

VA



U.S. Department
of Veterans Affairs



Lethal Means Safety: How PTSD Clinicians Can Have the Conversation

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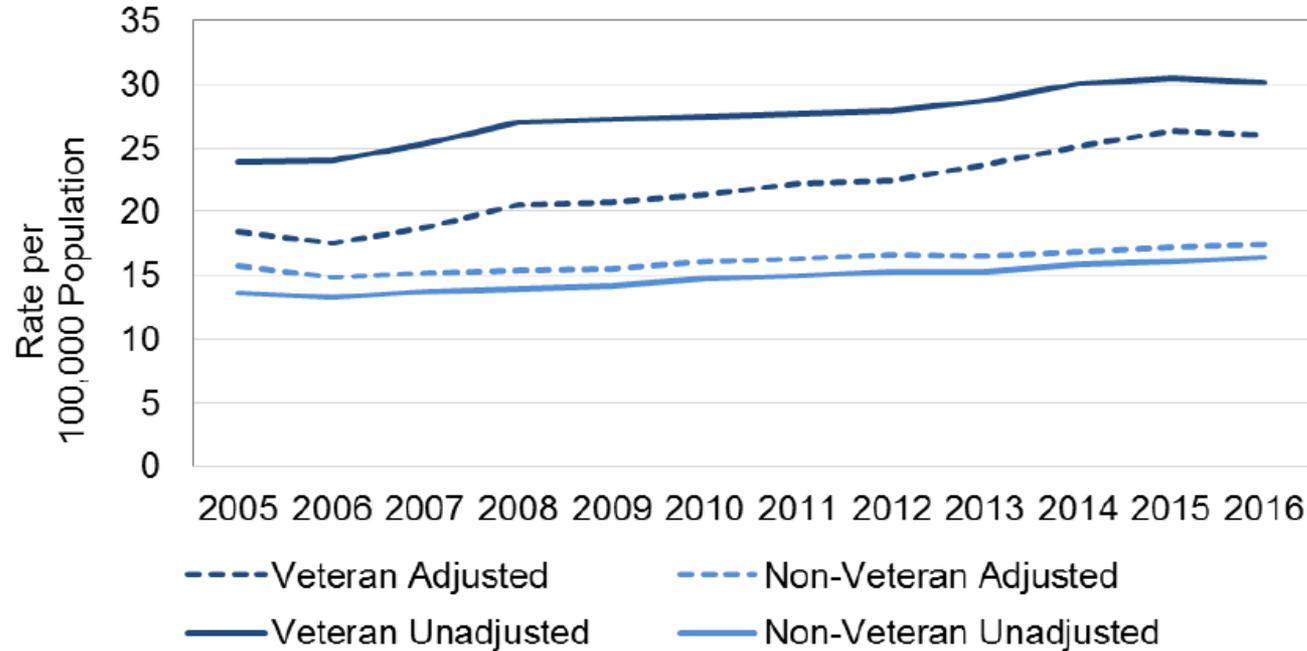
Presentation Outline

- **Why?** Lethal means safety during a critical period can save a Veteran's life
- **Who?** Strategies to promote Lethal Means Safety (LMS) should be discussed with all Veterans with High or Intermediate Acute or Chronic suicide risk
- **What?** Providing Lethal Means Safety Counseling (LMSC) & information about accessing tangible materials to facilitate lethal means safety (e.g., firearm locking devices, medication disposal kits) will save lives



Why? Evidence and Reasoning in Support of Lethal Means Safety

Figure 3: Suicide Rates, Unadjusted and Age- and Gender-Adjusted, Veteran and Non-Veteran Adults, 2005–2016



**VA National
Suicide Data Report
2005–2016**

Office of Mental Health and
Suicide Prevention

September 2018

From 2015 to 2016, the Veteran suicide rate decreased from 30.5 per 100,000 to 30.1 per 100,000.

Suicide rates for Veteran and non-Veteran adults increased from 2005 to 2016.

In 2016, the suicide rate was 1.5 times greater for Veterans than for non-Veteran adults, after adjusting for age and gender.

Table 1: Method of Suicide Among Veteran and Non-Veteran U.S. Adult Suicide Decedents, 2016

Method	Percentage of Non Veteran Adult Suicide Deaths	Percentage of Veteran Suicide Deaths	Percentage of Male Non Veteran Adult Suicide Deaths	Percentage of Male Veteran Suicide Deaths	Percentage of Female Non Veteran Adult Suicide Deaths	Percentage of Female Veteran Suicide Deaths
Firearm	48.4%	69.4%	53.9%	70.6%	32.4%	41.2%
Poisoning	16.0%	10.6%	9.8%	9.7%	34.2%	30.4%
Suffocation	26.8%	15.0%	27.8%	14.8%	23.7%	19.8%
Other	8.8%	5.1%	8.5%	4.9%	9.8%	8.6%



Colorado

Veteran Suicide Data Sheet, 2016



The U.S. Department of Veterans Affairs (VA) is leading efforts to understand suicide risk factors, develop evidence-based prevention programs, and prevent Veteran suicide through a public health approach. As part of its work, VA analyzes data at the national and state levels to guide the design and execution of the most effective strategies to prevent Veteran suicide.

The 2016 state data sheets present the latest findings from VA's ongoing analysis of suicide rates and include the most up-to-date state-level suicide information for the United States. This data sheet includes information about Colorado Veteran suicides by age, sex, and suicide method and compares this with regional and national data.

Western Region

- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
- Utah
- Washington
- Wyoming

After accounting for age differences,³ the Veteran suicide rate in Colorado:

- Was significantly higher than the national Veteran suicide rate
- Was significantly higher than the national suicide rate

Colorado Veteran Suicide Deaths, 2016

Sex	Veteran Suicides
Total	175
Male	160-170
Female	<10

To protect confidentiality, suicide death counts are presented in ranges when the number of deaths in any one category was lower than 10.

Colorado, Western Region, and National Veteran Suicide Deaths by Age Group, 2016⁶

Age Group	Colorado Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	Colorado Veteran Suicide Rate	Western Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	175	1,576	6,079	42.9	35.0	30.1
18-34	31	224	893	66.0	47.9	45.0
35-54	54	418	1,648	47.4	38.8	33.1
55-74	68	595	2,259	39.8	30.6	25.9
75+	22	337	1,274	29.3	33.4	28.3

Colorado Veteran and Total Colorado, Western Region, and National Suicide Deaths by Age Group, 2016⁶

Age Group	Colorado Veteran Suicides	Colorado Total Suicides	Western Region Total Suicides	National Total Suicides	Colorado Veteran Suicide Rate	Colorado Suicide Rate	Western Region Suicide Rate	National Suicide Rate
Total	175	1,110	11,105	43,427	42.9	26.1	19.0	17.5
18-34	31	344	3,061	11,997	66.0	25.6	16.6	16.1
35-54	54	404	3,854	15,467	47.4	27.7	19.5	18.6
55-74	68	290	3,155	12,162	39.8	25.0	19.9	17.3
75+	22	72	1,035	3,801	29.3	25.5	23.0	18.5



U.S. Veterans & Firearms

Veterans...

- Have a high degree of familiarity with firearms
- Are more likely to own firearms than those in the U.S. general population
 - *1 in 2 owns at least one firearm*
 - *1 in 3 stores a firearm loaded & unlocked*
- Are more likely to die from firearm-related suicide than those in the U.S. general population



Female Veterans

Female Veterans are significantly more likely to use firearms as a means of suicide, relative to civilian women

In 2016, 41.2% of female Veterans used firearms to die by suicide, compared to 32.4% of female non-Veterans

24.4% of female Veterans own firearms, compared to only 11.8% of female non-Veterans



Veterans with PTSD

2 studies of Veterans seeking care in PTSD residential programs
~1/3 of participants endorsed owning a firearm

Firearm ownership was associated
with:

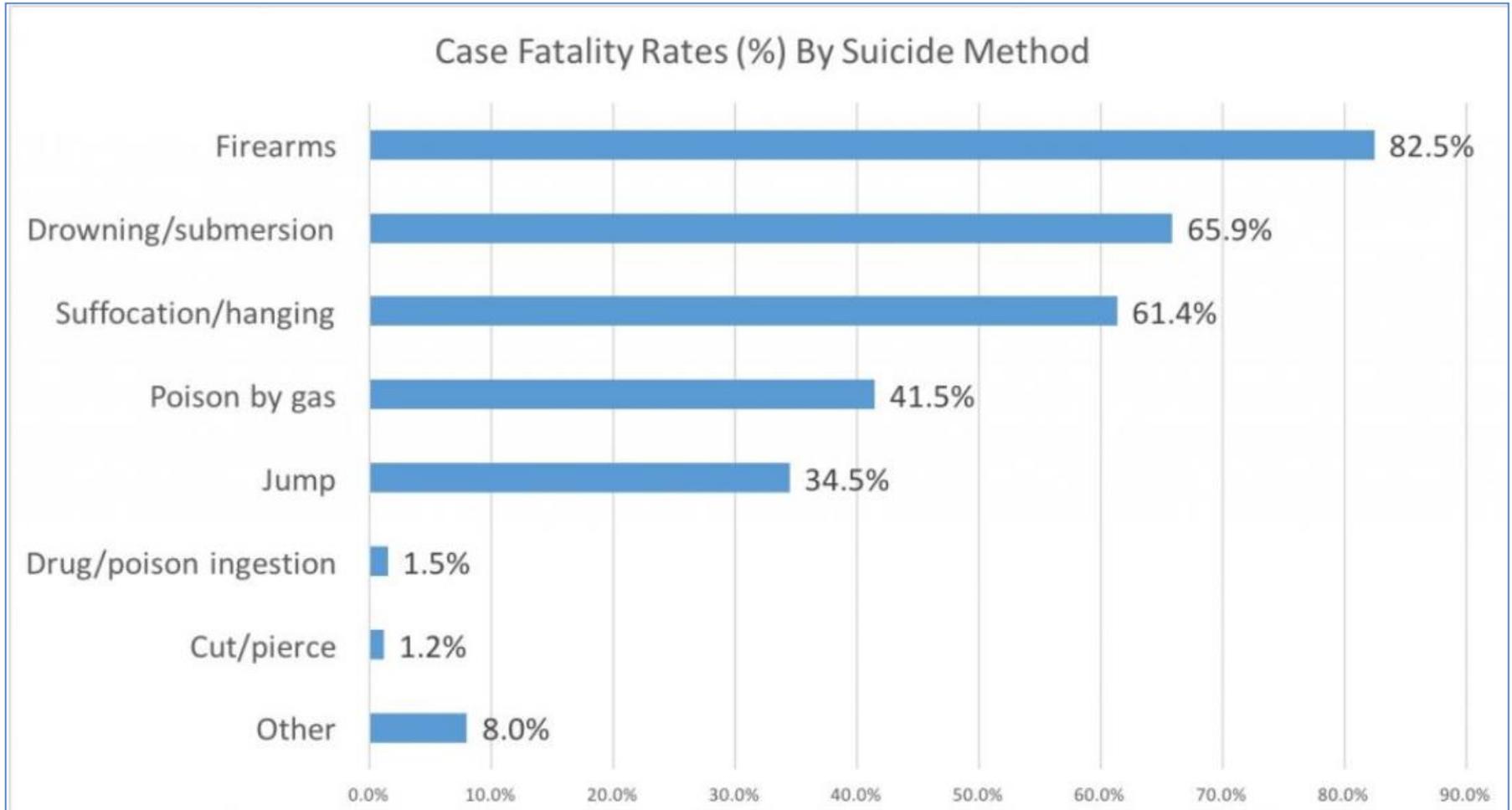
- Combat exposure
- Service in a war zone
- Number of deployments
- Lower rates of suicidal ideation
- Aggressive driving

Firearm ownership was not
associated with:

- PTSD symptom severity
- Hyperarousal symptoms
- Number of traumatic events
- Prior suicide attempt
- History of arrest

Limitation: Unknown generalizability to Veterans with PTSD who seeking outpatient care or who do not seek care

Lethality of Suicide Methods



Spicer & Miller, 2000; Image from: <https://www.hsph.harvard.edu/means-matter/means-matter/case-fatality/>



Firearm Access & Suicide

More than 15 U.S. case-control and cross-sectional studies have found that firearm access is an independent risk factor for suicide

Firearm ownership rates, independent of underlying rates of suicidal behavior, largely determine variations in suicide mortality across the 50 states



Are firearm owners just more suicidal than non-owners?

Are people who live in homes with guns more likely to have...

...experienced a mental health problem?	Yes	No
---	-----	----

...seriously considered suicide?	Yes	No
----------------------------------	-----	----

...attempted suicide?	Yes	No
-----------------------	-----	----

Are firearm owners just more suicidal than non-owners?

Are people who live in homes with guns more likely to have...

...experienced a mental health problem?

Yes

No

...seriously considered suicide?

Yes

No

...attempted suicide?

Yes

No

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Are people who live in homes with guns more likely to have...

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Are people who live in homes with guns more likely to have...

...experienced a mental health problem?

Yes

No

...seriously considered suicide?

Yes

No

...attempted suicide?

Yes

No



U.S. Veterans & Lethal Medications

- 10% of male and 30% of female Veteran suicides were due to intentional poisoning in 2016
- Most attention (appropriately) is now on opiate medications
 - Prescribed and unprescribed
 - Particularly patients receiving opiates + benzos
- Other medications are commonly implicated:
 - Acetaminophen
 - Antipsychotic / antidepressant
 - Anti-seizure



Other Lethal Means & Environmental Risks

- Strangulation
- Cutting with sharp objects
- Jumping from heights
- Suicides in inpatient VHA units



Most Suicidal Crises are Brief

Among 153 survivors of nearly fatal suicide attempts:

- **47% said it took less than 1 hour** between their decision to attempt suicide and their actual attempt
- **24 % said it took less than 5 minutes** for them to act

For a Veteran in crisis, lethal means safety during a critical period can make all the difference



Subsequent Suicide Attempts

What proportion of serious attempters eventually die by suicide?

75% **45%** **25%** **10%**



Subsequent Suicide Attempts

What proportion of serious attempters eventually die by suicide?

75% 45% 25% **10%** ←



Does it work?

- Most 18-21 year-olds in Israel serve in the Israel Defense Force (IDF)
- Early 2000s: 90% of IDF suicides were by firearm and most occurred on weekend leave
- 2006: IDF implemented a policy requiring soldiers to leave their weapons on base during weekend leave
- Suicide rate decreased by 40%
- Weekend suicides dropped significantly
- Weekday suicides did not



What do patients and gun owners think of it?

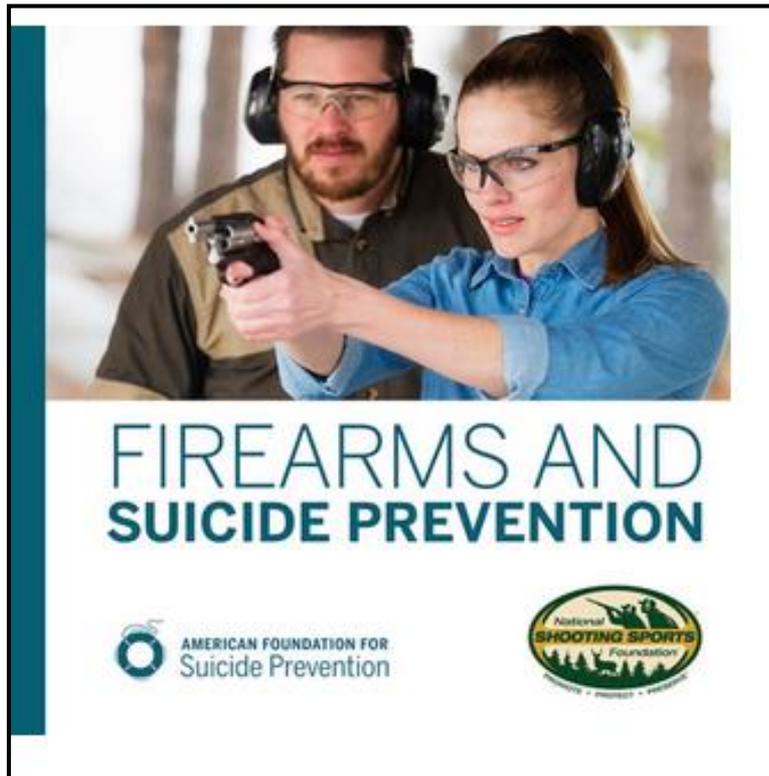
Perspectives: Patients

677 Veterans who had received VHA healthcare

Survey about the acceptability of firearm interventions (50% response rate)

- 93.2% of respondents endorsed one or more health system interventions addressing firearm access
- 75.0% endorsed interventions substantially limiting access
- Half of Veterans with household firearms would personally participate in at least one intervention that substantially limited access
- Among respondents with PTSD, 76% endorsed one or more high intensity intervention

Perspectives: Firearm Advocacy Organizations & Business Community



**CONCERNED ABOUT
A FAMILY MEMBER
OR FRIEND?**

ARE THEY SUICIDAL?

- Depressed, angry, impulsive?
- Going through a relationship break-up, legal trouble, or other setback?
- Using drugs or alcohol more?
- Withdrawing from things they used to enjoy?
- Talking about being better off dead?
- Losing hope?
- Acting reckless?
- Feeling trapped?

SUICIDES IN NH
far outnumber homicides

**FIREARMS ARE THE
LEADING METHOD**

**ATTEMPTS WITH A GUN
ARE MORE DEADLY**
than attempts with other methods

HOLD ON TO THEIR GUNS

- Putting time and distance between a suicidal person and a gun may save a life.
- For other ways to help, call the National Suicide Prevention Lifeline: 1-800-273-TALK (2725)

NH
S
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www.nhsc.org

Image: <http://www.nssfblog.com/nssf-afsp-suicide-prevention-partnership/>



Who? Veterans who may Benefit from LMS



Therapeutic Risk Management

- Clinically and medico-legally informed model for the assessment and management of suicide risk
- 3 main components
 - Augmentation of clinical risk assessment with structured instruments
 - Risk stratification tool with respect to severity and temporality
 - Collaborative development of a safety plan



Acute Risk and LMSC

ACUTE Therapeutic Risk Management – Risk Stratification Table		ROCKY MOUNTAIN MIRECC
HIGH ACUTE RISK		
<p>Essential Features</p> <ul style="list-style-type: none"> • Suicidal ideation with intent to die by suicide • Inability to maintain safety independent external support/help <p>Common Warning Signs</p> <ul style="list-style-type: none"> • A plan for suicide • Recent attempt and/or ongoing preparatory behaviors • Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse) • Exacerbation of personality disorder (e.g., increased borderline symptomatology) <p>Common Risk Factors</p> <ul style="list-style-type: none"> • Access to means • Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol) 	<p>Action</p> <p>Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.</p> <p>These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).</p> <p>During hospitalization co-occurring psychiatric symptoms should also be addressed.</p>	
INTERMEDIATE ACUTE RISK		
<p>Essential Features</p> <ul style="list-style-type: none"> • Suicidal ideation to die by suicide • Ability to maintain safety, independent of external support/help <p>These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.</p>	<p>Action</p> <p>Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).</p> <p>Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:</p> <ul style="list-style-type: none"> • frequent contact, • regular re-assessment of risk, and • a well-articulated safety plan <p>Mental health treatment should also address co-occurring psychiatric symptoms.</p>	
LOW ACUTE RISK		
<p>Essential Features</p> <ul style="list-style-type: none"> • No current suicidal intent AND • No specific and current suicidal plan AND • No preparatory behaviors AND • Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety <p>Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.</p>	<p>Action</p> <p>Can be managed in primary care.</p> <p>Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.</p>	

ACUTE Therapeutic Risk Management – Risk Stratification Table



HIGH ACUTE RISK

Essential Features

- Suicidal ideation with intent to die by suicide
- Inability to maintain safety independent external support/help

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)

Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.

INTERMEDIATE ACUTE RISK

Essential Features

- Suicidal ideation to die by suicide
- Ability to maintain safety, independent of external support/help

These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.

Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.



Chronic Risk and LMSC

CHRONIC Therapeutic Risk Management – Risk Stratification Table

HIGH CHRONIC RISK

Essential Features
Common Warning Sign

- Chronic suicidal ideation

Common Risk Factors

- Chronic major mental illness and/or personality disorder
- History of prior suicide attempt(s)
- History of substance abuse/dependence
- Chronic pain
- Chronic medical condition
- Limited coping skills
- Unstable or turbulent psychosocial status (e.g. unstable housing, erratic relationships, marginal employment)
- Limited ability to identify reasons for living

Action
 These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs).
 These individuals typically require:

- routine mental health follow-up
- a well-articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- routine suicide risk screening
- coping skills building
- management of co-occurring psychiatric symptoms

INTERMEDIATE CHRONIC RISK

Essential Features
 These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions.
 Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.

Action
 These individuals typically require:

- routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors.
- a well articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- management of co-occurring psychiatric symptoms

LOW CHRONIC RISK

Essential Features
 These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources.
 Stressors historically have typically been endured absent suicidal ideation.
 The following factors will generally be missing

- history of self-directed violence
- chronic suicidal ideation
- tendency towards being highly impulsive
- risky behaviors
- marginal psychosocial functioning

Action
 Appropriate for mental health care on an as needed basis, some may be managed in primary care settings. Others may require mental health follow-up to continue successful treatments.

CHRONIC Therapeutic Risk Management – Risk Stratification Table

HIGH CHRONIC RISK

Essential Features
Common Warning Sign

- Chronic suicidal ideation

Common Risk Factors

- Chronic major mental illness and/or personality disorder
- History of prior suicide attempt(s)
- History of substance abuse/dependence
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Action
 These individuals typically require:

- routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors.
- a well articulated safety plan, including means safety (e.g., no access to guns, limited medication supply)
- management of co-occurring psychiatric symptoms



Low Acute & Chronic Risk

- Lethal means safety counseling may be indicated based on your judgement
 - Protective factors?
 - Engagement in care & trajectory?
 - Expected life stressors?



What? LMSC & Tangible Materials to Facilitate Lethal Means Safety



Simply Put....

Working with Veterans and their caregivers, friends or family members to facilitate limiting access to lethal means during high-risk periods



You're Already Doing This

SAFETY PLAN	
Step 1: Warning signs:	
1.	<u>Suicidal thoughts and feeling worthless and hopeless</u>
2.	<u>Urges to drink</u>
3.	<u>Intense arguing with girlfriend</u>
Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:	
1.	<u>Play the guitar</u>
2.	<u>Watch sports on television</u>
3.	<u>Work out</u>
Step 3: Social situations and people that can help to distract me:	
1.	<u>AA Meeting</u>
2.	<u>Joe Smith (cousin)</u>
3.	<u>Local Coffee Shop</u>
Step 4: People who I can ask for help:	
1.	Name <u>Mother</u> Phone <u>333-8666</u>
2.	Name <u>AA Sponsor (Frank)</u> Phone <u>333-7215</u>
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name <u>Dr. John Jones</u> Phone <u>333-7000</u> Clinician/Pager or Emergency Contact # <u>555-822-9999</u>
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Hospital ED <u>City Hospital Center</u> Local Hospital ED Address <u>222 Main</u> Local Hospital ED Phone <u>333-9000</u>
4.	Suicide Prevention Lifeline Phone: <u>1-800-273-TALK</u>
Making the environment safe:	
1.	<u>Keep only a small amount of pills in home</u>
2.	<u>Don't keep alcohol in home</u>
3.	_____

Making the environment safe:

- Keep only a small amount of pills in home
- Don't keep alcohol in home
- _____



You're Already Doing This

Step 6: Making the Environment Safe

- Ask the Veteran which means he or she would consider using during a suicide crisis.
- Ask ***“Do you own a firearm, such as a gun or rifle?”*** and ***“What other means do you have access to and may use to attempt to kill yourself?”***
- Collaboratively identify ways to secure or limit access to lethal means:
Ask ***“How can we go about developing a plan to limit your access to these means?”***
- For methods with **low lethality**, clinicians may ask Veterans to remove or restrict their access to these methods themselves.
- Restricting the Veteran’s access to a **highly lethal method**, such as firearms, should be done by a designated responsible person—usually a family member, close friend, or the police.



What? LMSC – The Conversation



Approaches to LMSC

- LMSC is patient-centered, rather than a one-size-fits-all intervention
- Effective LMSC involves careful consideration of the language and stance we use with patients
- Whenever possible, LMSC involves ongoing follow up
- We still have a lot to learn about what constitutes effective LMSC for Veterans



Factors That May Impact Your Approach

- Your relationship with the Veteran
- Your knowledge about their access to guns or lethal medications
- Your knowledge of and comfort with guns or other means
- Urgency of situation
- Reasons for gun ownership or necessity of prescribed medications
- Patient's willingness to consider recommended changes
- Opportunity for follow up



The Message Matters

- 370 undergrads in the Southeast US
- Randomized to hear scripts about firearm safety in a hypothetical clinical encounter
- Asked about:
 - Acceptability
 - Intention to follow clinical recommendations
- Theory of Reasoned Action



Group 1

“My goal is to keep you alive and to protect you from hurting yourself or others.....Because I am concerned about your well-being, I want to have a conversation about means safety”



Group 2

“My goal is to keep you alive and to protect you from hurting yourself or others.....Because I am concerned about your well-being, I want to have a conversation about means restriction”



The Message Matters

“I want to have a conversation about means safety.”

More preferable

Greater intent to follow clinical recommendations to limit firearm access



Raising the Issue - One Example

“Lots of Veterans have guns at home. What some Veterans in your situation have done is store their guns away from home until they’re 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.”

“If temporarily storing them elsewhere is not an option, perhaps we can discuss some alternative ways to keep you safe until you’re feeling better.”



Principles of Motivational Interviewing

Evocation

Critical elements of change (desires, ability, reasons, needs) are within the person and the provider's task is to draw them out.

Collaboration

The person is the expert, the provider is a resource, and they work together.

Autonomy

The person, not the provider, must decide to change and provide the motivation for it.



LMS for Firearms: Temporary off-site storage during at-risk periods

Friend or relative

Provided they aren't prohibited from possessing firearms

Storage facility

Ammunition must be stored separately

Police departments

Some police departments will store temporarily at no charge

Pawn shops

Pawning the guns for a very small loan amount is reliable storage option; interest fees of ~15-20% monthly

Gun stores or gun clubs

Some may offer free or inexpensive storage options for people they know



LMS for Firearms: other options

- Any step(s) that increase the time and distance between a suicidal impulse and a gun will reduce suicide risk.
- A locked gun poses a lower suicide risk than an unlocked gun
- An unloaded gun poses a lower suicide risk than a loaded gun

Store guns unloaded

Store ammunition out of the home

Store guns and ammunition separately

Lock the gun

Store gun in a safe

Disassemble the gun



Locking Options



- Cable Lock
- Trigger Lock
- Lock Box
- Lifejacket
- Gun Safe / Cabinet



Keys to Success of Onsite Storage Options

- Give the lock key to someone else
- Asking someone to change safe combination
- Temporarily disassemble gun and store components (e.g., firing pin) with someone else



Summary of Safe Storage Options

Safest option is temporary off-site storage during high-risk time periods

Other options:

Lock it

Unload it

Remove ammunition

Disassemble it

Multiple options for locking devices are available

Ideally - Keep the key components elsewhere

LMS for Medications

Essential Meds

- Blister packets for home medications



Unneeded Meds

- Medication disposal kits
- Medication disposal bins in over 100 VAMCs
- Can also flush or dispose with coffee grounds (consider environment)

More info:

<https://www.pbm.va.gov/PBM/vacenterformedicationsafety/vacenterformedicationsafetyprescriptionsafety.asp>



LMS for Patients on Opioids

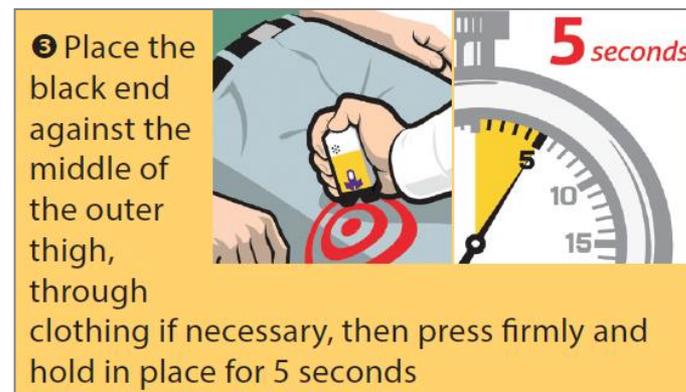
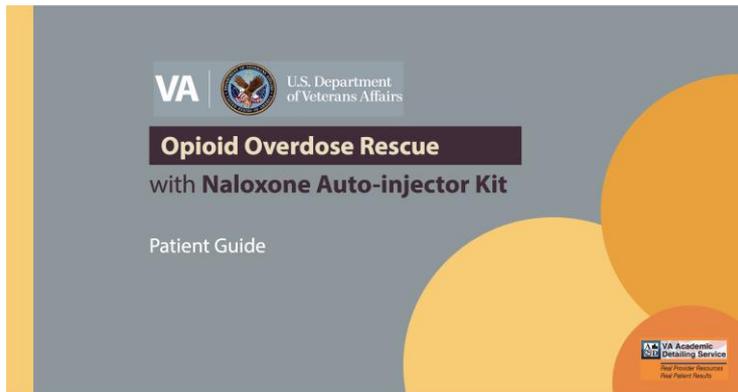
Indicated for patients with:

Suicide risk + access to opioids (prescribed or unprescribed)

Unintentional overdose risk (STORM Tool) + access to opioids

Naloxone nasal spray and autoinjectors available via the VHA pharmacy

Trainings available at PBM.VA.GOV





LMSC Documentation

- **Essential for healthcare providers to document their discussion about lethal means and LMSC**
- **For example**

“Given Veteran’s moderate acute risk for suicide, we discussed lethal means safety. Veteran agreed to have his brother store his firearm until the primary driver of his suicide risk (lack of housing) resolves.”

“Veteran remains at high chronic risk for suicide. Veteran shared that he has large amounts of unused and unneeded medications at home. I provided him with instructions regarding how to safely dispose of these medications. Veteran stated that he will call me tomorrow to confirm that he has disposed of these medications.”



LMSC with Veterans with PTSD

“Given the possible reluctance among many Veterans with PTSD to entrust their firearms to friends or loved ones before an alleviation of their posttraumatic symptomatology via treatment, clinicians might first focus on safe storage practices and not take the risk of damaging their rapport by immediately challenging this possible avoidance strategy.” (Smith et al., 2015)

- For Veterans with PTSD, firearms may bring a sense of safety. They can feel very vulnerable putting more distance between themselves and their firearms.
- Prolonged Exposure Therapy providers can address this through new learning and habituation to trauma-related beliefs regarding safety.
- Cognitive Processing Therapy providers can utilize the Safety module to explore the relation of firearms and trauma-related beliefs and assign specific thoughts for CDW work (e.g., using facts about number of injuries in homes with and without firearms).



Starting the Conversation

“How do you currently store your firearms/medications?”

“Can you think of anything you could do in addition to this to increase your safety during this tough time you are going through?”

“What concerns do you have about taking extra steps?”

“How can you help keep yourself safe from substances that can make things worse (e.g., removing alcohol/drugs from the home, deleting a dealer’s number from phone)?”



Combating Stuck Points

“If I get rid of my guns, I will just use another method to kill myself.”

- Research suggests that people often do not substitute their method.
- Even if the Veteran does use another method, almost every other method is less lethal and offers more time for rescue or for the person to change their mind.

“I need my guns for self-defense.”

- In a study using data from the National Crime Victimization Survey, people reported that they defended themselves with a gun in less than 1% of crimes (Hemenway & Solnick, 2015).
- Work with the Veteran to weigh the risk of owning a gun (e.g., harming self, harming someone else, danger to children in the home) and benefits of the rare case in which they might need use one to defend themselves



Case Example

- 29 y/o engaged, Caucasian, combat Veteran
- PTSD due to military combat trauma. He feels responsible for fellow soldier's death that he witnessed and believes he should have prevented.
- Chronic thoughts of suicide with a plan (e.g., hanging) and no intent; no past suicide attempt. Identifies guilt as main driver of suicidal thoughts.
- Access to loaded firearm at all times – either on his person or at his bedside
 - *“This is the only way I feel safe.”*
 - At intake, he states he is unwilling to consider any safe storage practices



Case Example (continued)

During the course of treatment, the Veteran has been able to identify trauma-related beliefs associated with having a firearm at all times.

If something bad happens again and someone else dies,
I could never live with myself.

I am responsible for
everyone else's safety.

My fiancé is going to die.

Someone is going to
break into my home.

I won't ever get over
what happened to Mikey.



Case Example (continued)

- Over the course of an evidence-based treatment, his views on the necessity of having a loaded firearm at all times started to shift.
- He was able to weigh the likelihood of “something bad” happening with the risks posed to himself and his fiancé.
- He realized how much he didn’t want to die and he committed to increased safety during increased periods of distress.
- First, he was willing to disarm his firearm when distressed (leaving the bullets in the drawer next to the firearm).
- Then, he was agreeable to putting the bullets in his gun safe until he felt better.
- Finally, he was comfortable locking up the gun in a safe under his bed and placing a copy of his safety plan on his safe.



Summary

- Suicide prevention is a priority.
- Facilitating LMS among at-risk patients is considered an essential, evidence-based component of effective prevention programs.
- Broad agreement that promoting LMS is important.
- Most Veteran suicides are firearm-related but medications are also an important cause of death; especially among female patients.
- Use risk stratification to identify which patients should receive LMSC.
- Patients with PTSD may have heightened concerns related to trust and safety that should be considered.
- LMSC can easily be integrated into EBPs for PTSD.
- The conversation requires practice – role-play with colleagues or consult with the Suicide Risk Management Consultation Program!

SUICIDE RISK MANAGEMENT Consultation Program

FOR PROVIDERS WHO SERVE VETERANS

Why worry alone?

The Suicide Risk Management Consultation Program provides free consultation for any provider, community or VA, who serves Veterans at risk for suicide.

Common consultation topics include:

- Risk Assessment
- Conceptualization of Suicide Risk
- Lethal Means Safety Counseling
- Strategies for How to Engage Veterans at High Risk
- Best Practices for Documentation
- Provider Support after a Suicide Loss (Postvention)

#NeverWorryAlone

To initiate a consult email:

SRMconsult@va.gov

www.mirecc.va.gov/visn19/consult



For More Information

**Rocky Mountain MIRECC:
www.mirecc.va.gov/lethalmeanssafety**

Means Matter: www.meansmatter.org

Free course on LMSC (CALM-Online): training.sprc.org

Veterans Crisis Line: veteranscrisisline.net



Thank you!
Questions or Comments?

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<https://www.mirecc.va.gov/visn19/index.asp>



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