussions, I think we can feel fairly comfortable that clinicians have some leeway to discuss firearms when we feel it to be clinically warranted. And risk perceptions or maybe misperceptions are the challenge at hand if you really want to effect firearm safety.

And with that, I'll wrap up, and I'm happy to take any questions. And if we don’t get to all the questions or any questions, please feel free to e-mail me with that contact information. Thank you.

Molly: Thank you so much. We do have a few pending questions already. I know a large number of our audience joined us after the top of the hour, so to submit your question or comment, please use the GoToWebinar control panel on the right-hand side of your screen. Click the arrow next to the word questions. That will expand the dialogue box, and you can then type your question or comment in there.

The first comment came in after the poll question regarding the increase of suicidality when firearms are present. This person writes having access to lethal means while active suicidal ideation increases, increases the chance of follow-through, meaning more completed suicide. So I think that they mean that the chance of it being a completed suicide increases with having lethal means in the home. Thank you to that commenter.

The first question: Wouldn’t the gun in the home increase the likelihood that the gun would be used in an attempt, but it doesn’t necessarily increase the chance that someone would attempt suicide in the first place.

Dr. Joe Simonetti: So I think I can probably wrap those two questions together with some data I did not present here. This is one of the keys to understanding why addressing firearm suicide is so important. The lethality of a firearm suicide attempt is incredibly high. If you look at suicide attempts by firearm, about 85 to 90% of the individuals who attempt suicide will die on that attempt and they will not survive to seek mental health care or have additional suicide attempts. When you look at all of the other attempts nationally by any other method, the combined lethality of those attempts is only about 5 to 10%. So it may or may not influence whether or not you have a first attempt, but certainly the odds of you surviving a firearm attempt are much lower than nearly anything else that you can do. I think that, I hope that addresses those questions.

Molly: Thank you. Very helpful. I believe you mentioned that about 66% of Veteran firearm owners owned a gun for safety purposes. Would you recommend that alternative means of safety be proposed like an alarm system to Veterans in lieu of firearms?

Dr. Joe Simonetti: That’s an interesting question. First, I think what I would say is that the general evidence shows that to have a firearm in the home puts you more at risk than it does offer protection to you. Using a firearm for self-defense in the United States is actually exceedingly rare. And so I think that’s the first thing that I would say. The second is certainly there are other ways that one might go about protecting him or herself, and we can probably name off 10 here. The extent to which that’s a convincing argument, I can’t comment on that. But certainly if there are other ways that someone would feel comfortable personally protecting themselves aside from a firearm, I think particularly for somebody who has elevated suicide risk, I would certainly feel comfortable making that recommendation.

Molly: Thank you. One quick question before we move on: I'm sorry I missed this, but are these Veterans who are VA users or Veterans in general?

Dr. Joe Simonetti: That’s a great question. The data I presented, and we have a couple manuscripts coming out, are on the overall Veteran population, but the papers themselves will report out data based on self-reported use of VHA healthcare services. I did not do a lot of work to stratify those findings for simplicity in this presentation except to say that for the most part, aside from the prevalence of mental health conditions, these findings do not appear to vary substantially between VHA users and non-users.

Molly: Thank you. Will future studies differentiate between combat units that regularly carry firearms, like the Army or the Marine Corps, against non-combat MOSs and will race and ethnicity be addressed?

Dr. Joe Simonetti: Those are great questions. In the manuscript, we will report the basic sociodemographics of the sample of Veteran firearm owners including race and ethnicity and along with the branch of the service that they were in. And so you’ll also be able to see in that how storage practices might vary across sociodemographic characteristics and service history. We do not have in our findings history of deployment and we don’t have, in particular, history of combat deployment. Though interestingly I just had a conversation earlier today about how we should really start thinking more about looking at firearm perceptions and storage practices and use based on history of combat exposure. And so in the future ideally, yeah, we’ll be able to tackle that very question.

Molly: Thank you. Did your research touch on the current political climate regarding gun ownership? If so, how did Veteran thoughts on gun ownership change when reframed around suicides rather than gun violence?

Dr. Joe Simonetti: That’s a really fascinating question, and we did not do any work on that within the Veteran population. Some of the data on the overall study published by Deborah Azrael, which you’ll be able to find, I believe did report some of these ownership and storage practices based on self-reported political identity. But we did not look at that within Veterans, and we did not actually look at that in terms of how you rephrase the context of these firearms discussions. But that’s an interesting suggestion. Thank you.

Molly: Thank you. What kind of research support have you received for your research on gun violence? In other words, who were the funders?

Dr. Joe Simonetti: That is a great question. So the funding for this study, I was not funded. This was funded through a private organization by the primary investigators and the designers of the study, but my work was basically pro bono. None of this support came from the VA.

Molly: Thank you. Do you have any data on suicidal people who have gotten rid of their guns?

Dr. Joe Simonetti: To my knowledge, those data don’t exist that I know of. I think the most relevant study, at least in terms of firearm lethal means safety that I can cite, actually comes from Israel. And back in 2006, you may know that most of Israeli citizens served in the force at some point. And in 2006 they looked at their suicide data and found that they had a spike in suicides in their younger service men and women. And so around that time in 2006, they enacted a policy, which was when you go home for weekend leave, you’re welcome to leave, but you can no longer take your firearm with you. And so go about your business, do whatever you’re going to do, but your gun stays on the base. And they enacted that policy, and essentially overnight the suicide rate among those individuals in the IDF forces fell by about 40%. And I think the causal inference comes from not just the timing that their suicide rate fell right after this policy was implemented, but that the suicide rate fell only on the weekends when the policy was implemented. It did not make an effect Monday through Friday when they were still on base. And so to the extent that they weren’t necessarily suicidal individuals, but I think it’s more helpful to think of this in terms of the fact that in some sense we’re all suicidal, or I'm sorry, in some sense we all have suicide risk factors or at risk for developing suicide risk factors. And so we can’t necessarily predict who is it this weekend who’s going to go out and attempt suicide.

Molly: Thank you. We have someone that wanted to offer up: I just want to share that CDC data reports that about 500,000, there are about 500,000 defensive uses of firearms per year. I think we were talking about people keeping firearms for self-defense versus keeping them locked up. Thank you.

The next question: Does the VA offer opportunities for safe storage of firearms for Veterans at risk?

Dr. Joe Simonetti: The VA currently does not have a formal program in place. The VA has had a gun lock distribution program for some time. So at many of our facilities, whether some of us are aware of it or not, you’ll find that gun locks are readily available. But that’s something we’re sort of working on going forward, but at this time not that I’m aware of, no.

Molly: Any recommendations on how to change misperception of risk?

Dr. Joe Simonetti: No. That’s something that I think we have to work on going forward. You know, I think that for a long time a lot of us have thought that, well jeez, if you just give people facts, they’ll be able to make decisions. But it turns out, I think, not just for gun owners, for most of us, our behaviors don’t stem from this perfect balance of empirical evidence. And I think that what we’re going to have to do is probably take a page from the playbook of things like vaccination or a lot of other behavioral change interventions that we’ve done. There have been a lot about shaping communication strategies around vaccination, for instance, which helps balance what I think clinicians should be recommending and what some individuals’ perceptions are about the risks of those recommendations. But in terms of communication strategies for firearm safety, aside from motivational interviewing techniques, which I think are highly relevant and are needed within this field, and improving our own understanding about some of the objectively demonstrated risks of firearm access, I have not yet done a lot of work to figure out what the best communication strategy is.

Molly: Thank you. Do you have a breakdown of the statistics by state?

Dr. Joe Simonetti: We unfortunately don’t. So this is a nationally representative survey, but the weighting scheme basically had us over- and under-sample individuals based on what we know to be VA demographics. But it would not allow us to make accurate assessments of state-level findings.

Molly: Thank you. Any insight into the reason why 30% of patients see it as inappropriate to discuss firearms? Any barriers we should be aware of or can aim to break down during normal conversation?

Dr. Joe Simonetti: We don’t have any further data on that, unfortunately. And I don’t know why half of Veteran gun owners and about one-third of Veteran non-gun owners don’t agree that it’s at least sometimes to talk about this in clinical settings. The reality is there is going to be some hesitancy for individuals to discuss this with us, so I think being delicate in how you approach it and getting permission to have this conversation, I think, is always a good tactic. There is a proportion of the population who do not think that as clinicians we should be talking about cigarette use. There are still some people on surveys who will report that pediatricians shouldn’t be talking about seatbelt use. And so there is a perception out there that injury prevention does not really fall within the context of clinical medicine. I think that’s unlikely to explain all of it.

A second issue might be that there are some very prevalent misperceptions about their, about whether suicide can be prevented or not. And so if you’re someone who does not believe that a gun increases suicide risk or you’re somebody who believes incorrectly that suicides cannot be prevented or if you’re somebody who believes that it’s irrelevant to remove a firearm because somebody will just use another method, which is inaccurate, then you might find it less relevant that we should be talking about this in the clinical context. But I wish we had more information from the survey, but we did not. Every time I do a survey, I wish I had added 20 more questions, but I guess that will have to be the next study. Great suggestions.

Molly: If a Veteran discloses that they are having suicidal ideation, is a follow-up question of the clinician whether or not they have firearms in the home?

Dr. Joe Simonetti: So I think that the best practices really are once you've identified suicide risk to do a couple of things. The first is to make sure that mental health and substance use treatment are being coordinated, and the second is environmental safety. And environmental safety really means a couple of things. It means assessing any type of lethal means that that individual might be at risk to use, whether that’s opiate or benzodiazepine medication in the household, acetaminophen, or obviously a firearm. And so in those scenarios, if you take a look at a lot of the suicide prevention materials out of the VA and really anywhere that people are doing suicide prevention, safety planning does include asking about access to firearms and making recommendations about firearm safety.

Molly: Thank you. Do you have any data on risk of violence perpetuation towards others, not suicidal violence in gun ownership?

Dr. Joe Simonetti: Not from this study. I mean the study doesn’t really inform anything on that. There are some data out there about homicide risk and firearm access, but that really is not my field, so I don’t feel quite good about making specific comments on that.

Molly: Thank you. Referring back to the Israeli study, did the Israeli study find out why the suicide rate had risen?

Dr. Joe Simonetti: I don’t know. In the published papers that were on that intervention specifically, I don’t think they commented on what was driving the increase in suicide or the high suicide rate to begin with. No.

Molly: Thank you. Has any study tracked the efficacy of the gun lock distribution?

Dr. Joe Simonetti: No. To my knowledge, the gun lock distribution has been tracked in terms of where we’re distributing the locks, which is which community partners or which VA facilities are requesting them. But there has really not been a good way to track the end users of those, and we have sort of made a specific effort not to track the end users. And certainly if you don’t track the end users, outcomes are very difficult to track.

Molly: Thank you. We have a comment that came in. This was referring to the Veterans who did not feel it appropriate to discuss firearms in a clinical setting. In my experience, individuals, Veteran and non-Veterans, tend to not see that guns are related to medical care. Therefore, unless a person is suicidal, the only reason for discussing them is to take them away. Thank you for that comment.

Dr. Joe Simonetti: Yeah, I think that’s a really helpful comment. The question initially was is it ever appropriate to discuss firearms in clinical settings? I suspect we might have had a different answer had we asked is it ever appropriate to discuss this for suicide prevention? Certainly I don’t a hundred percent of Veterans would have said yes, absolutely, but I think we would have had a difference response there.

Molly: Thank you. While we wait for any further questions from the audience to come in, do you have any concluding comments you’d like to make?

Dr. Joe Simonetti: No, I don’t think so other than to say that I really appreciate any feedback. And my e-mail is on the board, so please reach out to me if you have questions, comments about my presentation or any work going forward or particularly your experiences discussing firearms with Veterans, particularly Veterans at risk of suicide. And just thank you everybody for being here today.

Molly: Well, thank you very much for coming on and lending your expertise to the field, especially about such a high-priority topic. Thank you to our attendees for joining us. Today’s session has been recorded, and you will receive a follow-up e-mail with a link leading to the recording, so please forward that along to any colleagues you feel may be interested in this topic.

With that, I am going to close out the session now. So for attendees, please wait just a second while the feedback survey populates on your screen and take just a moment to fill out our few questions. It won’t take very long, but we look closely at your responses, and it helps us to continuously improve the presentations as well as the program as a whole. Thank you once again, everyone, for joining us. Thank you, Joe. Have a great day.

[ END OF AUDIO ]