Jefferson Health

DAVID FARBER ASPIRE CENTER
Vickie & Jack Farber Institute for Neuroscience

Evidence-Based Strategies to Reduce Suicide Risk

Matthew Wintersteen, PhD
Director, David Farber ASPIRE Center
Department of Psychiatry & Human Behavior

Agenda

- Brief, focused suicide risk assessment
- Developing effective safety plans
- Lethal means reduction

Disclosures

- Dr. Wintersteen has received research funding and contract grants from SAMHSA, CDC, PA Department of Human Services, American Association of Suicidology, American Foundation for Suicide Prevention, and the Brain & Behavior Research Foundation to conduct suicide prevention and education implementation research.
- His funded work from these agencies and organizations will not be directly discussed in this presentation, and he has no financial stake in any products or interventions discussed.

Suicide Risk Assessment

Assess Suicidal Desire and Ideation

1. Have you been having thoughts or images of suicide?
2. Do you think about wanting to be dead?
3. Thwarted Belongingness

   Do you feel connected to other people?

   Do you have someone you can talk to when you are feeling bad?
4. Perceived Burdensomeness

   Sometimes people think, "the people in my life would be better off if I were gone." Do you ever think that?

Joiner et al., 2009

Assess Resolved Plans and Preparations

5. When you have these thoughts, how long do they last (duration)?
6. How strong is your intent to kill yourself (0 = not intense at all; 10 = very intense)?
7. Past suicidal behavior:
   - *Have you attempted suicide in the past?*
   - *How many times?*
   - *Methods used?*
   - *What happened (e.g., hospitalization)?*
   - *Feelings about past attempts?*
   - *Non-suicidal self-injury?*
   - *Family history of suicide?*

Joiner et al., 2009

Assess Resolved Plans and Preparations

8. Do you have a **specific plan** of how you would kill yourself?
   - Look for vividness and detail
9. Means and opportunity:

   Do you have the pills (gun, etc.)?

   Do you think you'll have the opportunity to do this?
10. Have you made preparations for a suicide attempt (e.g., buying gun)?
11. Do you know when you expect to use your plan?
12. Fearlessness:

    Thinking about suicide, do you feel afraid (0 = very afraid; 10 = not at all afraid)?

Joiner et al., 2009

Assess Other Significant Findings

13. Precipitant stressors:

    Has anything especially stressful happened to you recently?

14. Do you feel **hopeless**?

15. Impulsivity:

    When you're feeling bad, how do you cope?

    Sometimes when people feel bad they do impulsive things to help them feel better. Has this ever happened to you?

16. Presence of psychopathology
    - As indicated by psychiatric assessment

Joiner et al., 2009

Developing Effective Safety Plans

APA PsycArticles: Journal Article

Why does safety plann

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Rogers, M. L.,

Research

JAMA Psychiatry | Original Inves

Comparison of th
With Follow-up v
in the Emergency

Barbara Stanley, PhD; Gregory K. Brown, P
Kerry L. Knox, PhD; Sadia R. Chaudhury, Ph

IMPORTANCE Suicidal behavior is
suicide rate has steadily increased
veterans are at particularly high ris
intervention strategies to address
particularly in emergency departm

OBJECTIVE To determine whether
with follow-up contact for suicidal
and improved outpatient treatme
established high-risk period.

ELSEVIER

Cogniti

Volum

Safety Planning
Intervention to

Barbara Stanley [a] [b], Gregory K. Br

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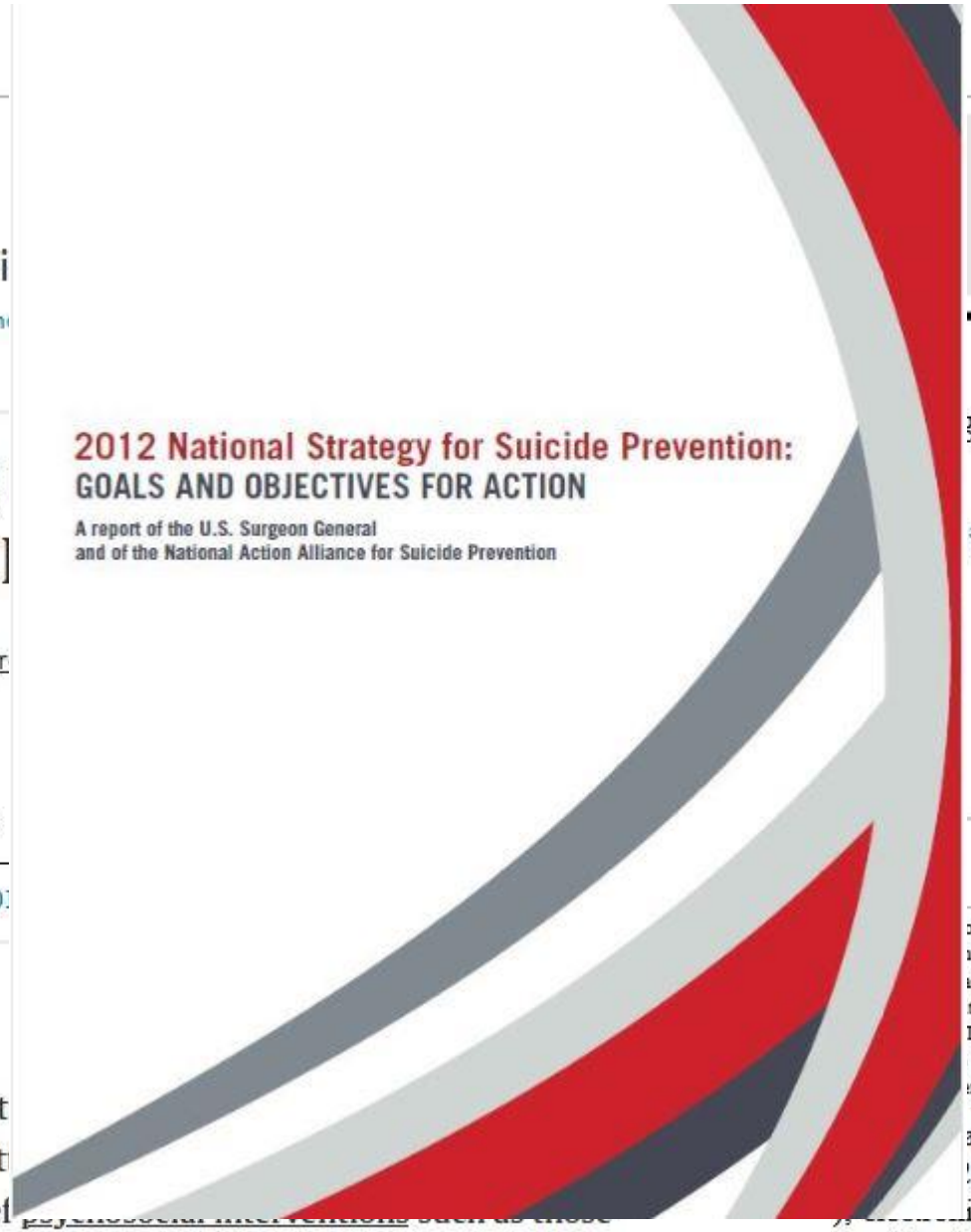
https://doi.org/10.1016/j.cbpra.2011.0

Abstract

The usual care for suicidal pat
(ED) and other emergency set
appropriate level of care. Brief psychosocial interventions such as those
administered to promote lower alcohol intake or to reduce domestic violence in



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Check for updates

on services in the Veterans Health
ut of the VHA's coordinated effort
afety plan. The current study aims
th safety planning for Veterans at
T) will be conducted examining if
intervention, PLF, compared to
rans over the course of the study.

arrative synthesis. **Findings.**
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Jeffe

Major Challenges

How can someone manage a suicidal crisis in the moment that it happens?

How can a clinician/counselor help the individual to do this?

Suicide Risk Assessment

Mental Health Referral/Treatment

"No-Suicide Contract"

No-suicide contracts ask individuals to promise to stay alive without telling them ***how*** to do so

No-suicide contracts may provide a false sense of assurance to the clinician

What is a Safety Plan?

- Prioritized written list of ***coping strategies and resources*** for use during a suicidal crisis
- Provides a sense of control/framework
- Brief process
- Accomplished via an easy-to-read format using the patient's own words
- Involves a ***commitment to the treatment process*** (and staying alive)

Who Develops the Plan?

Collaboratively developed by the clinician ***and*** the individual in any clinical setting

Individuals who have

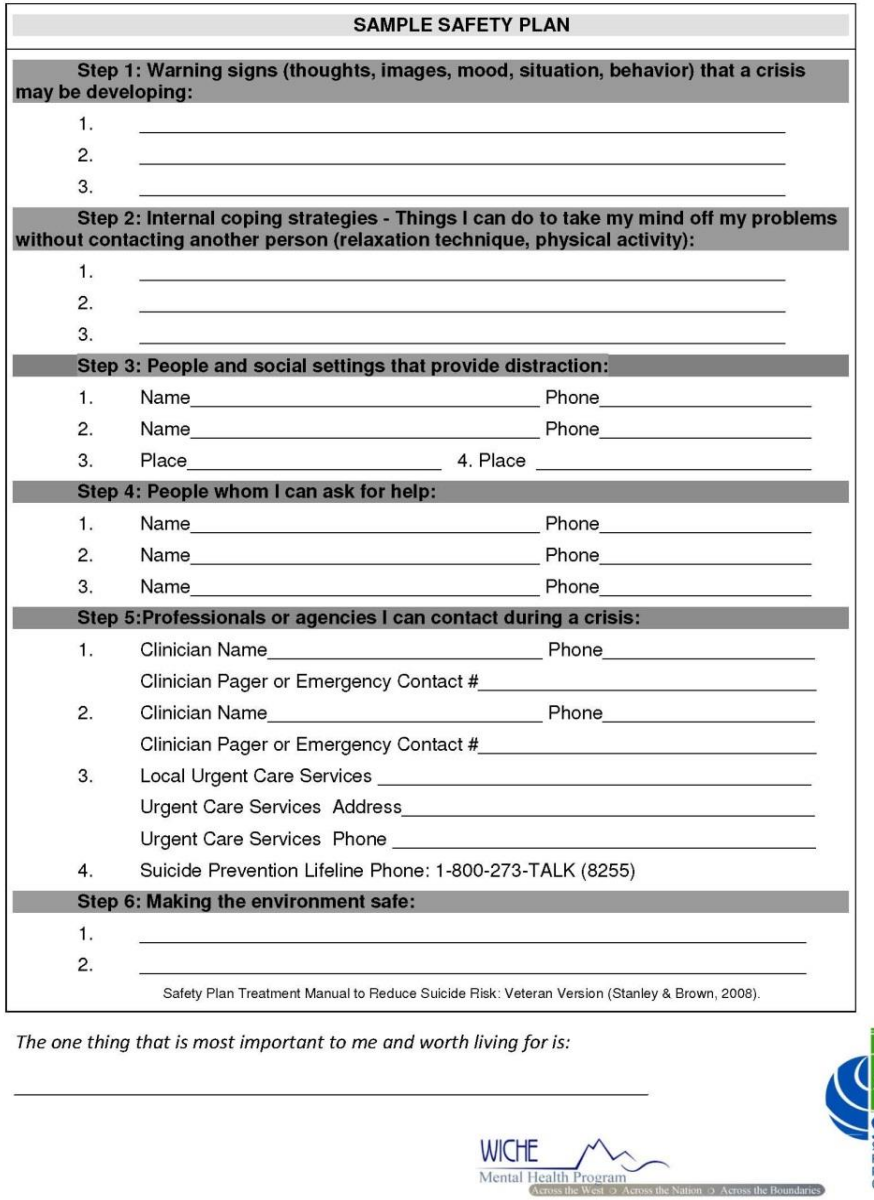
Made a suicide attempt	Have suicidal ideation	Have psychiatric disorders that increase suicide risk	Otherwise been determined to be at high risk for suicide

When is it Appropriate and Not Appropriate?

- Usually follows a suicide risk assessment
- A safety plan may be done at ***any*** point during the assessment or the treatment process
- Safety plan may not be appropriate when individuals are at ***imminent*** suicide risk or have ***profound*** cognitive impairment
- The clinician should adapt the approach to the individual's needs—such as involving family members in using the safety plan

How is it Done?

- Clinician and individual should sit ***side-by side***, use a problem solving approach, and focus on developing the safety plan
- Safety plan should be completed using a paper form with the individual for written documentation
- Many apps available:
  - Safety Net (iTunes)
  - Safety Plan (Android)



SAMPLE SAFETY PLAN

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

The one thing that is most important to me and worth living for is:

_____

WICHE Mental Health Program
Across the West · Across the Nation · Across the Boundaries

SPRC Suicide Prevention Resource Center

Pro Tip: Google search “Safety Planning Intervention”

Step 1: Recognizing Warning Signs

- Safety plan is only useful if individuals can recognize the warning signs
- Accurate account of the events that transpired before, during, and after the most recent suicidal crisis
  - “How will you know when the safety plan should be used?”
  - “What do you experience when you start to think about suicide or feel extremely distressed?”
- Write down the warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the individuals’ own words

Step 1: Recognizing Warning Signs Examples

- “I am a nobody.”
- “I am a failure.”
- “I don’t make a difference.”
- “I am worthless.”
- “I can’t cope with my problems.”
- “Things aren’t going to get better.”
- Images
- Flashbacks

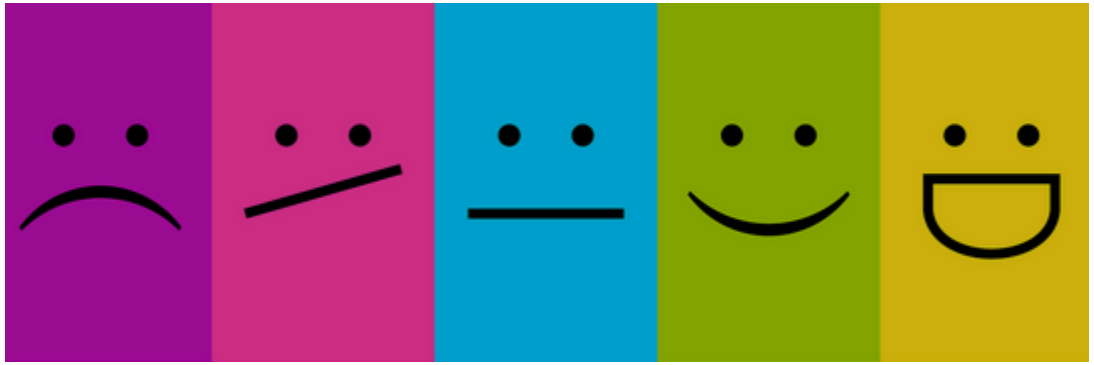
Step 1: Recognizing Warning Signs Examples

Thought Processes

- "Having racing thoughts"
- "Thinking about a whole bunch of problems"

Mood

- "Feeling depressed"
- "Intense worry"
- "Intense anger"



Step 1: Recognizing Warning Signs Examples

Behavior

- “Crying spells”
- “Isolating myself”
- “Using drugs”

Step 2: Using Internal Coping Strategies

- List activities that individuals can do without contacting another person
- Activities function as a way to help individuals take their minds off their problems and promote meaning in the individual's life
- Coping strategies prevent suicidal ideation from escalating

Step 2: Using Internal Coping Strategies

- It is useful to try to have individual cope on their own with their suicidal feelings, ***even if it is just for a brief time***
  - "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"

Step 2: Using Internal Coping Strategies

- Examples
  - Going for a walk
  - Listening to music
  - Playing an instrument
  - Take a hot shower
  - Walking the dog

Step 2: Using Internal Coping Strategies

Ask “How likely do you think you would be able to do this step during a time of crisis?”

Ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”

Use a collaborative, problem solving approach to address potential roadblocks

Step 3: Socializing with Family Members or Others

- Coach individuals to use Step 3 if Step 2 ***does not resolve the crisis*** or lower the risk
- Family, friends, and acquaintances who may offer support and distraction from the crisis

Step 3: Socializing with Family Members or Others

1. Ask “Who do you enjoy socializing with?”
2. Ask “Who helps you take your mind off your problems, at least for a little while?”
3. Ask individuals to list several people in case they cannot reach the first person on the list

Step 4: Contacting Family Members or Friends for Help

- Coach individuals to use Step 4 if Step 3 ***does not resolve the crisis*** or lower risk
- Ask "How likely would you be willing to contact these individuals?"
- Identify potential obstacles and problem solve ways to overcome them

- **WARNING:** Always include adults on the list!

Step 5: Contacting Professionals and Agencies

- Coach individual to use Step 5 if Step 4 ***does not resolve the crisis*** or lower risk
- Ask “Which clinicians should be on your safety plan?”
- Identify potential obstacles and problem solve ways to overcome them

Step 5: Contacting Professionals and Agencies

List names, numbers, and/or locations of

- Clinicians
- Suicide & Crisis Lifeline – 988

  (press "1" if veteran)

  (press "2" for Spanish-speaking subnetwork)

  (press "3" for LGBTQIA+)
- Local Crisis Number
- Urgent care centers

Step 6: Reducing the Potential for Use of Lethal Means

Ask individuals what means they would consider using during a suicidal crisis

Regardless, the clinician should ***always ask*** whether the patient has access to a firearm

Step 6: Reducing the Potential for Use of Lethal Means

- For methods of ***low lethality***, clinicians may ask individuals to remove or restrict their access to these methods themselves

  -For example, if individuals are considering overdosing, discuss throwing out any unnecessary medication

Step 6: Reducing the Potential for Use of Lethal Means

For methods of ***high lethality***, collaboratively identify ways for a responsible person to secure or limit access

-For example, if individuals are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place

Reason for Living

"The one thing that is most important to me and worth living for is…"

Implementation: What is the Likelihood of Use?

Ask: “Where will you keep your safety plan?”

Ask: “How likely is it that you will use the Safety Plan when you notice the warning signs that we discussed?”

Implementation: What is the Likelihood of Use?

Ask: “What might get in the way or serve as a barrier to your using the safety plan?”

-Help the individuals find ways to overcome these barriers

-May be adapted to brief crisis cards, cell phones or other portable electronic devices, must be ***readily accessible*** and ***easy-to-use***.

Implementation: Review the Safety Plan Periodically

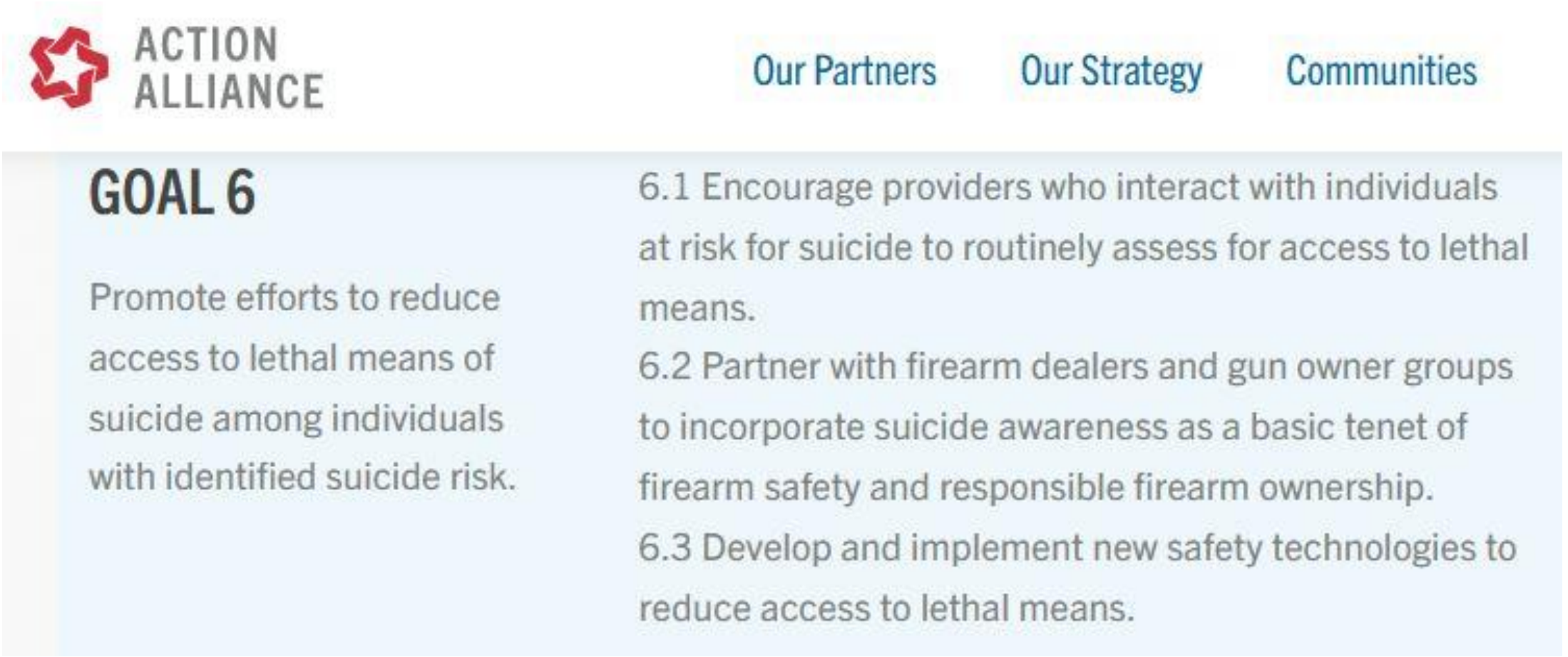
Periodically review, discuss, and possibly revise the safety plan after each time it is used

-The plan is ***not*** a static document

-It should be revised as individual's circumstances and needs change over time

Lethal Means Reduction

The Importance of Lethal Means Reduction



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The Importance of Lethal Means Restriction

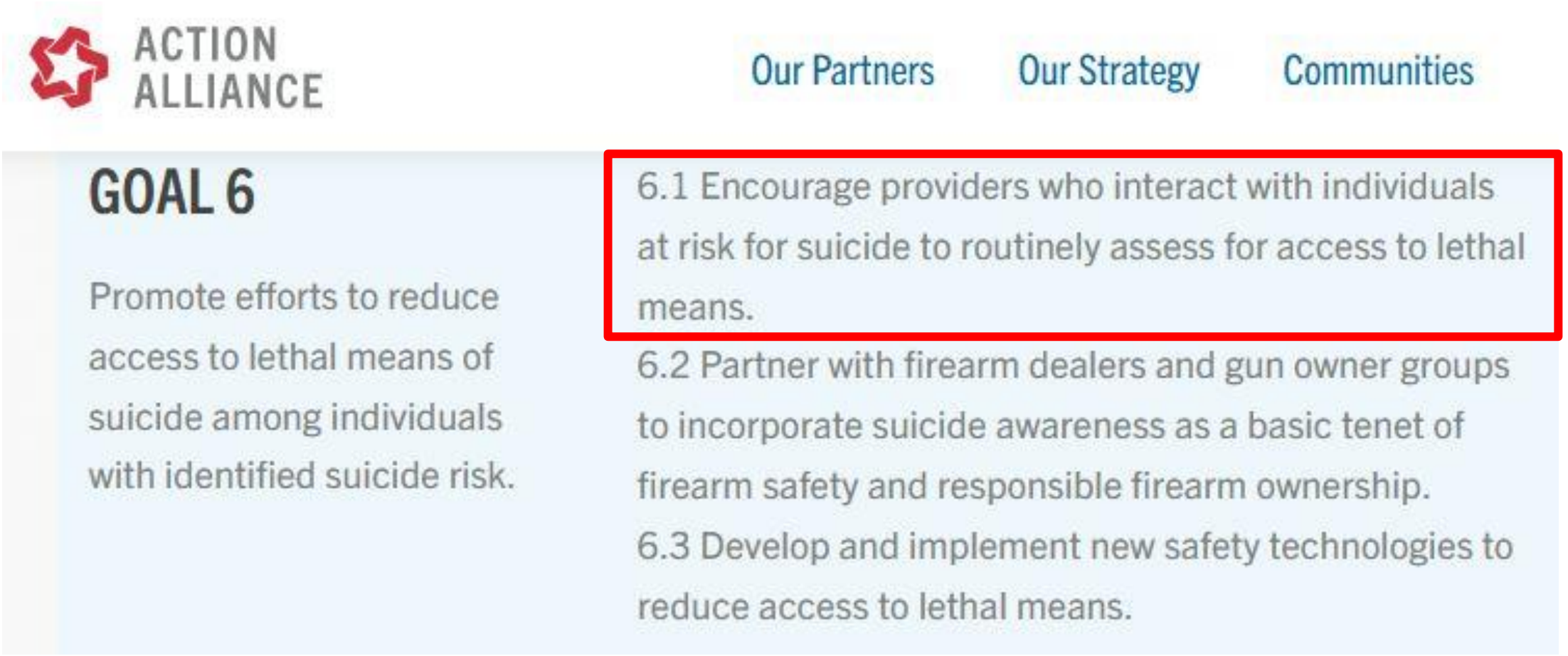

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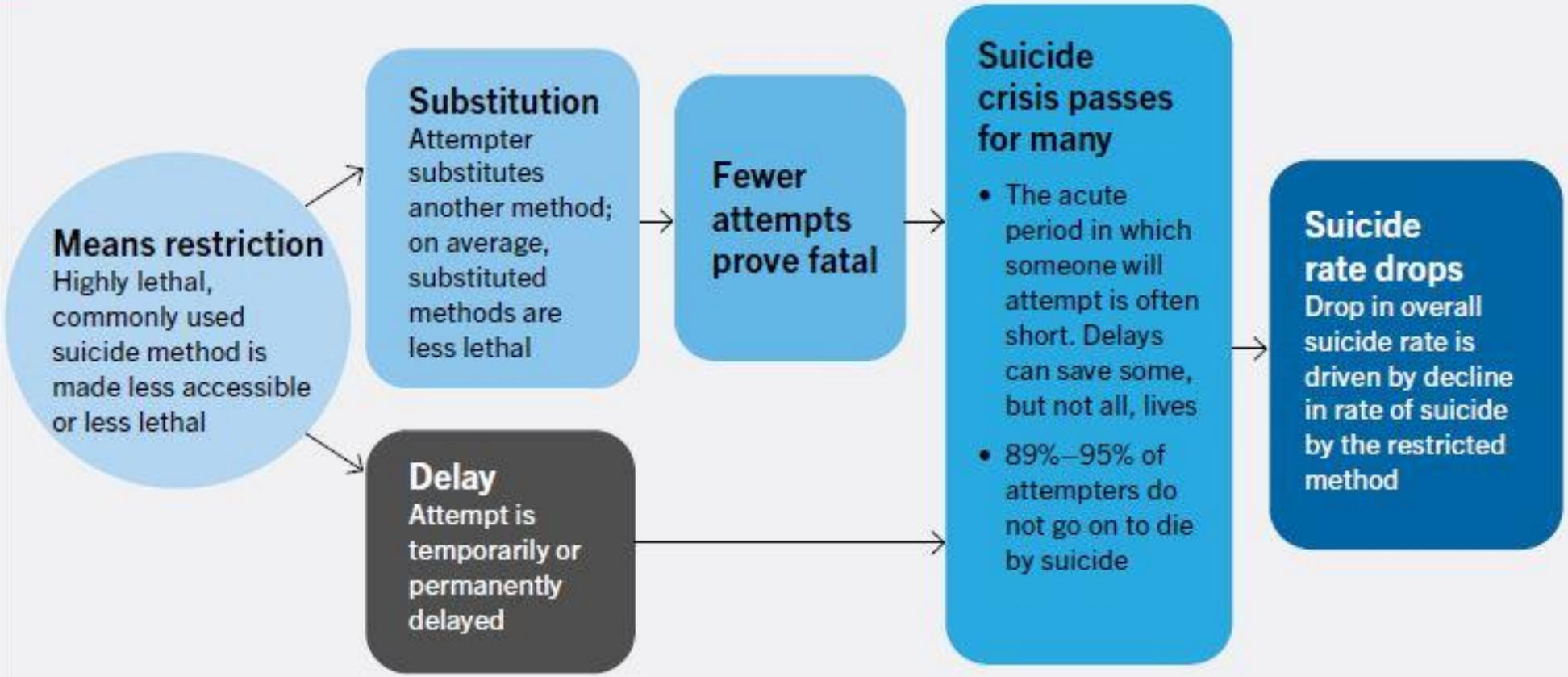
Figure 1. Conceptual model describing how reducing access to a highly lethal and commonly used suicide method saves lives at the population level (from Barber & Miller, 2014).



Note: When a highly lethal method is made less lethal at the population level (e.g., reducing carbon monoxide content of motor vehicle exhaust), the substitution is passive. That is, people attempting suicide with the method are unaware that, in effect, a less lethal method has been substituted for a more lethal method.

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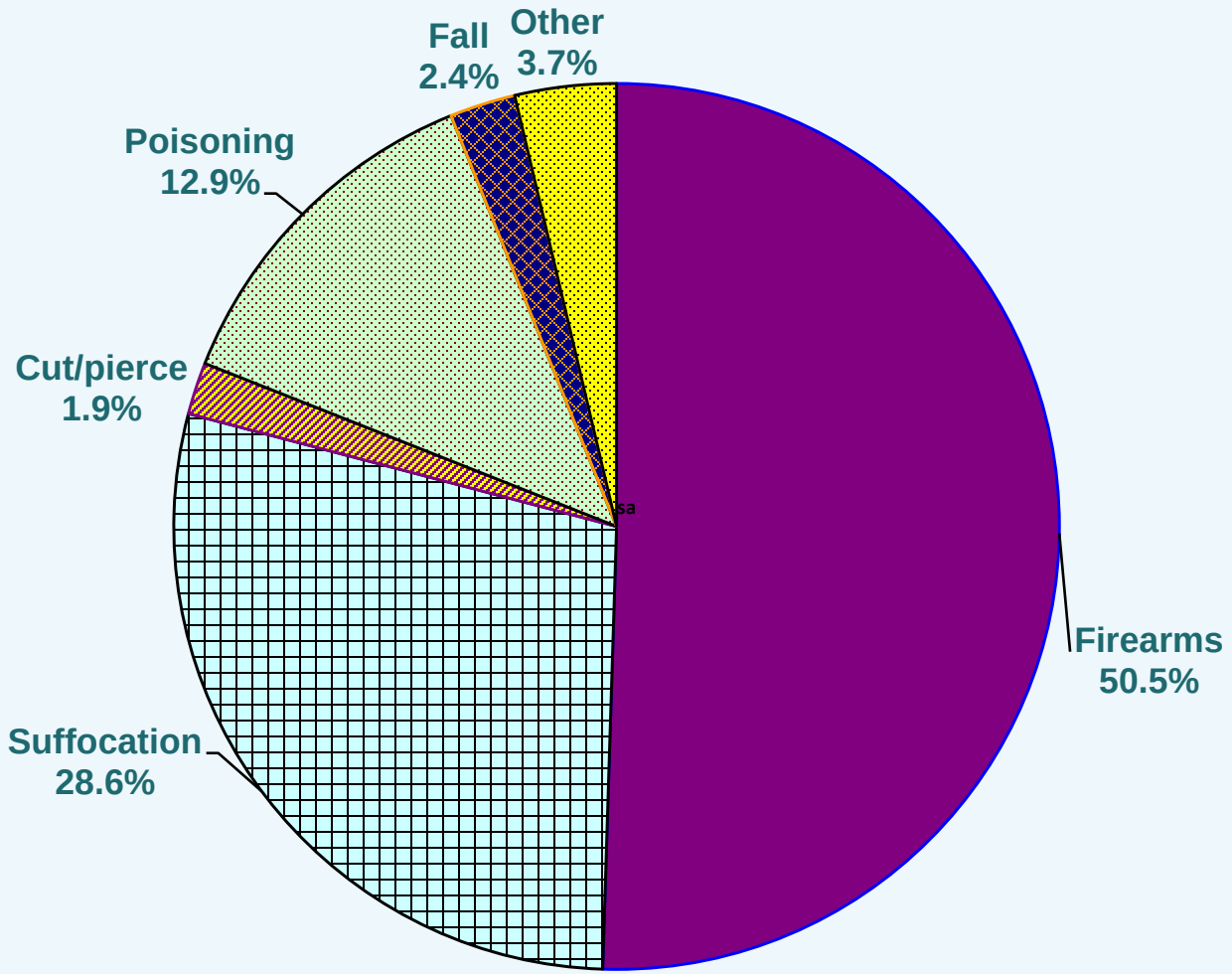
Method Choice and Suicide Outcomes

Suicide by Method – United States, 2018



Source: CDC vital statistics

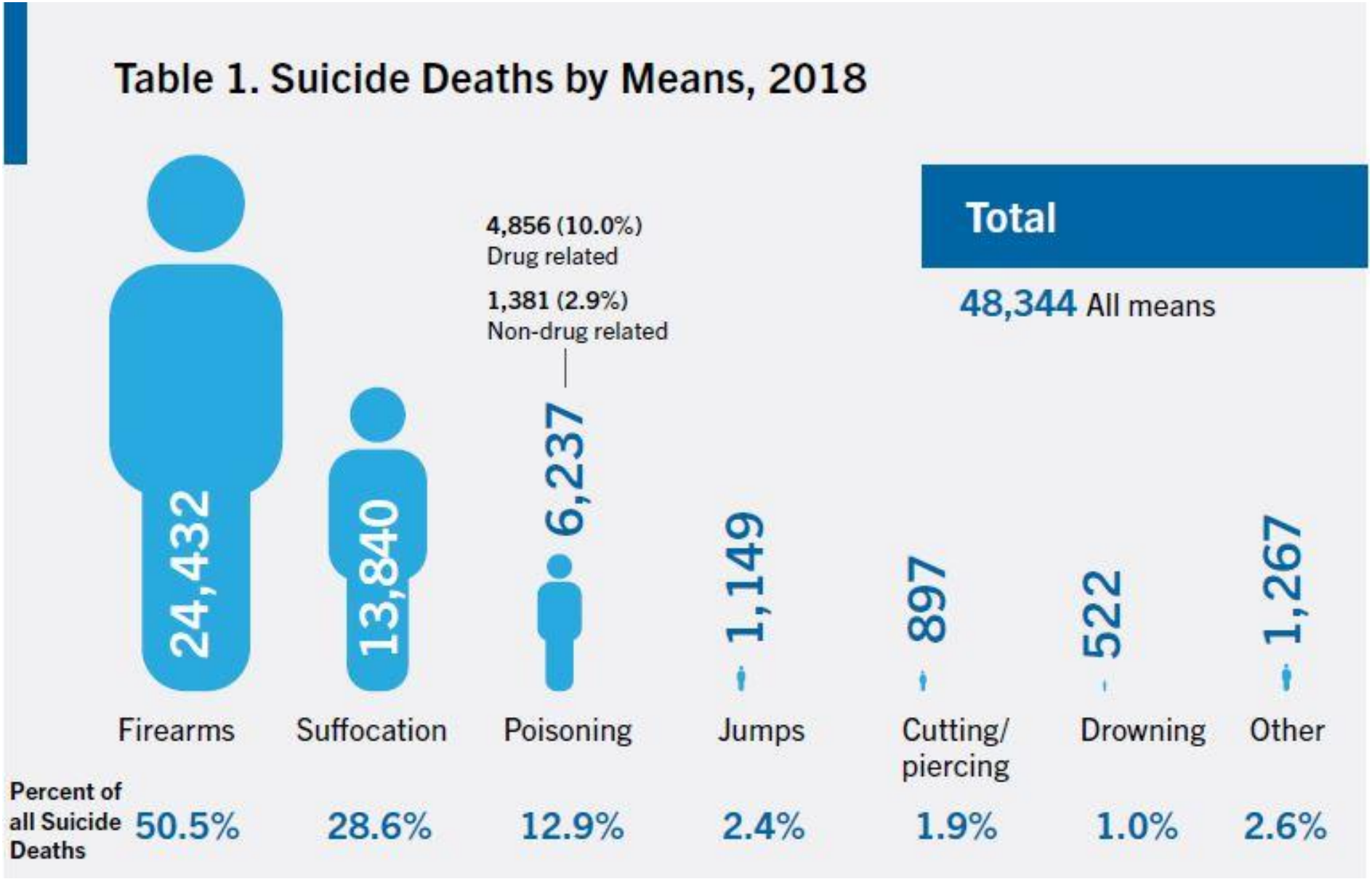


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Table 2. Suicide Deaths by Means—Males, 2018

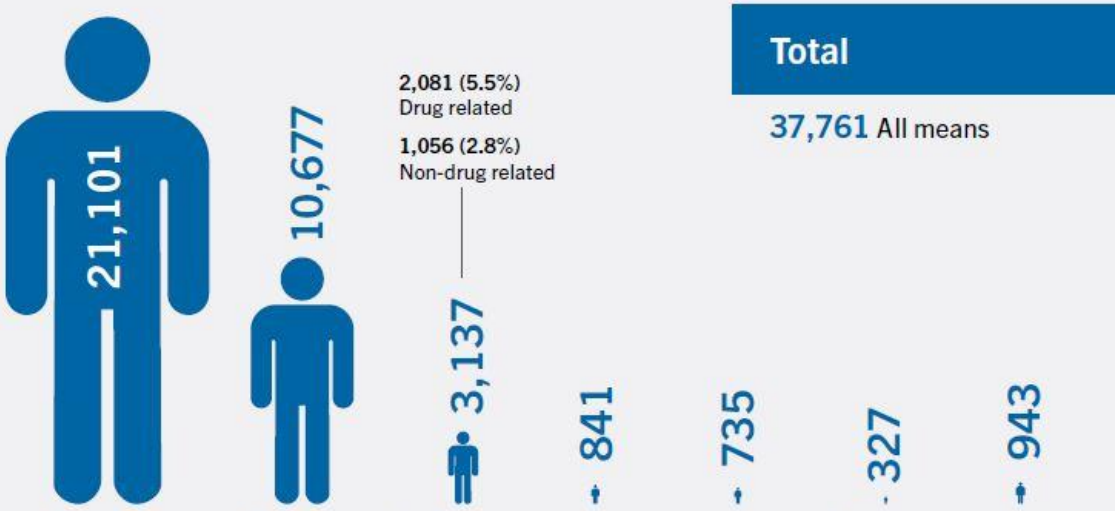
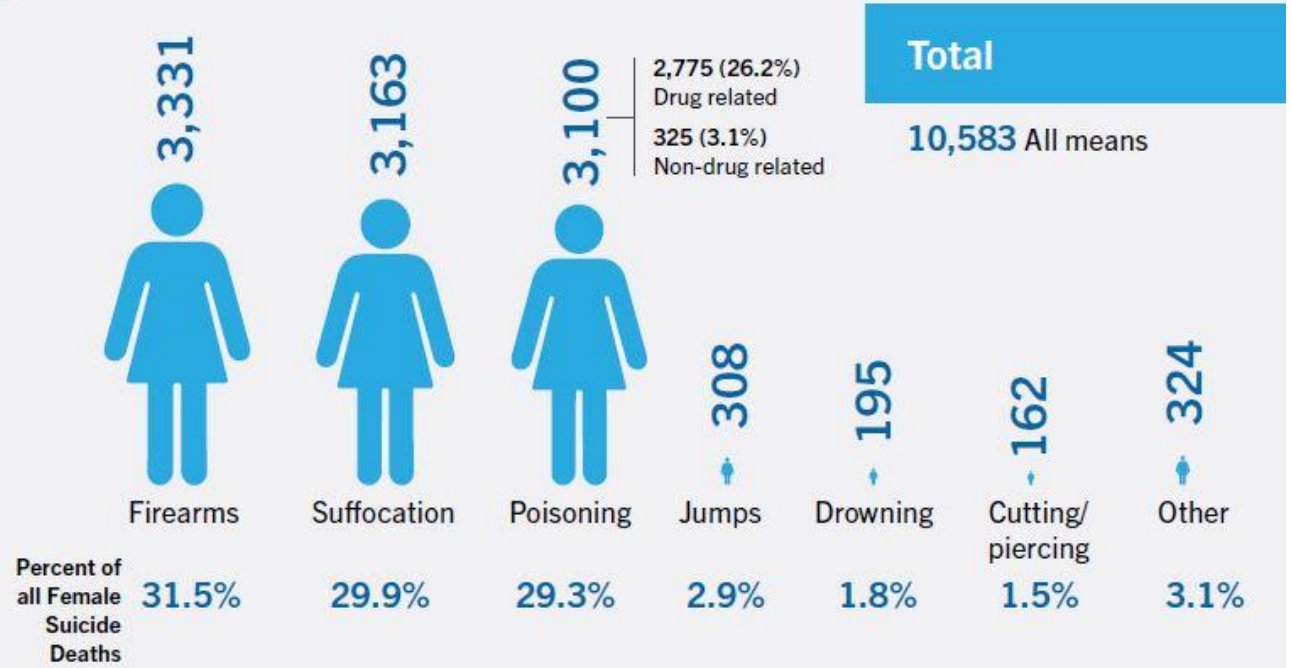


Table 3. Suicide Deaths by Means—Females, 2018



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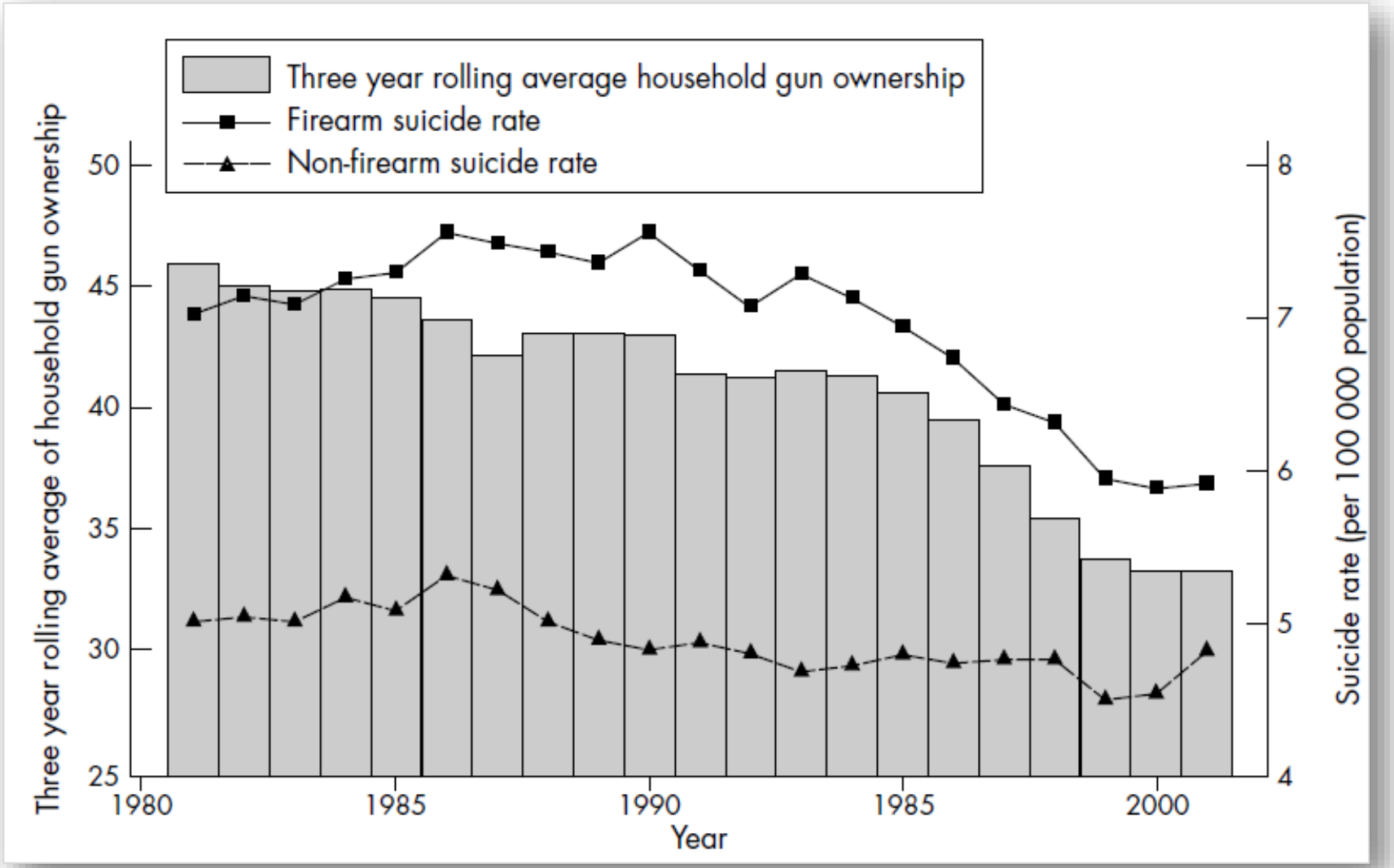
Key Firearm Considerations

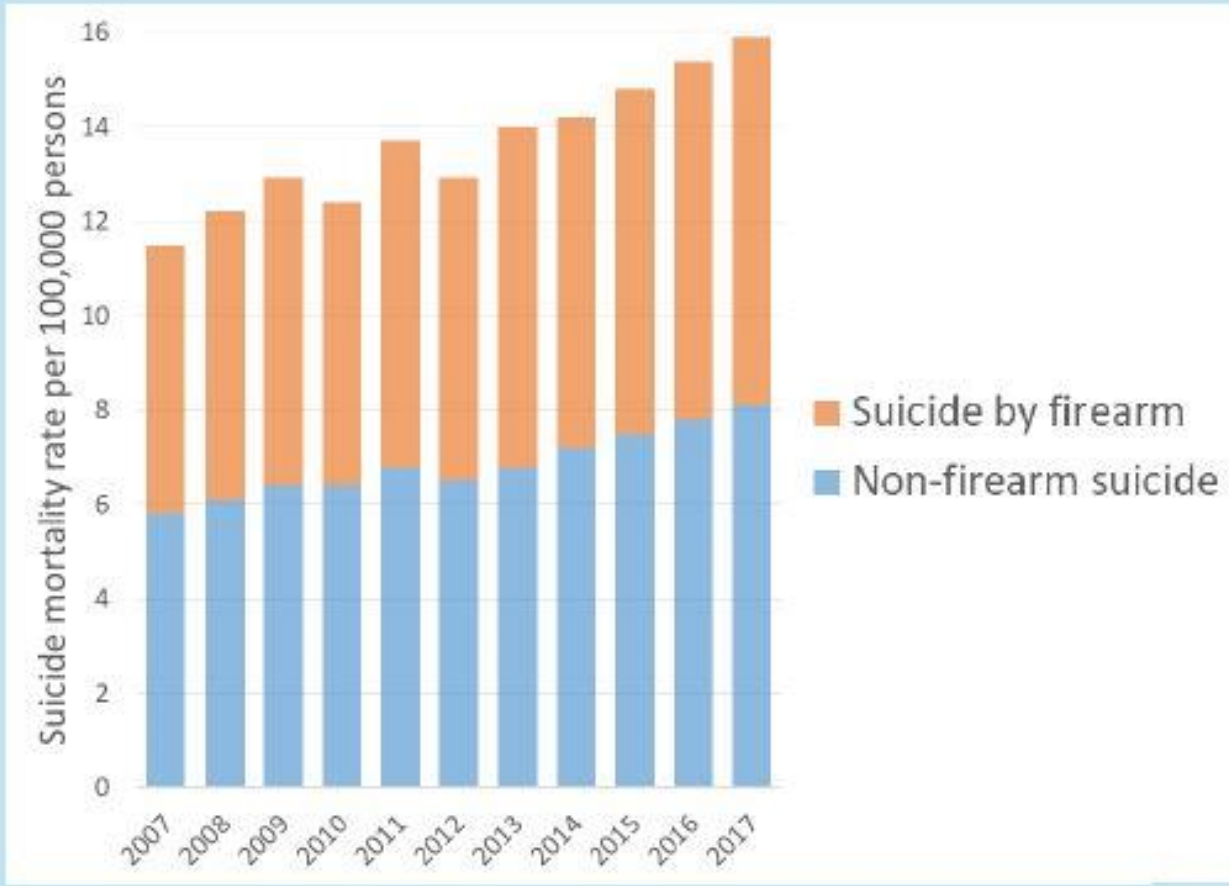
- Approximately 50% of American suicides are by firearm
- 85-95% of suicide attempts using a firearm result in death
- Firearm access is not associated with developing suicidal thoughts
- Firearm access is associated with death by suicide
- Firearm access may facilitate the rare transition from suicidal ideation to death by suicide

American Association of Suicidology, 2018

Household Gun Ownership and Firearms Suicide Rate*



*Miller, et al.,2006

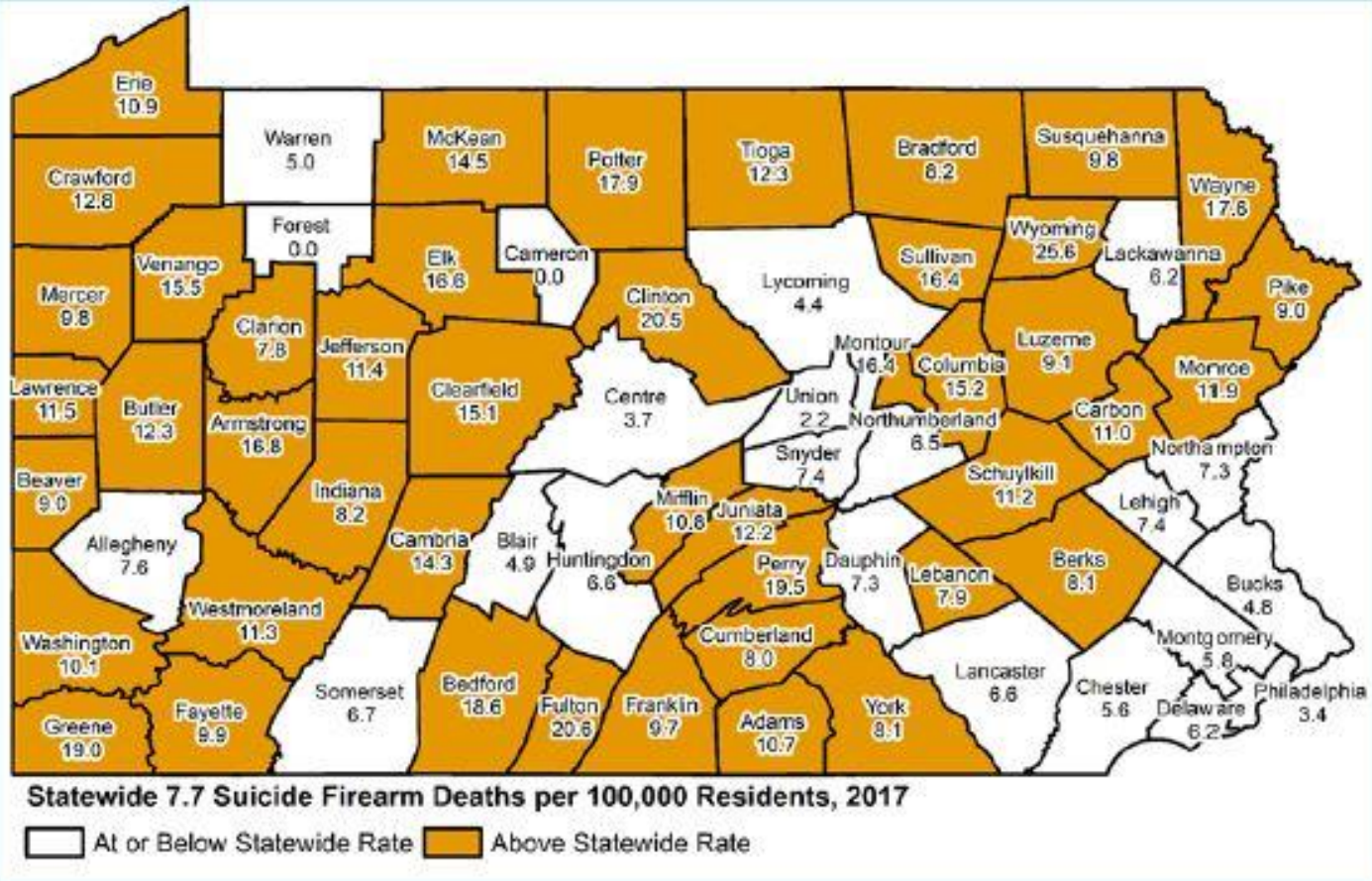


Suicide by firearm is on the rise in Pennsylvania.

One factor contributing to the rise in suicide is the rise in suicide by firearm. In 2017, 61% of firearm deaths in Pennsylvania were suicides [3] and nearly half of all suicide deaths were by firearm [1]. In Pennsylvania, firearms remain the most lethal method of attempting suicide – 85% of self-injury by firearm is fatal, compared to 3% of poisonings [4].

Data source: CDC Wonder

Rural Pennsylvania has seen the greatest rise in suicide deaths by firearm.



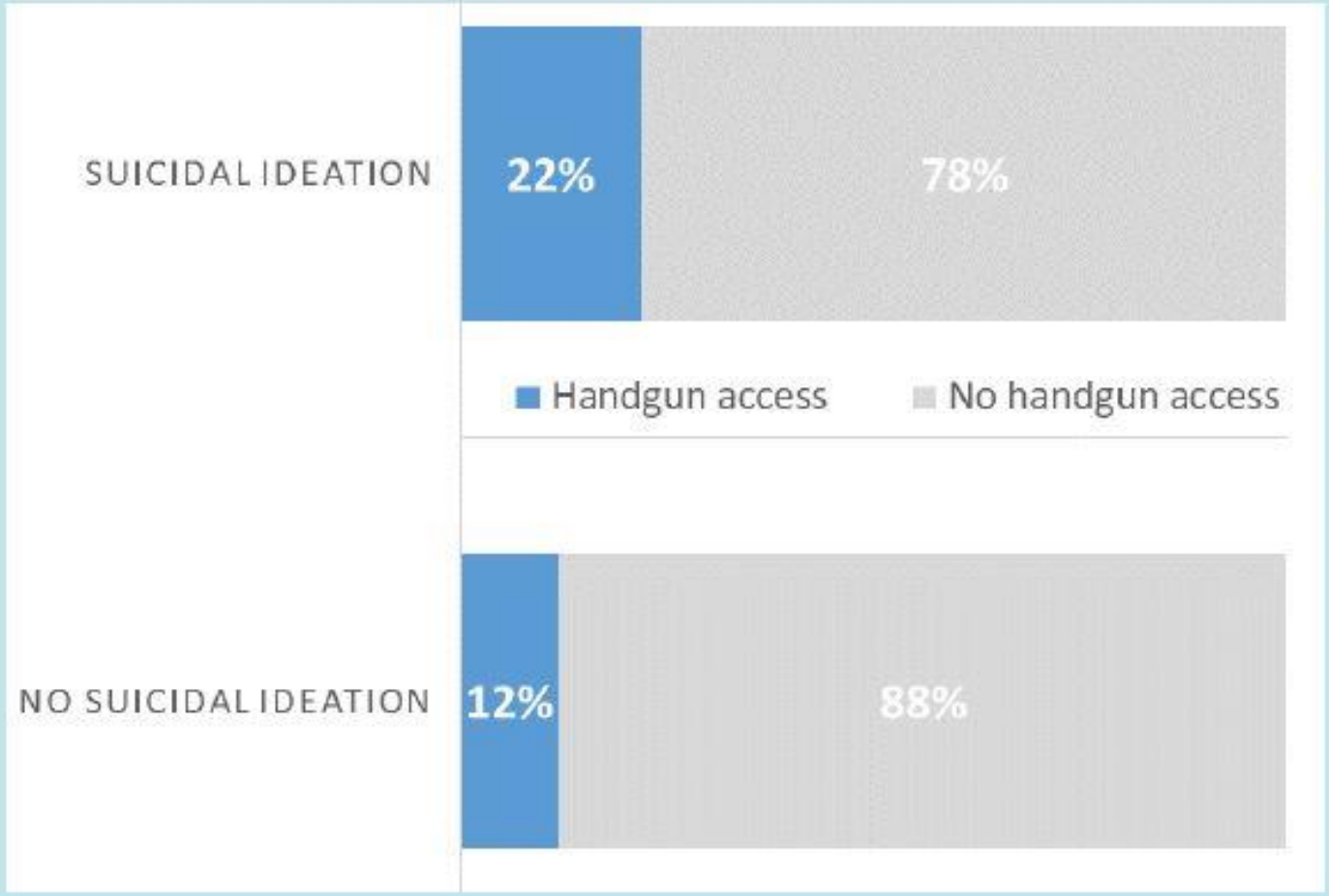
Data source: Pennsylvania Department of Health.
Prepared by the Center for Rural Pennsylvania

From 2007 through 2017, counties with the highest suicide by firearm rates were all rural counties [3]. In 2017, the counties with the highest suicide by firearm rates per 100,000 residents were Bedford (18.6), Clinton (20.5), Fulton (20.6), Greene (19), Perry (19.5), and Wyoming (25.6) [3]. In contrast, Philadelphia county had one of the lowest suicide rates (3.4), along with a mix of rural and urban counties, including Cameron (0), Forest (0), Union (2.2), Centre (3.7), Lycoming (4.4) and Bucks (4.8) [3].

Case-control Studies: Guns in the Home and the Method of Suicide*

Use of gun for suicide if kept in home	67- 88%
Use of gun if **not** kept in home	6-23%
Firearms & alcohol use (OR [95% CI]	7.3
Bought gun within 2 weeks of suicide	3%

*Brent, 1993; Kellerman, 1992; Shah, 2000

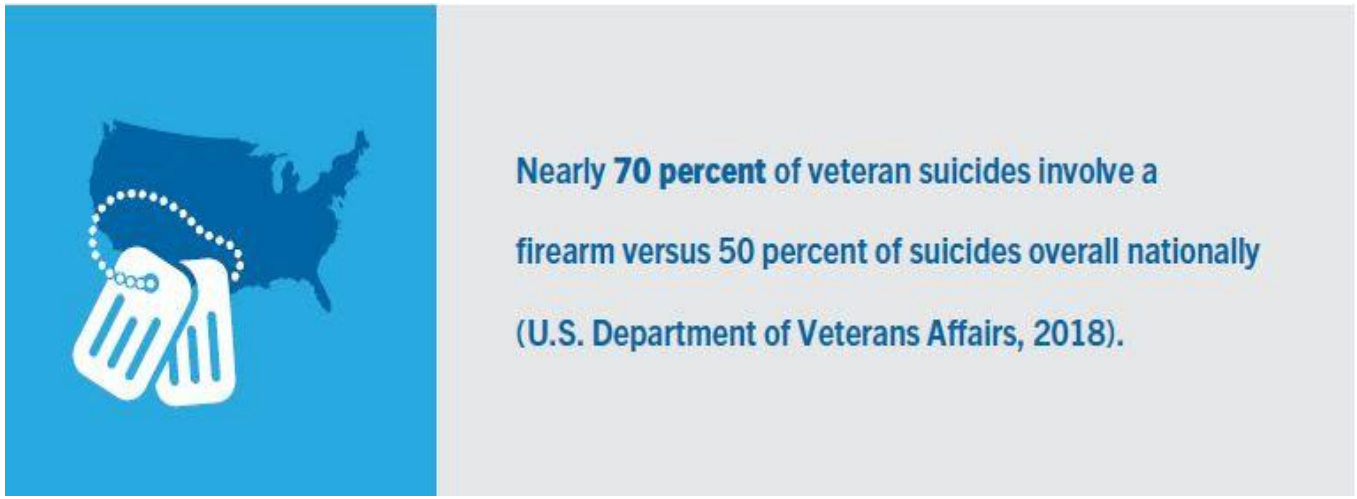


Students who have experienced suicidal thoughts are more likely to have easy access to handguns.

Nearly 15% of students have easy access to handguns (14.6%). This percentage increased among students who had considered suicide – 22% of students who considered suicide have easy access to handguns. Students in rural counties reported nearly two times more widespread ease of access to handguns [2].

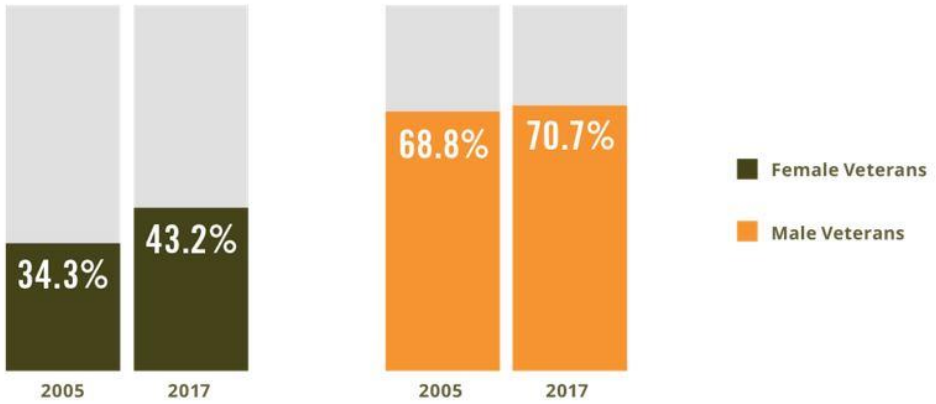
Data source: PAYS 2017

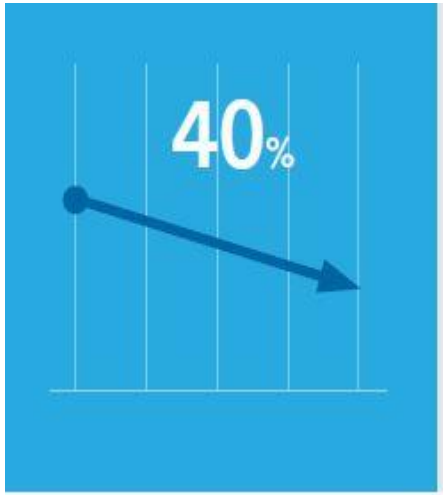
Veterans are at Significantly Higher Risk for Firearm Suicide



Nearly **70 percent** of veteran suicides involve a firearm versus 50 percent of suicides overall nationally (U.S. Department of Veterans Affairs, 2018).

MORE SUICIDES BY FEMALE VETERANS ARE BY GUN THAN EVER BEFORE—A NEARLY 26 PERCENT INCREASE SINCE 2005.





Lubin and colleagues (2010) observed a 40 percent decline in the overall suicide rate among Israeli Defense Force soldiers after a policy took effect in 2006 that limited their access to their military-issued firearms during weekend leave.

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Clinical Approaches to Lethal Means Counseling

Clinical Considerations

- Lethal means reduction should be discussed in the context of:
  - Suicide risk assessment
  - Safety planning
- The conversation should *always* be had
- Failure to discuss lethal means reduction could have legal implications

Who Needs Lethal Means Counseling?

Current suicidal thoughts

History of a suicide attempt

Struggling with mental health or substance abuse issues, especially when coping with painful life situations (e.g., relationship problems, legal problems, financial issues, unemployment, etc.)

Talk about Suicide

- No iatrogenic effects (Gould et al., 2005)
- Ask direct questions
- Be very specific with questions about means
- Let them know they are not alone
- Don’t rely solely on disclosure
  - Discuss with anyone who could be at risk
  - Discuss *before* a crisis occurs

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Facts Families Should Know

- Suicidal crises can escalate quickly
- Suicidal crises are hard to predict
- Reducing access to lethal means *before* a crisis occurs can be life-saving
- Simple steps can reduce access to lethal means:
  - Store firearms safely
  - Lock and limit medications
  - Offer resources: National Suicide Prevention Lifeline and other crisis services

988 SUICIDE & CRISIS LIFELINE

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Firearms Laws Relevant to Lethal Means Counseling

- Firearm Possession and Transfer Between Individuals
  - Federal law 18 U.S.C § 922(d) prohibits some individuals from possessing a firearm (e.g., felony conviction, DV misdemeanor, DV restraining order, history of involuntary hospitalization, mental incompetence, illegal controlled substances)
  - Resources: Harvard Means Matter, Gifford Law Center, NRA

Basic Safety Considerations

- Locked gun is safer than unlocked gun – regardless of who holds the key
- Unloaded gun is lower risk than loaded gun, particularly if ammunition is stored away from firearm
- Hiding guns is *NOT* recommended
- If a loaded gun is needed for self-defense, you must discuss risk of death by firearm suicide vs. risk of needing it for self-defense *and* discuss alternative self-defense strategies

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What Can Clinicians Do?

- Raise the issue
  - Motivate the family to reduce access to firearms and medications at home
    - “Guns are the most frequent method in suicide deaths and pills are the most frequent method for suicide attempts. So let’s start by reducing access to these methods.”
  - Assess how guns and medications are stored at home
    - “Let’s talk about medications in your house and where and how they are stored.”

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What Can Clinicians Do?

- Develop a Plan:
  - Storing firearms away from home is the safest
    - Relative or friend, self-storage unit, gun shop or shooting range, pawn shop, police department (https://www.holdmyguns.org/)
  - Best on-site options:
    - Lock in gun safe or tamper-free storage box – away from ammunition
    - Disassemble the firearm *and* store important element out of house or away
    - OBVIOUS TIP: keep keys, combinations, etc., away from those at risk

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What Can Clinicians Do?

- Reduce access to all medications:
  - Safely dispose of medications no longer needed
  - For medications still needed at home:
    - Keep only small quantities of OTC medications
    - Lock up medications more likely to be abused
    - Ask doctor or pharmacist for safe amount of prescription medications and only have that amount available
    - Do not lock up rescue medications (e.g., EpiPens, inhalers)
- Work to reduce access to other methods of focus

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What Can Clinicians Do?

- Document!
  - Agree on specific steps with responsible names and timetables
  - Document the plan and next step so individual can take with them
  - Confirm the plan was implemented through follow-up contacts
  - Document the record of your plan, implementation, and follow-up for the medical record

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Questions

For more information, contact:

Matthew B. Wintersteen, PhD
Director, David Farber ASPIRE Center
Thomas Jefferson University
Department of Psychiatry & Human Behavior
834 Chestnut Street, Suite 400
Philadelphia, PA 19107

matthew.wintersteen@jefferson.edu

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