Safety Planning

Goal 6: All children and adults with moderate or high risk for suicide will work collaboratively with a trained provider to develop an effective, individualized safety plan.

Rationale

Many individuals who present at emergency departments, crisis centers, or contact crisis hotlines will either not follow through with outpatient referrals or leave treatment within the first three months of care (Rudd, 2006). Therefore, it essential that providers utilize these contacts with the health care system to engage in brief interventions aimed at reducing risk. Safety planning takes advantage of findings that suicidal thoughts and intentions can ebb and flow over time, and that interventions that help an individual get through times of crisis can be effective in reducing suicidal behaviors. Safety planning draws from cognitive therapy interventions that utilize distraction and active coping strategies to manage suicidal thoughts. Safety planning has been tested as a component of evidence-based interventions targeting suicidal behavior (Wenzel, Brown, & Beck, 2009; Stanley, et. al., 2009) and has been identified as a best practice (Level 3) by the Suicide Prevention Resource Center. Safety planning is notably different from "no suicide contract" interventions, which do not identify how an individual and their family should respond if the individual becomes suicidal. There is minimal support for "no suicide contracts" and concerns have been raised that they may impede open communication between individuals and clinicians about suicidal intent (Rudd, Mandrusiak, & Joiner, 2006).

Description of the Safety Planning Intervention

The Safety Plan Intervention (SPI; Stanley & Brown, 2011) is a brief 20 to 45 minute intervention that provides an individual with a set of steps that can be used progressively to attempt to reduce risk and maintain safety when suicidal thoughts emerge. SPI should follow a comprehensive risk assessment after strong rapport has been developed. Safety plans should be developed within a collaborative process among a provider (including peer providers), the individual at risk, and his or her close family or friends. Safety planning can be a stand-alone intervention, utilized during crisis contacts (e.g., in emergency departments, mobile crisis contacts) or as a part of an on-going treatment relationship.

The Safety Planning Intervention includes the following **core components**, each of which is documented in the individual's plan:

- Recognizing warning signs of an imminent suicidal crisis, i.e. changes in mood, thoughts or behaviors.

- Utilizing internal coping skills that can help reduce distress;
- Using people in the individual's support network as a means of distraction from suicidal thoughts;
- Reaching out to family or friends to help manage the crisis;
- Contacting mental health professionals or emergency contacts (i.e. hotlines); and
- Reducing access to potential lethal means.

Training and Resources for the Safety Planning Intervention

Training. All individuals who will conduct safety planning with individuals at risk should be trained and competent in the intervention. Several resources are available to support staff training. An introductory training on SPI, lasting about 30 minutes, can be found on the Zero Suicide website. The training includes the rationale for the model, the core components, and a video example of Dr. Stanley intervening with a mock individual.

Additional training in safety planning is recommended and information on training resources is available at http://www.suicidesafetyplan.com/Training.html. The Department of State Health Services has also supported the development of in-state trainers in SPI. A list of regional trainers is available from Jenna Heise at Jenna.Heise@dshs.state.tx.us. The workshop training is 4 hours in length and consists of both didactic learning and role playing of safety planning steps to provide additional opportunities for practice and feedback. Follow-up coaching is recommended to assist providers learning the model to receive feedback on skills development and have an opportunity to bring questions and challenges to the trainer or their colleagues.

Manuals. Two documents detailing the safety planning intervention can be helpful for further information:

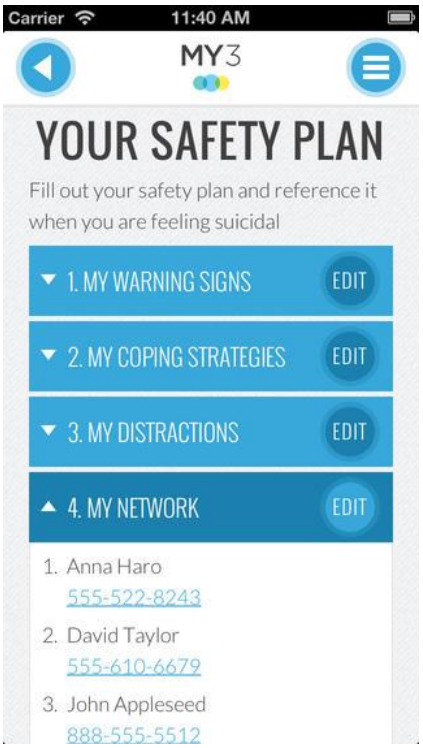
- A general description can be found at Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264. It can be access here - http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog__Beh_Practice.pdf
- A Safety Planning manual can be accessed through the Safety Planning website at http://www.suicidesafetyplan.com/Page_8.html
- A brief Safety Planning Guide for Clinicians is included in Appendix F.

Template. A template to support documentation of safety planning is included in Appendix G or can be accessed from http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf .

Mobile Apps. Two mobile applications have been developed to support SPI. Individuals at risk can utilize one of these applications to keep their safety plan in a convenient location (phone or mobile device), readily available for consultation if suicidal thoughts occur. Providers should ensure that safety plans are documented on paper first and provided to the individual and/or their loved ones. Both applications can be downloaded free from iTunes or GooglePlay.

Safety Plan

MY3



Fidelity to the Safety Planning Model

To ensure that SPI is being implemented with fidelity to the best practice model, a fidelity instrument has been developed by Drs. Stanley and Brown. The Texas Department of State Health Services has supported the training of a team of raters of SPI fidelity. Centers may submit a sample of audio or videotapes of safety planning interventions for review by fidelity raters. Following the analysis of ratings, a feedback report will be provided to leadership at the center. Analysis of SPI fidelity will be one component of the review for designation as a Suicide Safe Care Center. Please contact Jenna Heise at Jenna.Heise@dshs.state.tx.us to discuss the process for obtaining feedback on your agency's fidelity to the SPI model.

Counseling on Lethal Means Restrictions

A critical component of safety planning is counseling individuals at risk and their loved ones to limit access to lethal means. Research has shown that reducing access to lethal means can be an effective prevention strategy because many suicide attempts are impulsive acts undertake as a reaction to a short-term crisis. The best practice – Counseling on Access to Lethal Means (CALM) – was developed by Elaine Frank and Mark Ciocca. In CALM, the provider learns how to ask individuals and their families about their access to lethal means and to develop a plan to reduce access, particularly around firearms and medication.

A free, web-based training is available from the Suicide Prevention Resource Center at http://training.sprc.org/course/description.php - course3. The training requires approximately two hours to complete and includes didactic information and video-based examples of counseling interventions. All staff responsible for safety planning should complete this online training or a live training from a certified training provider. The developers offer master trainer certification if agencies prefer to provide face-to-face training.

Resources to Support Means Restriction

Safety planning frequently occurs during a time of crisis for families and families report it can be challenging to comprehend all of the information provided. In addition to written documentation of the collaborative safety plan, individuals and their family can benefit from written educational materials on supporting an individual at suicide risk. Agencies should identify preferred materials based on the identified audience for the information and have materials readily available.

Options for Family Educational Materials

- Reducing the Risk: Ways to Help During a Crisis – this brochure was developed as a part of the ZEST initiative and is available in Appendix G.
- Means Matter: Recommendations for Families – this brochure provides practical strategies for families on securing medication and firearms; it can be found at http://cdn1.sph.harvard.edu/wp-content/uploads/sites/127/2012/09/recommendations_for_families.pdf
- After a Suicide Attempt: A Guide for Taking Care of Yourself After Treatment in the Emergency Department (NAMI/SAMSHA) is available at https://store.samhsa.gov/shin/content/SMA08-4355/SMA08-4355.pdf
- After a Suicide Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department (NAMI/SAMSHA) is available at https://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf
- Suicide Safe Homes mobile application – this application is receiving its final approval and will become available soon

Moving Beyond – Community Expansion

The agency can provide leadership within the community by extending the use of the Safety Planning Intervention to other health care providers within the community through training and consultation. Suggested targets for training are emergency departments, crisis providers, and behavioral health providers. The organization may also provide leadership by partnering with community organizations and/or coalitions to provide education around reducing access to lethal means within the community. This may include providing gun locks at local events, collaborating with gun dealerships to display or disseminate suicide prevention materials, supporting the placement of barriers at high risk locations, or other community-led efforts. Information on community strategies for reducing access to lethal means is available from the Harvard Means Matter Campaign at http://www.hsph.harvard.edu/means-matter/

References

Rudd, M. D. (2006). *The assessment and management of suicidality.* Sarasota, FL: Professional Resource Press.

Rudd, M. D., Mandrusiak, M., & Joiner Jr, T. E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of clinical psychology*, *62*(2), 243-251.

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Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. American Psychological Association.