

SAFETY PLANNING INTERVENTION & MEANS RESTRICTION

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DISCLOSURE

- None

OBJECTIVES

- Review the Stanley Brown safety planning document to be used in the initiative
- Learn about safety planning as an active intervention
- Understand the different steps involved in the safety planning intervention
- Learn how to restrict the ways by which a patient can end their life during a crisis period

SAFETY PLANNING - AS AN INTERVENTION

Major Challenges

1. How can a patient manage a suicidal crisis in the moment that it happens?
2. How can a clinician help the patient do this?

What is Safety Planning?

- A brief clinical intervention
- Follows risk assessment
- A hierarchical and prioritized list of coping strategies and sources of support
- To be used during or preceding a suicidal crisis
- Involves collaboration between the patient and clinician

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen, H.A.). (2008).
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. Retrieved from
<http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf>

"No-Suicide Contracts"

- No-suicide contracts ask patients to promise to stay alive without telling them *how* to stay alive.
- No-suicide contracts may provide a false sense of assurance to the clinician.
- DON'T USE THEM!

No Suicide Contract



SAFETY PLAN: VA VERSION			
Step 1: Warning signs:			
1.	Name _____ Phone _____		
2.	Name _____ Phone _____		
3.	Name _____ Phone _____		
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:			
1.	_____		
2.	_____		
3.	_____		
Step 3: People and social settings that provide distraction:			
1.	Name _____	Phone _____	
2.	Name _____	Phone _____	
3.	Place _____	4. Place _____	
Step 4: People whom I can ask for help:			
1.	Name _____	Phone _____	
2.	Name _____	Phone _____	
3.	Name _____	Phone _____	
Step 5: Professionals or agencies I can contact during a crisis:			
1.	Clinician Name _____	Phone _____	
	Clinician Pager or Emergency Contact # _____	Phone _____	
2.	Clinician Name _____	Phone _____	
	Clinician Pager or Emergency Contact # _____	Phone _____	
3.	Local Urgent Care Services _____	Address _____	
	Urgent Care Services Phone _____		
4.	VA Suicide Prevention Resource Coordinator Name _____	Phone _____	
	VA Suicide Prevention Resource Coordinator Phone _____		
5.	VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician		
Step 6: Making the environment safe:			
1.	_____		
2.	_____		

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Tips for Developing a Safety Plan

- Ways to increase collaboration
 - Sit side-by-side
 - Use a paper form
 - Allow the patient to write
- Brief instructions using the patient's own words
- Easy to read
- Address barriers and use a problem-solving approach

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6 Steps of Safety Planning

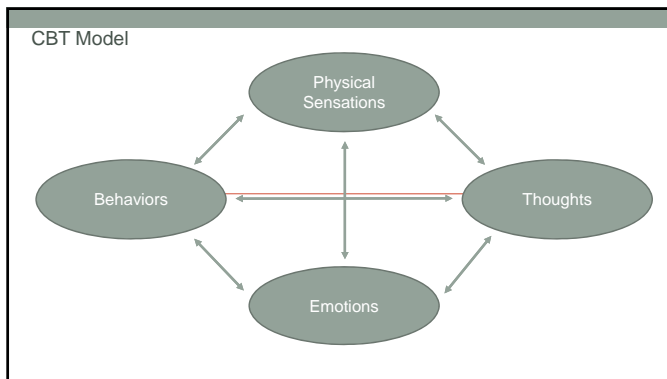
- Step 1: Recognizing Warning Signs
- Step 2: Using Internal Coping Strategies
- Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support
- Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve the Crisis
- Step 5: Contacting Professionals and Agencies
- Step 6: Reducing the Potential for Use of Lethal Means

Step 1: Recognize Warning Signs

- Purpose: To help the patient identify and pay attention to his or her warning signs
- Recognize the signs that immediately precede a suicidal crisis
- Personal situations, thoughts, images, thinking styles, mood or behavior
- "How will you know when the safety plan should be used?"
- Specific and personalized examples

Step 1: Recognizing Warning Signs Examples

- Automatic Thoughts
 - "I am a nobody"
- Images
 - "Flashbacks"
- Mood
 - "Feeling hopeless"
- Behavior
 - "Crying"
 - "Not answering the phone"
 - "Using drugs"



Step 2: Using Internal Coping Strategies

- Purpose: To take the patient's mind off of problems to prevent escalation of suicidal thoughts
 - **NOT** to solve the patient's problems
- List activities the patient can do *without contacting another person*
- This step helps patients see that they can cope with their suicidal thoughts on their own, even if only for a brief period of time
- Examples: Go for a walk, listen to inspirational music, take a hot shower, play with a pet

Step 2: Using Internal Coping Strategies

- Ask "How likely do you think you would be able to do this step during a time of crisis?"
- Ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to address potential roadblocks.

Step 3: People and Social Settings that Provide Distraction

- Purpose: To engage with people and social settings that will provide *distraction*
- Also increases social connection
- The client is not telling someone they are in distress during this step
- Importance of including phone numbers and multiple options
- Avoid listing any controversial relationships

Step 3: Socializing with Family Members or Others

- Ask "Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings."
- Ask "Who do you enjoy socializing with?"
- Ask "Where can you go where you'll have the opportunity to be around people in a safe environment?"
- Ask patients to *list* several people, in case they cannot reach the first person on the list.

Step 4: Contacting Family Members or Friends Who May Offer Help

- Purpose: To explicitly tell a family member or friend that he or she is in crisis and *needs support*
- Can be the same people as Step 3, but different purpose
- If possible, include a family member or friend in the process by sharing the safety plan with them

Step 4: Contacting Family Members or Friends Who May Offer Help

- Coach patients to use Step 4 if Step 3 *does not resolve the crisis* or lower risk.
- Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or
- "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
- Ensure that patient picks someone that would not make a crisis worse

Step 5: Contacting Professionals and Agencies

- Purpose: The client should **contact a professional** if the previous steps do not work to resolve the crisis
- Include name, phone number and location
 - Primary mental health provider
 - Other providers
 - Urgent care or emergency psychiatric services
 - Crisis Text Line – text HOME to 741741
 - National Crisis Hotline 800-273-TALK (8255)
 - 911

MEANS RESTRICTION

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MEANS RESTRICTION

-Restricting the ways (*means*) by which patients may end their life

- Clinician Pager or Emergency Contact # _____
 2. Clinician Name _____ Phone _____
 Clinician Pager or Emergency Contact # _____
 3. Local Urgent Care Services _____
 Urgent Care Services Address _____
 Urgent Care Services Phone _____
 4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____

2. _____

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The one thing that is most important to me and worth living for is: _____

First let's understand what happens in a suicide attempt

- Acute episodes of suicide are generally brief
- Someone suicidal is more likely to pick a method with convenient access
- In general someone suicidal will pick one way of trying to end their life and may not actively pursue another
 - Even when the first method fails
- Removal of the most significant means to end one's life increases survival through intense emotional pain

Reducing the Potential for Use of Lethal Means

- Consider completing this step even if the client has not identified a suicide plan
- Eliminate or limit access to any potential lethal means
- Always ask about access to firearms
- Discuss medications and how they are stored and managed
- Consider alcohol and drugs as a conduit to lethal means

Step 6: Reducing the Potential for Use of Lethal Means

- Ask "What ways do you have access to and are likely to use to try to end your life?"
- Ask "How can we go about developing a plan to **temporarily** limit your access to these means?"
- The clinician should **always** ask whether the client has access to a firearm.

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with *low lethality*, clinicians may ask clients to remove or restrict their access to these methods themselves.
 - For example, if clients are considering overdosing, discuss disposing of unnecessary medication.
 - Can provide copy of patient's county medication disposal guide via Google

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.
 - For example, if clients are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place.

Means Restrictions with gun owners

- Key words: **collaboratively**, and **short term**
- Specify you are not asking them to give up their gun
- You are asking them to temporarily let go of a weapon until the crisis passes
- Working collaboratively and specifying short term leads to better buy in

Duration of Intervention

- Less than 10-15 minutes
- Included as part of Safety Planning Intervention document

Clinical Experiences with Means Restriction

- Usually takes 5-10 minutes
- Patients have by far been willing to follow through

Implementation

- Ask what is the one most important thing to me worth living for
- Assess how likely it is that the patient will use the safety plan
- Problem-solve around any barriers
- Examples of barriers
 - Difficult to reach out to others
 - Don't like the name
- Discuss where the patient will keep the safety plan
 - Multiple copies; wallet-size versions
- Review and update the safety plan frequently

Implementation

- Decide with whom and how to share the safety plan
- Discuss the location of the safety plan
- Discuss how it should be used during a crisis

It's Always About the Relationship

- Be familiar enough with the Safety Planning steps that you don't have to go through it by rote
- Have a conversation with the patient as you develop the plan
- Recognize strengths and skills and help apply those to the safety plan
- Draw on the patient's history, as he or she is telling it, to support the positive side of the ambivalence

Most Suicidal People...

- Do not want to end their lives, they want an end to their psychological pain and suffering
- Tell others that they are thinking about suicide as an option for coping with pain
- Have psychological problems, social problems and limited coping skills – all things mental health professionals are usually well trained to tackle

(Jobs, 2006)

What You Bring to the Relationship

- Degree of comfort in talking about suicide.
- Awareness of the intensity of your own feelings in dealing with suicidal patients.
- Awareness of the role ambivalence is playing.
- Understand and have compassion for the role suicidal thoughts are playing in the person's life.
- Bring options as most suicidal patients are searching for ways to end their pain.
- Familiarity with Warning Signs, Risk and Protective Factors; but don't limit yourself to checklists or algorithms or assessment measures alone.

Bring Hope to the Relationship

"It is clear that the capacity to think about the future with a sense of hope is absolutely protective against suicide. It follows that a sense of hopefulness within our future thinking and key beliefs help us weather the rough spots that we invariably encounter in life. Alternatively, the absence of hopefulness- particularly in the absolute sense of hopelessness- is an extremely pernicious risk factor for suicide.... there is perhaps no single construct that has been more highly correlated with completed suicide than hopelessness".

(Beck, 1986; Brown, Beck, Steer, & Grisham, 2000)

REFERENCES

- Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen. H.A.). (2008).
- *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*. Retrieved from <http://www.sprc.org/library/SafetyPlanTreatmentManualReduceSuicideRiskVeteranVersion.pdf>
- Beck, 1986; Brown, Beck, Steer, & Grisham, 2000
- Jobes, 2006

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