Firearm safety represents a critical public health goal in the US, and the importance of this issue is further magnified in the veteran population. One-third of veteran firearm owners store a firearm loaded and unlocked.¹ Suicide accounts for 54% of firearm deaths in the US,² and veterans who die by suicide are more likely to use a firearm than nonveterans.³ Veteran suicide prevention efforts have converged in recent years around developing and evaluating firearm safety interventions, including safety discussions between clinicians and veterans.⁴ Although research supports firearm safety interventions as a promising public health approach, many clinicians are uncomfortable initiating these discussions⁵ and may fear offending veterans.

The findings from Aunon et al⁶ challenge the entrenched assumption that veterans may respond negatively to firearm safety discussions. Results showed that 73% to 88% of veteran firearm owners report that physicians and other health care professionals should at least sometimes talk to patients about firearms and firearm safety across a variety of clinical situations (eg, risk of suicide, mental health or behavioral problems, abusing or being addicted to alcohol or drugs, being a victim of domestic violence, Alzheimer disease or another dementia, or going through a hard time). Furthermore, the rate of endorsement of firearm safety counseling in the current study was nearly identical to a prior study that used a very similar design but sampled the US adult population (76%-89%),⁷ highlighting that, in this context, veteran beliefs may be similar to the general population. Therefore, clinicians may find discussions about firearm safety are more acceptable to veteran patients than many might expect.

Within the Veteran Health Administration (VHA), the largest health care system in the US, there are important opportunities to expand the dissemination of firearm safety initiatives among its health care professionals. Since the VHA has invested heavily in disseminating clinical practice guidelines⁴ and implementing national efforts to advance clinical practices in this area, the training and education of its clinicians is vital. It is notable that in 5 of the 6 clinical scenarios, Aunon et al⁶ observed even higher acceptance rates among veterans who use the VHA relative to those who do not. Despite this, most veterans report not having conversations with their health care clinicians about firearm safety. The results from Aunon et al⁶ provide an important training resource to improve acceptance and implementation of firearm discussions among VHA clinicians, including those in mental health, primary care, emergency departments, and other key health care settings.

Findings from this study highlight the importance of at least 2 brief suicide prevention interventions implemented in VHA and elsewhere. Lethal means safety counseling (LMSC) is an approach in which access to specific lethal means, including firearms, is assessed, and then efforts are made to reduce access to those means among patients at elevated risk of suicide. Research about nuanced factors associated with acceptable firearm safety messaging (eg, who is the best messenger) is advancing rapidly; it is possible clinicians are not the ideal messengers, but the findings from Aunon et al⁶ support the view that they may be acceptable enough. Safety plans are a second approach in which clinicians typically assist patients in selecting strategies to use should suicide risk increase in the future. Making the patient’s environment safer is a key step in safety planning, and this step invites a discussion about firearm access, storage, and safety measures.

Patient reactions to such interventions will likely be heavily dependent on clinician delivery. The data from Aunon et al⁶ do not speak to clinician needs, but prior research suggests that there is a critical need for clinician training—more than 70% of emergency physicians reported that they wanted training on procedures for patients at high risk of firearm injury.⁸ Clinicians would also benefit
from training emphasizing cultural competence with firearm owners and using a collaborative approach. Effective interventions are needed to realize the opportunity suggested in the results from Aunon et al.\textsuperscript{6}

It was encouraging and surprising that only minor differences in beliefs were observed among geographic regions in the US. This suggests that different approaches to clinical interventions may not be needed by geographic region. It is possible that veteran firearm owners share cultural characteristics and beliefs, regardless of geography. However, this issue requires additional research since several participant characteristics and more granular geographic variation were not considered in these data (eg, rurality).

Notably, Aunon et al\textsuperscript{6} also found that 78% of veteran firearm owners believed clinicians should discuss firearm safety with patients with dementia at least sometimes. Alzheimer disease and related dementias are projected to increase dramatically in the next several decades. Risks of suicide and other forms of violence are elevated in this cohort, but firearm safety counseling with dementia patients remains very rare. However, best practices are available to assist clinicians in the management of firearm access among patients with dementia,\textsuperscript{8} including a VHA safety plan intervention that includes lethal means safety counseling for clinicians working with veterans with dementia.\textsuperscript{9} The results from Aunon et al\textsuperscript{6} should help allay fears among VHA clinicians about using these resources.

It is important to note that the findings by Aunon et al\textsuperscript{6} are relevant to all clinicians working with veterans, not just VHA clinicians. Less than half of veterans use VA health care. Therefore, any veteran prevention goal must employ strategies to engage partners in the community or use other public health approaches that do not depend upon connections to VA health care. The VA has been active in promoting such goals, especially in the suicide prevention field. For example, the VA recently funded Community Engagement and Partnerships Coordinators and managers across the country who support local and state-level initiatives to improve suicide prevention. The results from Aunon et al\textsuperscript{6} should be useful for alleviating community clinician fears about talking with veterans about firearms.

While the article from Aunon et al\textsuperscript{6} are useful, there is a key limitation—veteran responses to hypothetical scenarios may not reflect their actual responses to a clinician engaging them in firearm safety discussions. The few studies that have examined actual patient reactions to firearm safety discussions have reported high levels of acceptance but have been limited by small sample sizes and the use of qualitative methods. Establishing the acceptability of firearm safety discussions among firearm-owning veterans will require additional studies with patients that have been approached by clinicians for firearm-related discussions.

Clinician fears about veteran firearm discussions may spring from unfair stereotypes about veterans’ political views or their stance on guns. While veteran demographics differ from the general population in some important ways, it is important to note that veterans are a very large, diverse group. They come from every state in the country and include many (if not most) major occupational categories represented in the US. The findings from Aunon et al\textsuperscript{6} help challenge assumptions that may serve as a barrier to effective firearm safety interventions.
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REFERENCES