Experts: Restricting troops' access to firearms is necessary to reduce rate of suicides

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The horror of war, repeated deployments, the operations tempo, failed relationships, financial problems, legal trouble, depression, PTSD, TBI.

Many reasons have been suggested to explain the substantial rise in the suicide rate of soldiers that began in 2004.

Numerous prevention efforts were launched, hundreds of millions of dollars spent on studies and task forces, resilience programs and increasing access to mental health care.

Yet eight years and hundreds of deaths later, the suicide rate hasn't improved. The number of suspected suicides in 2012 among active-duty soldiers was 166 at the end of October, surpassing the 165 total for all of 2011.

What's gone wrong? Why hasn't the Army or Defense Department been able to reduce the number of suicides?

Experts say it's because efforts have ignored the most evidence-backed, proven prevention method: making suicide harder by restricting access to lethal means.

"There are two ways to reduce suicide: You can make it harder for them to die in an attempt, or you can heal underlying distress," said Dr. Matthew Miller, the associate director of the Harvard Injury Control Research Center at the Harvard School of Public Health.

"The idea is to restrict methods that are the most lethal, to provide a second chance," Miller said.

"Means restriction," as it's called in public health, has been proven to reduce the suicide rate in a wide variety of places.

In 2006, after years of suicides among young men in the Israel Defense Forces, authorities forbade the troops from bringing their rifles home on weekends. Suicides dropped by 40 percent, according to a 2010 study by psychiatrists with the IDF and the Sheba Medical Center.

Those attempting suicide for the most part act on impulse, often after surprisingly brief periods of deliberation. But the impulse also passes. A survey of people who deliberated about killing themselves but did not act found that for about half, the suicidal period lasted less than an hour, according to Miller.

Among people who made near-lethal attempts, 24 percent took less than five minutes between the decision to kill themselves and the actual attempt. Seventy percent took less than an hour, according to a 2001 University of Houston study of 153 survivors.

Although people who attempt suicide often suffer from psychological distress, Miller said, they don't act until a "last straw" — a loss, a humiliation, an arrest.

"That's the time when you can lose control of your ability to act in a sensible way," he said. "When you are at your wits' end, what you can reach for determines whether you live or die. All you have to do to die is lose control for one minute.

"If you're in a house with a gun, there's a lot more of a chance you're going to die," he said.

Living in a home with a gun increases the suicide death risk two- to 10-fold, Miller said.

Firearms were used in 68 percent of Army suicides in 2010, according to an Army Health and Violence report released this year. Most often, soldiers shot themselves to death at home or in the barracks.

By comparison, more than half of suicides by U.S. civilians annually involved firearms, according to data from the Centers for Disease Control and Prevention.

A matter of rights

As the Army's vice chief of staff from 2008 until he retired in March, it was part of Gen. Peter Chiarelli's job to try to reduce the suicide rate. After reviewing hundreds of suicide reports, the conclusion was inescapable, he said in a recent interview with Stars and Stripes.

"There's nothing worse than the abuse of alcohol and the ability to get your hands on a weapon," he said.

Drug overdoses, by comparison, were far less lethal, causing only 4 percent of suicides and 56 percent of suicide attempts.

It was another statistic that most confounded Chiarelli: Half the soldiers who killed themselves had not slipped under the radar or avoided professional help. They'd seen a mental health provider, whether it had been six months or six hours before the suicide.

"In the four years I was vice — in all four years — between 49 and 51 percent had gone in to seek help," said Chiarelli, who now heads a Seattle nonprofit brain-injury research organization called One Mind for Research.

In each case, a presumably well-intentioned social worker, doctor or other expert had written on these soldiers' records: "Not a danger to himself or others," Chiarelli said. "That just drove me crazy."

About two years ago, Chiarelli read a medical journal article sent to the Pentagon's upper echelons by Adm. Mike Mullen, then chairman of the Joint Chiefs of Staff. The article described how voluntary means restriction in a group of people with an extremely high suicide risk had reduced the suicide rate — to zero.

Chiarelli wanted to try it.

"Quite frankly, all I was trying to get done was the ability of our folks to ask the (potentially suicidal) person about his weapons and make a recommendation that they would separate themselves from the weapon — turn it in, give it to a friend — until the suicidal feelings passed."

But it wasn't possible.

"I was told by my lawyers that even that would cause issues," Chiarelli said. "I was told there would be huge problems with the NRA."

Commanders typically disable or take the firearms of deployed troops identified as potentially suicidal, but they do not have that authority with private firearms kept off base.

Last year, the National Rifle Association successfully lobbied Republican legislators to include in the annual defense authorization bill a measure barring commanders from collecting information about troops' personal weapons. The law was widely interpreted to mean that commanders could not ask about the weapons or suggest they be stored elsewhere. The NRA said it was defending Second Amendment rights.

"I think it's ridiculous," Chiarelli said. "Nobody was infringing on anybody's Second Amendment rights. We weren't going to go out to their house and confiscate weapons."

Last week, Chiarelli was joined by more than a dozen senior retired generals and admirals who sent a letter to Congress to amend the law they said "dangerously interferes" with the ability of commanders to help troops, according to The Washington Post. "The law is directly prohibiting conversations that are needed to save lives," the letter said.

Sen. John Kerry, D-Mass., was trying to add language amending the law to the Senate version of the 2013 National Defense Authorization Act bill, the Post reported Monday. The House version of the bill that amends the law has already passed, the Post said, and authorizes mental health professionals and commanding officers to ask servicemembers about firearms and ammunition when they believe them at risk for suicide.

Legislators have said that this year they'll clarify the law so that commanders, as well as other "gatekeepers" such as chaplains and doctors, are allowed to discuss weapons if they have "reasonable grounds" to believe the person is at high risk of committing suicide or harming others. There has been movement within the Defense Department to suggest voluntary means restriction to troops.

The Pentagon has helped hand out more than 65,000 gun locks this year. In a planned safety campaign, troops and their families will be reminded that they can store personal weapons in the base armory, and that it's never a good idea to store weapons with ammunition.

Plus, a "working group focused specifically on means restriction" will brief a General Officer Steering Committee, according to DOD spokeswoman Cynthia Smith.

The Defense Department and Department of Veterans' Affairs are working together on joint clinical practice guidelines for suicide that will include means restriction and "safety planning," Smith said.

Means restriction remains little understood in many parts of the military, or as a former Army psychiatrist said, is politically "the third rail."

"It's definitely not popular to talk about restrictions on firearms in the military," said Lisa Jaycox, co-author of a recent RAND Corp. report for the military on suicide that recommended means restriction among other methods. "It goes against the grain of the institution."

A 2008 New England Journal of Medicine article by Miller and his associate David Hemenway said many U.S. physicians are unfamiliar with the evidence linking guns to suicide and believe that anyone serious enough about suicide to use a gun would find another equally effective method if the gun weren't available.

"This belief is invalid," the article states.

Army psychiatrists and other medical providers are on the front lines of those charged with keeping troops from killing themselves. Yet, an Army Medical Command spokeswoman said the command had nothing to say about means restriction.

"In Army Medicine, we deal with those aspects of suicide as it relates to a Soldier's mental health, not as it relates to their access to weapons," she wrote in an email.

The spokeswoman referred questions to a spokesman for the Army Suicide Prevention Program, who did not respond to emailed questions.

Jackie Garrick, acting director of the new Defense Suicide Prevention Office at the Pentagon, said the long-standing prevention emphasis on suicide awareness, caring and treatment remained key. She said many soldiers, if they didn't have access to a weapon, would use some other method.

"I think means does matter," she said. "But what we want to do is get to the problem before they get to a tipping point."

"We need to know our troops at the command level," she said. "We need to engage leadership and families. We need to back up the mountain instead of just worrying about the firearm."

In 1999, the Army devised a suicide prevention campaign plan that said many of the same things, including the need to "destigmatize" mental health care.

"Although our first line of defense will be our soldiers, peers or battle buddies, truly our most valuable player in suicide prevention will be the first line supervisor," the plan said. "They must be able to recognize serious personal problems ... must make the time to really learn about their soldiers, including their personal life ... be trained to recognize the symptoms of serious mood disorders ... and have a genuine concern for the overall welfare of their soldiers."

Civilian suicide prevention plans also have called for communities to offer more connectedness and compassion. Feeling connected to other people is protective against suicide; a more compassionate society or Army seems like a worthy goal.

But it's not a strategy, Miller said.

"It's not useful. It's not actionable," he said. "The question is, 'What can you do?' Not how do you restructure society."

Col. (Ret.) Elspeth Cameron Ritchie, a psychiatrist and former adviser to the Army surgeon general, said that despite best efforts troops have had largely negative experiences with seeking military mental health treatment, which, she said, they find "humiliating."

"Going into the waiting room, sitting there for an hour — soldiers hated it," she said. "Having people see them, they hated it."

Seeking help might be a sign of "strength," as the Army is trying to convince soldiers, but Ritchie said the process isn't a good fit with a lot of young men; they don't want to sit around and discuss their feelings.

"What hasn't been tried is gun safety," Ritchie said.

She said that two-thirds of suicides happened not on deployment but at home, most often on bases with high operations tempos.

But Fort Drum, in upstate New York, was an exception.

"New York has restrictive gun laws," Ritchie said. "So, it's not so easy to get drunk, get a gun and shoot yourself."

According to a July 2012 story in USA Today, soldiers at Fort Carson, Colo., who had attempted suicide listed 10 reasons on average they'd tried to end their lives, including psychological pain, chronic sadness and desperation.

They didn't want to die, said Army Col. Carl Castro, coordinator of $50 million in suicide prevention research and treatment as head of the Military Suicide Research Consortium, which did the study. They wanted, he told the newspaper, "the pain they're currently in to stop, and they don't see any other way out."

The Fort Carson study showed that instead of trying to treat underlying illnesses such as depression, the Army should "teach soldiers skills at quelling emotional pain," the story said. How to do that wasn't discussed.

The same group — The Military Suicide Research Consortium — in a July report to Congress on best prevention practices noted that there was little evidence of the effectiveness of most prevention methods. Means restriction, the report said, was "a particularly important and effective strategy" and had been shown to reduce overall suicide rates.

"Specifically, suicide rates have decreased following firearm control legislation; detoxification of domestic gas; restriction on barbiturates; alteration of the packaging on analgesics; construction of bridge barriers; mandatory use of catalytic converters in motor vehicles; and the use of lower toxicity anti-depressants," the report said. "Studies demonstrate that method substitution is rare."

In the U.S. — not only in the military — the suicide prevention focus has been on discussing risk factors and asking family, friends and others to spot pre-suicidal behavior and get troubled people into treatment.

Most people who try to kill themselves "usually tell someone," according to an Army website dedicated to suicide prevention.

Research doesn't support that. Almost 70 percent of soldiers who killed themselves and nearly 90 percent of those who attempted to "did not communicate their intent," the Army health and violence report says.

Why the Army rate increased over the past years remains unclear. Stresses from deployment, the operations tempo and surge-related recruiting standards are all thought to play a role.

In 2010, 54 percent of troops who committed suicide and 59 percent of those who attempted had not deployed, Army Secretary John McHugh told reporters at a September press conference, according to the Army Times. Eighty-nine percent had not engaged in combat.

More than 90 percent of people who survive a suicide attempt do not go on to kill themselves, according to a 2002 review of 90 studies published in the British Journal of Psychiatry. That held true even when people who had attempted suicide were followed for a decade and for those who used lethal means, such as jumping in front of a train or off a bridge or using a gun, Miller said.

Some 20 percent made another nonfatal attempt, Miller said. About 70 percent made no further suicide attempts.

"There's lots of opportunity to act," Miller said. "If people are struggling, if they've had setbacks like divorce, arrest, financial troubles; if they've stepped up drug and alcohol consumption; if they're not sleeping or are having mood swings or feel despair ...

"Why not have the conversation?" Miller said. "To respectfully involve them in a discussion so that they can act in their own enlightened self-interest and in the interest of their families and the people that they care about, to temporarily remove the gun?"

Miller said troops could decide to make a "Ulysses contract," named for the Greek warrior who spent a decade in the Trojan War. While on his voyage home, Ulysses avoided being called to his death by the enchanting voices of the sirens who lured sailors to shipwreck.

"He wanted to hear the sirens," Miller said. "He bound himself to the mast so he couldn't act."