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Firearm Lethal Means Safety with Military Personnel and Veterans: Overcoming Barriers using a Collaborative Approach

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Abstract

Suicides by firearm have increased over the past decade among United States service members and veterans. As firearm access is a suicide risk factor, firearm-related lethal means safety is critical to suicide prevention. However, identity, occupational, and cultural barriers may deter efforts to promote lethal means safety with service members and veterans. The current manuscript describes a collaborative framework to guide mental health providers' in conducting firearm-related lethal means safety with service members and veterans, including within the context of Safety Planning. In approaching firearm lethal means safety conversations with patients, clinicians must work to overcome their own reticence, address patient concerns directly, and remain culturally sensitive to the values of the military and veteran communities. This approach is illustrated using case vignettes that encompass addressing firearm-related lethal means safety with service members and veterans.

Keywords

firearms; lethal means safety; military personnel; veteran; suicide

Suicide among United States (U.S.) military personnel and veterans is a significant public health concern (Department of Veterans Affairs [VA], 2019; Reimann & Mazuchowski, 2018). From 2005 to 2017, the age- and sex-adjusted suicide rate among U.S. veterans increased from 18.5 to 27.7 per 100,000 (VA, 2019). Rates of suicide among active duty service members in the Department of Defense (DoD) similarly increased from 18.7 per 100,000 in 2011 to 24.8 per 100,000 in 2018 (Tucker et al., 2020).

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Firearms are the primary method of suicide among active duty military personnel (65.4%; Pruitt et al., 2019) and veterans (70.7% among male veterans and 43.2% among female veterans; VA, 2019). Of active duty military suicide deaths involving a firearm, a majority involved personally-owned firearms (90%), rather than military-issued firearms (10%; Pruitt et al., 2019). Access to firearms is associated with elevated risk for suicide planning and suicidal self-directed violence, with nationwide surveys and meta-analytic reviews showing a seven times greater likelihood of a suicide plan involving firearms, and two to three times greater likelihood of suicide, among individuals with access to firearms (Anglemyer et al., 2014; Betz et al., 2011; Dempsey et al., 2019). Thus, elevated rates of firearm-related suicide among U.S. service members and veterans—relative to other U.S. adults (Kaplan et al., 2009)—are likely partially attributable to their higher rates of firearm ownership and military cultural influences that encourage owning personal firearms (Cleveland et al., 2017). Furthermore, this may relate to high rates of storing firearms unlocked (66.6%) or loaded (46.7%) within the veteran population (Simonetti et al., 2018), as these storage practices are associated with a three to four times greater likelihood of suicide (Dempsey et al., 2019; Shenassa et al., 2004).

Safety Planning (sometimes referred to as Crisis Response Planning) is a brief, collaborative intervention focused on preventing suicide by providing a concrete set of steps to guide patients in coping and seeking help when they are in distress (Stanley & Brown, 2012). Clinical practice guidelines specify that outpatient management of suicide risk should include a Safety Planning intervention to decrease suicide risk and establish clear steps for the patient to follow if a crisis emerges (VA & DoD, 2019). Thus, when Safety Planning, the patient and provider delineate a specific plan that details what the patient will do when faced with a crisis related to suicide risk. This includes identifying warning signs, detailing internal and external coping strategies, listing supportive persons whom the patient can ask for help, and indicating emergency resources and how they can be accessed (e.g., phone number for a mental health provider, Veterans Crisis Line, 9-1-1; Stanley & Brown, 2012). Compared to a risk assessment and referral model, patients who receive a Safety Planning intervention are significantly less likely to engage in suicidal self-directed violence over a six-month period (Stanley et al., 2018).

A crucial part of the Safety Plan is taking steps to decrease access to lethal means—especially firearms given their lethality—in the patient's environment (Stanley et al., 2020). Decreasing access to lethal means of suicide, often referred to as lethal means safety, can be accomplished by working with the patient to temporarily remove lethal means from the patient's immediate environment (VA & DoD, 2019). If removal of firearms is not possible, then providers can work with the patient and their family members to reduce access to patient's access to firearms by storing firearms more safely in the patient's environment (Jin et al., 2016). This can be accomplished by ensuring that firearms are stored with a trigger or cable lock and secured in a tamper-proof safe, and by storing ammunition in a separate location (Bryan et al., 2011). In these cases, the intent of these storage practices is to slow and reduce impulsive access to firearms during temporary moments of crisis (Hoyt & Duffy, 2015).

The strongest evidence for the effectiveness of decreasing access to firearms comes from population–level interventions that show correspondence between less firearms access and lower rates of suicide (for a review see Anglemyer et al., 2014). For example, a study among the Israeli Defense Force showed that decreasing access to military-issued firearms when off-duty significantly reduced suicide deaths (Lubin et al., 2010). Of note, several studies have shown that clinical interventions to decrease access to firearms can significantly improve safe firearm storage practices (Barkin et al., 2008; Runyan et al., 2016). Unfortunately, retrospective review of veteran suicide deaths among VA patients indicates that those whose primary mechanism of injury was a firearm were less likely to have received an intervention to decrease their firearms access (Ammerman & Reger, 2020). Because up to two-thirds of service members and veterans report not storing firearms safely (i.e., not in a firearm safe or secured with a firearm lock; Simonetti et al., 2018), interventions to increase safe firearm storage are critical to reduce suicide among these groups (Bryan et al., 2019).[1]

Notwithstanding the benefits of Safety Planning interventions more broadly (Bryan et al., 2019; Stanley et al., 2018), service members and veterans may express reluctance to participate in such interventions – particularly in regard to lethal means safety specifically (Simonetti et al., 2020). A number of factors may influence willingness to reduce access to firearms, including veteran identity, concerns for personal or household safety, occupational concerns, and fear of being ostracized by fellow service members and veterans (Burek, 2018; Hoyt & Duffy, 2015; Jakupcak et al., 2017; Weiss & Coll, 2011). Guidance on how to address these barriers remains limited, despite the critical need to promote lethal means safety within clinical settings. The aim of this paper is to provide direction on addressing these challenges when engaging service members and veterans in lethal means safety discussions, including within the context of Safety Planning interventions. The intended audience for this paper is mental health providers working in outpatient settings with service members and veterans.[2]

A Collaborative Approach

Conversations regarding firearm safety with service members and veterans may involve various entities, including the patient and provider, as well as family members, the healthcare system, and potentially the military chain of command (Hoyt & Duffy, 2015; Hoyt & Repke, 2019). To account for these multiple perspectives, a patient-centered care approach can be used. Patient-centered care is defined as “active collaboration and shared decision-making between patients, families, and providers to design and manage a customized and comprehensive care plan” (NEJM Catalyst, 2017). In the context of Safety Planning and lethal means safety discussions, patient-centered care involves shared

[1]A common misconception is that limiting access to one form of lethal means (e.g., firearms) will result in the patient attempting suicide with another form of lethal means (e.g., hanging). Although there are limited cases of lethal means substitution among high-risk individuals, research from numerous settings suggests that lethal means substitution is relatively rare (Anestis et al., 2017; Daigle, 2005; Yip et al., 2012). With firearms in particular, the relatively low risk of lethal means substitution is greatly outweighed by the likely benefit of decreasing access to this highly lethal form of self-directed violence.

[2]Despite the focus of the current article to outpatient mental health settings, this focus is not exclusionary. Discussions regarding firearms lethal means safety can be valuable for discharge planning in other settings as well, including inpatient settings and as part of routine risk assessments in emergency departments (Frierson, 2020; Runyan et al., 2016).

plans between the patient and the care team to ensure that patient preferences, values, and traditions are respected (Wittink et al., 2020). Even for active duty military patients whose occupational requirements include carrying a firearm, safe storage can be established as a collaborative treatment goal (Hoyt & Candy, 2011). Given the import of shared decision making to empower the patient and ensure uptake in use of the Safety Plan (Matarazzo et al., 2014), this type of collaborative model is optimal for suicide prevention interventions, especially for mental health providers working with military personnel and veterans. For example, in military and veteran outpatient mental health service settings, this approach to firearm lethal means safety can impact several facets of care, including overcoming provider reticence to have lethal means safety conversations and addressing patient concerns, while also being culturally sensitive. These are delineated further below.

Overcoming Provider Reticence

Despite recommendations to engage at-risk service members and veterans in firearm-related lethal means safety discussions (VA & DoD, 2019), several provider-level factors may deter having these conversations. Research suggests that firearm-related conversations are rarely initiated by patients (Valenstein et al., 2020). In a study of veterans receiving VA mental health care, less than half (44%) of those with household firearms who had recently been suicidal reported ever having had a conversation about firearms with their clinicians (Valenstein et al., 2020). Other studies also suggest that providers infrequently assess and document firearm access with VA patients, including those who screen positive for suicidal ideation (Denneson et al., 2016; Dobscha et al. 2014).

Providers may be reticent to have firearm-related conversations due to inexperience or lacking adequate knowledge about firearms, causing them to question whether inquiring about firearms is within their range of competency (Slovak et al., 2008). In some cases, providers may mistakenly worry that asking about firearms in clinical settings violates institutional policies or state and federal laws, despite several court findings upholding the right of the provider to inquire about and document a patient's firearm access and related risk (Betz & Wintemute, 2015; Wintemute et al., 2016). Providers may also fear harming the therapeutic alliance by offending a patient with strong views about firearm ownership (Simon, 2017). All of these factors may result in provider avoidance of firearm-related discussions, creating a barrier to caring for service members and veterans who are at risk for suicide.

Nonetheless, several professional bodies support healthcare professionals having direct, informed discussions about firearms, emphasizing that it is crucial for accurate information about firearms safety to be disseminated as broadly as possible (Anestis et al., 2018; Weinberger et al., 2015). In working to overcome these barriers, providers should also be aware that numerous stakeholders indicate that routine screening and discussions about firearms safety are appropriate. In a recent national survey of U.S. adults, 54% of firearm owners indicated that provider discussions about firearm safety are at least "sometimes appropriate" (Betz et al., 2016). Moreover, recent qualitative research suggests that veterans may be open to discussing their firearm access with healthcare providers when there is rapport and trust (Monteith, Holliday et al., 2020; Simonetti et al., 2020). In another study

with a series of focus groups with patients, providers, family members, and VA facility leaders, there was broad support for routine firearm-related lethal means safety discussions among these groups (Walters et al., 2012). Furthermore, these focus groups identified a number of potentially acceptable approaches to decreasing firearm access among at-risk veterans, including involving family members, encouraging safe firearm storage (both in the home and off-site), and partnering with veteran service organizations to facilitate temporary storage of firearms (Walters et al., 2012). Finally, the VA healthcare system was seen as having a legitimate and necessary role in addressing firearm access—especially during periods of elevated acute suicide risk—across patients, family members, and providers (Walters et al., 2012). Taken together, these results suggest that discussions regarding lethal means safety are supported and encouraged by a number of involved stakeholders.

Acknowledge and Address Patient Concerns

In 2017, only 51.5% of active duty military suicide decedents sought mental health care in the 90 days prior to their death (Pruitt et al., 2019). Similarly, among a sample of veterans who died by suicide, less than half had a mental health care visit in the prior year, and only 21% had a mental health care visit in the 30 days preceding death (Denneson et al., 2010). Stigma and concerns about the repercussions of receiving treatment for mental health conditions on privacy and occupational opportunities can deter service members and veterans from seeking services (Acosta et al., 2014; Dickstein et al., 2010; Goode & Swift, 2019). Stigma may be further compounded by beliefs that contact with behavioral health providers will result in restricted freedoms, such as losing access to firearms (Keyes et al., 2019). Specifically, 21% of post-9/11 veterans indicate that the possibility of personal firearms being taken away was a barrier to seeking mental health care (National Academies of Sciences, Engineering, and Medicine, 2018). These concerns also have been illustrated by media reports that some veterans perceive the process for receiving free firearm locks from the VA (e.g., forms requiring reporting of names and number of firearms in the home) to represent a “gun registry” (Thompson, 2018). Among active duty service members, recommendations for short-term reduction of firearm access must be addressed by commanders in a way that encourages help-seeking and minimizes career-impacting stigma (Hoyt & Duffy, 2015). Indeed, the greater career risk may be the negative impact of untreated mental health symptoms (Hom et al., 2017). Acknowledging career concerns can therefore potentially help to drive a therapeutic discussion between patients and providers that balances risk and individual freedoms (Betz & Wintemute, 2015).

An approach that is consistent with patient-centered care in acknowledging and addressing patient concerns is Motivational Interviewing (Miller & Rollnick, 2012). Motivational interviewing operates under a framework of understanding an individual’s openness to changing a particular behavior (e.g., storing firearms more safely). Providers then work to meet the individual at their specific stage of change, then utilize specific techniques to decrease ambivalence to changing one’s behavior while increasing the patient’s likelihood of success. For example, providers working with military personnel or veterans at elevated risk for suicide and with access to firearms could initially explore the patient’s desire to change their firearm access. Questions would be posed in an open-ended manner, empathetically, and with reflective statements. Additionally, methods of decreasing ambivalence might

include exploring the discrepancy between current behaviors and one's goals or values – for example, by using double-sided reflections (e.g., "You mentioned you maintain firearm access because you like to hunt, *and at the same time,* you also stated that you are worried about what you might do if you have easy access to your firearms when you are thinking about suicide."). Such approaches can help patients to perceive the dissonance between their behaviors and therapeutic goals, as well as engender autonomy in their own behavior change.

Providers can also work to facilitate small or incremental behavior change and utilize positive reinforcement to enhance patient's sense of self-efficacy in changing their behaviors. For instance, this may entail understanding what the patient *is* open to changing and working to explore how this can be accomplished. Methods of engaging patients in this process can include exploration of the benefits and drawbacks of changing one's behavior, focusing on the benefits of change rather than sustaining problematic behavior. Especially when discussing firearm access, it may be important to focus discussions on both short- and long-term benefits and drawbacks (e.g., firearms may provide an immediate sense of safety, but also may increase long-term risk for self- or other-directed violence).

Thus, consistent with a Motivational Interviewing approach, providers can potentially reduce ambivalence among service member and veteran patients by being mindful of how they frame discussions around firearm safety and being attentive to the language used in such discussions. In a vignette-based study of provider recommendations, participants endorsed greater intent to follow through with clinical recommendations regarding firearm access when the discussion emphasized means "safety" rather than "restriction" (Stanley et al., 2017). Aligning firearm storage behavior with underlying reasons for ownership (e.g., increasing safety and security) also may help to overcome ambivalence toward reducing risk through safe storage. Even small behavior changes can be helpful in this endeavor, such as storing ammunition separately from firearms or collaboratively agreeing on specific at-risk periods during which firearms should be secured in a safe or by another person, such as a trusted family member. Safe storage practices also can significantly decrease risk of unintentional death for all household members (Dahlberg et al., 2004), which may serve as an important motivation to store firearms safely.

Military Culture Sensitivity

Attempting to reduce firearm access among service members and veterans at risk for suicide also may be complicated by specific cultural and occupational barriers (Hoyt & Duffy, 2015). Shared decision making can ensure that discussions about firearms respect patients' values and autonomy, and are culturally-informed (Burek, 2018; Matarazzo et al., 2014). Recognizing and respecting a veteran's history of military service, and having carried a firearm in defense of the nation, can be key to initiating a collaborative discussion from which to emphasize safety (Hoyt & Duffy, 2015). Providers should be aware of the perceived personal sacrifice being made by patients in choosing to reduce firearm access (Bryan et al., 2011). By considering local cultural norms (e.g., inclusive of rural or urban communities; Monteith, Wendleton, et al., 2020), and individualizing the message to focus on the safety of the patient and their family members, providers can have more

effective conversations about firearm lethal means safety. From a military culture standpoint, discussions of unsafe firearm storage practices may include exploring with the patient the discrepancy between unsafe practices and foundational training in firearm safety provided to all service members (e.g., “you mentioned you keep your firearm stored next to your bed loaded, and at the same time, you noted that you were trained to store your firearm unloaded…”). Collaborative discussions—which may include the patient, provider, family members, and/or military commanders—about the value of safe firearm storage can elicit better commitment from service members and veterans in adhering to a Safety Plan (Hoyt & Repke, 2019).

The function of an individual’s firearm ownership also may be a crucial consideration in discussions of values related to firearm ownership. Veterans and service members may own personal firearms for a variety of reasons, including to increase personal safety, to participate in sport shooting, for mementos or collecting purposes, or for other hobbies (Cleveland et al., 2017; Monteith, Holliday, et al., 2020; Simonetti et al., 2020). For example, service members may receive commemorative pistols from their military units, such as when completing a tour of duty. Telling veterans that they must surrender cherished mementos of their combat service could erode personal identity and exacerbate cognitions driving suicidal ideation. If firearm lethal means safety discussions are not conducted in a culturally sensitive manner that attends to reasons for firearm ownership, veterans may lose trust in their clinicians and the broader healthcare system and abstain from seeking care.

One way that providers can address these concerns is by emphasizing that there are only limited cases in which firearm access would be formally limited. Consistent with an emphasis on patient autonomy, acting on recommendations for decreasing access to firearms is voluntary for veterans. Similarly, U.S. Army and DoD policy for suicide risk reduction emphasizes voluntary safe storage of privately-owned firearms in unit arms rooms as a primary step in establishing a Safety Plan (Department of Defense, 2017; Hoyt & Duffy, 2015; Hoyt & Repke, 2019). In certain limited cases, duty limitations that reduce access to firearms may be recommended to service members’ unit commanders (Hoyt, 2013). However, in providing patient-centered care, providers can emphasize that such recommendations are typically only made when a service member has been unresponsive to treatment for suicidal ideation or not engaging with their Safety Plan (U.S. Army Medical Command, 2016).

Another common concern driving veterans’ firearm ownership and storage behaviors is personal and household protection, with many veterans endorsing strong personal values about safety and security (Simonetti et al., 2018). This may be particularly salient among women veterans, in which the desire for protection following interpersonal violence may prompt firearm access and unsafe storage practices (e.g., keeping a loaded firearm easily accessible; Monteith, Holliday, et al., 2020). These concerns for personal safety may be tied to trauma exposure and may be particularly salient among those with posttraumatic stress disorder (PTSD) symptoms (Stanley et al., 2020). For example, although overall PTSD symptoms do not appear to be associated with firearm ownership (Heinz et al., 2016), PTSD-related hyperarousal symptoms are associated with being more likely to store firearms loaded and in unsecure locations (Stanley & Anestis, 2020).

Approaching Firearm Lethal Means Safety: Case Vignettes

To illustrate this approach, we provide fictional case vignettes that highlight principles of overcoming provider reticence and addressing patient concerns while being culturally sensitive to military and veteran communities when discussing firearm lethal means safety while formulating a collaborative Safety Plan.

Vignette #1: Active Duty Service Member

Sergeant Charlie is a noncommissioned officer in the Army who previously deployed to Afghanistan. His partner recently insisted that he seek care after he had several incidents of reckless behavior and was unable to sleep without regularly checking the house for intruders and other threats. During the initial intake evaluation, his therapist diagnoses him with combat-related PTSD. Sergeant Charlie reluctantly discloses that he has experienced intermittent thoughts of suicide and states, “I don’t really care if I live or die.” He denies that he would ever act on these thoughts and indicates that he has no specific suicide plan. The therapist notes, however, that Sergeant Charlie did not respond to questions on the intake form about firearm access. Sergeant Charlie states, “That’s a stupid question. I’m a soldier, of course I have access to firearms.” The therapist acknowledges his comment and explains that she asks all patients this when they describe feeling the way that Sergeant Charlie does. Sergeant Charlie responds, “Well, my hunting rifles are my right and none of your business.” The therapist acknowledges that this can be a very personal and sensitive topic for people and indicates, “I’m not asking you to give up your hunting rifles. I just want us to figure out the best way for you to be safe when you are having thoughts of suicide, so that we can work together to meet your treatment goals. Reducing your access to firearms during periods of distress can be one of the best ways to do that.” Sergeant Charlie responds irritably, “This is why I didn’t want to come here, because I knew you’d just label me as crazy and try to take my rifles.” The therapist responds empathically, reinforcing his decision to seek care, and asks if it would be okay to revisit this again. Sergeant Charlie reluctantly agrees.

This vignette illustrates that patients can react negatively to a provider broaching the subject of firearm access and that patients may respond with ambivalence or anger during such discussions. Despite the patient’s initial reaction, several aspects of the provider’s behavior are worth highlighting. First, the provider directly inquired about access to firearms, rather than avoiding the topic when the questions were not answered on the assessment form. Second, the provider also explained the rationale for asking about firearm access. Although it might have been preferable to explore the patient’s beliefs about his firearm access and risk for suicide, as well as his frustration at being asked about his firearm access, the therapist responded in a manner that leaves the door open for subsequent conversations during the course of treatment.

As part of the treatment plan, the therapist referred Sergeant Charlie to a group-based intensive outpatient program for PTSD at a large military installation. During the program, he was identified as having elevated suicide risk, but expressed

> frustration with his outpatient therapist having suggested that he reduce his access to his hunting rifles. He indicated that participation in regular hunting trips was an important part of his family relationships, both with his father and his son. His fellow group member, Sergeant Sierra, suggested that Sergeant Charlie freeze the key to his gun safe in a block of ice and keep it in the chest freezer for the game from his hunting trips. Sergeant Sierra reasoned that it would take time for the block of ice to melt, so that Sergeant Charlie would not be able to use his impulsively. He agrees to integrate this into his existing Safety Plan.

This vignette also highlights several key aspects of a patient-centered dialogue regarding firearm-related lethal means safety. First, the suggestion came from a peer who showed respect for Sergeant Charlie's right to possess firearms and keep them in his home, which aligns with research suggesting that peer-based interventions and discussions may be particularly acceptable to veterans (Simonetti et al., 2020). Second, the suggestion was culturally sensitive, in that it was attuned to the specific function of the rifles (i.e., hunting rather than personal safety) and integrated cultural aspects (i.e., chest freezer for game). Third, Sergeant Sierra's suggestion addressed the concern of impulsivity by delaying access to the firearms, simultaneously addressing Sergeant Charlie's concern about surrendering his firearms. Similar approaches may help to facilitate discussions with patients about firearm access.

Vignette #2: Male Veteran Residing in a Rural Community

> Tom is a Vietnam-era veteran who recently presented to his local VA Medical Center's outpatient mental health clinic through a walk-in appointment. He has lived in rural communities since separating from the Navy and has not engaged in mental health treatment despite endorsing symptoms of depression that meet criteria for major depressive disorder. He meets with a psychologist, Dr. Laura, for the first time and discloses feeling hopeless. He also reports that the only thing he has to look forward to is going skeet shooting with his "old Navy buddy" over the weekend.

Based on his initial clinical presentation, it is clear that Tom has potential warning signs for suicide (e.g., feeling hopeless), as well as a history of depression. From an organizational perspective, Dr. Laura should assess his acute and chronic suicide risk, including his current access to firearms (and other lethal means) and plans for firearm access in the near future. Dr. Laura can consider multiple factors to ensure she is approaching firearm lethal means safety with Tom in a patient-centered fashion. Beforehand, however, she seeks to better understand his acute suicide risk and the potential role of firearms in his suicide risk.

> Dr. Laura begins by assessing Tom's acute suicide risk. Tom discloses he has thought about suicide in the past, including a time when he planned to kill himself using his handgun approximately one year ago. However, he never acted on this plan because of his grown children and household pets. Dr. Laura asks if Tom is currently considering or planning to kill himself, which he denies for similar reasons. Dr. Laura discusses that suicide risk can be dynamic and works with Tom to understand potential drivers of his suicide risk (e.g., feeling hopeless). They also discuss methods of coping (e.g., calling his friend, breathing exercises), including

those accessible in his rural community, where internet and phone service can be limited. She reviews potential emergency resources with him (e.g., Veterans Crisis Line phone, text, and chat options; 911; Emergency Department). These are all collaboratively included on Tom's Safety Plan, which Tom agrees to practice using and keep in his wallet.

Of note, Dr. Laura's initial focus was not on Tom's firearm access. Rather, she calmly assessed his acute risk to inform next steps. Upon determining that more intensive treatment (e.g., hospitalization) was not warranted, she prioritized creating a Safety Plan together. She considered several factors when doing so, including prior information that Tom had disclosed (e.g., history of depression), as well as his environmental factors (rural), feasible coping skills, and access to emergency resources. This laid the groundwork for discussing firearm access after establishing rapport and ensuring ability to maintain safety autonomously.

After developing a Safety Plan, Dr. Laura then explains the rationale for better understanding Tom's firearm access. She inquires about what he enjoyed about owning a firearm. Tom reports that it reminded him of being in the military; a time he felt connected with friends. Tom states that is why he enjoys skeet-shooting with military friends. Dr. Laura explores with him the possibility of maintaining firearm access, but potentially decreasing his access to firearms when he is experiencing elevated acute suicide risk (e.g., feeling hopeless or depressed). Tom and Dr. Laura collaboratively discuss various options (e.g., use of a gun lock, storing the firearm and ammunition separately, giving the firearm to a friend or family member[3]), and Dr. Laura emphasizes that the safest option is removal of his firearms from his home. However, Tom indicates that removing his firearms from his home, even temporarily, is not a step he is yet willing to take. They agree that Tom will use a gun lock and ask an old military friend to hold the key when he feels hopeless. Tom also agrees to store an extra copy of his Safety Plan next to his handgun, along with a picture of his pets to remind him of reasons for living. Tom states that he likes that idea and is glad Dr. Laura did not insist he remove his guns, which she knows would be of limited utility and could potentially damage their growing rapport, thereby potentially preventing him from returning for additional sessions. Dr. Laura concludes the appointment by suggesting that, at their next appointment, they review and refine his Safety Plan together (including confirming his follow-up actions regarding his firearm), and also begin Cognitive-Behavioral Therapy for Depression to address some of the underlying symptoms contributing to his thoughts of suicide. Tom agrees to this plan.

This is a prime example of utilizing Safety Planning as a collaborative exercise (Matarazzo et al., 2014). Rather than solely conceptualizing potential risks of firearm access, Dr. Laura also conceptualized firearms as an important aspect of Tom's identity, a reminder of positive memories, and a mechanism for increasing social connection. She was able to balance this dialectic with the reality that there are times when firearm access can be risky, particularly since Tom had contemplated suicide via his firearm previously. She also recognized the

[3]Providers should be aware that laws regarding this last option differ by state.

length of time that it had taken him to finally seek treatment and was weighing the risks and benefits, including the risks of "pushing too hard" in the absence of an established therapeutic relationship. They worked to identify a method by which he would reduce his firearm access that was feasible, strength-based (e.g., incorporated his friend), and consistent with his values. Finally, Dr. Laura ended the session by setting an agenda for follow-up, including review of Tom's Safety Plan and a plan to initiate an evidence-based treatment for his depression. These are notable considering the veteran's lack of prior engagement in mental health treatment. His decreased ambivalence regarding treatment may have been driven, in part, by the collaborative approach and rapport developed during this meeting.

Case #3: Female Air Force Veteran

> Sandy recently began Prolonged Exposure Therapy to address PTSD symptoms stemming from a sexual assault which occurred during her basic training. While she was initially hesitant to open up to her social worker, she had made great strides in processing her sexual assault, including participating in imaginal exposure exercises. However, when Sandy presents for therapy today, she is uncharacteristically quiet. She keeps mentioning that the only thing that keeps her safe at night is the gun under her pillow. She also discloses she can't stop thinking about going to sleep and "not waking up."

Sandy has been engaged in PTSD treatment, but her clinical presentation at this appointment is not commensurate with prior sessions. Sandy reports increasingly engaging in unsafe behaviors aimed at feeling safer (e.g., having a firearm under her pillow) and is disclosing statements potentially consistent with suicidal ideation.

> Her social worker begins by asking open-ended questions to better understand whether something changed between today and their prior session. Sandy is initially hesitant to engage in conversation and replies with one-word answers. Over time, however, Sandy reports that she recently was physically assaulted by her current boyfriend. Sandy states that she no longer feels safe and keeps thinking that there must be something wrong with her because these things keep happening to her.

Thus, rather than immediately attend to the increase in suicide risk related to the firearm within the context of increased interpersonal stress, her social worker empathically sought to understand the reason for the recent change in her presentation and behavior, and recognized that this recent traumatic experience had resulted in an upregulation of Sandy's trauma-related beliefs about herself, the world, and others.

> The social worker validates the distressing experience of the physical assault, and discusses common reactions to trauma, including safety behaviors and trauma-related beliefs. She then discusses Sandy's reasons for having immediate access to a firearm, and Sandy reports that she is not open to "giving up" her firearm as she knows no other method of keeping herself safe. The social worker discusses how access to a firearm when experiencing suicidal thoughts increases risk. She prompts a conversation regarding benefits (e.g., sense of safety following the recent physical assault) and drawbacks (e.g., increased access to firearm during episode of

suicidal ideation increases her risk of dying by suicide) of firearm access in such circumstances, with Sandy recognizing that she can potentially increase her risk for hurting herself, as well as her young child, by maintaining her current firearm storage practices. Sandy and the social worker collaboratively develop a method of maintaining access to the firearm, while also finding ways to do so more safely (i.e., storing the firearm unloaded in Sandy's closet on the top shelf, using a firearm cable lock, with the key in a separate location that is not accessible to her child).[4]

Consistent with patient-centered care and principles of Motivational Interviewing, the social worker explored Sandy's openness to changing her behavior by collaboratively exploring benefits and drawbacks, framing behavioral decisions by discussing the role of family (i.e., child in the home). The social worker recognized that, for Sandy, sleeping with her gun under her pillow was a new behavior that facilitated her sense of safety and protection following a threatening event. This also may suggest an important underlying trauma-related belief to address over the course of treatment, but only after safety is further established. The social worker utilized a patient-centered approach to decrease suicide risk within the context of an evidence-based PTSD treatment (cf. Holliday et al., 2019). Importantly, the social worker utilized this session to focus on assessing and decreasing Sandy's acute suicide risk, but did not discontinue treatment for PTSD, as Sandy's trauma-related beliefs appeared to be a central driver of her firearm access, and potentially suicide risk as well (Horwitz et al., 2018; McLean et al., 2017; Monteith et al., 2019). Therefore, in Sandy's case, addressing PTSD symptoms as the primary target, while concurrently assessing and managing suicide risk (and prioritizing doing so when warranted), was essential.

Conclusion and Next Steps

In addressing firearms as the leading method of suicide among service members and veterans, a patient-centered approach may simultaneously increase patients' safety while overcoming organizational and cultural barriers to reducing access to lethal means. Patient concerns regarding stigma, privacy, and safety can be addressed by providers addressing their own anxieties and ambivalence regarding these topics and broaching the topic of firearm lethal means safety through shared decision making.

The vignettes presented herein illustrate potential approaches to integrating cultural and contextual factors (e.g., rurality, trauma history) when discussing lethal means safety, including in the context of Safety Planning, with patients who may initially be ambivalent. In turn, given the limited research on interventions to reduce firearm suicides among military personnel and veterans, additional research is warranted. Specifically, further investigations remain necessary as both the VA and DoD continue to advocate and disseminate the use of Safety Planning (e.g., VA's Advanced Training in the Safety Planning Intervention). Additionally, research focused on better understanding optimal clinical approaches to intervening upon suicide risk and firearm access in these populations remains similarly needed.

[4]In such instances of re-traumatization, providers can provide additional resources to ensure patient safety (e.g., assess intimate partner violence [IPV], refer to a VA IPV coordinator).

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Public Significance Statement

Identity, occupational, and cultural factors may impede firearm-related lethal means safety interventions among service members and veterans at risk for suicide. This article proposes a collaborative approach to firearm-related lethal means safety that overcomes provider reticence, addresses patient concerns, and is culturally sensitive to military and veteran communities.