Firearm injury mortality is a leading cause of death in the United States, and recent trends show its burden worsening. This burden is not distributed equally, and recent increases in firearm mortality rates are most pronounced among the demographic groups and regions that were already among the most affected. Descriptive epidemiology that sharpens our understanding of how firearm mortality is evolving is a critical prerequisite to identifying and addressing this worsening public problem and the accompanying health disparities.

In their recent descriptive epidemiology study, Rees et al further honed that understanding in their analysis of firearm mortality trends from 1990 to 2021, and how these trends break down by demographics (including within age, sex, race, and ethnicity combinations), intent (homicide, suicide, unintentional), urbanicity, and region. This fine-grained analysis confirmed much of what we already know about firearm injury epidemiology: the urban-rural divide, in which firearm homicides were concentrated in urban regions while suicides were concentrated in rural regions; sex differences, in which males had 7 to 17 times higher rates of firearm mortality than females, depending on mechanism; and racial disparities, in which older White men had higher rates of firearm suicide whereas the disproportionate burden of firearm homicides occurred among younger Black men. At the same time, Rees et al added novel insights into heterogeneity in intent-specific trajectories over the last 3 decades and underlined new and concerning trends, such as increasing suicide rates among females. The study by Rees et al also succinctly displayed the regional diffusion over time to show, for example, increasing concentration of firearm homicides in the Southeast US.

The findings reported by Rees and colleagues underscore the need to discuss and address health disparities in firearm violence. At the heart of the unequal distribution of firearm fatalities is a history of structural inequalities in the US, most notably structural racism and discrimination. Residential segregation and community divestment disproportionately affect minoritized racial and ethnic groups (such as Black and American Indian or Alaska Native individuals), minoritized gender identities, and other people with marginalized identities. Not only does the empirical evidence show that these factors are linked to higher stress responses, anxiety, and depression, but they are also related to higher levels of violence—particularly firearm violence. But racial disparities do not exist in a vacuum, and it is increasingly important to recognize how multiple social identities intersect (eg, ethnicity, class, gender, sexuality, and skin tone) to create unique challenges for different subgroups. For example, the specific racism experienced by Asian individuals during the COVID-19 pandemic is associated with mental distress and firearm purchase and carriage, placing Asian individuals at an elevated risk of firearm injury and mortality more recently.

An important corollary of the structural inequalities—differential violence exposure—is implicated in increased risk of future violence and related factors and is a critical leverage point for addressing health disparities in firearm violence. For example, trauma-informed practices in family, clinical, school, and community settings show promise in improving psychosocial outcomes among youth exposed to violence and may be one important component of addressing disparities of firearm injury and mortality. Community interventions focusing on environmental changes that enhance positive social activity and, in the process, increase neighborhood guardianship and social control are an important avenue for breaking cycles of interpersonal violence. Indeed, evidence suggests that programs addressing factors at multiple levels, including individual (eg, enhancing self-efficacy and intention to recognize and report warning signs of violence), family (eg, parenting), and community (eg, cleaning and improving vacant and blighted properties) may decrease rates of youth violent...
assault.5 Similarly, violence interruption programs, like CureViolence,6 offer an important adjunct to other approaches.

Policies also play a critical role in tackling the root and proximal causes of firearm violence and may help to alleviate health disparities. Broader policy directions—progressive policies in particular—may interact with such community-based approaches in achieving primary prevention. For example, improved college affordability, unemployment insurance, and increased public spending generally have potential to increase economic opportunity and social mobility in a way that can lessen some of the upstream contributors to structural inequality.7

Meanwhile firearm-specific policies offer key primary and secondary prevention strategies for tackling more proximal causes of firearm injury and mortality. The recent increases in firearm mortality rates noted by Rees et al2 mirrors a recent surge in firearm sales, which could be partially addressed by purchasing and licensing laws. Additionally, more focused policies can address firearm disparities by targeting at-risk populations. For example, in most incidents in which a woman is killed by an intimate partner, the homicide involved a firearm; this suggests policies allowing firearm restrictions on those making violent threats or with a history of violent convictions may lower firearm mortality among women. Similarly, Extreme Risk Protection Orders may serve a critical role in some scenarios, such as when someone is at known risk for suicide (given the dramatically increased lethality of a firearm-related suicide attempt relative to other methods) or has made threats to others. Other firearm policies specifically related to child firearm access, such as child access prevention laws and higher minimum purchase age requirements, may help to address the leading cause of death among that group. While firearm policies are a critical piece, care must be taken to ensure that policies are applied equitably and do not widen existing health disparities (eg, as evidence suggests is the case with Florida’s “Stand Your Ground” law).8

Firearm violence is a worsening problem in the United States, as health disparities have widened in recent years. Addressing this problem cannot focus solely on the individual, as there are many structural factors at the community level and societal level broadly driving the current trends, and placing responsibility on the individual is both unproductive and misplaced. Individual-level approaches surely have a place, but given the significant regional variability in the dominant intent and mechanism of firearm violence, and in the populations involved, those approaches must be context-specific. Reversing the current trend requires a change of the current culture and policies around guns and the root causes of unjust risk exposure, racism, and discrimination (societal level), changing communities in ways that enhance cohesiveness and make it easier to move about safely (community level), and helping to facilitate individual behaviors that promote firearm safety and reduce propensity for retaliation (individual level). Only by counteracting the upstream and structural causes of firearm violence can we begin to curb the firearm mortality epidemic in the US for all people equally.
REFERENCES