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ORIGINAL ARTICLE

Informing Federal Policy on Firearm Restrictions for Veterans with Fiduciaries: Risk Indicators in the Post-Deployment Mental Health Study

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Abstract
This article examines the public safety rationale for a federal policy of prohibiting gun sales to veterans with psychiatric disabilities who are assigned a fiduciary to manage their benefits from the Department of Veterans Affairs. The policy was evaluated using data on 3200 post-deployment veterans from the Iraq and Afghanistan war era. Three proxy measures of fiduciary need—based on intellectual disability, drug abuse, or acute psychopathology—were associated in bivariate analysis with interpersonal violence and suicidality. In multivariate analysis, statistical significance remained only for the measure based on acute psychopathology. Implications for reforms to the fiduciary firearm restriction policy are discussed.

Keywords Veterans · Mental Illness · Suicide · Gun violence · Fiduciary

Introduction

Every day, an estimated 20 US military veterans die from suicide, about two-thirds of them using a firearm. Veterans are significantly more likely than civilians to use firearms as a suicide method, and the extremely high lethality rate of intentional self-injury with a gun—about 90% of attempts being fatal—contributes to an overall veteran suicide rate 21% higher than the civilian rate, after adjusting for age and sex (United States Department of Veterans Affairs 2016). What laws and policies are intended to reduce intentional firearm-related injuries specifically in the veteran population, and do they work? This article examines a federal firearm restriction policy that could help prevent suicide among veterans: the prohibition of firearm sales to mentally "incompetent" veteran beneficiaries with fiduciaries appointed to manage their financial benefits from the US Department of Veterans Affairs (VA). We address the emerging controversy surrounding the fiduciary firearm prohibition and recent legislative efforts to repeal it. We present new empirical analysis relevant to the public safety rationale and legal justification for the policy: its targeting, implementation, and effectiveness, as well as its possible unintended adverse consequences.

The Firearm Restriction Policy for "Incompetent" VA Beneficiaries: Current Status and Emerging Controversy

Limiting legal access to firearms for veterans at risk of self-injury or interpersonal violence has been a component of federal efforts to prevent gun-related suicide and violent behavior since 1998, when the National Instant Criminal Background Check System (NICS) was initiated as an information tool designed to block the purchase of firearms by prohibited individuals. The Brady Law, enacted in 1994 (Brady Handgun Violence Prevention Act 1994), required federal agencies including the VA to report to the FBI for inclusion in the NICS the records of beneficiaries who are legally prohibited from purchasing firearms. The Veterans Benefits Administration (VBA) appoints a fiduciary to manage a veteran's benefits after determining that a veteran "because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs" (38 CFR

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3.353). The VA's regulatory definition of mental incompetence and need for a fiduciary closely matches one of the criteria for federal firearms restriction originating in the 1968 Gun Control Act (GCA): "…as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease…lacks the mental capacity to contract or manage his own affairs" (18 U.S.C. Chapt. 44, Gun Control Act). Thus, in compliance with the GCA and the Brady Law, the VA since 1998 has reported to the FBI the names of any veterans who are assigned fiduciaries, and these veterans' names have been added to the NICS as persons prohibited from purchasing or possessing firearms.

The NICS Improvement Amendments Act of 2008 (P.L. 110–180) required VA to notify beneficiaries who are proposed for a determination of incompetency that this will result in loss of gun rights under the Brady Law. VA is also required to provide an avenue for affected beneficiaries to appeal the incompetency determination in order to have their firearm rights restored (US Department of Veterans Affairs 2013). The 21st Century Cures Act (P.L. 114–255) codified VA procedures related to the appeal of incompetency determinations for the purpose of relief from federal firearm disabilities (Congressional Research Service 2017).

By the end of 2016, there were 167,815 active records in the NICS associated with VA-reported beneficiaries with appointed fiduciaries (Congressional Research Service 2017). This represents a corrected total based on a reconciliation completed in 2016 between the VA and FBI-NICS to remove erroneous entries, duplicate entries, competent beneficiaries, and deceased beneficiaries from NICS. In 2015, the VA served 233,473 incompetent beneficiaries with fiduciaries. Of the total number served in the fiduciary program, 134,256 (57.5%) were veterans; 83,508 (35.8%) were surviving spouses; 13,125 (5.6%) were adult disabled children or dependent parents, and the remaining 2584 (1.1%) were minor children. A total of 35,053 (15%) of these cases involved "proposed" fiduciaries awaiting a final competency determination, which would account for the fact that the number reported to the NICS is lower than the total served in the fiduciary program. Also, dependent children are not reported to NICS (Veteran Benefits Administration 2017). In the majority of cases (158,069 individuals, or 79.7% of those with completed incompetency determinations), the fiduciary is appointed as a "legal custodian" with control over the veteran beneficiary's VA disability, pension, or other support payments.

Limited information is available on the specific psychiatric disorders and types of impairments of incompetent VA beneficiaries currently enrolled in the NICS. An unpublished statistical report to Congress in 2015 (Swanson and Bonnie 2015) provided the following breakdown of mental-health-related diagnoses among VA beneficiaries reported to NICS: schizophrenia-spectrum, 36.5% (about half of those being classified as "paranoid type"); post-traumatic stress disorder, 22.3%; bipolar disorder, 5.6%; depression, 4.4%; and major neurocognitive disorders (formerly defined as "dementias"), including Alzheimer's disease, and traumatic brain injury (TBI), 31.2%.

The fiduciary gun-restriction policy has drawn criticism from some commentators in the legal academy (Flynn-Brown 2013; Stewart 2016). These critics object that a federal regulation and corresponding administrative process that were designed originally to determine a veteran's need for assistance in managing money are used to create a unique firearm prohibition under the 1968 Gun Control Act in a way that effectively applies only to veterans. The argument is that the VA's fiduciary appointment process is functionally but not legally equivalent to a formal, court-based adjudication of mental incompetence or a judicial finding of dangerousness that would be sufficient to limit the Second Amendment right with due process.

The VA's determination of need for a fiduciary occurs without formally or routinely assessing whether a financially-challenged veteran is also at risk of harm to self or others. The decision also does not require a hearing before either a judge or other objective, duly authorized administrative officer in which the facts of the matter could be presented and challenged. By the linking of fiduciary assignment to NICS reporting, the VA's assessment of a beneficiary's financial incompetence becomes entangled with a separate and unrelated policy promulgated by the Department of Justice, with the result that the affected veterans' gun rights are restricted under an assumption of dangerousness without a determination of whether significant risk exists in any particular case.

Like the VA, the Social Security Administration (SSA) uses an administrative (non-judicial) process to appoint representative payees to manage the funds of civilian disability beneficiaries who are found to be mentally incompetent. In 2016, a new policy was initiated that required reporting these SSA beneficiaries to the NICS, citing the VA's analogous NICS-reporting policy as a precedent for federal agencies' compliance with the NICS Improvement Act (Social Security Administration 2016). However, the SSA requirement was repealed in 2017, thus perpetuating an apparent disparity in the treatment of civilian and veteran recipients of federal disability benefits with respect to firearm rights. Also in contrast to the VA's fiduciary NICS-reporting process, states report the records of adults placed in legal guardianship status to the NICS only after a state probate court has rendered a legal finding of mental incompetence (Pinals et al. 2015; Search 2015); a guardian gains control over another person's property through a formal legal process designed to safeguard the rights of the mentally incompetent individual (American Bar Association 2017).

Despite recent reforms intended to enhance the appellate process for veterans who wish to contest the VA's determination of incompetency (21st Century Cures Act 2016), the policy's critics contend that the VA's fiduciary NICS-reporting practice continues to unfairly repurpose an administrative judgment of financial incapacity as a firearms prohibitor without the benefit of a formal, court-based adjudicative process commensurate with the gravity of removing a constitutional right. Further, critics of the policy argue that mismanaging money and misusing a gun involve very different functional impairments with no necessary connection. These issues have fueled ongoing complaints that the policy abridges the affected veterans' Second Amendment right to bear arms, as well as Fifth Amendment due process protections when their liberty or property rights are limited by the federal government (Flynn-Brown 2013).

Proposed remedial legislation in Congress (Veterans' Second Amendment Rights Restoration Act 2018) would uncouple the loss of gun rights from VA fiduciary appointment going forward, and would provide an expedient opportunity for gun rights restoration to those with existing records in the NICS due to fiduciary assignment. Under the proposed new law, a veteran with an appointed fiduciary could not be prohibited from firearms unless the Federal Government, in a court or judicial review board proceeding, has met the burden of proving by clear and convincing evidence that the veteran is a danger to self or others.

In some sense, these legal critiques invite an empirical question: Is there an evidence-based, public-safety rationale for attaching gun rights to the fiduciary standard? What do we know, scientifically speaking, about the relationship between the ability to manage money and the risk of harm to self or others? Recent research on post-deployment adjustment of Iraq and Afghanistan war veterans has found a modest statistical correlation between a measure of financial decision-making capacity and self-reported suicidality and interpersonal violent behavior. In a nationally representative random sample of 1388 separated veterans and reservists from this era, participants were tested on basic money management skills and also queried about violence and suicidal behavior and thoughts (Elbogen et al. 2012).

Veterans who scored poorly on financial management abilities were about twice as likely to report suicidal ideation and attempts, using illicit drugs, engaging in violent behavior, and getting arrested, compared to those with good management skills. The differences in relative risk associated with the measure of financial incapacity were statistically significant, even though the majority of veterans with this measured incapacity were not violent or suicidal. In other research, a study of civilians with psychiatric disabilities who were found incompetent to manage their supplemental security income (SSI) benefits reported that having a family member appointed as a ''representative payee'' was significantly associated with increased risk of violent acts by the incompetent beneficiary against family members, though the causal direction of this association was unclear (Elbogen et al. 2005).

While such evidence from survey research is suggestive, and would appear to provide at least some empirical justification for reporting the records of incompetent VA beneficiaries to the NICS, none of these previous studies has examined the actual population of incompetent veteran beneficiaries with records in the NICS. Thus, the policy's impact on those directly affected by it remains unknown. Research evidence is needed to evaluate the rationale for the present policy, and to guide any reform efforts in the balancing of risk and rights. This article addresses these issues with additional empirical evidence based on a new analysis of veteran data from the VA Mid-Atlantic Post-Deployment Mental Health Study (N = 3200). Three proxy measures of veterans' need for a fiduciary are described and compared in their respective statistical associations to independent measures of violent behavior and suicidality. Implications of the findings for fiduciary gun restriction policy are discussed.

Methods

Sample

The Post-Deployment Mental Health Study (PDMH) (Brancu et al. 2017) is an ongoing project enrolling Iraq/Afghanistan-era veterans at four VA medical centers in the Mid-Atlantic region of the US The study is conducted by the VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC), beginning in 2005 as a baseline study, research registry, and data warehouse to facilitate research on the mental health and illness of individuals who served in the military on or after September 11, 2001. Most participants had received care from a VA medical facility; a mailing to VA-enrolled veterans was the primary recruitment method. More detailed information about the project is available elsewhere (Brancu et al. 2017). The present study includes all participant data accrued by September 15, 2016 (n = 3200). The PDMH was approved by IRBs at each collaborating site, and our analysis of de-identified data was approved by the Durham VA IRB.

Measures

Outcome Measures

Suicide risk and interpersonal violence risk were each measured dichotomously. Suicide risk was indicated by a score of 3 or greater on the Beck Scale for Suicide Ideation (Kumar and Steer 1995); violence risk by answering "yes" to the

question, "During the past 30 days, have you had trouble controlling violent behavior (e.g., hitting someone)?"

Proxy Measures of Fiduciary Need

PDMH data were used to construct and evaluate three alternative proxy measures of fiduciary need. The measures were derived both theoretically and empirically, through an iterative deductive and inductive process. We began by operationalizing each component of the VA's regulatory criteria for appointment of a fiduciary, and then selected measures available in the PDMH data that research literature would posit as valid indicators of those components. The specific operational definition of need for a fiduciary, that is, that the veteran "…because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs…", can be broken down into three elements: (1) functional impairment manifest in the failure to appropriately manage one's own affairs; (2) lack of mental capacity as the proximal cause of failing to manage one's own affairs; and (3) presence of an injury or disease as the proximal cause of mental incapacity, and thereby a distal cause of failing to manage one's own affairs. Throughout this process, we also informally consulted several practicing VA psychiatrists for their opinion regarding the correspondence between each proposed proxy measure of need for a fiduciary, on the one hand, and common clinical case characteristics, on the other hand, which in practice (according to these psychiatrists) would likely lead to a referral of a veteran patient for evaluation of financial competency and appointment of a fiduciary.

The first proxy is a direct measure of significantly impaired intellectual and adaptive functioning, using the Shipley Institute of Living Scale (SILS) IQ-equivalent test (Zachary et al. 1985) with a cutoff score below 70. This measure offers face validity as an indicator of both functional impairment (such as the inability to manage one's own financial affairs) and mental incapacity; it has been widely used as a marker of intellectual disability or generalized neurodevelopmental disorder. As a purely functional measure, the IQ-equivalent proxy does not exclude any particular etiology or type of illness or injury as the cause of cognitive deficit.

The second proxy equates to a measure of illicit drug use problems: having a current SCID (First et al. 1994) diagnosis of drug abuse (any drug diagnosis except alcohol.) The rationale for including this proxy is based partly on discussions with VA clinicians regarding the practice of fiduciary referral when there is evidence that a veteran may be using VA benefits to purchase illicit drugs. While this may not be typical of current practice, these informal reports are consistent with court documents in the case of Clennan v. Shinseki, a 2013 decision by the US Court of Appeals for Veterans Affairs to deny a veteran's appeal of a fiduciary appointment:

> The psychologist opined that the 'continued cannabis use is detrimental to [Mr. Clennan's] further progress and needs to be stopped.' He suggested that Mr. Clennan was using his Social Security and VA pension benefits to purchase the marijuana and therefore proposed that he 'have his competency removed for the use of his funds'….VA medical and regional office center sent Mr. Clennan a letter that…proposed to find him incompetent to manage his pension benefit payments." (US Court of Appeals 2013)

It is not known to what extent this approach to assigning fiduciaries is broadly representative of VA practice.

The third fiduciary proxy is based on a combination of three indicators of serious, severe mental illness accompanied by acute symptoms of psychopathology—a set of conditions known to correlate with functional impairment that would be expected to significantly limit a person's ability to manage his or her own affairs. The specific components of the proxy were: (1) a SCID (First et al. 1994) diagnosis of a mental illness or substance abuse disorder; (2) a self-reported history of inpatient treatment for mental illness or substance abuse disorder (any hospitalization for treatment of an "emotional or substance use problem, including war stress or PTSD", at a VA or non-VA hospital); and (3) a score of 3 or higher on the SCL-90 (Kinney et al. 1991) subscales measuring active symptoms of depression, hostility, paranoia, or psychoticism. It should be noted that a substantial, but unknown proportion of these individuals would be redundantly disqualified in the NICS by dint of having a history of involuntary commitment to a mental hospital.

Other Variables

Demographic, clinical, service-use and combat exposure characteristics were also included in the analysis. We used the following indicators to describe the sample's demographic characteristics: age (1 = younger than 35); gender (1 = male); education (1 = high school or less); marital status (1 = married); living alone; having low social support (1 = lowest quartile of Medical Outcomes Study Social Support Survey (Sherbourne and Stewart 1991), 57 for this sample); employment status (1 = not working); residential status (1 = not living at home). Racial/ethnic background was measured in three categories: White, Black, and Other. A three-category version of SCID diagnosis was created: No diagnosis, any PTSD, or any other diagnosis. We measured other clinical characteristics and trauma exposure dichotomously: Self-reported service-connected mental health disability (1 = mention of psychiatric issue in free-text answers coded by study staff); trauma (1 = a score of greater than 35

on the Davidson Trauma Scale, Davidson 2004); traumatic life events (1 = highest quartile of Traumatic Life Events Questionnaire-Modified, Kubany et al. 2000, which was 6 or more events in this sample); combat exposure (1 = highest quartile of Combat Exposure Scale, Lund et al. 1984, which was 20 or higher in this sample); traumatic brain injuries (1 = two or more TBIs recorded using TBI Screen, Ivins et al. 2003); alcohol use problem (1 = score of 8 for men or 7 for women on the Alcohol Use Disorder Identification Test, Bradley et al. 1998); drug use problem (1 = score of 6 or greater on the Drug Abuse Screening Test, Skinner 1982). Past service utilization was captured by two indicators of self-reported outpatient and inpatient treatment for mental health or substance abuse (1 = ever received). In addition, self-reported combat exposures were measured dichotomously (serving in a combat unit in a war zone, firing a weapon in a combat situation, ever being under enemy fire, and ever being wounded or injured in a war zone).

Analysis

We used Chi square tests to assess statistical significance of associations in frequency tables (Table 1). We used SAS PROC LOGISTIC to estimate odds ratios associated with each of three proxies, reporting 95% confidence intervals and the statistical significance of each outcome (Table 2). Odds ratios were adjusted by including demographic, clinical, service use, and combat exposure variables described above, with the following exceptions: we omitted from multivariate models any variables that had been used to create the proxy under consideration, and those that were redundant or overlapping with the proxy component variables. For example, in models estimating associations with the SMI proxy, we omitted SCID diagnosis, psychiatric hospitalization history, and acute symptoms as independent covariates, because these measures had been used to create the proxy, and also omitted the Davidson Trauma Scale because of its overlap with SCID diagnosis. The problem of missing data was managed by multiple imputation (m = 10); estimates were pooled using SAS PROC MIANALYZE.

Results

Proxy Measures of Fiduciary Need and Their Correlates

The IQ-based measure identified 74 of 3200 veterans, 2.3% of the PDMH sample. Of note, 52.7% of these individuals were not working and 31% had a low degree of social support. Regarding clinical characteristics, 88% had a lifetime psychiatric diagnosis, assessed by the Structured Clinical Interview for DSM-IV (SCID); 64.9% had a history of treatment for mental health or substance use disorder (with 32.4% having been hospitalized for these problems); 78.4% had some significant trauma-related psychological symptoms (scoring above 35 on the Davidson Trauma Scale); 9.5% self-reported a history of two or more traumatic brain injuries (TBIs) (Ivins et al. 2003); 6.8% had significant symptoms of alcohol use disorder (AUDIT) and 10.8% had likely illicit drug use disorder (DAST).

The proxy for current drug (non-alcohol) use disorder identified 72 of 3200 veterans, or 2.2% of the PDMH sample. Similar to those identified by the IQ proxy, over half (59.7%) were not working and over a third (36.1%) reported low social support. By definition, all had a SCID diagnosis of substance use disorder, and most also had a SCID diagnosis of PTSD (59.7%) or a score above 35 on the Davidson Trauma Scale (66.7%). Most had a history of outpatient treatment for mental health or substance use disorder (72.2%) and over a third (38.9%) had been hospitalized for these disorders as well. Despite a current diagnosis of drug use disorder, only 61% of those identified by this proxy measure were classified by the DAST as having a drug use problem. About a fifth (22.2%) had indications of a co-occurring alcohol problem, as measured by AUDIT.

The acute-SMI-based proxy indicator of fiduciary need identified 93 of 3200 veterans, 2.9% of the PDMH sample. The large majority (75.3%) of these veterans were not working and 51.6% had a low degree of social support. Regarding clinical characteristics, unlike the IQ-based measure, all of those identified by the acute-SMI-based proxy (by definition) had lifetime psychiatric diagnoses and a history of inpatient hospitalization; and 96.8% scored above 35 on the Davidson Trauma Scale screen for PTSD; 28.0% reported two or more past TBIs; 21.5% had indications of alcohol use disorder (AUDIT) and 29.0% had indications of illicit drug use disorder (DAST).

Table 1 presents the prevalence of a positive fiduciary classification for each alternative proxy measure, along with the associations of these indicators to a set of demographic, clinical, functional, and service use characteristics in the PDMH sample. Tests of statistical significance of these bivariate associations indicate the salience of observed differences in the proportions identified with fiduciary need among those with various characteristics and conditions.

Demographic and clinical characteristics were associated with assignment to each fiduciary group. Notably, having less than a high school education, not working, and reporting low social support were associated with classification in all three proxy groups. Gender and living alone were not associated with any proxy group. Being under age 35 was associated with inclusion in both the SMI and SA group, and not being married was associated only with the SA group. Trauma symptoms, a history of outpatient and inpatient treatment for MH or SA, and acute MH symptoms

Table 1 Percent of sample identified as needing a fiduciary for each proxy measure, by demographic, clinical, service use characteristics, and risk of study outcomes (n = 3200)

Sample characteristics	Total sample	IQ-based proxy (n = 74)		SA-based proxy (n = 72)		Acute SMI-based proxy (n = 93)	
	N	n	(%)	n	(%)	n	(%)
Age < 35							
No	1487	36	(2.42)	60	(4.03)***	53	(3.56)*
Yes	1713	38	(2.22)	12	(0.70)	40	(2.34)
Sex							
Female	650	14	(2.15)	10	(1.54)	13	(2.00)
Male	2550	60	(2.35)	62	(2.43)	80	(3.14)
Education: HS or less							
No	1890	26	(1.38)***	25	(1.32)***	44	(2.33)*
Yes	1305	48	(3.68)	47	(3.60)	49	(3.75)
Married							
No	1494	31	(2.07)	57	(3.82)***	48	(3.21)
Yes	1701	43	(2.53)	15	(0.88)	45	(2.65)
Live alone							
No	2071	55	(2.66)	48	(2.32)	73	(3.52)
Yes	365	6	(1.64)	11	(3.01)	6	(1.64)
Low social support							
No	1808	37	(2.05)*	32	(1.77)***	31	(1.71)***
Yes	622	23	(3.70)	26	(4.18)	48	(7.72)
Racial/ethnic background							
White	1529	21	(1.37)**	24	(1.57)	42	(2.75)
Black	1508	49	(3.25)	42	(2.79)	42	(2.79)
Other	122	3	(2.46)	4	(3.28)	8	(6.56)
Not working							
No	1945	35	(1.80)*	29	(1.49)***	23	(1.18)***
Yes	1245	39	(3.13)	43	(3.45)	70	(5.62)
Not in home							
No	2168	50	(2.31)	40	(1.85)***	55	(2.54)***
Yes	268	11	(4.10)	19	(7.09)	24	(8.96)
SCID diagnosis							
None	1033	9	(0.87)***	0	(0.00) [def.]	0	(0.00) [def.]
Any PTSD	1176	49	(4.17)	43	(3.66)	79	(6.72)
Other	991	16	(1.61)	29	(2.93)	14	(1.41)
Service-connected disability—MH							
No	2505	48	(1.92)**	54	(2.16)	46	(1.84)***
Yes	695	26	(3.74)	18	(2.59)	47	(6.76)
PTSD (Davidson > 35)							
No	1733	15	(0.87)***	24	(1.38)***	2	(0.12)***
Yes	1445	58	(4.01)	48	(3.32)	90	(6.23)
Outpatient treatment (MH/SA)							
No	1490	26	(1.74)*	18	(1.21)***	5	(0.34)***
Yes	1631	48	(2.94)	52	(3.19)	85	(5.21)
Ever hospitalized (MH/SA)							
No	2713	50	(1.84)***	44	(1.62)***	0	(0.00) [def.]
Yes	482	24	(4.98)	28	(5.81)	93	(19.29)
MH symptoms: SCL-90 > 3							
No	2763	56	(2.03)***	55	(1.99)***	0	(0.00) [def.]
Yes	303	16	(5.28)	17	(5.61)	93	(30.69)

Table 1 (continued)

Sample characteristics	Total sample	IQ-based proxy (n = 74)		SA-based proxy (n = 72)		Acute SMI-based proxy (n = 93)	
	N	n	(%)	n	(%)	n	(%)
IQ < = 70							
No	3126	0	(0.00) [def.]	71	(2.27)	88	(2.82)*
Yes	74	74	(100.00)	1	(1.35)	5	(6.76)
2 or more TBIs							
No	2769	67	(2.42)	59	(2.13)	67	(2.42)***
Yes	431	7	(1.62)	13	(3.02)	26	(6.03)
Alcohol problem (AUDIT)							
No	2931	69	(2.35)	56	(1.91)***	72	(2.46)***
Yes	264	5	(1.89)	16	(6.06)	20	(7.58)
Drug problem (DAST)							
No	3001	66	(2.20)	28	(0.93)***	66	(2.2)***
Yes	197	8	(4.06)	44	(22.34)	27	(13.71)
Combat Exposure Scale (highest quartile: 20 or higher)							
No	2393	47	(1.96)*	47	(1.96)	49	(2.05)***
Yes	799	27	(3.38)	24	(3.00)	44	(5.51)
Traumatic life events (TLEQ highest quartile: 6 or more events)							
No	2301	48	(2.09)	43	(1.87)*	38	(1.65)***
Yes	899	26	(2.89)	29	(3.23)	55	(6.12)
Suicide risk							
No	2875	60	(2.09)**	58	(2.02)**	51	(1.77)***
Yes	320	14	(4.38)	14	(4.38)	42	(13.13)
Violent behavior							
No	2899	61	(2.10)*	54	(1.86)***	53	(1.83)***
Yes	294	13	(4.42)	18	(6.12)	39	(13.27)

Sample N varies with missing data on some variables

Statistical significance: *p < 0.05, **p < .01, ***p < .001

on the SCL-90 scale were associated with inclusion in all three proxy groups, if not already part of their definition. Self-report of a service-connected MH disability and high scores on the Combat Exposure Scale were also associated with inclusion in the IQ- and acute SMI-based proxy groups. Traumatic life events were associated with inclusion in the SA- and SMI-groups.

Table 1 also presents information about suicidal risk and interpersonal violent behavior in the full PDMH sample and by proxy group. Three-hundred-and-twenty veterans were at heightened risk of suicide, and proxy groups for acute SMI, IQ, and substance abuse included 14, 14, and 42 of these individuals, respectively. There were 294 veterans who reported recent violent behavior. Of these, 13, 18, and 39 were classified to be at risk of fiduciary need according to criteria for acute SMI, IQ, and substance abuse history.

Table 2 presents a comparison of the alternative proxy measures of fiduciary need with respect to the two outcomes of particular relevance to VA policy of linking firearms prohibition to fiduciary assignment: suicidality and interpersonal violent behavior. We found that rates of both suicidality and violence were significantly elevated in veterans who were identified by any one of the proxy measures, with unadjusted (bivariate) odds ratios in range of 2.15–8.4. However, those identified by the acute-SMI-based proxy had substantially higher rates of violence than those identified by the IQ or drug abuse proxy (41.9 vs. 17.6% and 25.0%, respectively), as well as higher rates of suicidality (45.2 vs. 18.9% and 19.4%, respectively). With controls for relevant demographic and clinical covariates in a multivariate logistic regression model, neither the IQ- nor drug abuse-based proxies were statistically significantly related to either violence or suicidality. However, in equivalent multivariate models the proxy indicators based on acute psychopathology were both found to remain significantly associated with increased risk of interpersonal violence and suicide (adjusted OR 3.25, p < .0001 for violence; adjusted OR 3.27, p < .0001 for suicidality).

Table 2 Fiduciary proxy measures and risk of suicidality and interpersonal violence: bivariate and adjusted associations

	N	n at risk	(% at risk)	Bivariate unadjusted associations[a]		Multivariable adjusted associations[b]	
				O.R.	95% C.I.	O.R.	95% C.I.
Suicidality risk models							
IQ-based proxy							
No	3121	306	(9.80)				
Yes	74	14	(18.92)	2.15	(1.19–3.89)*	1.13	(0.57–2.22)
SA-based proxy							
No	3123	306	(9.80)				
Yes	72	14	(19.44)	2.22	(1.23–4.03)**	1.31	(0.64-2.65)
Acute SMI-based proxy							
No	3102	278	(8.96)				
Yes	93	42	(45.16)	8.36	(5.46–12.81)***	3.25	(2.00–5.28)***
Interpersonal violence risk models							
IQ-based proxy							
No	3119	281	(9.01)				
Yes	74	13	(17.57)	2.15	(1.17–3.97)*	1.1	(0.56–2.18)
SA-based proxy							
No	3121	276	(8.84)				
Yes	72	18	(25.00)	3.44	(1.99–5.94)***	1.83	(0.93–3.57)
Acute SMI-based proxy							
No	3101	255	(8.22)				
Yes	93	39	(41.94)	8.21	(5.33–12.66)***	3.27	(2.01–5.32)***

Statistical significance: *p < 0.05, **p < .01, ***p < .001

[a]Sample size was n = 3195 for suicidality risk and n = 3193 for violence risk bivariate models, due to missing outcome data

[b]Models are adjusted for demographic and social characteristics (age, education, marital status, social support, employment, residential status, race/ethnic background); clinical and functional characteristics not part of fiduciary proxy measure (SCID psychiatric diagnosis, alcohol and drug abuse problems, multiple TBIs, IQ-equivalent measure of intellectual functioning); services utilization not part of fiduciary proxy measure (VA service-connected psychiatric disability, receipt of outpatient mental health and substance abuse services, history of psychiatric hospitalization,) war and trauma experience (served in warzone, served in warzone with combat, fired weapon in combat, under enemy fire, wounded in war zone, Combat Exposure Scale, Traumatic life events, Davidson trauma scale). Estimates are pooled results from multiple imputation

Discussion

Since 1998, the VA has reported the names of over 167,000 incompetent beneficiaries to the NICS, rendering these individuals legally ineligible to purchase or possess firearms. A proposed new law, the Veterans' Second Amendment Rights Restoration Act of 2018 (S.2386), would provide a process for veterans to have their names expediently removed from the background check database and have their gun rights restored, by placing the burden on the Federal Government to prove by clear and convincing evidence in a court or judicial review board proceeding that the veteran is a danger to self or others. In the same manner, the law would uncouple the loss of gun rights from routine assignment of VA fiduciaries in the future. The proposed law is ostensibly motivated by a concern for fairness. What consequences might follow, for veterans and the public?

Unfortunately, there is very limited information publically available about the population of veterans deemed to be financially incompetent who have historically been reported to the NICS, and whether they, on average, have elevated rates of suicidality or violence. In the absence of such direct information, this study used a large survey database of post-deployment Iraq and Afghanistan-era veterans' mental health to develop three proxy measures of fiduciary need, capturing intellectual disability, illicit drug abuse, and serious and acute psychopathology. These proxy measures were based on the regulatory criteria for fiduciary appointment, combined with external information about VA practice and the application of alternative clinical paradigms regarding the target population and purpose of the program. The proxy measures each identified 2–3% of the population of participants in the PDMH study. Together the proxies captured 7.0% (n = 225) of the PDMH sample. To put this

in comparative context, the total number of veterans with fiduciaries represents about 10% of the total number of veterans with service-connected mental health disabilities; 2% of the total number of veterans served by the Veterans Health Administration; and less than 1% of the total US veteran population (US Department of Veterans Affairs 2017).

Irrespective of which proxy measure was used—intellectual disability, substance abuse, or acute psychopathology—rates of suicidality and violence were found to be significantly elevated in veterans who were identified as needing a fiduciary, as shown in Table 2. The strongest net associations were seen for the acute psychopathology proxy, with nearly half of those identified reporting violence or suicidality, and with significant effects maintained in the presence of controls in a multivariate statistical model. Indeed, the acute serious mental illness indicator was associated with a tripling of the risk of suicidality and interpersonal violence, after adjusting for covariates. This finding would suggest that NICS reporting is most appropriate for veterans in the fiduciary program who have a diagnosis of a serious mental illness combined with acute psychiatric symptoms and a history of inpatient treatment. The evidence also supports the policy goal of providing a meaningful opportunity for gun rights restoration, if symptoms subside over time and the veteran's illness is persistently controlled in treatment. The public safety case for putative risk-based reporting to NICS is weaker for veterans identified solely by the illicit drug abuse proxy or intellectual impairment.

A limitation of the study is that its outcome measures—self-reported suicidal ideation and trouble controlling violent behavior—do not directly assess the risk of misusing a firearm, which is the ultimate issue for NICS reporting. However, gun-involved suicide and homicide clearly are subsets of these broader categories of concern. This study was also limited with regard to its sample and indirect measure of fiduciary need. A larger and older sample would be needed to capture risk associated with age-related neurocognitive disorders, which are likely to be the most common reason why an older veteran would be assigned a fiduciary. For a fuller understanding of risk among veterans with fiduciaries, direct study of those with fiduciaries, such as an evaluation administrative data from the Veterans Benefits Administration in combination with medical data from the Veterans Health Administration, would provide further insight into how fiduciaries are assigned by the VA, in practice, along with the level of associated suicide and violence risk across age and service-era cohorts.

A challenge for policy-making in this arena is that categorical prohibitions may be simultaneously too broad and too narrow, such that they include non-dangerous individuals and exclude others who pose a real threat. In this regard, it is possible that most veterans who have been assigned a fiduciary do not pose a substantial risk to themselves or others, and that many of those who are at elevated risk have not been assigned fiduciaries; we would know more about this if data on veterans with fiduciaries were available. Ideally, an effective public health approach to restricting firearms access for veterans at risk of harming themselves or others would be targeted broadly, and not limited to those who are proposed for a determination of financial incapacity. However, such an approach would also be based on identifying the presence of strong correlates or known indicators of danger to self or others, taking into account an individual's observed risky behaviors and experience over time. In the interim, the results of this study suggest that certain operational definitions of likely need for fiduciary management of a veteran's benefits are indeed significant correlates of dangerousness, albeit indirect and fairly nonspecific indicators. Future research may guide efforts to optimize the processes both for determining a veteran's need for financial assistance and identifying those who pose a significant firearm safety concern, in a way that appropriately balances risk and rights.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committees and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the Post-Deployment Mental Health study.

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