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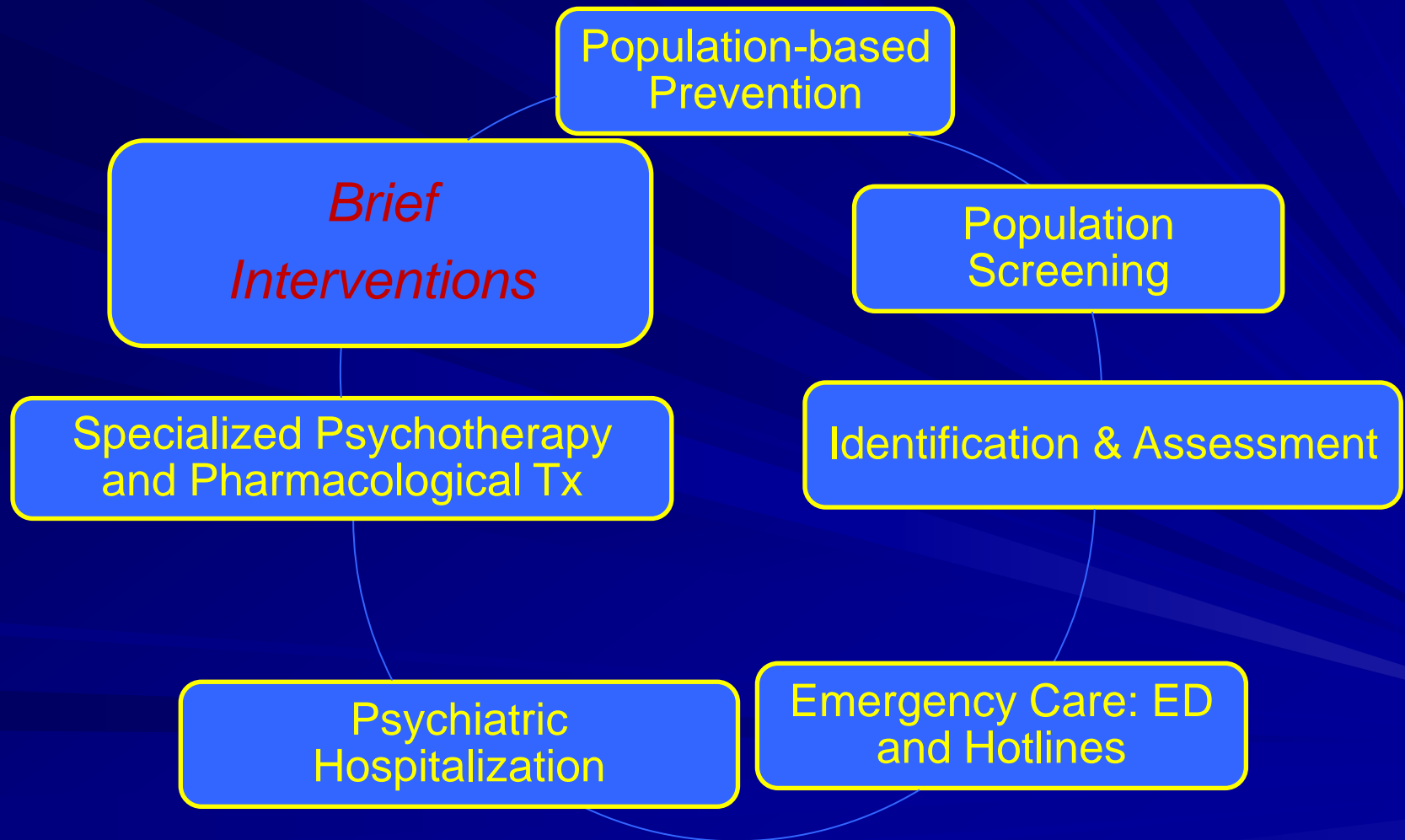
The Safety Planning Intervention and Other Brief Interventions to Mitigate Risk with Suicidal Individuals

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Suicide Prevention Components



Characteristics of Brief Suicide Interventions

- Goals: 1. to prevent suicidal behavior; 2. to increase suicide-related coping; 3. to decrease ideation; 4. to enhance treatment engagement
- Distinguished from crisis interventions which aim to defuse the current crisis
- Brief Interventions range from single session to multiple sessions
- Variety of intervention approaches:

Psychoeducation

Crisis response planning

Single session cognitive behavior therapy

Motivational interviewing/treatment engagement

Outreach follow-up: Letters, postcards, phone calls

Combination of these approaches

Rationale for Brief Interventions:

1. Problem with Treatment Refusal

- Ongoing outpatient treatment is not for everyone--- “Been there, done that.”
“Stigma.” “Not my cup of tea.”
“Inaccessible.”
- Males less likely to seek/accept help; more likely to commit suicide

Rationale for Brief Interventions:

2. Problem with Treatment Engagement

- At risk patients are difficult to engage in outpatient psychotherapy (Lizardi & Stanley, 2010; Trusz, et al., 2011)
- 11-50% of attempters refuse or drop out of outpatient therapy quickly (Kurz & Moller, 1984)
- Adolescents and young adults tend to have attitudes that are inconsistent with long term therapy:
 - “The past is the past. It won’t reoccur.”
 - When mood improves, it’s hard for them to imagine that it could worsen again

Rationale for Brief Interventions:

3. Problem with Treatment Retention

- Up to 60% of suicide attempters ≤ 1 week of treatment post ED discharge (Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995; Trautman et al., 1993; Taylor & Stansfield, 1984)
- Of those who do attend treatment, 3 months after hospitalization for an attempt, 38% have stopped outpatient treatment (Monti et al., 2003)
- After a year, 73% of attempters will no longer be in any treatment (Kruee & Hales 1988)

Rationale for Brief Interventions:

4. Current Treatments Have Not Decreased Suicide Rates

- We have empirically supported psychotherapies but the rate of suicide has not decreased (WISQARS, 2012)
- Limited availability; Limited efficacy

Rationale for Brief Interventions:

5. 'Accessibility' and Low Cost

- Sentinel event/teachable moment opportunity (Boudreaux, 2012)--- teachable moment is often best demonstrated with a significant emotional or traumatic event, emphasis on the 'moment'
- Strike while the iron is hot
- LOW cost, LOW (but not no) burden, easy to implement individually and ***system-wide (AIM)***; easy to train
- Missing spoke in the suicide prevention process
- Therefore, it's important to intervene whenever suicidal individuals are accessible and most in danger

Treating depression is important
but developing strategies to cope
with suicidal urges is also crucial.



At the same time, it's important to not expect too much from brief interventions.

They should be considered one aspect of suicide prevention, e.g. cholesterol lower drugs for cardiac disease.



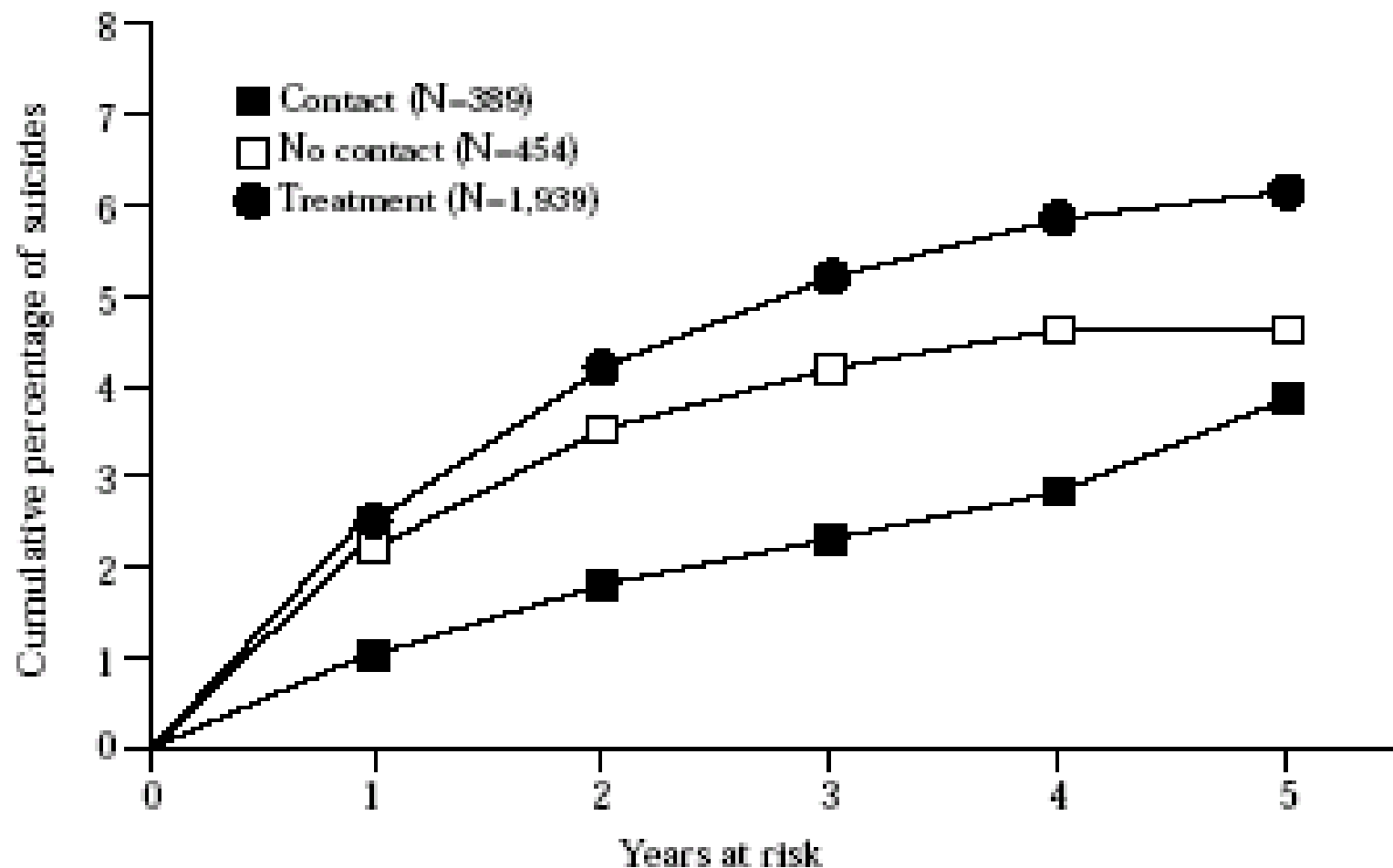
Contact Letter Intervention

Sent every 1-4 months over 5 year period

Dear *Patient's Name*:

“It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you.”

Cumulative Percentage of Suicides



Source: Motto & Bostrom, 2001

WHO/EURO Multicentre Study on Suicidal Behaviour (SUPRE-MISS)

- Brief intervention and contact for patients recruited from emergency departments was effective in reducing subsequent suicide mortality among suicide attempters in low and middle-income countries.

Study Intervention: Brief Intervention & Contact

- 1-hour individual information session
 - suicidal behavior as a sign of psychological and/or social distress
 - risk and protective factors
 - basic epidemiology
 - alternatives to suicidal behaviors
 - referral options (referred as clinically appropriate)
- 9 follow-up contacts (phone calls or visits, as appropriate)
- Compared with TAU

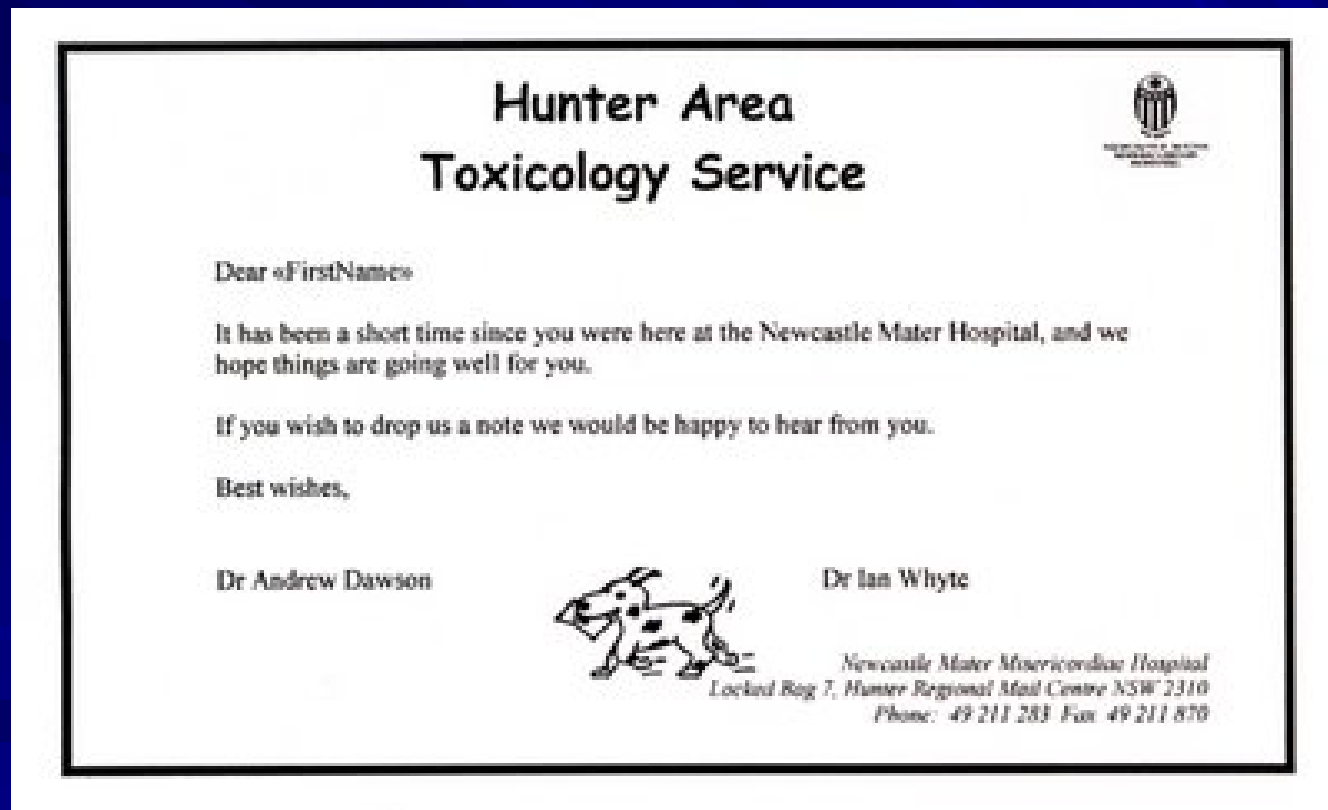
Fleischmann et al., 2008

Mortality at 18-month Follow-up

Status	TAU <i>N</i> = 827		BIC <i>N</i> = 872		χ^2	<i>P</i> -value
	(<i>n</i>)	(%)	(<i>n</i>)	(%)		
Died of any cause	22	2.7	11	1.3	4.36	0.037
Died by suicide	18	2.2	2	0.2	13.83	< 0.001

Fleischmann et al., 2008

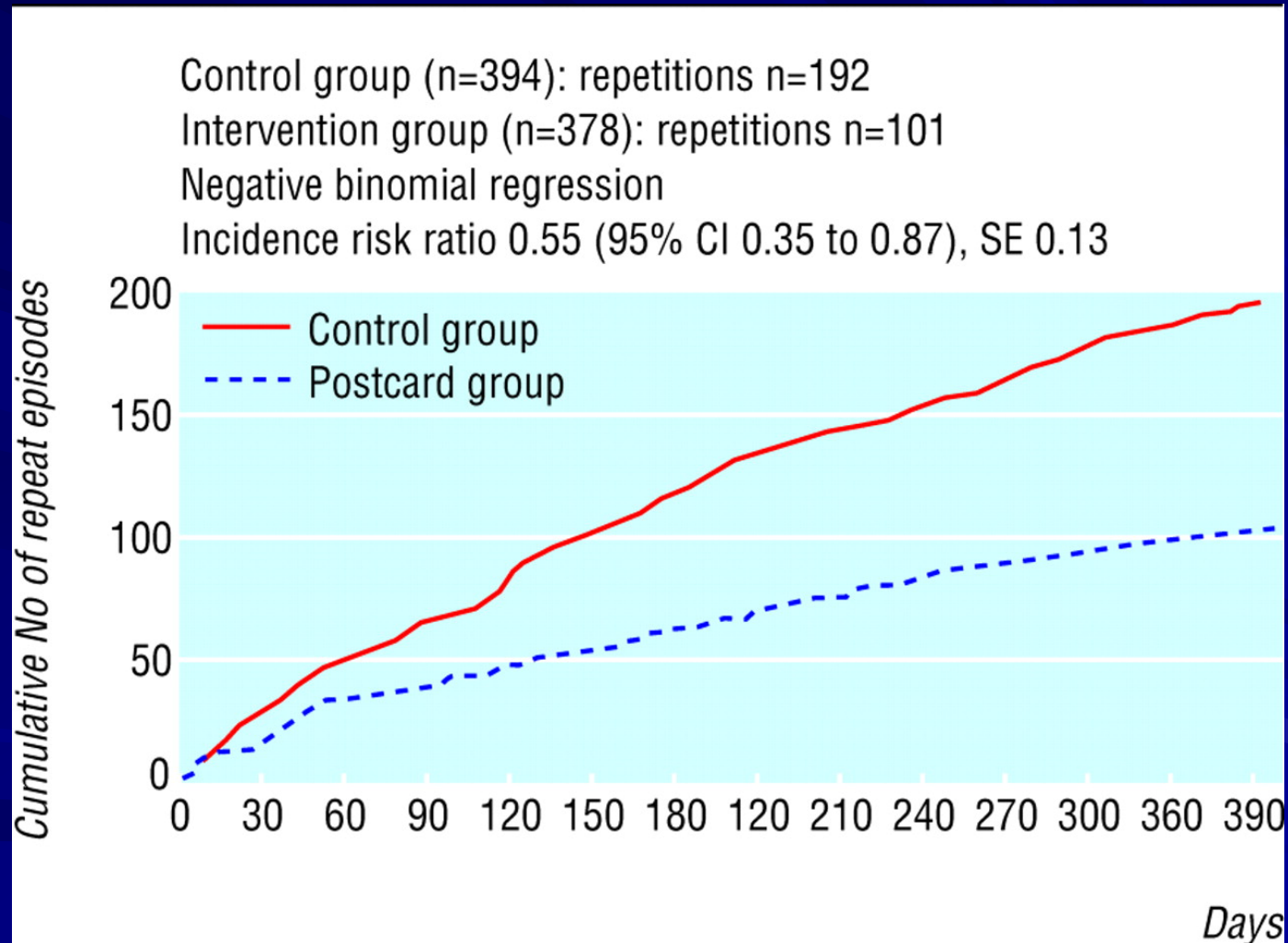
Postcards from the EDge



Postcards from the EDge

- Recruited patients from a regional toxicology unit who had presented to emergency departments in New South Wales, Australia.
- All patients had sought an evaluation following an intentional self-poisoning (overdose).
- Sent 8 non-demanding postcards to patients (in sealed envelopes) over a 12-month period following discharge.

Cumulative # of Repeat Episodes of Hospital-Treated Deliberate Self Poisoning: Reduced # episodes; not individuals; Effect in females not males



Carter, G. L et al. BMJ 2005;331:805

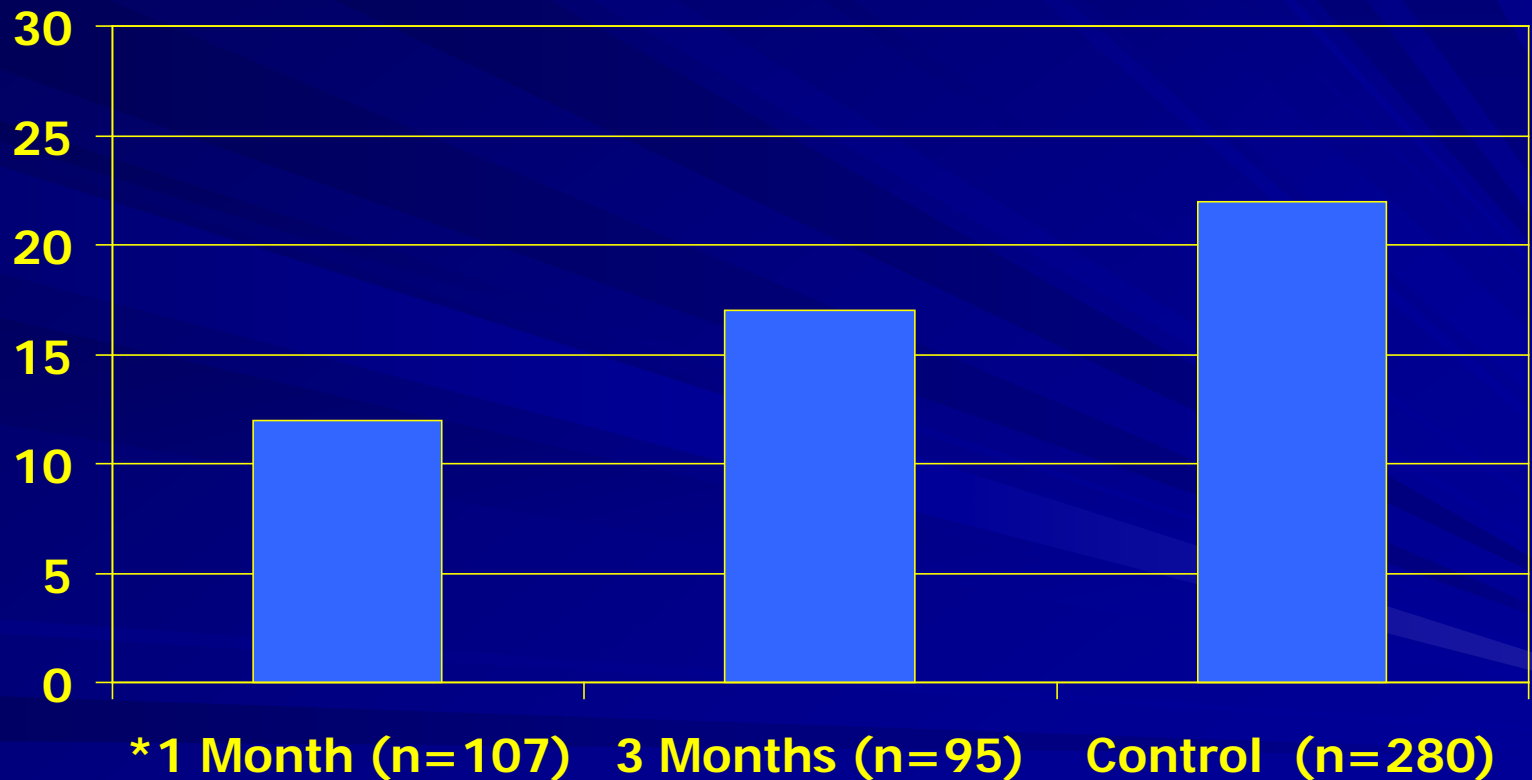
Telephone Contact for Patients Discharged from the ED

- To determine the effects over one year of contacting patients by telephone one month or three months after being discharged from an emergency department for deliberate self poisoning compared with usual treatment.
- 13 EDs in the northern part of France

Telephone Contact Intervention

- Psychiatrists with at least 5 years of experience in managing suicidal crises telephoned the participants.
- Reviewed treatment recommended in the ED. If treatment was difficult to follow a new one was suggested or referred back to the ED if they were at high risk.
- A supportive approach was used based on empathy, reassurance, explanation, and suggestion.
- Participants' general practitioners were given details of the telephone contact and its conclusions.

Proportion of Patients who Re-Attempted Suicide during the 13 month Follow-up



* $p = .03$; Intent-to-Treat Results not significant. Vaiva et al., 2006

Vaiva et al. Ongoing Study

Three Components: Crisis cards, Telephone Follow-up, Postcards

CARTE RESSOURCES

Téléphone disponible 24h/24

03.20.44.42.15

Programme ALGES

N° d'urgence : Samu 15

Sites Internet utiles

www.sos-suicide-phenix.org
www.suicide-ecoute.fr
www.info-depression.fr
www.sos-amitie.org

GEFS
GROUPEMENT D'ETUDES ET DE PREVENTION DU SUICIDE





Bonjour Véronique,

Cette petite carte en espérant que les choses continuent d'aller mieux pour vous.

Sinon, nous vous rappelons nos coordonnées :

Pr Michel WALTER

Urgences psychiatriques
Hôpital La Cavale Blanche
CHRU de Brest
29609 BREST Cedex
Téléphone : 02.98.34.74.66

Programme ALGES

Hello !...

Philippe,

Nous vous avons accueilli il y a peu de temps et nous espérons que les choses vont mieux pour vous.

Si vous voulez nous adresser un petit mot, nous serions heureux d'avoir de vos nouvelles.

Très cordialement,

Pr Guillaume VAIVA

Centre d'Accueil et de Crise
Hôpital Fontan
CHRU de Lille
59037 LILLE Cedex
Téléphone : 03.20.44.42.15

Programme ALGES



Enhanced Personal Follow-up Contact: Mixed Findings

- Allard (1992) Intensive intervention and outreach vs. usual care; 3 suicides in intensive intervention; 1 suicide in control group
- Welu (1977) In home follow up for 4 months with add'l therapies as needed reduced self inflicted injury
- van Heeringen et al. (1995) Outreach to patients after missed appointment was helpful
- Chowdhury et al. (1973) Home visits vs. usual care did not diminish self injury

DBT in the ED

- Sneed et al. 2003---Case reports demonstrating usefulness of DBT strategies to increase engagement in outpatient care by chronically suicidal, high ED utilizers

Safety Planning Intervention (SPI)

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graph TD; A[Safety Planning Intervention (SPI)] --> B[To reduce suicide risk and enhance coping]; A --> C[To increase treatment motivation and enhance linkage];
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To reduce suicide risk
and enhance coping

To increase
treatment motivation
and enhance linkage

Origin of Safety Planning Intervention

(Stanley & Brown, 2008; 2012)

- To maintain safety of high risk patients in outpatient treatment trials (Penn CT study for adults; TASA study for suicidal adolescents)
- Compilation and ordering of evidenced-based suicide interventions
- Expanded and modified as a stand alone intervention for the VA and in civilian Eds
- This one type of SP—others in ASIST and Jobes CAMS

Safety Planning Evidence Base

- Incorporates elements of four evidence-based suicide risk reduction strategies:
 - means restriction
 - teaching brief problem solving and coping skills (including distraction)
 - enhancing social support and identifying emergency contacts, and
 - motivational enhancement for further treatment.

Target Population for Safety Planning Intervention

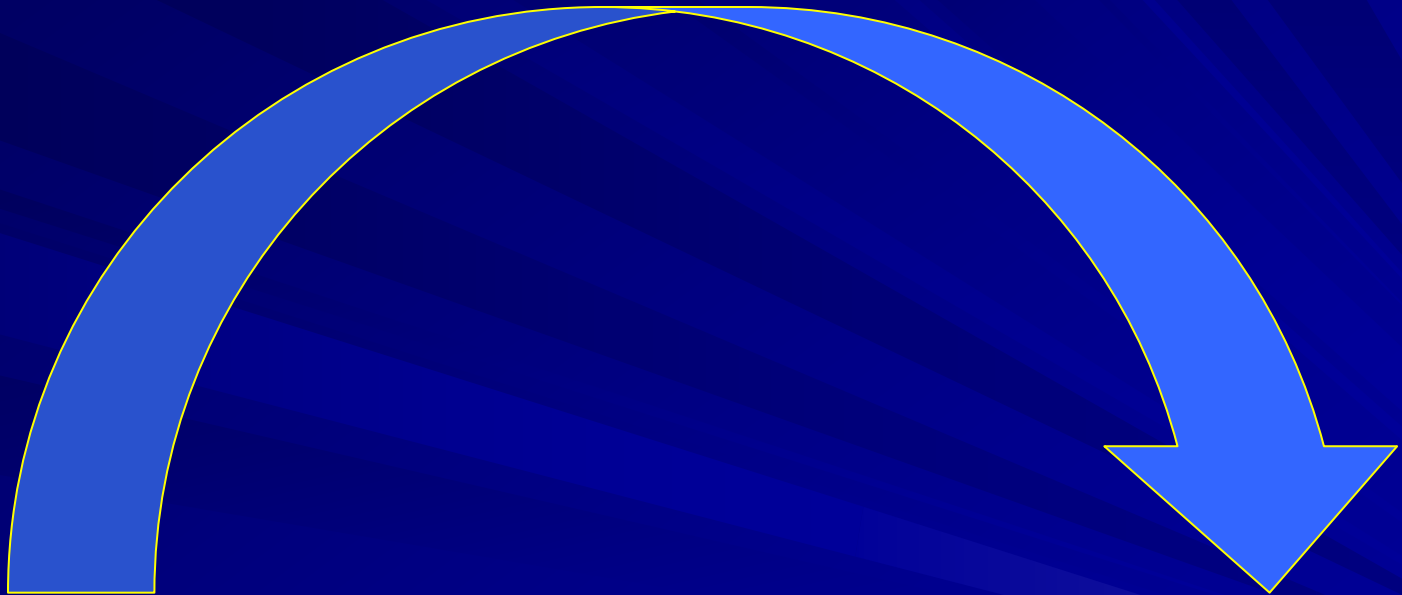
- Individuals at increased risk but not requiring immediate rescue (e.g. on phone can't report that they won't act on SI)
- Patients who have...
 - made a suicide attempt
 - suicide ideation particularly those in the moderate to high risk range
 - psychiatric disorders that increase suicide risk
 - otherwise been determined to be at risk for suicide

'Theoretical' Approaches Underlying SPI

Three theoretical perspectives:

1. Suicide risk fluctuates over time (e.g., Diathesis-Stress Model of Suicidal Behavior, Mann et al., 1999)
2. Problem solving capacity diminishes during crises---over-practicing and a specific template enhances coping (e.g. Stop-Drop-Roll)
3. Cognitive behavioral approaches to behavior change (Emphasize on behavioral)
 - Behavioral strategies to identify individual stressors that have precipitated suicidal behavior in the past.
 - Therapist and patient collaborate to determine cognitive-behavioral strategies patient can use to manage suicidal crises.

Suicide Risk Curve: SPI used to prevent risk from rising too high



Safety Planning Intervention Overview

- Prioritized written list of coping strategies and resources for use during a suicidal crisis.
- Helps provide a sense of control.
- Uses a brief, easy-to-read format that uses the patient's own words.
- Can serve to motivate people to engage in treatment if the plan is found to be useful.
- Can be used as a single session intervention or incorporated into ongoing treatment

SPI Rationale

- Development and implementation of a safety plan is considered treatment
- Helps to immediately enhance patients' sense of self-control over suicidal urges and thoughts
- Conveys a feeling that they can “survive” suicidal feelings
- Similar to rationale for a fire drill or rehearsal

Safety Planning Compared to Other Suicide Interventions

- Safety Planning differs from other suicide interventions:
 - readily accessible to patients and professionals
 - can be implemented in a single session
 - can likely be administered with a minimum of training by a broad range of clinicians including physicians, psychologists, nurses, social workers and paraprofessionals
 - is appropriate for all patients with suicide-related concerns presenting to urgent care settings

Safety Plan: Overview of Process

- Safety plan includes a hierarchical, step-wise increase in level of intervention from “within self” strategies up to going to psychiatric ER
- Although the plan is stepwise, patients need to know that if one step is unavailable that they don't stop and wait till it is available

Overview of Safety Planning: 6 Hierarchical Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Caveats

- Safety Planning Intervention (SPI) is not designed to substitute for more intensive treatments
- SPI is not the only safety plan tool (e.g. ASIST, CAMS)

Recognizing Warning Signs

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

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

Social Settings Providing Distraction

23%	Bookstore/library/coffee shop
23%	Gym
23%	Shopping
23%	Park
23%	Church
15%	Friend's Home

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

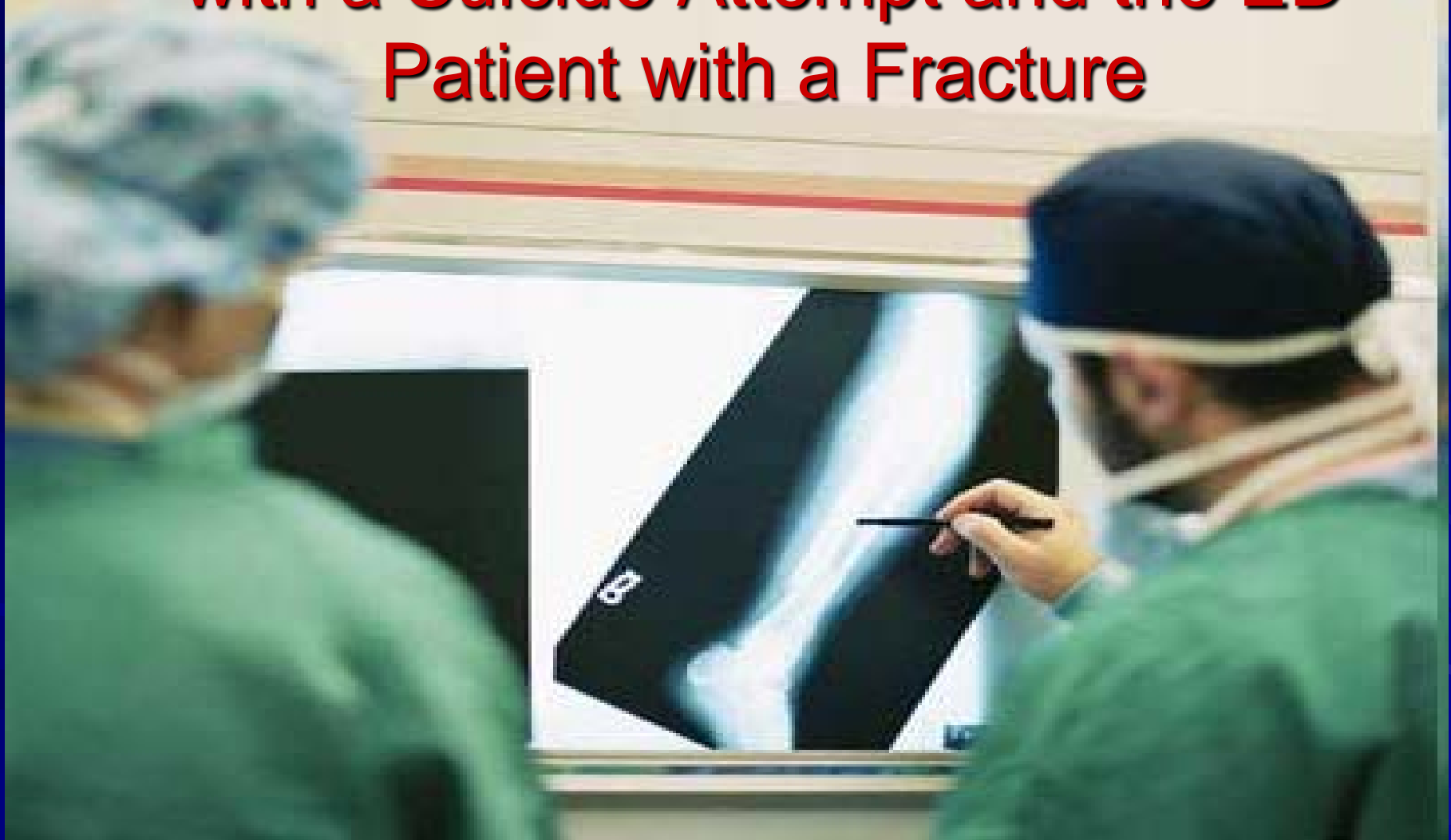
Example: SPI in Urgent Care/ED Settings

- Most suicidal individuals who go to the ED for help attend very few outpatient treatment sessions
- ED visit is a teachable moment
- Therefore, it's important to intervene whenever individuals are accessible

Typical Strategy for Crisis Intervention

- Assess imminent danger
- Refer for treatment
- But, given the limited success of ED referrals, alternative strategies that include immediate intervention ought to be considered
- Crisis contact may be the ONLY contact the suicidal individual has with the mental health system
- May be able to increase its “therapeutic” capacity

Contrast the Urgent Care Patient with a Suicide Attempt and the ED Patient with a Fracture



Patient with apparent fracture

- Diagnose---exam and x ray
- Treat--apply a cast
- Refer for follow-up

SPI as an equivalent intervention for the suicidal patient



SPI as a 'Cast' for the Suicidal

- Safety Planning Intervention is the equivalent of putting a cast on a broken limb
- Provides immediate intervention to those who do not need require inpatient hospitalization
- Fills the gap between emergency room discharge and follow up treatment

Initial SPI Findings

Comparison of Suicide Ideation for High SI ED Patients: 3 Month Follow-up: SPI < no SPI

	Those Receiving Safety Planning			Comparison Group			Analysis		
	N	Mean/Median	SD	N	Mean/Median	SD	t	df	p
SSI Baseline	15	19.4	5.3	27	19.1	6.1	.		.
SSI Follow-up	15	1.6	2.9	27	6.3	7.8	.		.
SSI Change	15	-17.8	4.8	27	-12.8	8.9	2.4	40	0.02

Effectiveness of SPI

- Interviewed 100 'moderate' risk Veterans who were given the SPI in a VA ED
- Interviewed 3 mo-2 years after ED visit
- All remembered the SPI was done in ED
- All could say where their plan was currently
- 91% felt the safety plan was very helpful in making them feel connected to and cared for at the VA
- High satisfaction with SPI (1-5 Likert-type scale) Satisfaction rating = $1.34 \pm .54$.

SPI Evaluation

- Most Veterans (93%) indicated that they would recommend the interventions to a friend (and 6% had already done so).
- No Veteran thought the safety plan intervention was harmful but 5% felt it was too long, did not target anger enough or found it difficult to use when depressed.

Evaluation by Veteran Users

When asked which aspects of the safety plan were most useful,

- 33.3% internal coping strategies
- 25% sources of social support
- 8.3% recognizing warning signs
- 12% reported that simply having a crisis plan was helpful
- 12% reported that having the safety plan enhanced their sense of self efficacy. For example, one Veteran noted that *“You don't realize what to do when you are in that (suicidal) situation, having planned activities like going to a coffee shop and remembering to breathe are effective.”*

Suicidal Individuals' Reactions

- “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) 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.”
- “How has the safety plan helped me? It has saved my life more than once.”

Current Uses

- VA --- High suicide risk Veterans
ED demonstration project for moderate risk Veterans not requiring hospitalization
- NY State OMH Outpatient Clinics---Standard of Care
http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- Crisis Hotlines (NSPL) particularly follow-up calls
- EDs, Inpatient Units, Outpatient Clinics (as initial part of treatment with suicidal patients)
- Identified as a Best Practice on the SPRC-AFSP Registry of Best Practices for Suicide Prevention

Next Steps

- Complete RCT underway at Walter Reed
Outcomes---suicide events and suicide-related coping (new measure)
- Alternative delivery modes---workbook format; SPI groups; interactive mode; peer support
- Expansion of SPI---to include reasons for living/hope kit

Reasons for Living

- Identify Reasons for Living
- Instill a sense of hope
- Construct a Hope Box or Survivor Kit
 - Pictures
 - Letters
 - Poetry
 - Prayer Card
 - Coping Cards



Safety Planning Intervention Resources

- Stanley & Brown, *Cognitive & Behavioral Practice*, April, 2011 epub.
- Safety Planning in the VA (*Stanley & Brown VA Safety Planning Manual*, 2008)
- SPI designated as a *Best Practice* by the SPRC/AFSP Registry of Best for Suicide Prevention
- www.suicidesafetyplan.com
- bhs2@columbia.edu