Suicide Prevention Safety Planning

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Suicide Prevention Safety Plan

What is a safety plan?

- A safety plan is a list of prioritized coping strategies and resources that people at risk for suicide can use in times of emotional distress or during a crisis.
- Safety plans are brief and written from the patient's perspective.

How do you develop a safety plan?

A safety plan should include **six steps** for ensuring the patient's safety:

1. Recognize warning signs.
2. Identify internal coping strategies.
3. Identify people and social settings that can provide distraction.
4. Family members and trusted friends who could offer support.
5. Professionals and Agencies to contact for help.
6. Making the environment safe.

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“No-suicide” contracts

- Typically entails a patient agreeing to not harm themselves
- Despite a lack of empirical support, commonly used (up to 79%) by mental health professionals

- Not recommended for multiple reasons
  - No medical or legal protection
  - Negatively influences provider behavior
  - Not patient-centered

Safety Plan

MY SAFETY PLAN

Please follow the steps described below on your safety plan.
If you are experiencing a medical or mental health emergency, please call 911 at any time.
If you are unable to reach your safety contacts or you are in crisis, call the Veterans Crisis Line at **1-800-273-8255 (press 1).**

Step 1: Triggers, Risk Factors, and Warning Signs

Signs that I am in crisis and that my safety plan should be used:

1. _____
2. _____
3. _____
4. _____
5. _____

Step 2: Internal Coping Strategies

Things I can do on my own to distract myself and keep myself safe:

1. _____
2. _____
3. _____
4. _____
5. _____

Step 3: People and Social Settings that Provide Distraction

Who I can contact to take my mind off my problems/help me feel better:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____
5. Name: _____ Phone: _____

Public places, groups, or social events that help me feel better:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Step 4: Family Members or Friends Who May Offer Help

Who I can tell that I am in crisis and need support:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____
5. Name: _____ Phone: _____
6. Name: _____ Phone: _____

Step 5: Professionals and Agencies to Contact for Help

Mental Health professionals or services I can contact for help:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____

Veterans Crisis Line: 1-800-273-8255, press 1
VCL Text Messaging Service: Text to 838255
VCL Chat: https://www.VeteransCrisisLine.net/Chat

Dial 911 in an emergency

If I need to go to an emergency room or urgent care, I will go to: _____
ER Address: _____
ER Phone: _____

Step 6: Making the Environment Safe

These are the ways I will make my environment safer and barriers I will use to protect myself from lethal means:

_____

_____

These are the people who will help me protect myself from having access to dangerous items:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____

Other Resources:

Virtual Hope Box Smartphone App	www.MakeTheConnection.net
My3 Safety Plan Smartphone App	www.VetsPrevail.org

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Introducing the Safety Plan

- When experiencing emotional distress, problem solving abilities often diminish. Having a concrete plan to refer to helps.
- Emphasize the plan is not meant to eliminate stress, solve problems or "cure" conditions. It is a very specific plan for preventing crisis with the goal of managing acute stressors independently.

Considerations for persons with SUDs:

- Discuss relationship between substance use and suicidal ideation. Opportunity to reflect on the role of alcohol/substances have played in previous suicidal thoughts or behaviors.
- Safety Plans can also be thought of relapse prevention plans.

Step 1: Warning Signs

ASK: How will you know when you are in crisis and that the safety plan should be used? What are your personal red flags?

Describe what the personal and specific warning signs are:

- Can be thoughts, feelings, behaviors, physical sensations, or images
- Examples: isolating in my room, not sleeping, feeling overwhelmed, nightmares, feeling like a burden to my family
- After warning signs have been identified, remind the person that the presence of warning signs are in indication that the Safety Plan should be put into action. Explain that the plan should ordinarily be used in a stepwise fashion UNLESS they need emergency rescue.

<u>Considerations for persons with SUDs:</u>

- Many individuals will report increased use or relapse as a warning sign. Consider increased frequency/severity of urge to use to be the warning sign.

Step 2: Internal Coping Strategies

ASK: What can you do on your own, to help you stay safe and not act on your suicidal thoughts or urges in the future? What have you done in the past to stay safe?

- These are things the patient can do independently.
- Meant to be used when warning signs are present, to calm, de-escalate and distract.
  - Assess the likelihood that they will use these strategies
  - Ask: What would get in your way of doing these activities?
  - Be specific
  - Collaboratively problem solve obstacles

Internal Coping Strategies

- Count to 100
- Play with your pet
- Write something (in a journal, poems, etc.)
- Outdoor exercises (examples: hiking, bike riding, going to the gym)
- Go on a walk
- Deep breathing
- Visualize a safe/pleasant place
- Cook or bake
- Clean
- Play a musical instrument
- Sing or hum a song
- Gardening
- Take a long walk out side
- Watch an engaging TV show (examples: comedy, sports)
- Pray or meditate
- Recycle/repurpose old items
- Think about and/or act on your values (examples: relationships, work, spirituality, health/wellbeing, recreation, Listen to music
- Watch the sunset/sunrise
- Take a bath/shower
- Go fishing
- Draw, doodle, or craft
- People watching
- Play cards
- Sit in the sun
- Photography

Step 3: People and Social Settings that provide distraction

- ASK: Who can you contact who helps take your mind off problems or helps you feel better? What public places, groups or social events help you feel better?
- Friends, family who provide a distraction.
- Examples of places to go: coffee shop, library, bookstore, mall, park, gym, etc. (but now we need to consider COVID safety; taking a walk, taking a drive etc.)
- Ensure that the contacts and places that they are likely to contact or visit. Do not list places that they have never been to before and may have no intent to visit but "sound good."

<u>Considerations for persons with SUDs:</u>

- Do not list places associated with previous alcohol/drug use.
- Do not list people that are likely to use in front of you.

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Step 4: Family and Friends who may offer help

ASK: Who are the friends or family members who should be included in your plan? Who is supportive of you and who do you think you can contact in a time of crisis?

- Mention that these can be the same people that are listed on Step 3, they just serve a different purpose in Step 4 (i.e., discussing distress rather than distraction).
- Examples: supportive family, friends, pastor, partner, sponsor etc..
- If a patient discloses lack of support consider other interventions to address social isolation, like connecting with peer support, group therapy, etc.
    - If they express doubt about this step, role play and rehearsal may be useful.

<u>Considerations for persons with SUDs:</u>

- Many persons with long history of SUD may have strained interpersonal relationships. Normalize that sometimes patients may not be able to identify persons to list on Step 4.
- Discuss connecting with an AA/NA sponsor

Step 5: Professionals and/or agencies that can help

- ASK: Who are the mental health professionals or professional peer supports who should be included in your plan?
- Counselor, therapist and/or psychiatrist
- National Suicide Prevention Lifeline
  - Talk/Text/Chat
- Other professional organizations
- Community agencies
- Urgent care or Emergency Rooms

*Write contact information on the Safety Plan!

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Step 6: Making the Environment Safe Decreasing what is Unsafe

ASK: What items in your environment might you use to hurt yourself? What can we do to make your environment safer?

Highlight that in times of crisis, people may act impulsively, so increasing distance between them and what may be unsafe in their environment is important.

- Firearms – Encourage removing firearms during times of distress. Have a trusted friend keep the firearms until you are feeling better. If unwilling, consider gun locks, gun safe, separating ammo from gun, keeping safety plan on gun safe.
- Medications – remove old/stockpiled meds, use pill box, have someone else administer medication.
    - If opioids are of concern, ask if they have a Naloxone kit and recommend they obtain one.

<u>Considerations for persons with SUDs:</u>

- Dispose of current substances
- Delete dealers number from phone
- Distance self from others who are using

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Safety Planning: Tips for Success

- Be specific with what is listed, use patient's language
- Make it personal and relevant
- Make sure they have a copy!
- Keep copies in multiple places
- Share with someone you trust
- Update whenever a major change occurs, or 1-2 times per year
- Review the plan often
- Consider smart phone Apps: Virtual Hope Box, Safety plan App.

Safety Plan: VA Mobile

- Introduction to the Safety Plan App
- Safety Plan | VA Mobile

Additional Resources:

Developing a Safety Plan

Overview for VHA Clinicians

The Veterans Health Administration (VHA) has updated the Safety Planning Intervention Manual, a guide for VHA clinicians that defines the best practices for developing safety plans with Veteran patients.

Safety planning should be used with Veterans who meet one or more of the following criteria:

- Attempted suicide or engaged in suicidal behavior
- Reported suicidal ideation
- Have psychiatric disorders that increase suicide risk
- Are otherwise determined to be at risk for suicide (e.g., patient record flags identifying Veterans at high risk for suicide)

The outcome of safety planning intervention is a personalized safety plan: a prioritized list of coping strategies and sources of support that the Veteran can use before or during a suicidal crisis. The best safety plans are brief, easy to read, and written in the Veteran's own words.

Well-developed safety plans can help Veterans recognize when they are experiencing a crisis and guide them in following specific steps to prevent them from acting on suicidal thoughts and urges. The safety plans are an essential part of emergency preparedness, as problem-solving abilities often diminish during a crisis.

The safety plan is not just a form — it's an important clinical intervention that should be developed thoughtfully and collaboratively by the clinician and Veteran.

See the other side of this handout for the six steps of developing a safety plan.

Access the updated Safety Planning Intervention Manual and training materials from the **Mental Health Services SharePoint**. The safety plan template is available in the VA Computerized Patient Record System.

If you or someone you know is in crisis, call the Veterans Crisis Line at **1-800-273-8255 and Press 1**, chat online at **VeteransCrisisLine.net**, or text **838255**.

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SUICIDE PREVENTION SAFETY PLAN

*If the Veteran declines to complete the Safety Plan OR if you are reviewing an existing Safety Plan with the Veteran and no changes are needed, please complete the ***Suicide Prevention Safety Plan Review/Decline*** note to document the review or decline.*

If creating a new Safety Plan, or if, upon review, changes need to be made to an existing Safety Plan, continue with this note, completing ALL fields and incorporating changes.

The Safety Plan is a pre-determined written list of coping strategies and sources of support that Veterans who are at risk for suicide can use before or during a crisis. The rationale for using a Safety Plan is to help Veterans recognize when they are experiencing a crisis and to use specific strategies to avert a crisis and prevent them from acting on their suicidal thoughts and urges. The Safety Plan serves as an emergency plan to use during crises when problem solving abilities often diminish.

The Safety Plan is a brief, easy-to-read document that uses the Veteran's own words. To foster collaboration, it is best to complete a paper and pen version of the plan with the Veteran prior to entering it into the EHR. The template allows for a limited number of characters per line and a limited number of lines. Once you click 'finish,' however, you can add beyond those character and line limits for cases where the Veteran has developed a particularly robust and detailed Safety Plan. Veterans must be given a hard copy of the Safety Plan as it may serve as a reminder to engage in strategies to reduce risk. Many Veterans may also choose to enter much of the safety plan information into a related smartphone app, such as MY3 or Virtual Hope Box.

Before introducing the Safety Plan template or form, it is recommended that the clinician ask the Veteran to briefly describe his or her crisis that was associated with an increased risk for suicide. For example, the clinician may ask, "Would you tell me what happened when you experienced a crisis and were in danger of acting on your suicidal feelings?" Offer empathy and support when asking about the crisis. From the Veteran's description, it is helpful for the Veteran to identify the warning signs associated with the beginning of the crisis and to observe how suicidal thoughts come and go as the crisis diminishes. The rationale for obtaining this information is for the Veteran to see how it may be possible to avert or de-escalate a crisis by recognizing when a crisis begins or worsens and then using coping strategies and other sources of support in a step-by-step way. Explain that suicidal feelings do not last indefinitely and that having strategies to cope in place beforehand can help manage a suicidal crisis and allow the crisis to pass without engaging in suicidal behavior.

Inform the Veteran that once the Veteran recognizes the warning signs, then he or she should follow the steps described on the Safety Plan. If following the coping strategies described for one step is unhelpful for de-escalating the crisis, then encourage the Veteran to go to the next step on the Safety Plan and continue to follow the steps until the crisis is diminishes and the risk for suicide is lower. However, also inform the Veteran that it is not necessary to follow this list of strategies before reaching out for help.

After the Safety Plan is developed, review the entire Safety Plan with the Veteran, assess the likelihood that the Safety Plan will be used, and problem-solve with the Veteran any barriers to using the plan. Discuss where the Veteran will keep the Safety Plan, specifically. Evaluate whether the content and format is appropriate and feasible for the Veteran's capacity and circumstances.

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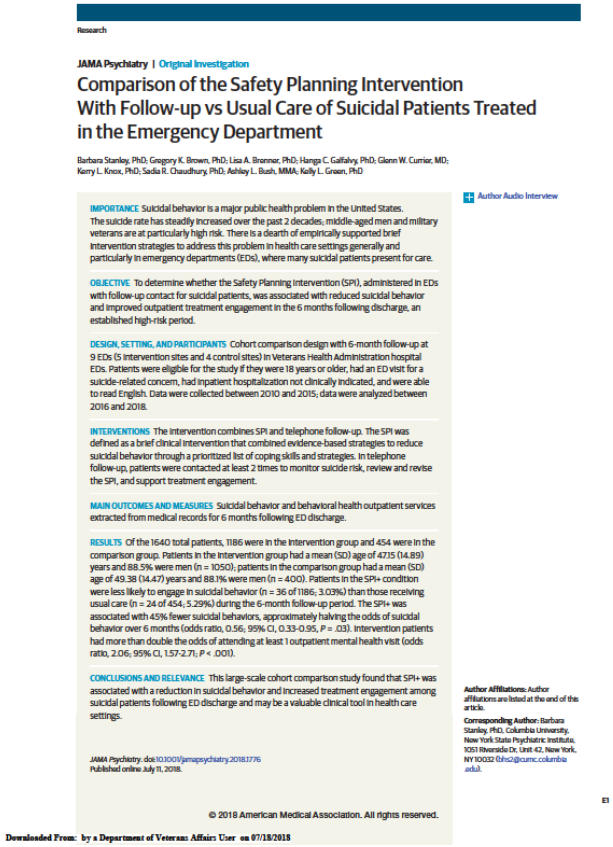
Additional Resources:



Research

JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Bronner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MIMA; Kelly L. Green, PhD

Author Audio Interview

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades, middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

DESIGN, SETTING, AND PARTICIPANTS Cohort comparison design with 6-month follow-up at 9 EDs (5 intervention sites and 4 control sites) in Veterans Health Administration hospital EDs. Patients were eligible for the study if they were 18 years or older, had an ED visit for a suicide-related concern, had inpatient hospitalization not clinically indicated, and were able to read English. Data were collected between 2010 and 2015; data were analyzed between 2016 and 2018.

INTERVENTIONS The intervention combines SPI and telephone follow-up. The SPI was defined as a brief clinical intervention that combined evidence-based strategies to reduce suicidal behavior through a prioritized list of coping skills and strategies. In telephone follow-up, patients were contacted at least 2 times to monitor suicide risk, review and revise the SPI, and support treatment engagement.

MAIN OUTCOMES AND MEASURES Suicidal behavior and behavioral health outpatient services extracted from medical records for 6 months following ED discharge.

RESULTS Of the 1640 total patients, 1186 were in the intervention group and 454 were in the comparison group. Patients in the intervention group had a mean (SD) age of 47.15 (14.89) years and 88.5% were men (n = 1050); patients in the comparison group had a mean (SD) age of 49.38 (14.47) years and 88.1% were men (n = 400). Patients in the SPI+ condition were less likely to engage in suicidal behavior (n = 36 of 1186; 3.03%) than those receiving usual care (n = 24 of 454; 5.29%) during the 6-month follow-up period. The SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behavior over 6 months (odds ratio, 0.56; 95% CI, 0.33-0.95, $P = .03$). Intervention patients had more than double the odds of attending at least 1 outpatient mental health visit (odds ratio, 2.06; 95% CI, 1.57-2.71; $P < .001$).

CONCLUSIONS AND RELEVANCE This large-scale cohort comparison study found that SPI+ was associated with a reduction in suicidal behavior and increased treatment engagement among suicidal patients following ED discharge and may be a valuable clinical tool in health care settings.

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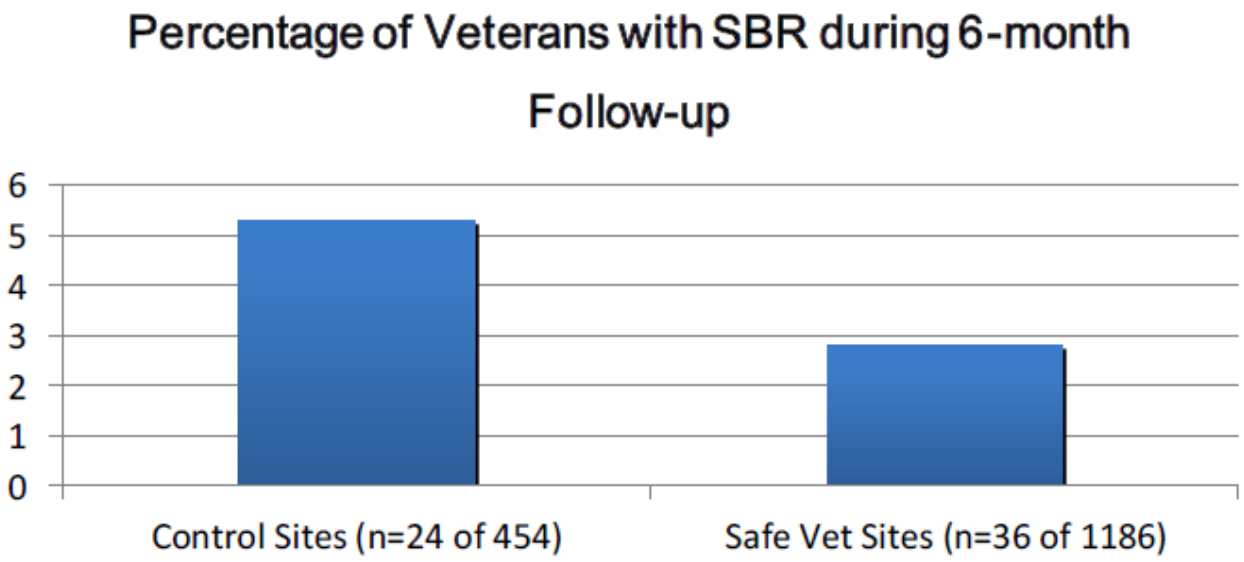
Does SPI help to decrease suicidal behavior? Suicide Behavior Reports (SBR) During Follow-up



$\chi 2(1, N = 1640) = 4.72, p = .029$; OR = 0.56, 95% CI: 0.33, 0.95

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). JAMA Psychiatry

SAMHSA
Substance Abuse and Mental Health Services Administration

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