# TYPE IN THE CHAT

YOUR NAME, TITLE, ORGANIZATION, AND ANY QUESTIONS YOU HAVE ABOUT REDUCING ACCESS TO LETHAL MEANS

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# REDUCING ACCESS TO LETHAL MEANS TO PREVENT SUICIDE

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# LEARNING OBJECTIVES

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**After this presentation participants will be able to:**

- **Describe the research base for lethal means reduction to prevent suicide**
- **Discuss ways to approach reducing access to lethal means for suicidal patients**

# THE CASE FOR SUICIDE PREVENTION IN HEALTH CARE

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- **Nearly all individuals who die from suicide (83 %) receive health care in the year prior to death.**

- **45% of people who died by suicide had contact with primary care providers in the month before death.**


Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., ... & Operskalski, B. H. (2014). Health care contacts in the year before suicide death. *Journal of general internal medicine*, *29*(6), 870-877.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a revi ew of the evidence. American Journal of Psychiatry, 159(6), 909-916.

# NEW YORK STATE SUICIDE PREVENTION PLAN

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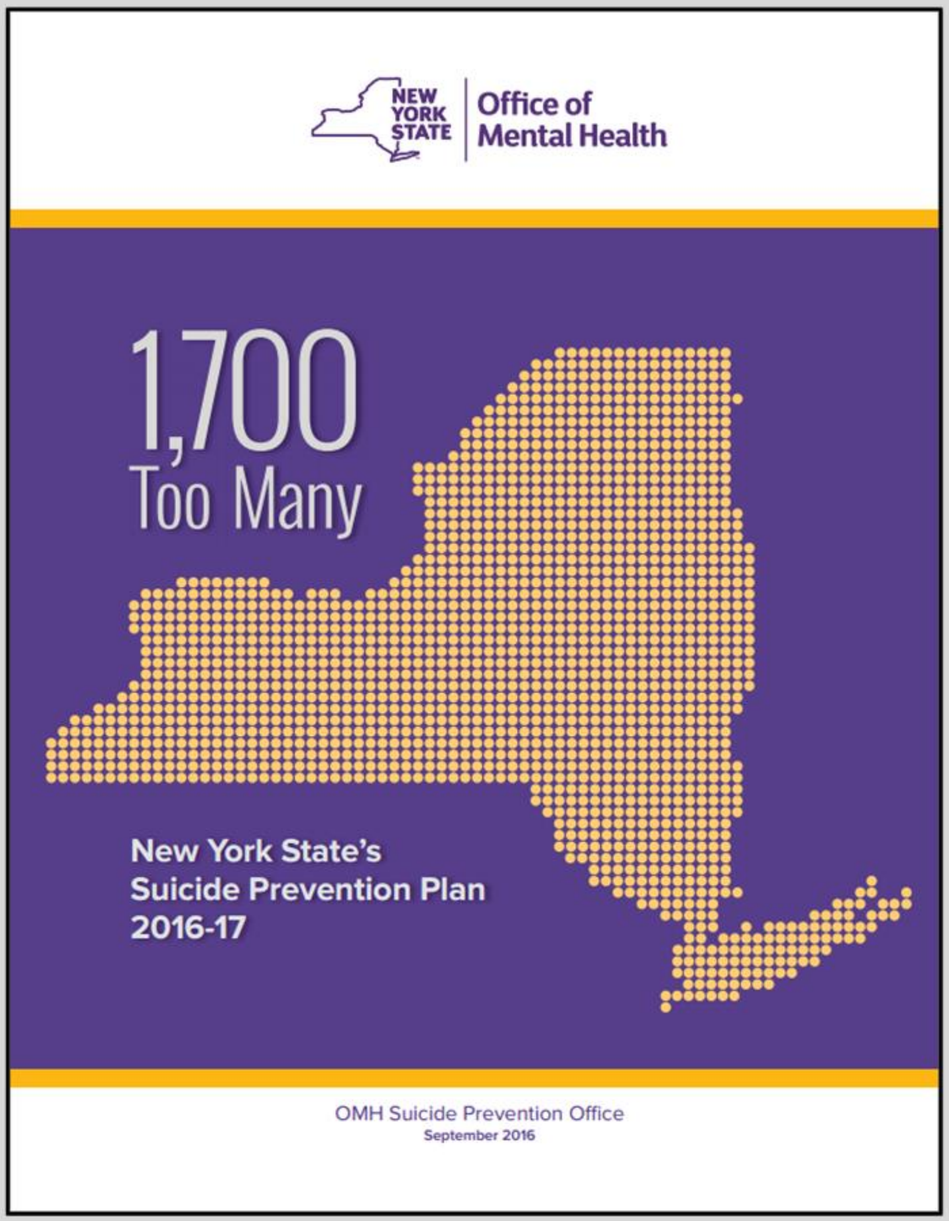


## Three Strategies

1. **Prevention in Health and Behavioral Healthcare Settings**
2. **Prevention Across the Lifespan in Competent, Caring Communities**
3. **Surveillance and Data-Informed Suicide Prevention**

https://www.omh.ny.gov/omhweb/resources/publications/suicde-prevention-plan.pdf

# THE CASE FOR SUICIDE PREVENTION IN HEALTH CARE

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Sentinel Event Alert

**A complimentary publication of The Joint Commission**
**Issue 56, February 24, 2016**

**Detecting and treating suicide ideation in all settings**

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6,7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

## Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

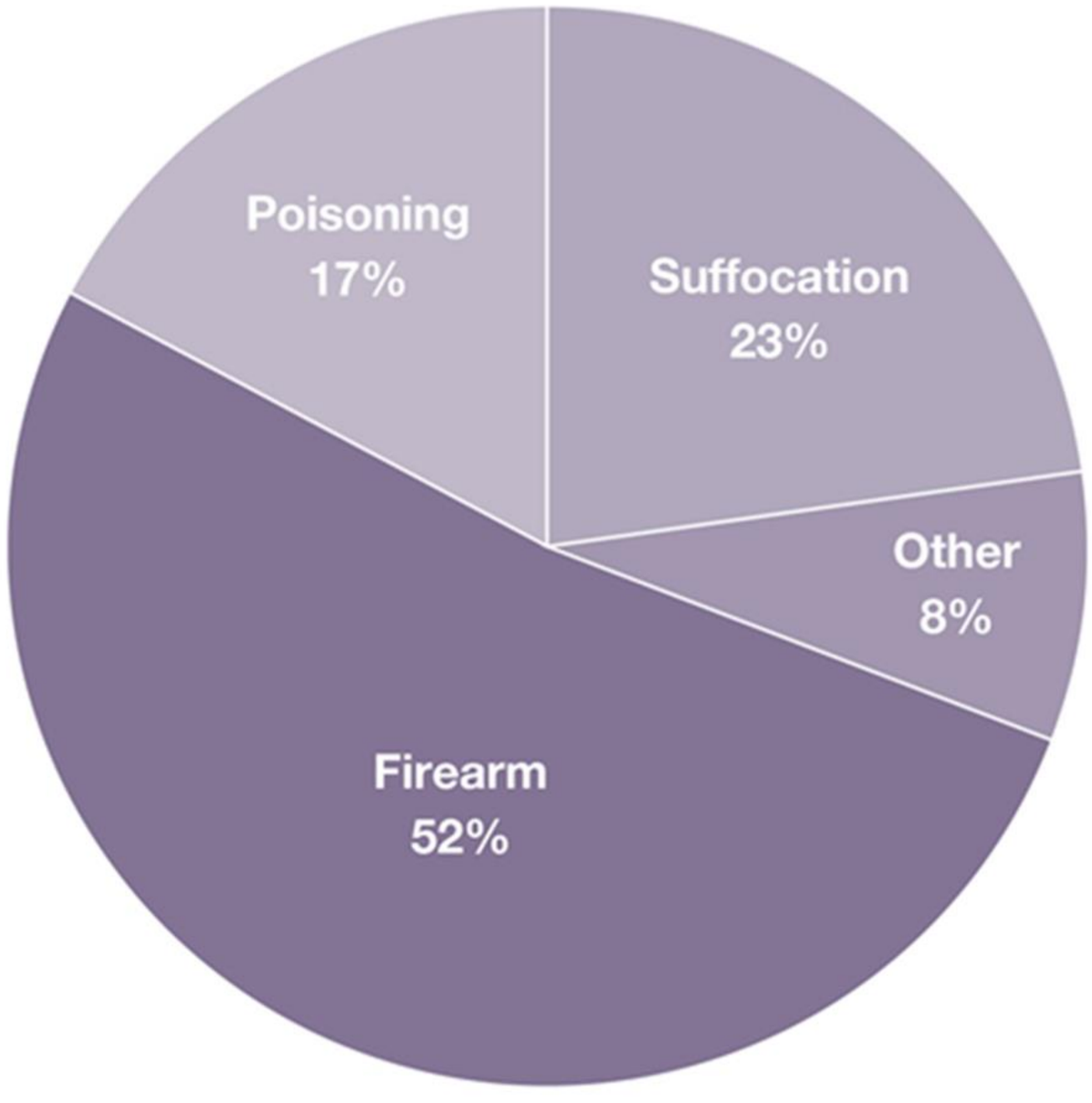
**For all patients with suicide ideation:**

- **Give every patient the National Suicide Prevention Lifeline number, 1-800-273-TALK (8255).**
- **Conduct safety planning by collaboratively identifying possible coping strategies with the patient.**
- **Restrict access to lethal means.**

https://www.jointcommission.org/sea_issue_56/

# Means of Suicide, United States

(Average 2000–2013)




Note: Percentage may not total 100% due to rounding

Source: WISQARS Fatal Injury Reports, 1999-2013

# MEANS OF SUICIDE BY SEX, U.S. (AVERAGE 2000-2013)

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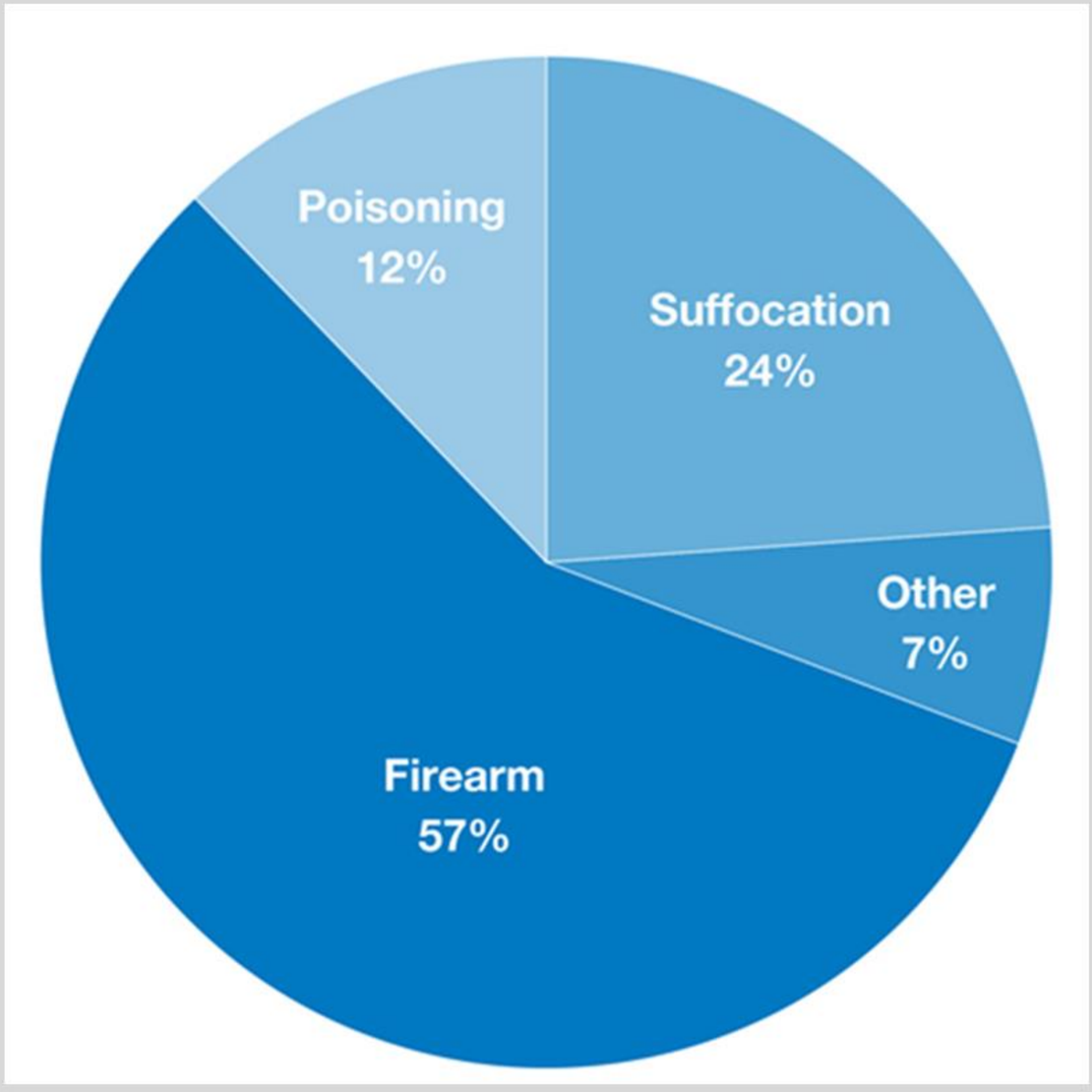
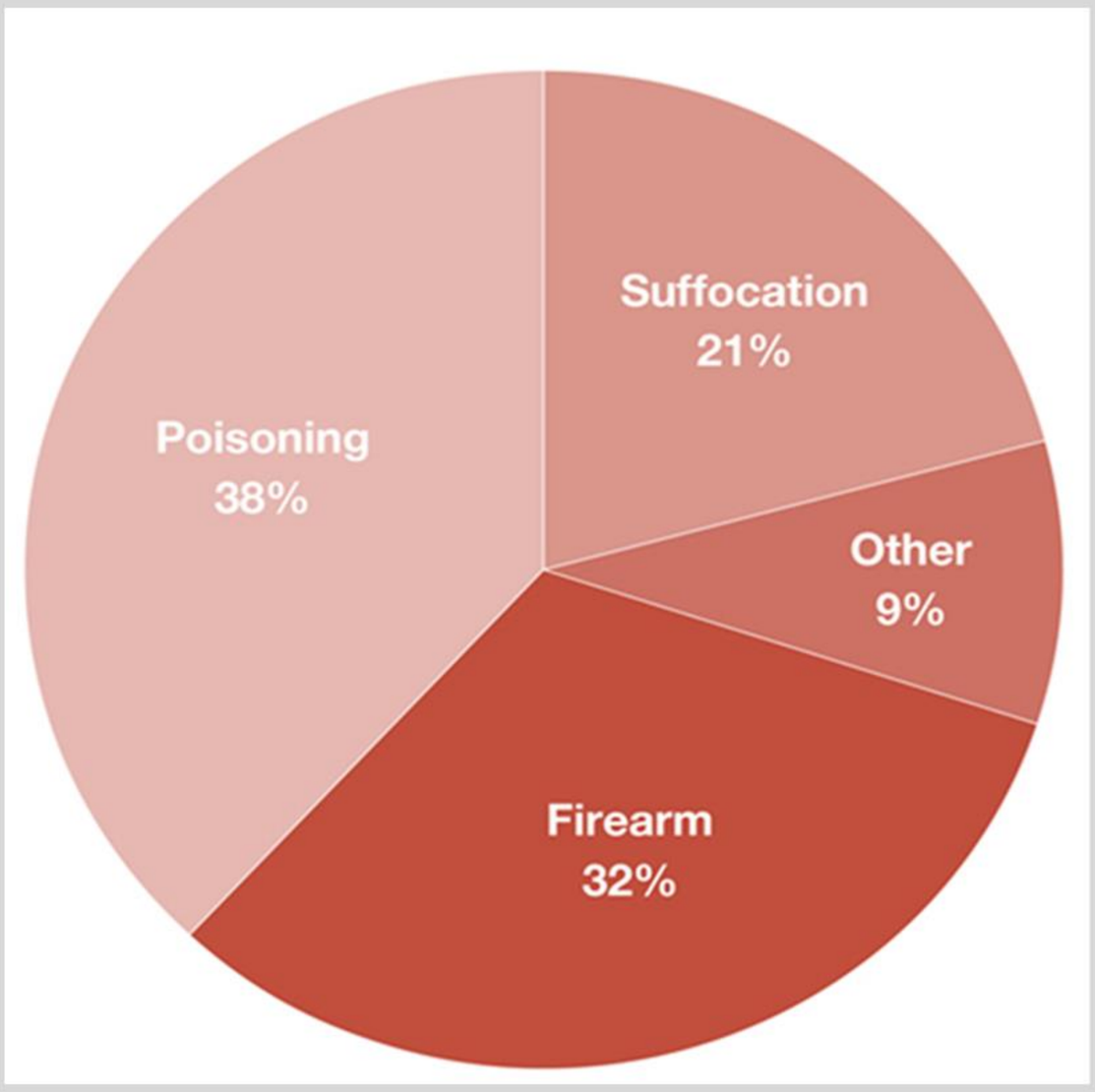
## Males




## Females




Note: Percentages may not total 100% due to rounding, Source: WISQARS Fatal Injury Reports, 1999-2013

WHAT IS REDUCING ACCESS TO LETHAL MEANS?

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# Reducing a suicidal person's access to highly lethal means

# REDUCED ANALGESIC PACKAGING

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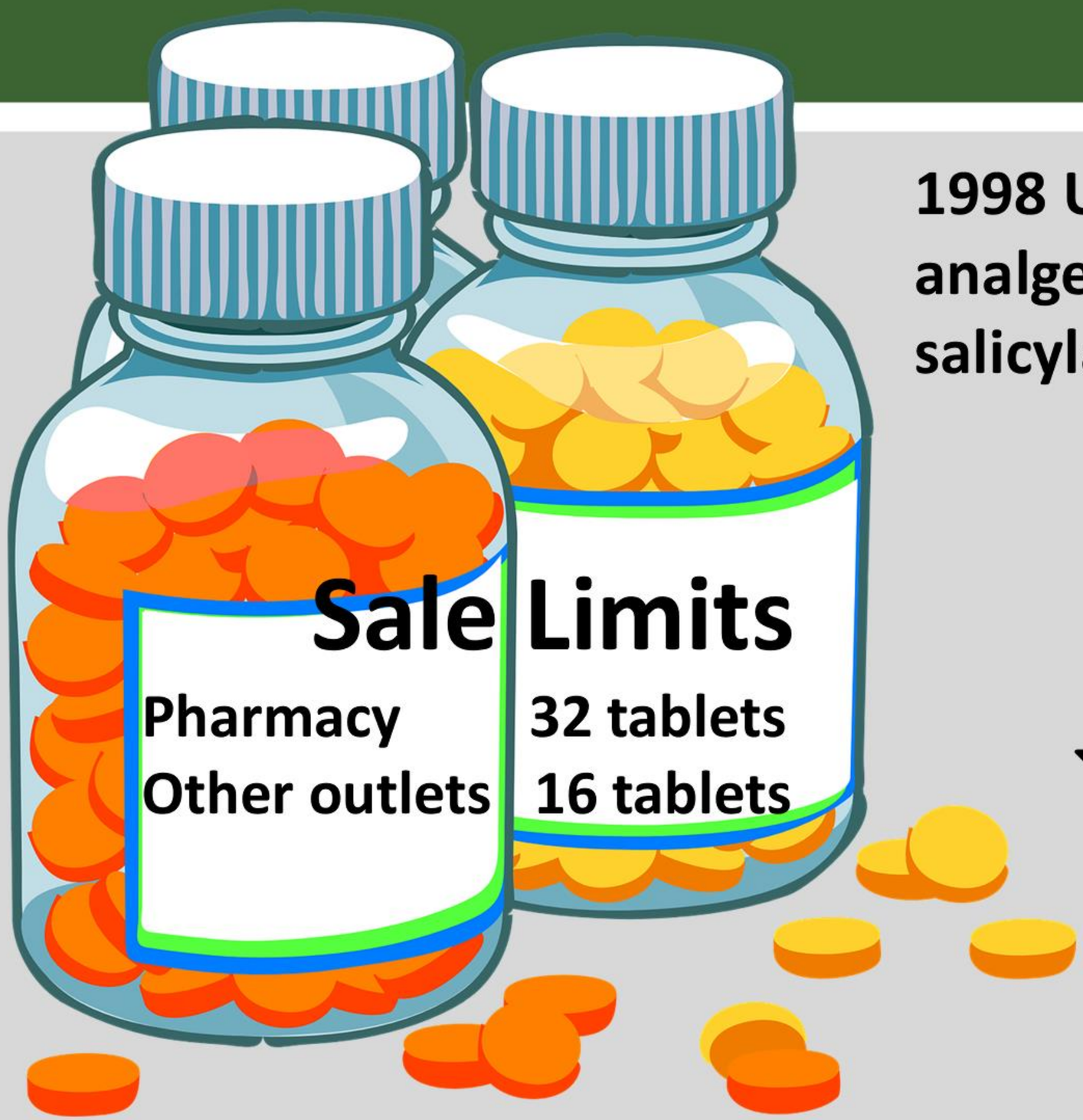


**1998 UK Law: Limited pack sizes of analgesics (acetaminophens and salicylates)**

**22% decrease**

**in self-poisoning deaths from acetaminophens and salicylates over 3 years**

http://www.sprc.org/resources-programs/reduced-analgesic-packaging

# DOMESTIC GAS COMPOSITION

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## Gas Composition

Pre 1950's: 10-20% CO
Early 1950's: 1.1% CO
Post 1958: almost no CO

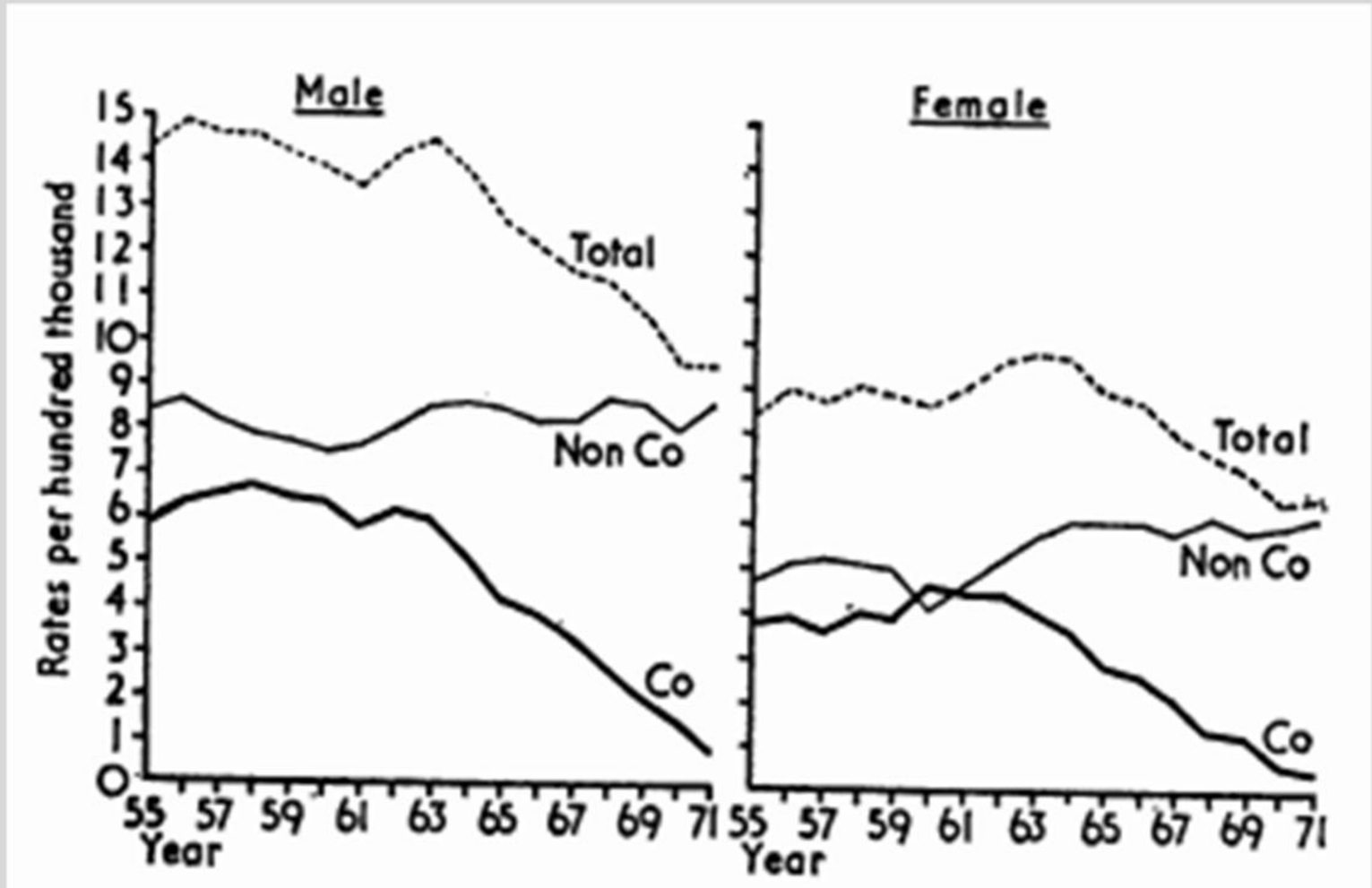


FIG. 4. England and Wales: sex-specific suicide rates by mode of death.

Kreitman N. The coal gas story. United Kingdom suicide rates, 1960-71. Br J Prev Soc Med. 1976 Jun;30(2):86-93.

# IDF FIREARM ACCESS

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## Israeli Defense Force

**2003-2005**: average of 28 suicides per year

**2006:** POLICY CHANGE- weapons not brought home on weekends

**2007-2008:** average of 16.5 suicide per year

**40% decrease**

**in suicide deaths, mostly due to decreased firearm suicides on weekends**

Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., & Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. Suicide and Life-threatening behavior, 40(5), 421-424.

# BASIS FOR MEANS REDUCTION

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- Many suicide attempts occur with little planning during a short-term crisis.

- Intent isn't all that determines whether an attempter lives or dies; means also matter.

- 90% of attempters who survive do NOT go on to die by suicide later.

https://www.hsph.harvard.edu/means-matter/

# NATIONAL STRATEGY FOR SUICIDE PREVENTION

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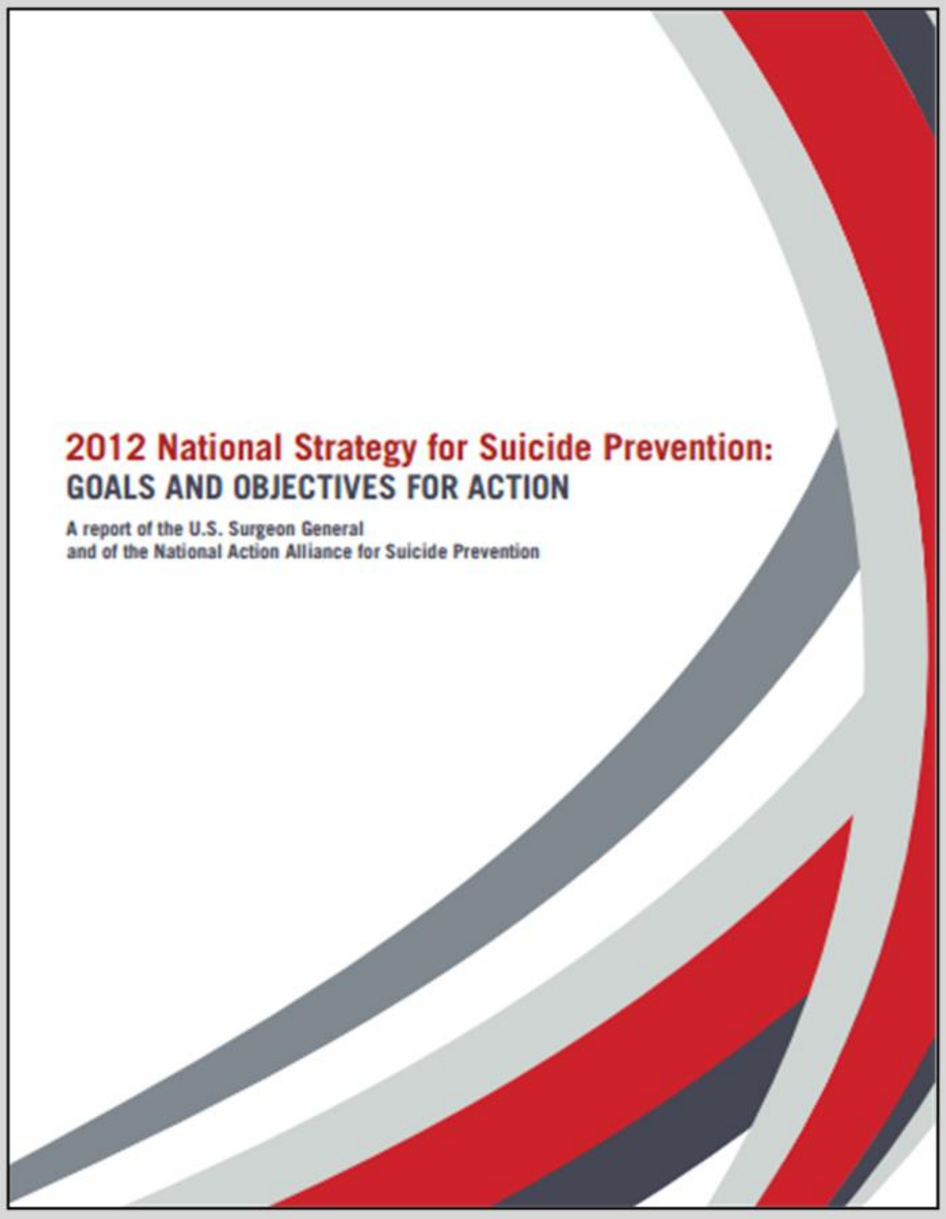


## Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk

## Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means

https://www.ncbi.nlm.nih.gov/books/NBK109917/pdf/Bookshelf_NBK109917.pdf

# WHAT IS SAFETY PLANNING?

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**Safety Planning Intervention consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis.**

Stanley, B., & Brown, G. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256–264.

# 6 STEPS OF SAFETY PLANNING

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1) **Recognizing warning signs**
2) **Using internal coping strategies**
3) **Socializing distractions**
4) **Contacting friends or family members**
5) **Contacting professionals**
6) **Reducing access to lethal means**

Stanley, B., & Brown, G. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256–264.

# STEP 6: REDUCING ACCESS TO LETHAL MEANS

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- **ASK: "What means do you have access to and are likely to use to kill yourself?"**
- **ALWAYS ASK ABOUT ACCESS TO FIREARMS**
- **<u>Collaboratively</u> identify ways to secure or limit access to these means**
- **Examples: Avoid driving on bridges, have spouse dispense medications, identify friend to store firearms for the time being**

Stanley, B., Brown, G. K., Karlin, B., Kemp, J. E., & VonBergen, H. A. (2008). Safety plan treatment manual to reduce suicide risk: Veteran version. Washington, DC: United States Department of Veterans Affairs.

# WORKING WITH PATIENT'S FAMILY

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- If patient is an adult, obtain consent. Follow agency protocols
- Explain your concerns
- Review the patient's safety plan
- Address lethal means specifically, including firearms

  "Lots of people have guns at home. What some families in your situation do is store their guns away from home until the person is feeling better, or lock them and ask someone they trust to hold onto the keys. If you have guns at home, I'm wondering if you've thought about a strategy like that."

- Document, document, document

https://www.hsph.harvard.edu/means-matter/recommendations/clinicians/

# REDUCING FIREARM ACCESS

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- One gun? There's usually more. Ask about all of them
- Advise that the safest option is not having firearms at home until the situation improves
  - Consider temporarily storing firearms outside of the home
    - Friend or family member- consult federal and local laws
    - Law enforcement- some departments will store or dispose of firearms
- If unwilling or unable to remove firearms, discuss safe storage

https://www.hsph.harvard.edu/means-matter/recommendations/clinicians/

# REDUCING MEDICATION ACCESS

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- Consider having a family member dispense medications as needed

- Prescription take-back programs

- Examine prescribing practices-- consider more frequent refills

https://www.hsph.harvard.edu/means-matter/recommendations/clinicians/

# REDUCING ACCESS TO OTHER METHODS

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- Methods that can't be completely removed: trains, bridges
- Key idea: Time and distance between the patient and means of suicide

# COUNSELING ON ACCESS TO LETHAL MEANS (CALM) TRAINING

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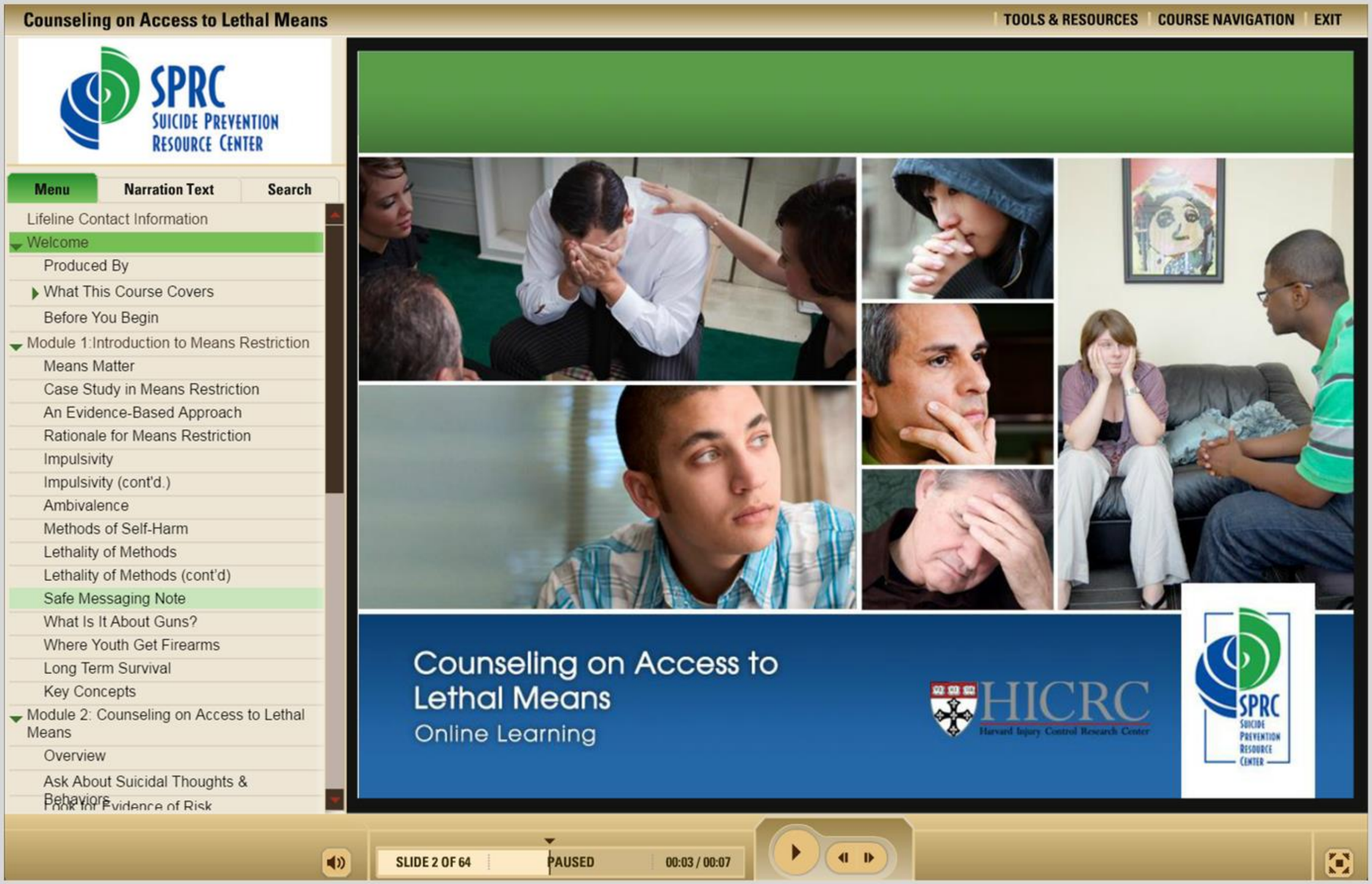


http://training.sprc.org/enrol/index.php?id=3

# A COMPREHENSIVE APPROACH TO SUICIDE PREVENTION

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http://www.sprc.org/effective-prevention/comprehensive-approach

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