Development and Preliminary Evaluation of an Education Program for Primary Care Teams on Discussing Firearms Storage Safety with Veterans

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Abstract

Background

Reducing access to lethal means is one of the few empirically supported approaches for lowering suicide rates, and safe firearms storage practices have been associated with reduced risk of death by suicide. Although there is substantial opportunity for primary care to assist in addressing lethal means with veterans, approaches to intervention and educating staff are not well documented. We sought to 1) describe development of an education program for primary care teams to help them discuss firearms storage safety (FSS) with veterans during primary care visits; and 2) conduct a preliminary evaluation of the pilot education program.

Methods

We used an iterative process involving veterans and primary care staff stakeholders to develop program content, format, and supplemental materials. A grounded theory approach was used to analyze data from focus groups and individual interviews. Following piloting of the program with 71 staff members in two primary care clinics, we analyzed pre- and post-training participant surveys of program satisfaction and attitudes and behaviors related to firearms safety.

Results

During the development phase, 68 veterans and 107 staff members participated in four veteran focus groups and four primary care focus groups, respectively, and/or individual interviews. The program that was developed, "*'Just in Case': Discussing means safety with veterans at elevated risk for suicide,"* addresses knowledge and skills learning objectives, and includes video demonstrations and skills practice. Survey data obtained just prior to the two pilot training sessions showed low self-reported rates of discussing firearms safety with veterans who may be at elevated risk for suicide. Immediate post-training data showed generally high satisfaction with the program and significant improvements in participant self-reported ratings of the importance of, and comfort with FSS.

Conclusions

The program shows promise as a means for educating primary care staff to deliver messaging about firearms safety to veterans. Additional research is needed to refine and evaluate impacts of this or similar training programs on clinician and veteran behaviors over time.

Background

Veterans are 1.5 times more likely to die by suicide compared to non-veterans(1). Veterans are also significantly more likely to use firearms as a means of suicide compared to the general population(2).

Reducing access to lethal means is one of the few empirically supported approaches for lowering suicide rates(3,4), and safe firearms storage practices are associated with reduced risk of death by suicide(5-7).

Means safety counseling (MSC) approaches have been developed in an effort to reduce deaths by firearms and other suicide methods(8,9). MSC rests on the premise that moments of increased suicide risk are often fleeting, and that preventive steps can be taken to reduce the likelihood of making an attempt(10). MSC is considered a clinical best practice for individuals with known risk(11), and increasingly supported by multiple national organizations to enhance preventive safety behaviors(12-14). Promising models exist for MSC, such as those incorporated into *Counseling on Access to Lethal Means (CALM)*(8,15). Typically, MSC consists of a conversation between a counselor and an at-risk individual, often in clinical settings, whereby the at-risk individual is counseled to reduce their access to firearms or other lethal means. Bryan(16) recently found that a training program for VA-based clinical staff led to higher rates of clinician-reported counseling of veterans about firearms safety. While the study participants included a small proportion of physicians and nurses, the majority of the sample was comprised of social workers and psychologists.

While MSC can theoretically be delivered in any clinical setting, it is rarely delivered in primary care. In particular, discussions about firearms take place infrequently in non-mental health settings(17-19). Primary care clinicians are often uncomfortable discussing firearms with patients due to perceived barriers, such as lack of knowledge or personal experience with firearms, or concerns about negative impacts to the therapeutic alliance(20). Traditional MSC can be time intensive, and competing demands during brief appointments also likely limit the ability and willingness of primary care clinicians to discuss firearms(8,9).

Yet, primary care is a critically important setting for identifying and engaging veterans at risk for suicide. Half of individuals, including veterans, who die by suicide are seen in primary care settings in the month prior to death(21,22). Most individuals who receive mental health treatment receive it only in the primary care setting(23). Many patients who might benefit from discussions about firearms storage safety (FSS) in particular will be missed if interventions are not developed specifically for primary care. FSS discussions specifically include 1) advising veterans to keep firearms locked and unloaded when not in use; and 2) strategizing about additional ways to reduce access to firearms in situations when suicide risk may increase, such as during a crisis. Over the past decade, many healthcare systems, including the Veterans Health Administration (VHA), have implemented standardized approaches to screening for mental health conditions, including suicidal ideation. In this context, incorporating FSS discussions more routinely into primary care workflow may allow for intervention *before* a patient develops a crisis.

Our research has demonstrated that both primary care teams and veterans support having FSS discussions during primary care visits, with certain caveats(24-26). The purpose of this manuscript is to 1) describe

stakeholder-informed development of an education program to help primary care teams discuss FSS during primary care visits; and 2) present results of a preliminary evaluation of the pilot program.

Methods

Setting and Samples

The goal of the overall project was to develop an education program to facilitate delivery of FSS by VHA primary care teams. The first phase, focused on developing the program itself, was designated as a quality improvement activity by the VA Medical Center where the study was conducted, a large, urban medical center in the Pacific Northwest. The second phase, which focused on evaluating the pilot program, was approved by the facility's Institutional Review Board. During the first phase, we worked with veteran and primary care teams to explore attitudes toward FSS, and to gather input on development of the training program. Three local veteran organizations were identified via word-of-mouth, and organization leadership was approached to set up focus group meetings. All members of these organizations were invited to respective group meetings to create a convenience sample of veterans. A fourth group of veteran consultants, identified via communications with leaders of the above three groups, was created to provide input into this specific project. We also conducted focus groups with primary care teams at three VA community-based outpatient clinics (CBOCs) and one hospital-based primary care clinic. Five large primary care clinics associated with the Medical Center were invited to participate in the sessions; we met with the first four clinics that responded. Finally, six veterans and five primary care providers completed individual, semi-structured interviews following the focus group meetings. The total number of clinicians who participated in group and/or individual sessions was 107 and the total number of veterans who participated in group and/or individual sessions was 68.

Development of the Training Program

The methods and findings from the focus group meetings and individual interviews with veterans and staff have previously been published(24-26). **Table 1** shows a summary of findings regarding attitudes and advice given by these stakeholders which specifically informed development of the training program.

From this prior work, we learned that primary care staff would like examples of how to effectively speak about FSS with veterans. To this end, we extracted sample messages regarding FSS by reviewing existing messaging on FSS publicly available on-line. A set of messages were presented to veterans and clinicians during individual interviews to refine a set of sample scripts for staff to be able to use during visits. To identify potential messages, extensive searches were conducted in several databases, including PubMed, PsycINFO, ISI Web of Knowledge, and The Cochrane Library for the time period from the early 2000's to 2017. In addition, we evaluated content and artifacts (e.g., brochures) that had been designed to limit access

to lethal means available from organizations, campaigns, and other initiatives on lethal means safety. Specifically, we evaluated materials developed for individual firearm owners and clinicians who may interact with patients who own firearms. We identified an initial set of 60 messages, scripts, or text from awareness campaigns for our dataset. We then grouped the messages in an effort to inform our ultimate aim, that is, development of scripts for use by primary care staff to facilitate FSS conversations. After several iterations of review (by KC and EK), messages were classified as being: 1) ice-breakers (e.g., opening statements), 2) context (e.g., why conversation is happening), 3) facts about firearms/suicide/risk, 4) safety tips, and 5) frequently asked questions (e.g., will my mental health diagnosis prevent me from owning a firearm?).

Table 2 shows the messages we abstracted from our search and presented to veterans and clinicians, and the rating scales associated with each domain. Interviews lasted for approximately one-hour and were recorded and professionally transcribed. Within each domain, we first asked participants to rate each message using Likert-type scales, and asked them to explain why they thought a particular message was acceptable or not acceptable. Across veteran and clinician interviews, we calculated mean scores of ratings (because the sample size was small, these ratings served as non-parametric indicators of acceptability). We then used a descriptive qualitative analysis approach(27-29) to identify a set of highly acceptable messages based on the expertise and experiences of the interviewee participants. After incorporating actionable qualitative suggestions (e.g., wording changes or content changes), the study team combined highest rated messages in each domain to create a set of scripts organized by level of risk (i.e., low risk for suicide vs. higher level of risk). For example, one script developed for lower risk patients was as follows, “Because rates of suicide by firearms are high among veterans, and depression and PTSD increase risk for suicide, I am talking to all of my patients who may have depression or PTSD about the safe storage of firearms in the home. Would it be okay if we talked about that for a few minutes?”

In addition to developing sample scripts for staff to use to guide firearms safety discussions, as was done in the initial analysis of staff and veteran attitudes(24-26), we used a grounded theory approach(30-32) to identify candidate learning objectives for the training program and to guide program format.

We learned from focus group meetings that primary care teams and leadership preferred that training sessions be brief (preferably a maximum of 1.5 hours), as primary care staff frequently participate in trainings on competing high priority topics. Primary care teams had also expressed interest in having written materials available to help educate veterans and to normalize conversations about safe firearm storage. Suggestions included having a pocket-card which contained scripts they could examine prior to FSS discussions and patient-facing posters or brochures, which might be placed in waiting rooms or exam rooms. We therefore collaborated with VA’s Office of Mental Health and Suicide Prevention (funder of this project) and obtained input from the National Shooting Sports Foundation (https://www.nssf.org/) to create a pocket card for staff(33) and a brochure for primary care patients(34).

Education Program Evaluation

Between April and July 2019, we piloted the training program in two of the Medical Center's larger primary care clinics. Participants were asked to complete questionnaires just before, then immediately at the end of each session. Questionnaires included items to assess experiences and attitudes related to firearms and to discussing firearms during primary care visits. The post-session questionnaire also inquired about satisfaction with the educational program. Item responses were captured using 4-point Likert scales (4-point scale: excellent, good, fair, poor). T-tests and Chi square were used to compare pre-session to post-session responses.

Results

Based on information from the focus groups and individual interviews, our team developed the interactive education session, *"'Just in Case': Discussing Means Safety with Veterans at Elevated Risk for Suicide."* The program was designed to last 1.5 hours, include approximately 20-25 participants, and to be led by two local facilitators: a mental health clinician (in this case, a psychiatrist), and a primary care provider (in this case, an internist). We also recommend including a veteran firearm owner (in our case, a VHA employee) to offer perspective regarding firearms ownership and answer questions that might regard on how firearms work. Program knowledge and skills objectives are presented in **Table 3.** The PowerPoint® presentation (*available on request from the authors*) includes several video segments that serve as examples and are designed to prompt further discussion. The program is broken down into approximately 50 minutes of didactive and 20 minutes of skills practice. We developed the *GROW* Model to provide a framework to guide FSS discussions (**G**et ready; provide a **R**eason for the discussion; **O**ffer brief advice; and communicate **W**e're here to help).

Table 4 provides an abbreviated outline of the program content. Program materials provided in a binder for participants at the beginning of sessions included slide outlines, clinician pocket card, patient brochure, copies of several key references(7,35), suicide risk stratification table developed by the VA Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Suicide Prevention(36), a brief compendium of how firearms work and firearms terminology, and a set of sample scripts to use in the skills portion of the education session and to guide discussions with patients (**Table 5**).

Based on the Medical Home model, VHA developed Patient Aligned Care Teams (PACTs) to deliver primary care(37). Together, 71 staff participated in the two pilot sessions held at two clinics including all PACT members: licensed independent practitioners (physicians and nurse practitioners), registered nurses, licensed practical nurses, and medical staff assistants (MSAs). Forty-five percent of participants identified themselves as nurses, 18% as physicians, 3% as nurse practitioners, and 32% as MSAs/other support staff. Sixty-eight percent of participants were women. Eighty-six percent of staff members reported working in direct patient care 50% of the time or more. In the baseline questionnaires, 58% of participants reported ever having discussed firearms safety with a veteran, and 44% reported having offered a firearm cable lock to a

veteran (note that cable locks are provided free to veterans as part of VHA's suicide prevention strategy). Immediately post-session, participants reported a high degree of satisfaction with the program: Across the two clinics/sessions, 88% rated the quality of the program; 94% rated the usefulness of the information; and 92% rated the structure of the session as good to excellent.

Participants also reported significant improvements compared to baseline in 1) the importance they placed on speaking with patients about firearms safety (3.27 vs. 2.91; p=.01); 2) ratings of being able to effectively speak with patients about firearms safety (3.26 vs 2.72; p<.0001); and 3) level of comfort speaking with patients about firearms safety (3.07 vs. 2.73; p=.034). Participants' ratings of the extent they know enough about firearms to discuss firearm safety with patients did not change significantly post-course to pre-course (2.91 vs. 2.62; p=.085) for the 51 (72%) participants who completed pre- and post-course surveys.

Comments on training program implementation: Despite five larger clinics being invited to participate in the pilot training program, only two initially volunteered. A main obstacle noted by several clinic leaders was that there were many training needs for which they did not have time. Clinic managers also said that 1.5 hours would likely be the most time they could devote to the program if it were delivered in one session though the content and format were developed to be delivered in approximately two hours. In addition, despite our plan to present the program to smaller groups (ideally fewer than 20) to facilitate discussion and skills practice, the clinics preferred to have large groups participate in the sessions.

Discussion

This is the first project we have identified to use an iterative, stakeholder-informed process to develop and evaluate a program to teach staff to deliver firearms safety messaging in primary care settings. The education session we developed addresses knowledge and skills learning objectives and includes video demonstrations and skills practice; supplemental materials included a pocket card, which provides sample scripts to guide conversations, and a brochure to be used in primary care clinics. We piloted the program with 71 staff members who reported low baseline rates of discussing firearms safety with veterans. An immediate post-training evaluation showed generally high satisfaction with the program and that participants reported significant improvements in ratings of the importance of and comfort with FSS.

We identified a number of challenges to implementing the program, including competing demands on clinical leadership to find time for sessions, and their desires to have all staff participate at once. We had hoped to deliver content in smaller group sessions to facilitate having more time and support for skills development. We also confirmed that 1.5 hours was not enough time to cover all the material. Although one possibility would be to try to arrange for longer sessions, there may be value in separating the program into several sessions to allow for more question and answer time and post-session planning by care teams. We

know from prior work that impacts of clinician training interventions can decay over time(38). Delivering the program over several sessions over time might also help reinforce the material and any learned behaviors.

Research on messaging models such as the SBIRT (Screening, Brief Intervention, Referral and Treatment) for risky drinking(39,40), the “5 As” for smoking cessation(41), and motivational interviewing approaches(42,43) suggest that when clinicians are trained to deliver brief sets of health messages, it can have positive impacts on patient behaviors. We found that, after delivery of this stakeholder-informed educational content, participants reported high satisfaction and an increase in knowledge and comfort related to FSS. Future work will be important in assessing whether these gains are sustained over time, whether they translate to changes in practices at the provider or clinic level, and ultimately, whether they impact patient behaviors(38). Next steps would include delivering a larger series of training sessions and evaluating clinician behaviors (both self-reported and observed) over time. Using standardized patients to gauge staff performance or identify a cohort of patients who are recipients of FSS messaging to evaluate their responses to the messaging could be helpful. It would also be important to ensure that training components align with newly published national consensus guidelines for firearm injury education for medical professionals(44).

We utilized a stakeholder engagement to develop this educational course. We believe this approach is necessary given the potential sensitives of discussing firearm safety, particularly among veterans and that including firearm owners with specialized knowledge in the process may help inform firearm storage safety recommendations. This approach could also potentially improve the credibility of course content and messengers. In prior work among a national sample of firearm owners, Anestis et al(45) found that, among 14 different individuals (e.g., friends) and groups (e.g., law enforcement), compared to other messenger groups, respondents were less likely to rate “physicians or medical professionals” as the best messengers to teach firearm owners about safe firearm storage for the purposes of suicide prevention. In this study, military veterans were ranked as one of the best groups of messengers. Alternatively, our and others’ prior work on firearms safety(20,24,26,46) suggests that firearms safety messaging by clinical staff is acceptable to veterans, when done respectfully.

In addition to lack of information on clinician and veteran behaviors, there are other limitations to this work. Most of the data used to develop the course were derived from individuals living in urban or suburban areas in the Pacific Northwest. Veterans and clinicians from other parts of the country or rural areas may have differing perspectives; some of the scripts we developed may not be as acceptable or effective in other patient populations. It is possible that some of the individuals who did not complete post-session evaluations were less satisfied with the course.

Conclusions

This education program shows promise as an approach toward helping move suicide prevention upstream into settings that often encounter patients at greater suicide risk and who may not interact with specialty mental health. More research is needed to refine and evaluate impacts of this or similar training programs over time.

Declarations

Ethical Approval: The first phase of the project was designated as a quality improvement activity by the VA Medical Center on 6/15/2018 (no reference number). The second phase of the project was approved by the Medical Center's Institutional Review Board (IRB) on 11/30/2018 (reference #4347); the IRB approved a waiver of written informed consent; all participants were provided an information sheet and gave verbal consent to participate.

Methods: All methods were performed in accordance with relevant guidelines and regulations.

Consent for publication: Not applicable

Availability of data and materials: The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests

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Authors' contributions: SD and MG conceived of the project. SD, MG, KC, EK, JS, and JB designed and participated in delivery of the training program. EK and VE extracted and analyzed quantitative data for the program evaluation. SD and SN were major contributors to writing of the manuscript; all authors provided edits. All authors read and approved the final manuscript.

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Other Disclosures: None.

Disclaimers: None.

Abbreviations

Means safety counseling (MSC), Counseling on Access to Lethal Means (CALM), firearms storage safety (FSS), Veterans Health Administration (VHA), VA Portland Health Care System (VAPORHCS), community-based outpatient clinics (CBOCs), Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC), Patient Aligned Care Teams (PACTs), medical staff assistants (MSAs), SBIRT (Screening, Brief Intervention, Referral and Treatment).

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Tables

Table 1—Summary of Themes from Development Phase(24-26)

Attitudes—Veterans	Attitudes—Primary Care Staff
• Discussing firearms safety is acceptable and necessary, even if discussions are uncomfortable. • Veterans support a team-based approach because staff other than providers may have more rapport and contact with the veteran. • Some Veterans do not support direct questioning about firearm ownership due to fears of having firearms taken away or having their access to firearms limited. Some said they would not feel comfortable telling the truth. • Veterans feel there is an opportunity to link FSS discussions with VHA's Whole Health approach. • Primary care teams should use a conversational approach to FSS rather than using a script or checklist to engage veterans in a non-judgmental manner. • Primary care teams should provide rationale for FSS discussions and information regarding legal consequences for disclosing firearm ownership. • Providers should be transparent in their purpose for asking about firearms. • Providers should acknowledge and respect veterans' unique relationship with firearms.	• Firearms storage safety (FSS) discussions are within the scope of primary care. • A team-based approach to FSS in Primary Care involving nurses or veteran peers would be effective in minimizing impact on workflow. • Directly asking veterans about firearm ownership as a way of opening up the conversation may not be the best strategy. • Providing patient preventive or safety information, such as using Whole Health model, as context for firearm ownership questions can increase patients' comfort levels. • Primary care staff should examine personal biases about firearm ownership and prevent biases from impacting the therapeutic relationship. • Primary care staff are often uncertain about legal issues including temporary transfer laws, extreme risk protection orders, and if there are circumstances when a patient's firearms might be removed or reported.
Advice on Training Content from Veterans and Primary Care Staff	
The following advice/suggestions were reported in both veteran and primary care staff sessions as being important when engaging in FSS discussions: • Conveying care about patients' safety—safety drives the discussion. • Tailoring messages to the person and the situation. • Expressing that veterans have control over safe storage practices. • Avoiding judgmental language. • Engaging in personalized and effective communication. Primary care staff also recommended training on firearm basics, having written materials such as brochures to provide more information and help normalize FSS conversations, greater understanding of firearms laws, and having scripts to facilitate firearms discussions.	

Table 2. Message Ranking Exercise (based on Means Safety Messages from Public Sources)

Domain	Set-Up	Sample Messages presented to Stakeholders
Ice-breakers	Patient vignette: Joe is a 56-year old veteran who is seeing his VA primary care clinician for the first time. As part of his new patient intake, Joe answers questions about PTSD and depression. Joe's depression score is high. After Joe describes his symptoms and the clinician acknowledges how he is doing, the provider can open up a conversation about means safety in several ways:	1. Everyone experiences tough times. During such times, some of us may not be in the right state of mind to be handling weapons. 2. Our mission is to treat patients "whole health," both body and mind, and that includes thinking about the safety of our home. 3. At the VA, we are trying to improve the accessibility and variety of mental health services and screening because suicide by a firearm is the leading cause of veterans' deaths. 4. At the VA, we are committed to the mental and physical health and safety of our veterans and the people they love. 5. Hey, I know a lot of veterans own firearms. I don't care if you do or don't, but here are some things to consider if you find yourself in a bad place down the road 6. I do want to mention that sometimes a crisis hits and people who are already struggling suddenly experience suicidal feelings. Those feelings often go away in a matter of hours or days, but they can feel overwhelming.
Why is the conversation happening?	From our meetings with veterans, we learned that veterans feel comfortable talking about weapons safety when they understand the reason for doing so (e.g., patient safety). I would like to read you some sample reasons that providers could give and ask you to rate <u>how acceptable</u> the statements are to you.	7. I am talking with you about all of this because, as your provider, my concern is with your health and safety. 8. Because the rates of suicide by firearm are increasing, I am talking to all of my patients who are dealing with depression and PTSD about firearm and medication safety. 9. We know that most suicides are impulsive; and evidence shows that if you can put some time and distance between suicidal thoughts and grabbing your weapon this increases the likelihood of staying safe. 10. As your provider, my primary concern is about your personal safety. For this reason, I want to tell you what we know about

		PTSD or depression and suicide. 11. Firearms in the home are like any other potentially dangerous household risk, such as chemicals in cleaning supplies, backyard pools, alcohol and cigarettes, prescription medication, or fire hazards. With any of these potential hazards, you can take steps to protect yourself and your family. 12. Some of my patients have firearms at home, and some firearm owners who are going through tough times choose to make their firearms less accessible. Are you interested in talking about that?
Facts about suicide and increased risk	Now, I would like to review some facts about suicide that providers could share with patients to underscore the importance of depression, PTSD, and increased suicide risk among veterans. I will ask you to rate the importance of each message.	13. Suicide using a firearm is a leading cause of death among Veterans, but it is preventable. 14. Often, people with PTSD or depression have moments where something happens and they have a crisis, and may be feeling out of control and suicidal. Studies are showing that within a 5-minute period of feeling suicidal a number of Veterans do something they might not otherwise do. 15. Many suicide attempts occur with little planning during a short-term crisis. When someone feels overwhelmed in crisis, impulsive actions could tragically mean a life lost to suicide. 16. Approximately 70% of military suicide deaths involve the use of firearms. Having access to a firearm during a suicidal crisis increases the odds of a lethal suicide attempt. 17. Putting time and distance between a suicidal person and a firearm may save a life. The odds of survival go up for three reasons: 1. Suicidal crisis is often brief. 2. Deadliness of an attempt often depends in part on the method. 3. 90% of those who attempt suicide and survive don't attempt suicide again.
Safety tips	Now, I would like to review some safety tips that providers could share with patients to talk	18. What some veterans in your

	about weapons safety specifically. Please rate the importance of these safety tips.	situation do is to store their firearms away from home until they are feeling better or they use a gun lock. 19. I would encourage you to add some barriers between you and your weapon, whether that be removing a firing pin, or handing your keys to a spouse. Don't do something you can't take back. 20. Remember, nearly all firearms accidents in the home can be prevented simply by making sure that firearms are kept unloaded and locked up when not in use, with ammunition secured in a separate location. 21. If someone is at risk, help keep firearms from them until they recover. It's like holding on to a friend's keys when they are drunk.
Frequently asked questions	Veterans have told us that one strategy to make veterans more comfortable talking about weapons safety would be for providers to give patients information on what "VA's policy" for mental health issues, describe what will happen to a patient's weapon if she/he is diagnosed with a mental health issue, and dispel myths about mental health and weapons seizures.	1. Unless we were concerned about you being an imminent risk to yourself or others, which would result in you being hospitalized, the VA would not report your gun ownership to any authorities—there would be no impact on your ability to own firearms. 2. For people who have PTSD or depression, the VA does not report firearms ownership to federal government or state officials. 3. Just having a mental health diagnosis will not cause you to lose your firearms. 4. The VA does not have a "can't get a firearm list" for people who have PTSD or depression. 5. In this clinic, we respect your right to own weapons, and we want to make sure that we support you.
Message Sources	Department of Veterans Affairs; National Shooting Sports Foundation; Project ChildSafe (a program of the NSSF); American Foundation for Suicide Prevention; Veterans Crisis Line; Rocky Mountain Mental Illness Research, Education and Clinical Center for Suicide Prevention; Defense Suicide Prevention Office; Massachusetts Office of the Attorney General & Massachusetts Medical Society; Oregon Suicide Prevention (Keys); Seattle & King County Public Health Department (LOK-IT-UP); The Suicide Proofing Initiative (Oakland County)	
	Scale used to rank messages: 1-Perfectly acceptable 2-Acceptable 3-Slightly unacceptable 4-Neutral 5-Slightly unacceptable 6-Unacceptable 7-Totally unacceptable	

Table 3. Knowledge and Skills Objectives for "'*Just in Case': Discussing means safety with veterans at elevated risk for suicide*"

Knowledge
• Describe the rationale for discussing means safety with veterans in primary care. • State outcomes resulting from discussing means safety with patients. • Outline key steps in assessing suicide risk in general in primary care. • Describe a simple model for discussing means safety with veterans. • Explain how gun locks work, and specify several ways to secure firearms. • Describe how patients and veterans feel about discussing firearms in the context of primary care visits. • Explain what VA can and can't do legally with regard to restricting access to firearms. • State approaches to enhancing safety for other types of lethal means (e.g. medications). • List several approaches to initiating means safety discussions. • Identify biases you may have about firearms or veterans who own firearms.
Skills
• Use patient-centered interviewing techniques to create rapport and facilitate open discussion about means safety. • Choose approaches to opening means safety conversations that fit with your knowledge of the patient and the clinical context. • Use veteran-centric language to talk about firearms and means safety options. • Work with your local team to identify opportunities and roles related to facilitating means safety discussions with veterans at risk. • Efficiently integrate means safety messaging into your workflow

Table 4. Brief Outline of Training Program Content

- Welcome and introductions
- Review goals of course
- Case illustration
- What is (lethal) means safety?
- Key principles underlying means safety approaches
- Duration of Suicidal Crises
- Veterans, Firearms and Suicide
- Safe gun storage practices reduce risk of suicide
- Means Safety Interventions have potential to change storage practices
- Veterans' Firearm Storage Methods
- Reasons veterans own firearms
- Majority of firearms owners and firearms organizations take safety seriously
- Summary of options to enhance safety
- How/why does this impact Primary Care?
- The Means Safety *Messaging* Approach
- How do patients/veterans feel about discussing firearms?
- How do veterans feel about discussing firearms?
- Primary Care Staff views
- Legal Concerns—VA rules/regulations
- Having the Conversation–When?
- Having the Conversation—How?
- Preferred Language/Terms
- The GROW Model and Examples
- Practice Session
    - Two scenarios
    - Pair up and trade roles (patient and staff)
- Group Discussion/Question and answer
- Useful resources
- Next Steps for Teams

Table 5. Final Sample Scripts for Session Participants to use for Skills Practice and for FSS discussions with veterans

Reasons for the Discussion

***Some things you can say if you believe there is low risk for suicide*:**

- "I'm glad you're not having thoughts about suicide, but
    - Sometimes a crisis hits, and people can experience suicidal feelings.
    - There are things you can do to help you remain safe if that were to happen.
    - One of those things is to consider making changes in how you store firearms.
    - Would it be okay if we discussed that?"

- “A lot of veterans own firearms, and as your doctor/nurse, I care about your safety. Here are some things you might want to consider…”
- “Because rates of suicide by firearms are high among veterans, and depression and PTSD can increase risk for suicide, I am talking with all my patients who have depression or PTSD about safe storage of firearms. Would it be okay if talked about that for a few minutes?”

If you believe there is a higher level of risk:

- “Some of my patients who are firearm owners and who are going through tough times choose to make some changes in how they safely store their firearms. Would it be OK if we talked about that for a minute?”
- “A suicidal crisis can come on rapidly. We know that putting even a small amount of time and distance between having suicidal thoughts and a firearm can save a life. Some veterans choose to make changes in how they safely store their firearms.”

Phrases you can use if there are others in the household:

- “As your provider, I am concerned about the health and safety of you and your family/friends…”
- “Please be aware that kids can be more curious than we might realize, and that it’s common for teenagers to know exactly where firearms are hidden in the house. Are you aware of options for safely storing your firearms when they are not in use?”

Offer Brief Advice

If you believe there is low risk:

- “I would encourage you to use a locking device such as a gun lock, or to store your firearms in a lockbox or locked cabinet.”
- “Nearly all firearm accidents in the home can be prevented by making sure that firearms are kept unloaded and locked up, with ammunition stored in a separate location.”

If you believe there is a higher level of risk:

- “Some veterans choose to store their firearms away from home until they are feeling better. Is that something you might consider?”
- “I would encourage you to store your firearm away from your home, or temporarily ask a friend or relative to store the firearm for you.”

We're here to help

- "Here is a brochure with some suggestions for what you can do to store firearms and medications more safely. We also have firearm cable locks that I can give you free of charge."
- "Please contact our team if you have any questions about making your household safer."

***If you are more concerned, you can add*:**

- "I am also giving you information on how to reach how to reach our clinic, or in an emergency, the Veterans Crisis Line."
- "You've shared with me that you've been feeling really down for the past 6 months. I'm wondering if you'd be willing to meet with a behavioral health specialist who works on my team for a few minutes today to talk about how we can help you address these feelings..."

If the veteran raises concerns about consequences of disclosing firearms ownership:

- "Having a depression or PTSD diagnosis does not legally prevent you from owning or using a firearm."
- "[You have the right to own firearms]. I'm concerned about helping you stay safe since you've talked about having thoughts of suicide. Have you also been concerned?"
- "I don't need to know whether or not you own a firearm, but if you do, here are some things you might want to consider."

"I need a gun to protect myself"

- Response: "That's important, but there are a number of safe storage options. One option is a quick access lockbox. Here is a brochure that can help you decide which option is best for you"
- Response: The National Sports Shooting Foundation (NSSF) has lots of additional information on options and safety on their website."

Medication Safety

- Limit quantities of medications prescribed. If at higher risk, consider asking the patient to involve a family member/friend to help manage medications.
- Ask patients to:
    - Store medications in a secure area. If medications have abuse potential, consider a lockbox.
    - Dispose of any medication past its expiration date, no longer needed, or has not been used in 12 months.

- Provide patient information about disposal options: Check with local VA pharmacist about medication disposal options.