Virtual Safety Planning Intervention

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South Southwest Mental Health Technology Transfer Center

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South Southwest (HHS Region 6)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Safety Planning Intervention

ADAPTED WITH PERMISSION: STANLEY, B. (2015), SAFETY PLANNING INTERVENTION WITH SUICIDAL INDIVIDUALS: A BRIEF THERAPEUTIC INTERVENTION. *PRESENTED AT THE UNIVERSITY OF TEXAS, AUSTIN TEXAS,* FEBRUARY 26, 2015

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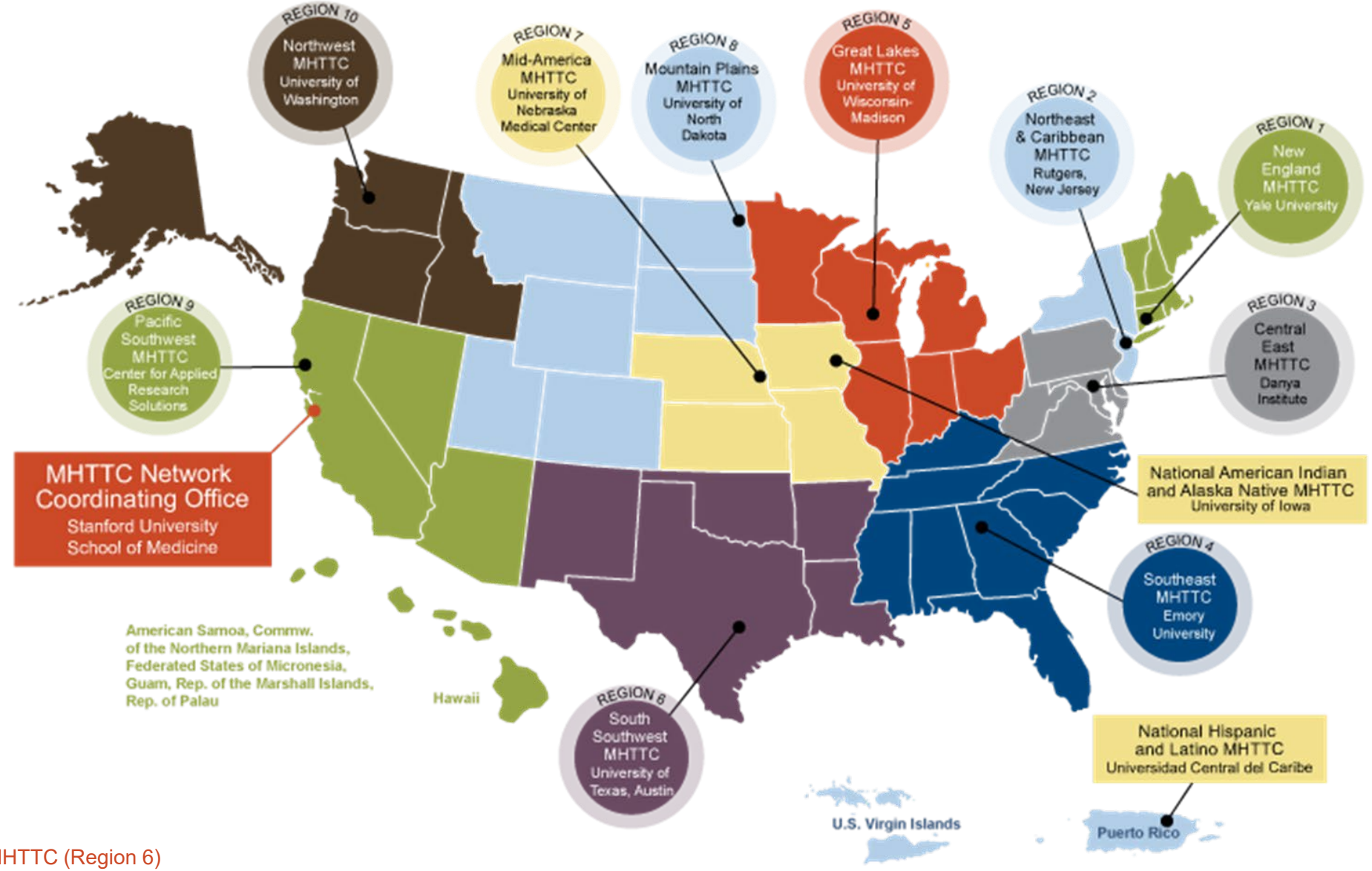
MHTTC Network

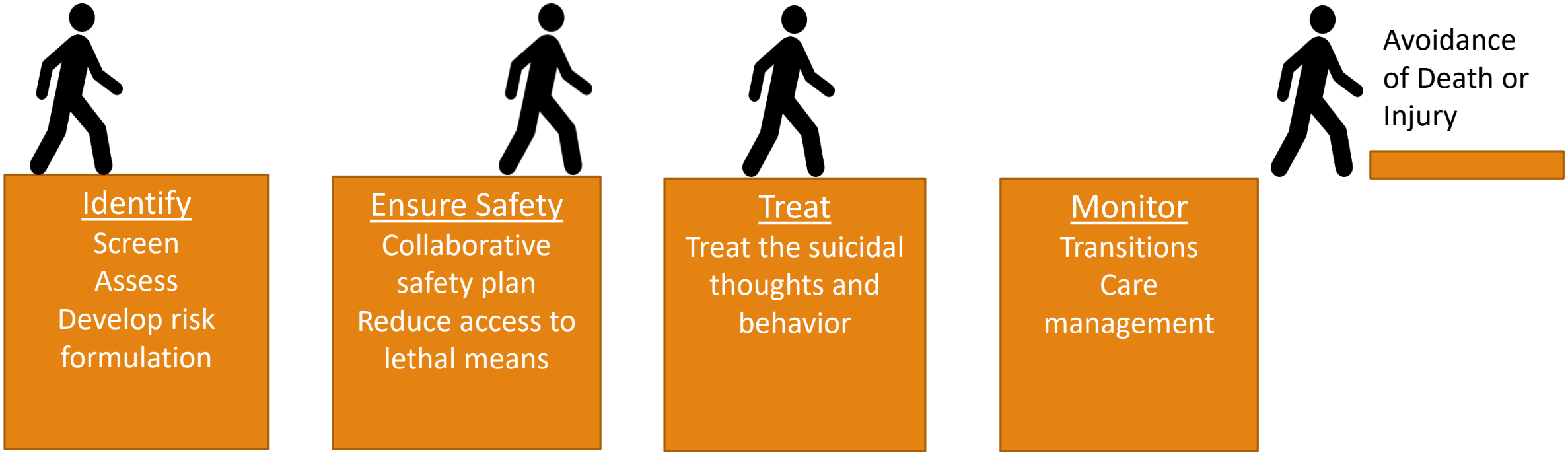


South Southwest MHTTC (Region 6)

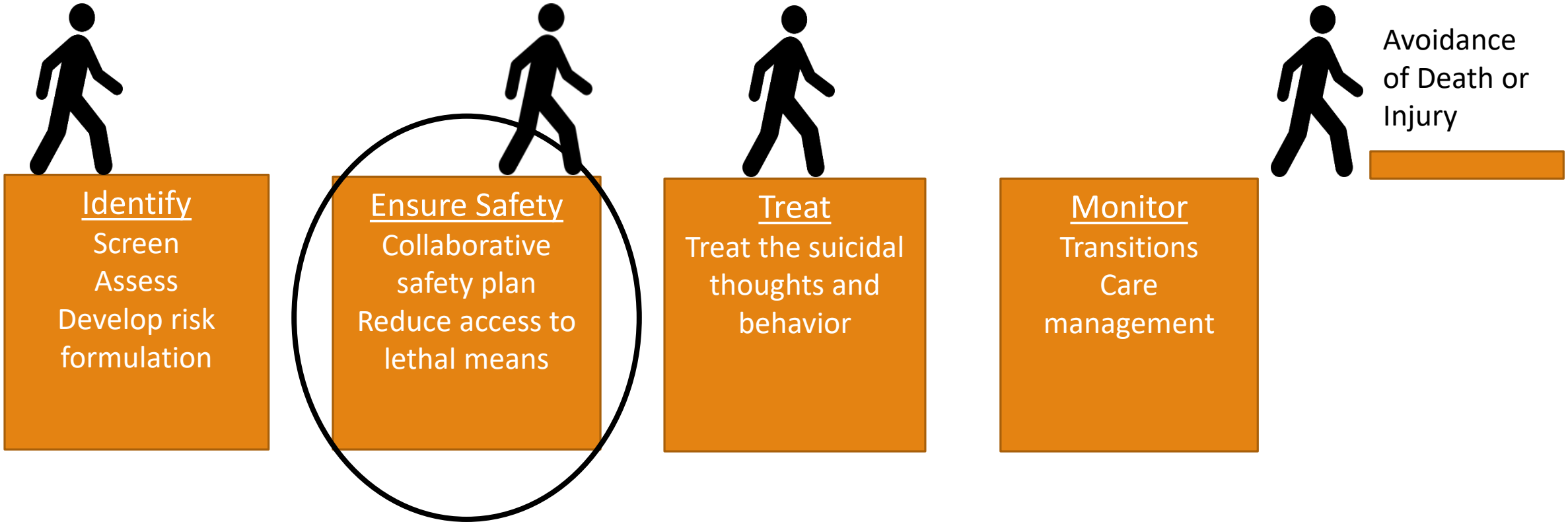
Welcome and Agenda

- Zoom meeting platform
- The training concludes at 12N CT and we will have frequent breaks
- Survey
- Participants will receive 3.5 CEUs
- Materials from today's training will be available

Avoiding the Gaps in the System



Avoiding the Gaps in the System



Brief Interventions: What are they?

- Can be single or multiple sessions
- May or may not include follow-up support
- Variety of approaches:
  - Psychoeducation
  - Crisis response planning
  - CBT
  - MI/Treatment Engagement
  - Outreach/follow-up (e.g., letters, postcards, phone calls)

Rationale for Brief Interventions

- 39% of those who die in the year following an attempt do so within 28 days of discharge from ED (Goldacre, et al., 1993)
- At-risk individuals frequently do not engage in outpatient therapy (Lizardi & Stanley, 2010; Trusz, et al., 2011)
- 11-50% of attempters refuse/drop out of therapy (Kurz & Moller, 1984)
- Up to 60% of suicide attempters attend <1 week of treatment post ED discharge (Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995)
- Of those who do attend therapy, 38% stop by 3 months and 73% after 1 year (Monti, et al., 2003; Krulee & Hales, 1988)
- We have EBPs, but the rate of suicide has continued to increase over the past 10 years (WISQARS, 2020)

Safety Planning Builds on Evidence

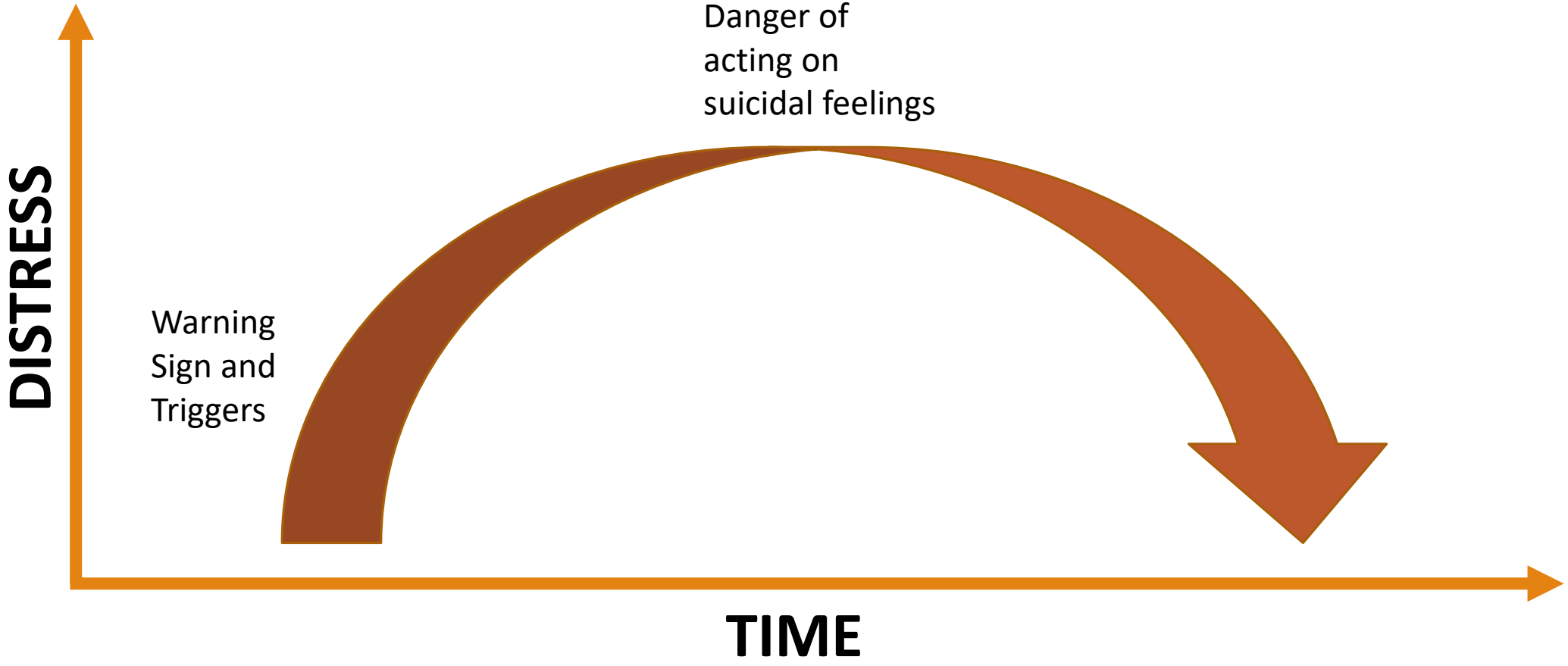
Incorporates elements of effective brief interventions and suicide risk reduction:

- Teaching self-monitoring skills
- Teaching brief problem solving and coping skills
- Enhancing social support and identifying emergency contacts
- Motivational enhancement for further treatment
- Enhancing hope and motivation for living
- Reducing access to lethal means

Assumptions Underlying Safety Planning

- Suicide risk fluctuates over time
- Individuals often fail to recognize their early warning signs
- Problem solving and coping capacity reduces during times of stress
- Working collaboratively helps ensure engagement and feasibility
- Over-practicing can help create rote memory (habit) for times of crisis

Suicide Risk Curve

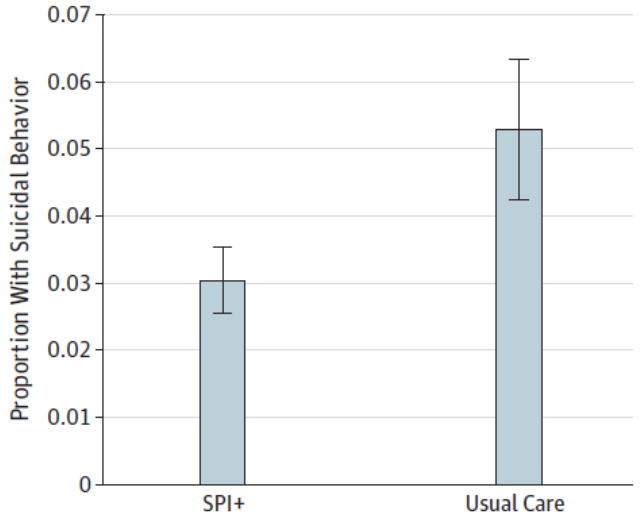


Outcomes of Safety Planning

- Initially studied as component in trials of CBT-Suicide Prevention (Brown, et al., 2005; Stanley, et al., 2009)
- Bryan, Mintz, Clemans, et al. (2017, 2018)
  - 76% reduction in suicide attempts compared to safety contract
  - Faster decline in suicidal ideation, fewer inpatient hospitalization days
  - Greater reduction in negative mood states and greater increase in positive mood
  - Lower likelihood of hospitalization when reasons for living included
- Stanley, Brown, Brenner, et al., (2018)
  - 45% fewer suicidal behaviors with safety planning and follow-up at 6 months

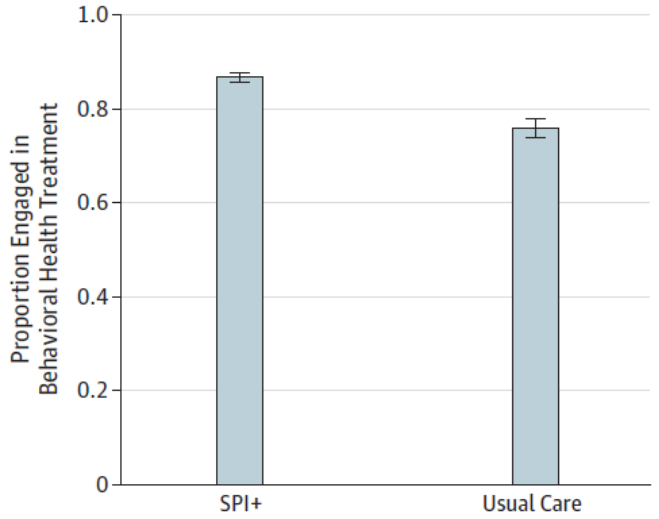
Suicidal Behavior and Treatment Engagement

Figure 1. Suicidal Behavior in 6-Month Follow-up for Safety Planning Intervention With Structured Follow-up Telephone Contact (SPI+) and Usual Care



Proportion of patients with suicidal behavior in the 6 months following emergency department discharge in SPI+ compared with usual care patients. Error bars denote the standard error of the proportion.

Figure 2. Treatment Engagement in 6-Month Follow-up for Safety Planning Intervention With Structured Follow-up Telephone Contact (SPI+) and Usual Care



Proportion of patients with at least 1 outpatient behavioral health appointment in the 6 months following emergency department discharge in SPI+ compared with usual care patients. Error bars denote the standard error of the proportion.

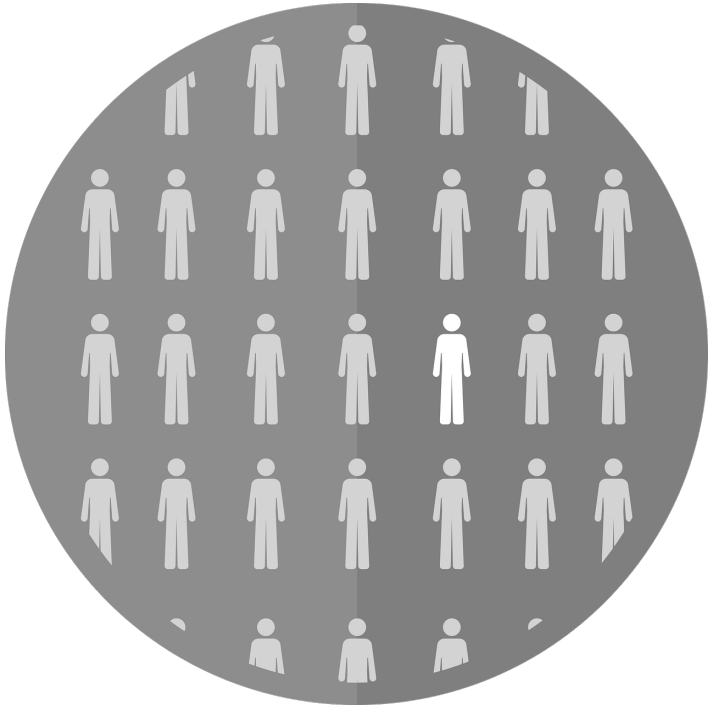
Stanley, et al 2018

Recommendations and Current Uses

- Considered best practice by Suicide Prevention Resource Center
- Highlighted as key component of engagement in Zero Suicide framework
- Cited in the recent Joint Commission requirements for accredited hospitals and behavioral health organizations (Nov. 2019)
- Used throughout Veteran's Administration

Target Population

- To be used when individual's risk is elevated (contemplating), but not imminent (active danger)
- Ideal for patients who have:
  - History of suicidal behavior
  - Recent history of suicidal ideation
  - Determined to be at risk, particularly in the moderate to high risk range
    - Psychiatric disorders that increase suicide risk (First Episode Psychosis)



Safety Planning Intervention: Overview

- Prioritized, written list of coping strategies/resources to use during a suicidal crisis
  - Starts with internal coping strategies and builds to external supports
- Step-wise increase in level of intervention
  - Steps can be skipped or done in different order
- Provides a sense of control
- Uses brief, easy-to-read format, uses the individual's own wording
- Can be used as a single session intervention and/or incorporated into ongoing treatment

What Safety Planning is not…

- Does not substitute for suicide-focused treatment
- Does not help if the individual is in imminent danger of self-directed violence
- Safety plans **<u>are not</u>** “No-Suicide Contracts”
  - Asks individuals to promise to stay alive without telling them how to stay alive
  - Can negatively impact rapport
- Safety plans are not the full puzzle, just one piece
- Safety planning is not a form to fill out or documentation

Steps in the Intervention

Stanley & Brown, 2019

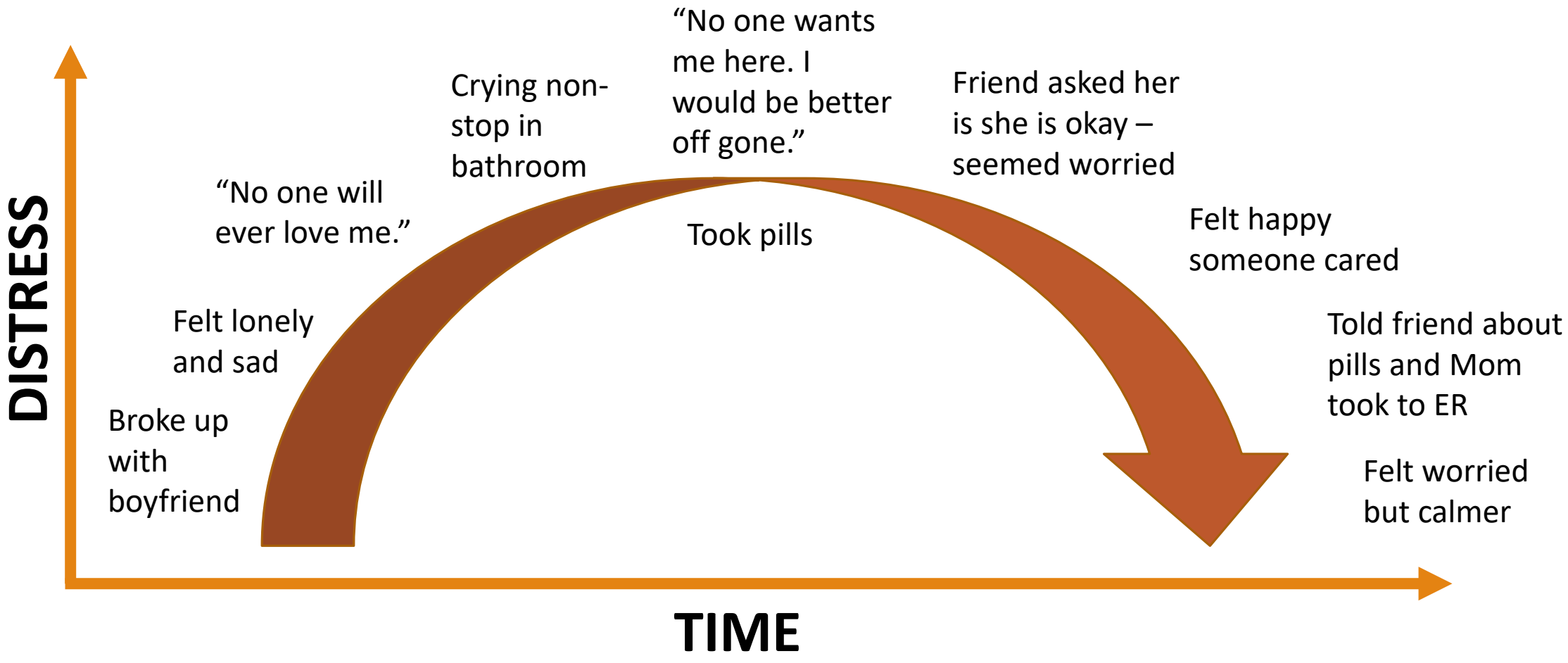
Prelude to the Safety Planning Intervention: “Telling the Story”

- Individual describes events, situations, and their reactions in detail
  - Opportunity to see warning signs, triggers, points of progression
- Construct a timeline of major events, including:
  - Thoughts, feelings, behaviors that were happening around the suicidal crisis
  - Understand what factors impacted the escalation of risk and what impacted the de-escalation of the crisis
  - “Chain analysis” or narrative interview
- Be a good listener, use reflective listener skills
- Summarize to help individual recognize warning signs and triggers, understand increase and decrease of risk, and opportunity to use coping skills before acting on suicidal feelings

“Telling the Story”

- Understand function of suicidal behavior from individual’s perspective
  - Behavior “makes sense” to the individual in the context of their history, vulnerability, and circumstances
- Empathize with the individual
  - Empathize with their strong feelings in the situation
  - Empathize with their desire to reduce the distress
  - Do not validate the belief that suicide is a valid option
- Do not try to solve problems at this point
- Focus instead on understanding the motivations for suicide

Julie – 15 year old



Mark is a 20-year-old student at the community college who entered the CSC program two months ago, following a hospitalization for psychosis symptoms. Two days ago, his parents took him to the ER after he admitted taking multiple medications in a suicide attempt. He was released from the hospital today and you are meeting with him and conducting safety planning. You ask Mark to tell you about what happened.

"I had been on campus for a while trying to read. It has been really hard to concentrate so I went to the library. I was trying to read for English, which I just hate. I just don't see how I am going to make it through the semester. I was trying to read when some jerk walks by and hits my chair. I know he did it on purpose and I let him have it. He called me a freak and said I shouldn't be there and walked off.

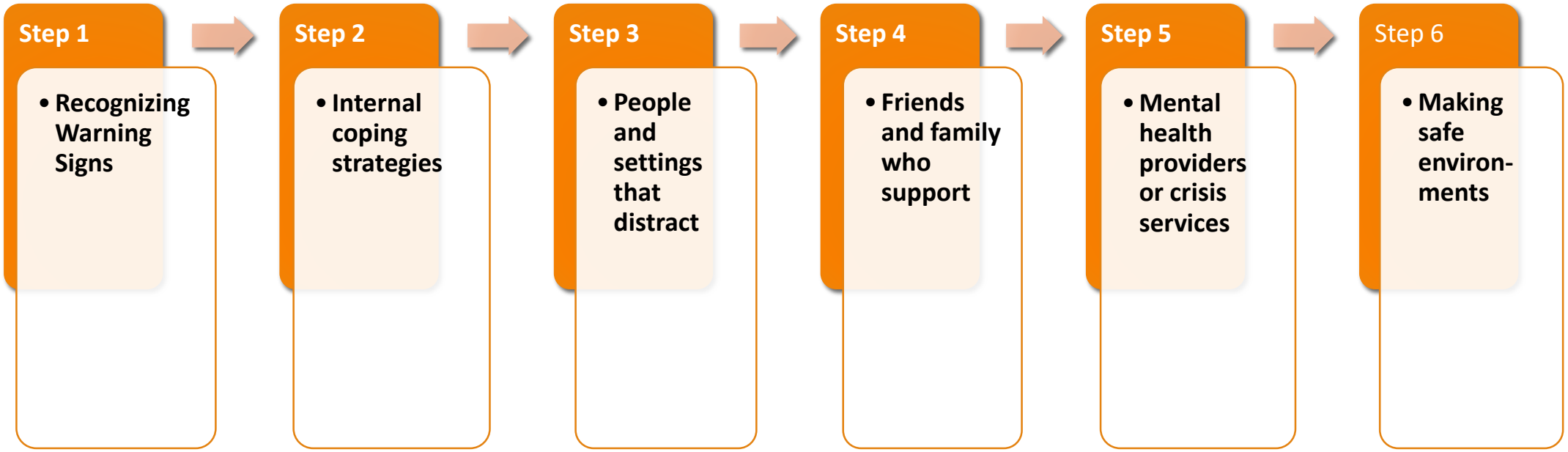
It just set me off. I kept thinking about how I stunk at school and was probably going to flunk out. None of the people I used to hang out with want to be around me anymore. I came home and went to my room so I could be alone. I was so angry at what that guy had done and hated that he called me a freak. I just kept thinking maybe he is right. I just went in the bathroom and took what pills I could find. I thought maybe it would calm me down and maybe I wouldn't wake up and maybe that wouldn't be so bad.

But after I did it, I really regretted it and knew it was stupid. I went and told my mom what I had done and she drove me to the ER. They made sure I didn't soak up too much of the medication and eventually I felt a little calmer and I knew how stupid it was."

Transition to Safety Planning

- Psychoeducation – suicidal feelings are temporary and not constant – ebb and flow
  - Crisis will end naturally without acting on the feelings
  - Introduce the safety plan as a way to help recognize the warning signs and take action to keep the crisis from escalating
- Relate back to the individual's narrative
  - Demonstrate how the suicidal thoughts come and go
  - Describe how the safety plan helps not to act on feelings until the suicidal thoughts become more manageable
- Enhance their sense of self-efficacy and self-control
- Explain that you will work together to come up with the plan

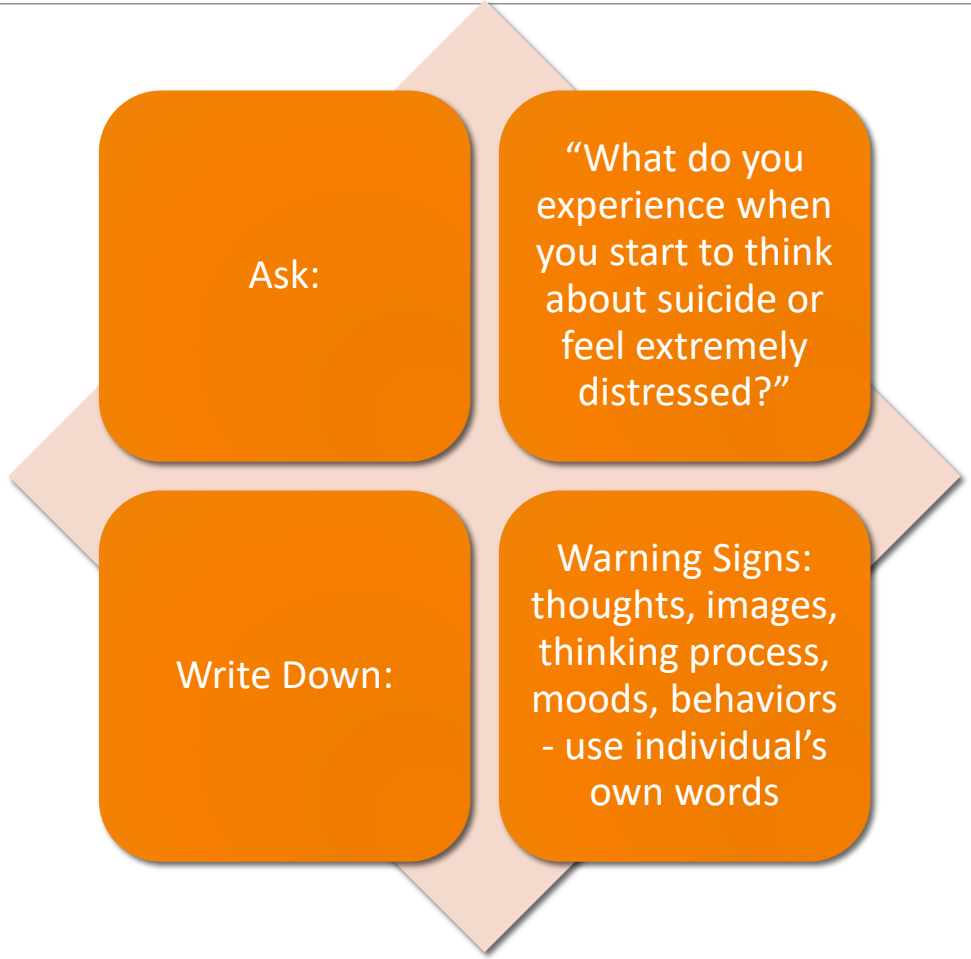
Safety Planning Intervention: 6 Steps



Step 1: Recognizing Warning Signs

- Safety Planning is only useful if the individual can recognize the warning signs
- Clinicians should obtain accurate account of the events before, during, and after the most recent suicidal crisis
  - Ask “How will you know when the safety plan should be used?”
  - Be specific!

Step 1: Recognizing Warning Signs

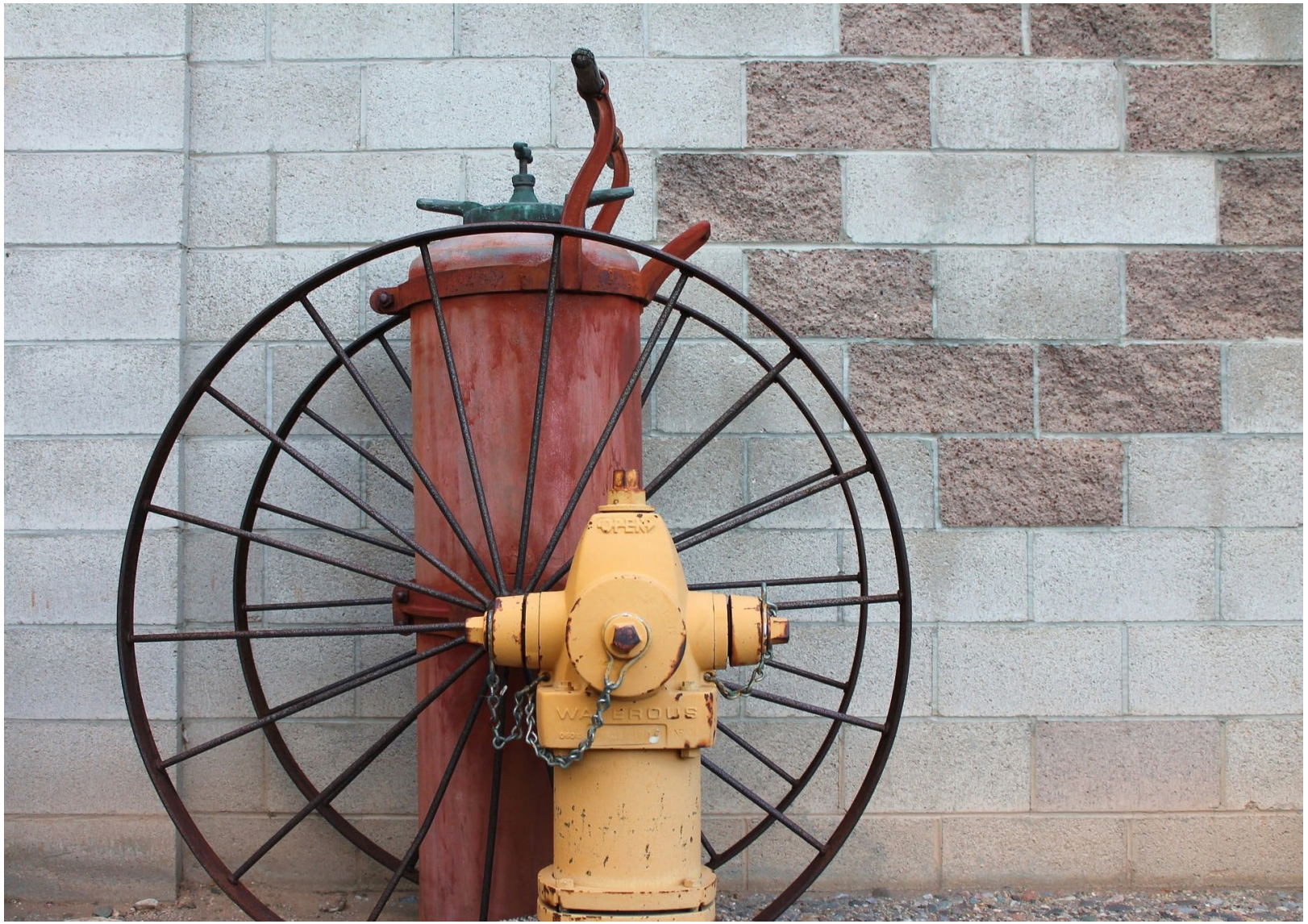


Recognizing Warning Signs

- 57% Low mood/crying
- 43% Social isolation
- 36% Irritability/anger
- 29% Increased sleep
- 29% Anhedonia, loss of interest in activities
- 14% Feeling numb
- 14% Loss of energy
- 14% Changes in appetite
- 7% Physical pain
- 7% Anxiety
- 7% Poor concentration

Self-Care Break

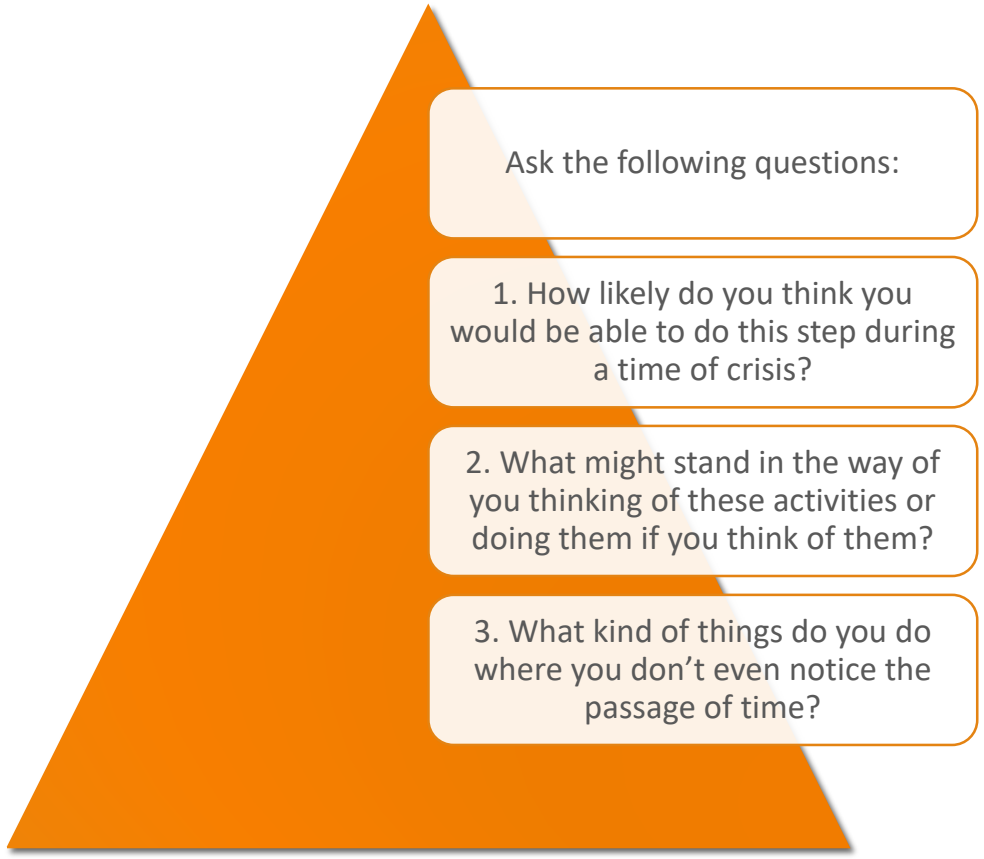
Training will resume at:



Step 2: Using Internal Coping Strategies

- List activities that individuals can do without contacting another person
- Enhances sense of self-efficacy even for a little while
  - Ask “What can you do, on your own, if you became suicidal again, to help yourself not to act on your thoughts or urges?”
- Activities function as distraction from individual’s problems and promote meaning in the individual’s life
- Coping strategies prevent suicidal ideation from escalating
  - Time passes, promotes the dissipation of the crisis period

Step 2: Using Internal Coping Strategies



Be sure to problem solve obstacles at each step!

Internal Coping Strategies

58% Watching TV

43% Reading

29% Music

21% Browsing the Internet

21% Video games

21% Exercising/Walking

14% Cleaning

14% Playing with Pets

7% Cooking

Be sure to get detail around each activity (e.g., what they would watch, play, do, or cook…)

Step 3: Using Socialization as a Means of Distraction

- Coach individuals to use Step 3 if Step 2 does not resolve the crisis or lower risk
- Suicidal thoughts are not revealed in this step
  - Socialization here is designed to “take your mind off your problems”
- Two options in this step:
  - Go to a “healthy” social setting (e.g., not a bar or club)
  - Family, friends, or acquaintances who may offer support/distraction from the crisis

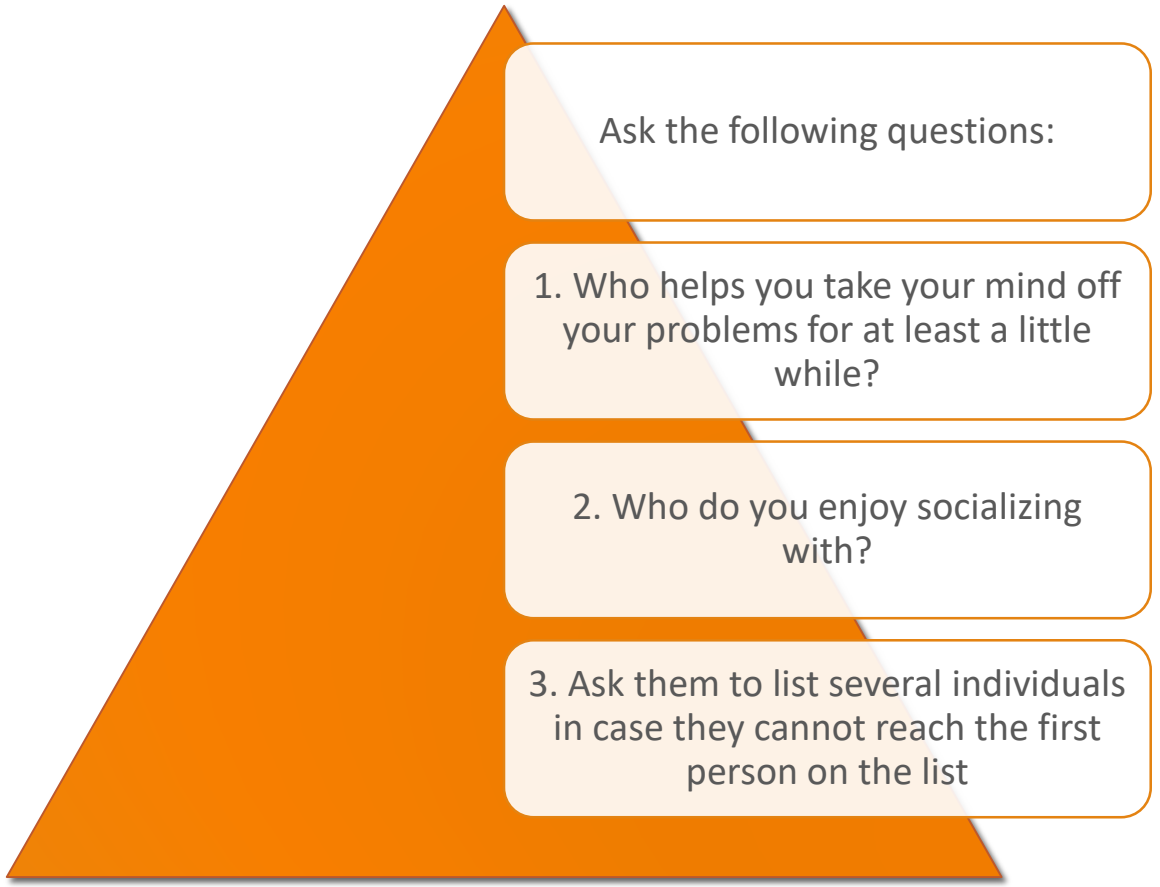
Step 3: Healthy Social Settings

- Ask: “Where do you think you could go that’s a healthy environment to have some social interaction?”
- Ask: “Are there places or groups that you can go to that can help take your mind off of your problems even for a little while?”
- Ask individuals to list several social settings
- Remember: Emphasize “healthy settings” (e.g., AA instead of neighborhood bar or club)

Social Settings Providing Distraction

- 23% Bookstore/library/coffee shop
- 23% Gym
- 23% Shopping
  - Note: for some, window shopping can be distracting, for others, it can be depressing
- 23% Park
- 23% Church
- 15% Friend's home

Step 3: Socializing with Family Members or Others



Step 4: Contacting Family Members or Friends

- Coach individuals to use Step 4 if Step 3 does not resolve the crisis or lower risk
  - Help individuals rely on their natural environment
  - For adolescents, never put other adolescents as contacts for this step. Typically list one parent.
- Ask the person if they feel comfortable sharing this plan with identified persons
  - “How likely would you be willing to contact these people?”
- Identify potential obstacles and problem solve ways to overcome them

Step 5: Contacting Professionals and Agencies

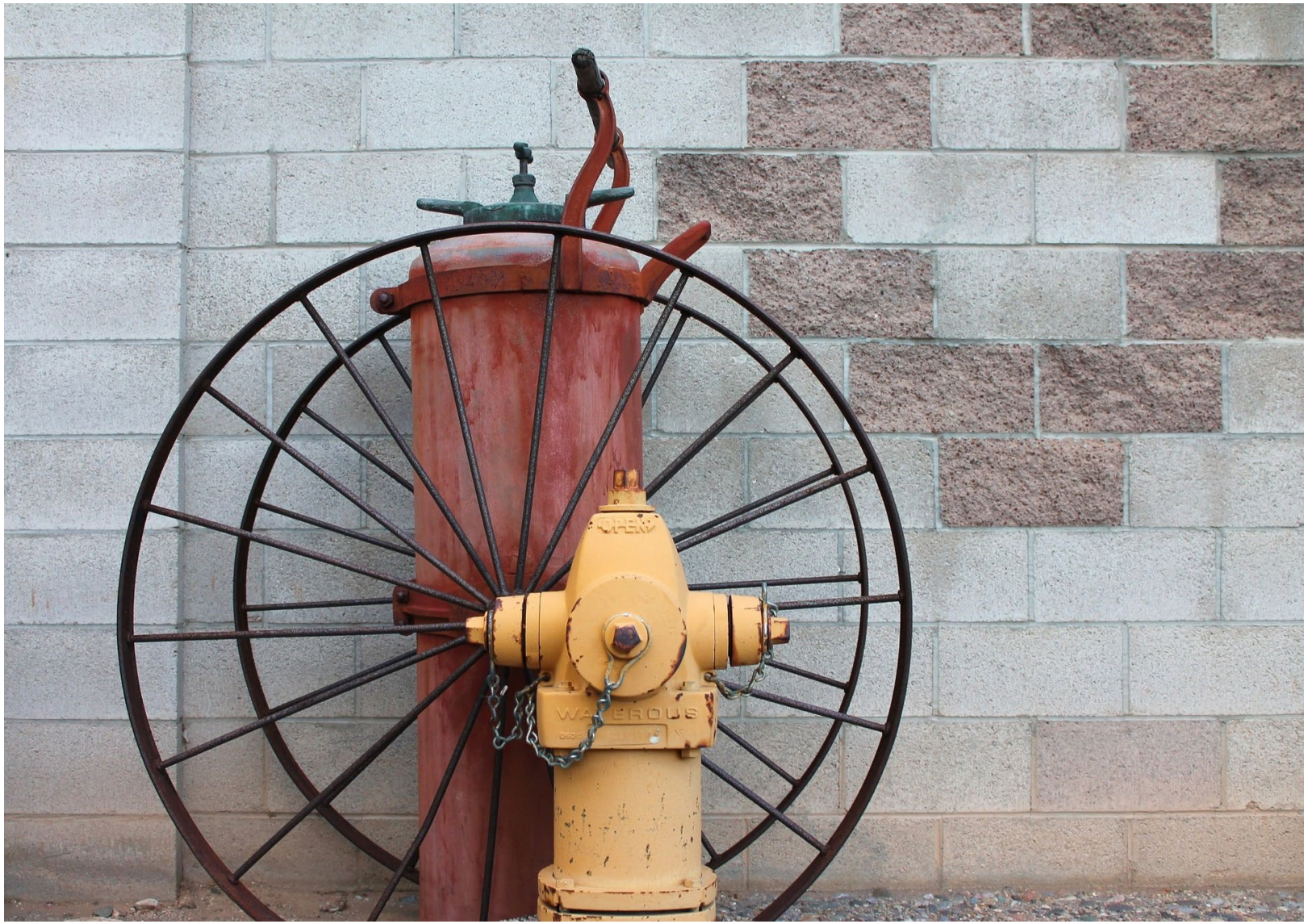
- Coach individuals to use Step 5 if Step 4 does not resolve the crisis or lower risk
- Ask: “What clinicians, if any, should be on your safety plan?”
  - Put people that are useable, not aspirational (e.g., do not take weekend call)
- Identify potential obstacles and develop ways to overcome them

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
  - Clinicians
  - Local ED or other emergency services
  - 988 Suicide and Crisis Lifeline
    - Call or text: 988
    - Chat: 988lifeline.org
- May need to contact other providers, especially if listed on the safety plan

Self-Care Break

Training will resume at:


OPEN
WATEROUS

Step 6: Reducing the Potential for Use of Lethal Means

- Ask individuals what means they would consider using during a suicidal crisis
  - ALWAYS ask about access to firearms
  - This is a process of negotiation with the individual
- Step is placed at the end of the safety plan to show individuals they have tools to cope so they won't try to hold onto means
  - If they have a sense of alternatives to suicide, they are more likely to engage in a discussion of means restriction

Step 6: Reducing the Potential for Use of Lethal Means

- For methods of low lethality (e.g., pills), providers may ask individuals to remove/restrict their access to these methods themselves
  - Specifically, discuss throwing out any unnecessary medication

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with high lethality, collaboratively identify ways for a responsible person to secure or limit access
  - If individuals are considering shooting themselves, suggest that they ask a trusted family member to store the firearm in a secure place and remove ammunition
  - Try to limit access in ways that increases the amount of time and effort required to use the preferred method

Means Restriction

- 50% Give pills to a friend or family member
- 20% Seek company/Don’t be alone
- 10% Place knife in a location that is difficult to access
- 10% Discard razor blades
- 10% Store pills at workplace
- 10% Avoid areas with bridges and trains when warning signs are present

Implementation: What is the Likelihood of Use?

- Ask: “Where will you keep your safety plan?”
- Ask: “How will you remember that you have a safety plan when you are in a crisis?”
- Ask: “How likely is it that you will use the safety plan when you notice the warning signs that we have 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 individual find ways to overcome these barriers
- May be adapted for:
  - Brief crisis cards
  - Cell phones
  - Other portable electronic devices
  - Must be readily accessible and easy-to-use
- Identify cues to use the safety plan

Self-Care Break

Training will resume at:

After the Safety Plan…

- Important to see individuals through the periods of risk
  - Follow up by phone to increase safety
  - Assess risk and help maintain safety during this transition via regular telephone contact
  - Review/revise the safety plan
  - Facilitate the transition to outpatient care, problem solve obstacles
- Calls should be made within 72 hours of discharge
- Continue calls until individual has attended outpatient care or no longer wishes to be called

Implementation: Review the Safety Plan Periodically

- Periodically review, discuss, and revise the safety plan after each time it is used and during follow up calls
  - This plan **is not** a static document
  - Should be revised as individual's circumstances/needs change over time

Important Caveats

- Individuals may not want to do one step
  - Encourage them, but don’t insist on completing every step
  - Sometimes people can’t think of anything/anyone
  - People know that certain strategies “just don’t work for them”
- This is a tool to help individuals, and although there are steps, if individuals are in imminent danger, they should seek the level of care that will keep them safe

Tips for Practice

- Only do as much risk assessment as needed to determine risk→ shift to safety planning
  - Should pause and explain this shift
  - Explain why you are doing a safety plan (e.g., rationale with suicide curve)
- SPI is not to prevent suicidal ideation from happening, but to keep the suicidal crisis from escalating

How Has the Safety Plan Helped Me?

“It helped me not to be such a tough guy and actually go for the help that I needed.”

“I would tell them (others at risk) that it saved my life.”

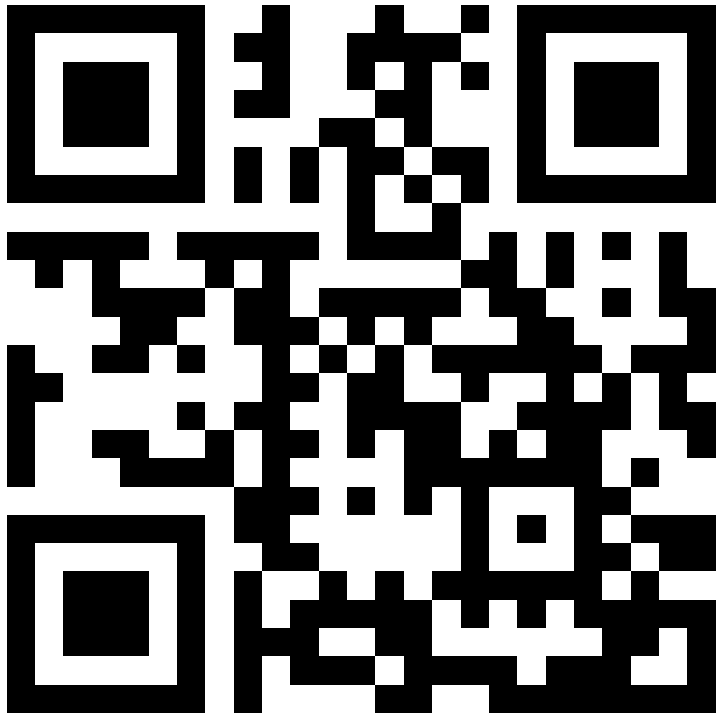
“I never thought I could do anything about my suicidal feelings. Now, I know that I am not at their mercy.”

“It has saved my life more than once.”

Safety Planning Intervention Resources

- Stanley B & Brown GK, A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*, 19:2, May 2012, 256-264.
- Safety Planning in the VA (*Stanley & Brown VA Safety Planning Manual, 2008*)
- Safety Plan template: www.suicidesafetyplan.com
- Safety Planning App available on iTunes
- Safety Planning webinars:
  - NASHPD August 2019: https://www.nasmhpd.org/content/ta-coalition-webinar-safety-planning-intervention-reduce-suicide-risk
  - CDC September 2017: https://deploymentpsych.org/content/cdp-presents-safety-planning-intervention-reducing-suicide-risk-20-sept-adobe-connect

Brief Survey



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