# Safety Planning Intervention:
## Current Evidence Base and Innovations


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# Disclaimer

- **Gregory K. Brown, PhD, Barbara Stanley, PhD, Lisa Brenner, PhD**
  - The presenters have no conflict of interest to disclose.
  - This presentation is based on work supported, in part, by the Department of Veterans Affairs and the Department of Defense, but does not necessarily represent the views of the Department of Veterans Affairs, the Department of Defense or the United States Government.
- **Lisa Brenner, PhD**
  - This work was in part supported by the Military Suicide Research Consortium (MSRC), funded through the Office of the Assistant Secretary of Defense for Health Affairs. Opinions, interpretations, conclusions and recommendations are those of the author and are not necessarily endorsed by the MSRC or the Department of Defense.

# Objectives

1. Discuss the evidence supporting the use of the Safety Planning Intervention to help Veterans manage suicidal crises
2. Describe qualitative data of Veterans' and staff experiences with using the Safety Planning Intervention
3. Discuss the ways in which the Safety Planning Intervention has been adapted or incorporated into other interventions

# Safety Plan Intervention

- 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 individual's own words
- Can be used as a single-session intervention or incorporated into ongoing treatment
- Usually takes 20 to 40 minutes


1. Stanley, B., & Brown, G. K. (with Karlin, B., Kemp, J., von Bergen, H.) (2008*). Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.* Washington, D.C.: United States Department of Veterans Affairs.
2. Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice,* 19: 256–264.

# Safety Plan: 6 Steps

(1) Identify the Warning Signs
"How do I know when to use the Safety Plan?"

(2) Internal coping strategies that could be employed without the assistance of another person

(3) People or social settings that could serve as a distraction

(4) Information for reaching out to friends or family members for help

(5) Information for contacting professionals and agencies

(6) Making the environment safe (i.e., limiting access to lethal means)

Stanley, B. & Brown, G. K. (2008, 2012)

# SAFE VET: VA Clinical Demonstration Project

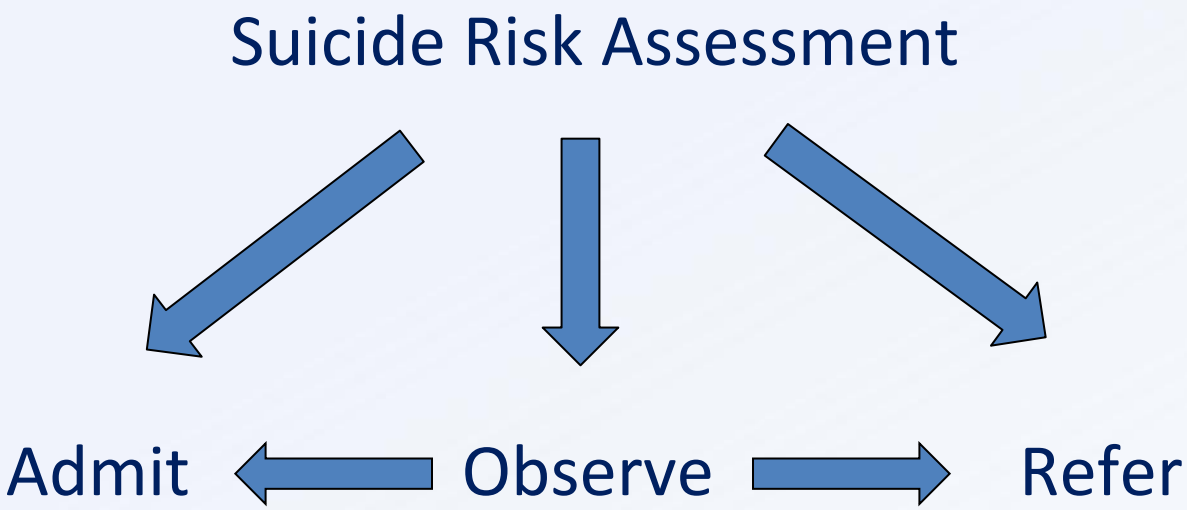
- In 2008, a Blue Ribbon Panel on Veteran Suicide was convened and recommended development and implementation of an Emergency Department (ED)-based intervention for suicidal Veterans who are discharged from the ED

- VA leadership responded to this recommendation and developed a clinical demonstration project:

- Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) project

Knox, K., L., Stanley, B., Currier, G., Brenner, L., Holloway, M., & Brown, G.K. (2012). An emergency department based brief intervention for Veterans at risk for suicide (SAFE VET). American Journal of Public Health. 102 suppl(1): S33-7, 2012

# Traditional ED Strategy



# SAFE VET: Revised ED Strategy

# SAFE VET Intervention

- **Structured Follow up Phone Calls by the project clinician who conducted the Safety Plan Intervention:**
  - Assess suicide risk
  - Review and revise safety plan
  - Remind of upcoming mental health appointments
  - Discuss and problem solve barriers to care
  - Provide additional referrals including rescue if needed
- **Calls were made 72 hours following ED discharge and weekly thereafter until the Veteran was engaged in care**

Knox, K., L., Stanley, B., Currier, G., Brenner, L., Holloway, M., & Brown, G.K. (2012). An emergency department based brief intervention for Veterans at risk for suicide (SAFE VET). *American Journal of Public Health.* 102 suppl(1): S33-7, 2012

# SAFE VET Questions

- **Is the Safety Plan and Structured Follow-up intervention provided by project clinicians at the SAFE VETS sites:**
  - Associated with lower percentage of patients with Suicide Behavior Reports for 6 months following the ED visit than control sites?
  - Associated with greater attendance to at least 1 mental health or substance abuse outpatient visit for 6 months following the ED visit than control sites?
  - Associated with fewer days to the first mental health or substance abuse outpatient visit for 6 months following the ED visit than control sites?

# SAFE VET Project Design

- Selected 5 VA EDs that provided the SAFE VET intervention
- Cohort comparison design: 4 VA EDs that did not provide the SAFE VET intervention and that were matched on:
  - Urban/suburban vs. rural
  - Similar number of psychiatric ED evaluations per year
  - Presence of an inpatient psychiatric unit at the VAMC
- Medical record data was extracted for the 6 months prior to and 6 months following the index ED visit
  - Suicide Behavior Reports
  - Mental Health and Substance Use Services

# SAFE VET Inclusion Criteria

- Sought medical evaluation at a VA ED
- Eligible for VA services
- 18 years of age
- Identified as being at risk for suicide based upon presenting complaints and/or the assessment of an ED clinician
- Discharged from the ED (hospitalized patients were excluded)
- For SAFE VET sites, must have met with SAFE VET project clinician and agreed to receive the SAFE VET intervention

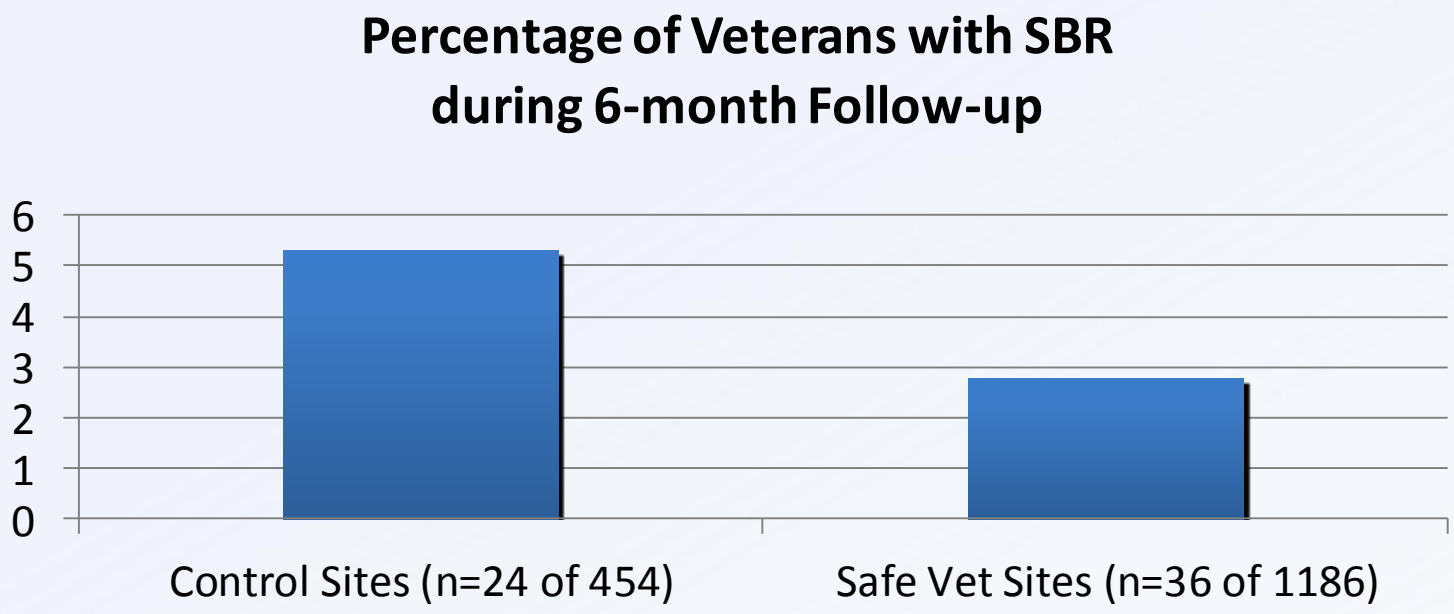
# SAFE VET: Enrollment

- Enrolled **1,186** Veterans at SAFE VET site EDs
  - Portland VA: 237 (20%)
  - Denver VA: 261 (22%)
  - Buffalo VA: 188 (15.9%)
  - Philadelphia VA: 317 (26.7%)
  - Manhattan VA: 183 (15.4%)
- Enrolled **454** Veterans with suicide risk and discharged from ED at Control sites
  - Long Beach VA: 150 (33%)
  - Milwaukee VA: 103 (22.7%)
  - San Diego VA: 77 (17%)
  - Bronx VA: 124 (27.3%)
- Total of **1,640** Veterans

# SAFE VET Services Provided

- Number who received Safety Plan Intervention:
  - SAFE VET Sites: 1,178 (99.3%)
  - Control Sites: 106 (23%)
- Follow-up Weekly Calls Until Engaged in Services
  - Veterans Who Completed at least 1 Call: 1,063 (89.6%)
  - Mean Number of Completed Calls: 3.7 (SD=3.3, Range: 0-26)
  - Mean Number of Attempted Calls but could not contact: 3.4 (SD=3.4, Range: 1-23)
  - Mean Number of Days Between First and Last Completed Call: 43.5 (SD=40, Range: 0-307)

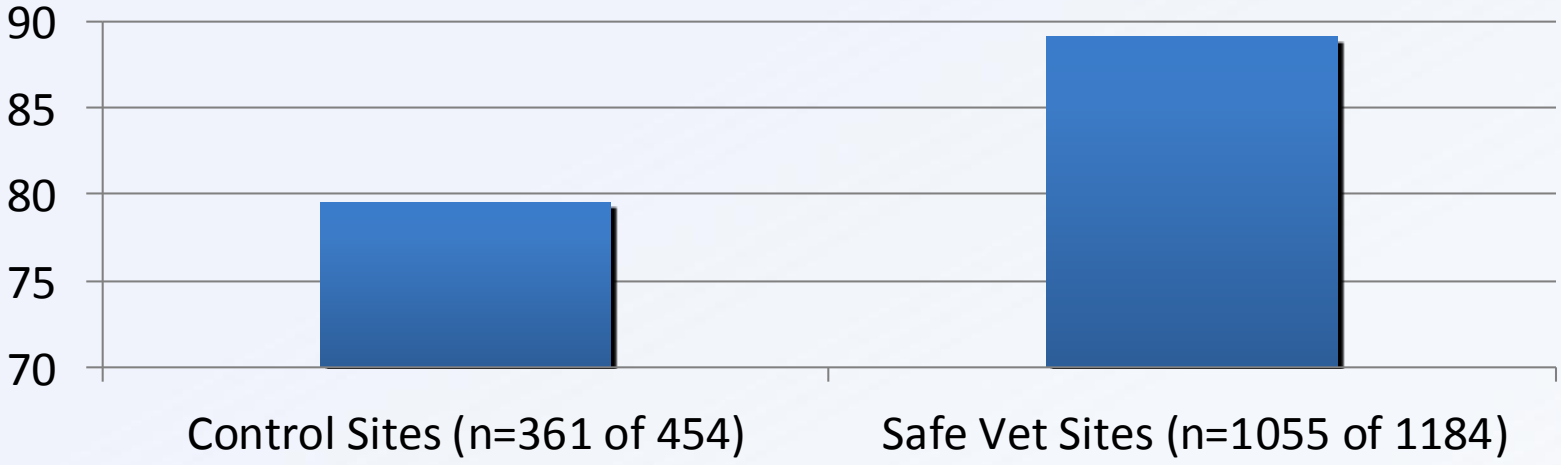
# SAFE VET Suicide Behavior Reports During Follow-up




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

# SAFE VET: Treatment Engagement During Follow-up

**Percentage of Veterans with at least 1 Mental Health or Substance Use Outpatient Session during 6-Month Follow-up**




$\chi 2(1, N = 1638) = 25.76, p < .001$; OR = 2.12, 95% CI: 1.57 - 2.82

# SAFE VET Treatment Engagement During Follow-up

- SAFE VET sites had significantly fewer days to the first attended mental health or substance use outpatient visit than those at Control sites, log-rank $\chi 2 = 23.27$; $p < .001$
  - SAFE VET sites: **39.2** days (95% CI: 35.99-42.38)
  - Control sites: **58.6** days (95% CI: 52.12-65.01).

# SAFE VET: DoD-Funded Research Study

- Aimed to rigorously evaluate the SAFE VET Clinical Demonstration Project
- Enrolled **238** Veterans from the Clinical Demonstration Project
  - SAFE VET ED sites (n = 143)
  - Control ED sites (n = 95)
- Completed research assessments at baseline and 1-, 3-, and 6-months post-baseline

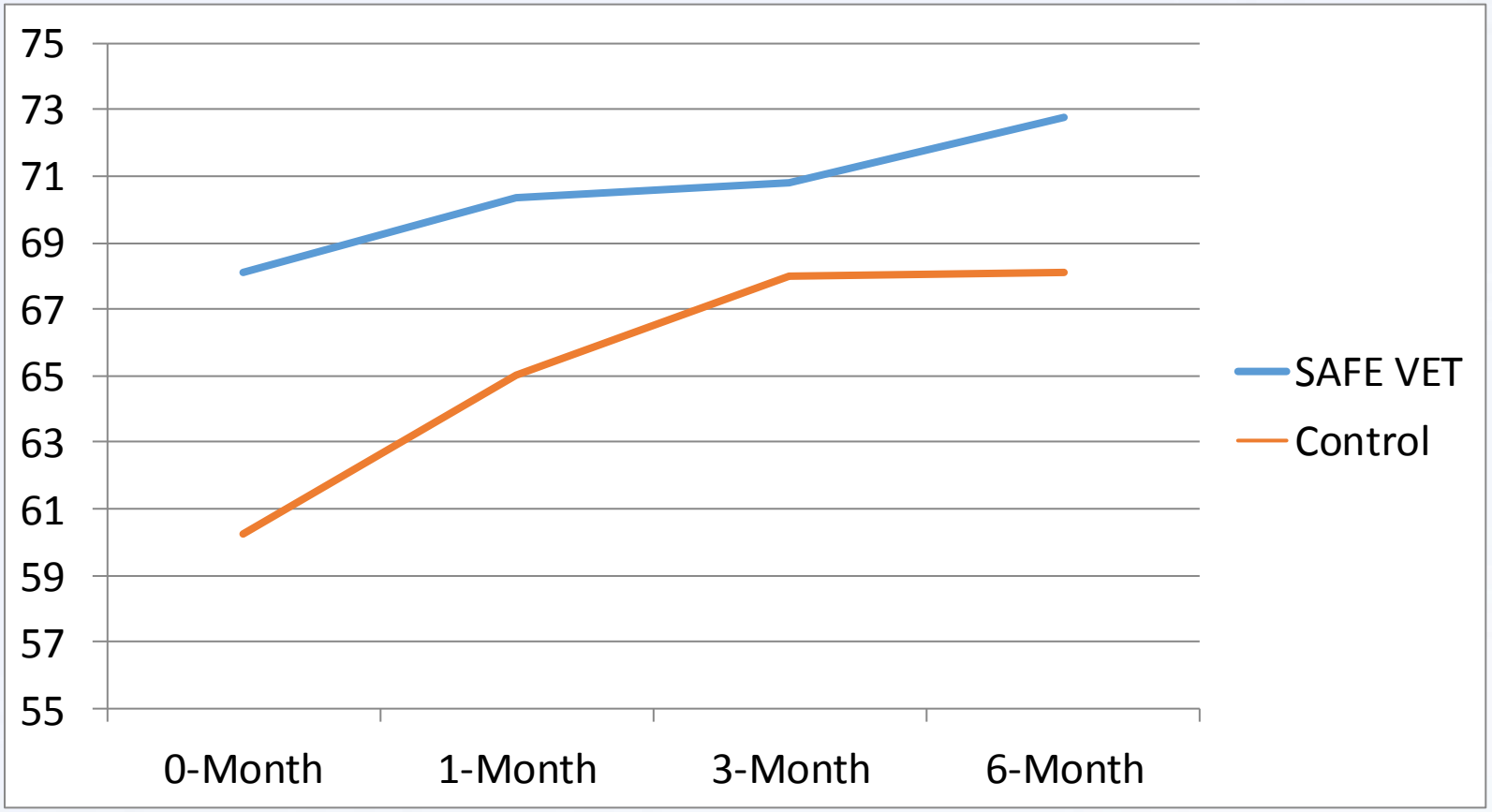
Currier, G. W., Brown, G. K., Brenner, L. A., Chesin, M., Knox, K. L., Holloway, M. G., & Stanley, B. (2015) Rationale and study protocol for a two-part intervention: Safety Planning and Structured Follow-Up among Veterans at risk for suicide and discharged from the emergency department. *Contemporary Clinical Trials*. *43,* 179-184.

# Suicide Related Coping Measure

- Description:
  - 21-item self-report Likert-type scale
  - Item responses range from 0: “Strongly Disagree” to 4: “Strongly Agree”
- Internal Consistency: Cronbach’s alpha = .88
- Factor Structure
  - Factor 1:
    - “When I am suicidal, I know of things to do by myself that help me feel less suicidal.”
    - “I can distract myself by doing other things or thinking about other things when I am feeling suicidal.”
    - “If one way of trying to cope with suicidal feelings does not work, I have other ways to try.”
  - Factor 2:
    - “I know it is important to limit access to weapons or other ways to hurt myself when I am feeling suicidal.”
    - “I recognize the circumstances or people that can make me suicidal.”

Stanley, B., Green, K., Holloway, M., Brenner, L., & Brown, G. K. (2015). Manuscript in preparation.

# Mean Scores on the Suicide Related Coping Measure




Mixed effects regression: Main effect z = 2.95, 95% CI: 1.67, 8.23, p = 0.003
Group by time interaction z = -2.16, 95% CI: -1.32, -0.66, p= .03

Stanley, B., Green, K., Holloway, M., Brenner, L., & Brown, G. K. (2015). Manuscript in preparation.

# SAFE VET Qualitative Study
# Part I: Veteran Interviews

- Conducted a study to determine Veterans experiences with SPI and to assess **feasibility** and **acceptability**
- 100 Veterans who had enrolled in SAFE VET completed a semi-structured interview with a mental health clinician to assess feasibility, acceptability, and effectiveness
- Interviews were transcribed, a coding system developed based on common themes, and frequencies of responses were calculated
- For Safety Plan questions, overall interrater reliability was high, kappa = .81, $p < .001$

Stanley, Chaudhury, Chesin, Pontoski, Bush, Knox & Brown (2015). Psychiatric Services, in press.

# SAFE VET Qualitative Study
# Part I: Veteran Interviews (n=100)

Is the SPI acceptable?

- 100% recalled completing the Safety Plan
- 97% were satisfied with the Safety Plan
- 88% identified its current location
- 61% reported having used the Safety Plan
- For those using the Safety Plan, aspects that were most helpful:
  - 52% social contacts/places for distraction
  - 47% social support for crisis help
  - 45% contacting professionals
  - 27% internal coping strategies

# SAFE VET Qualitative Study
# Part I: Veteran Interviews (n=100)

- 20% reported making changes to the safety plan either on their own or with a professional
- 18% reported choosing not to use it when they needed it:
  - 5% used a strategy not on the safety plan
  - 4% felt too distressed to use it
  - 2% thought it would not help
  - 2% did not want to appear weak

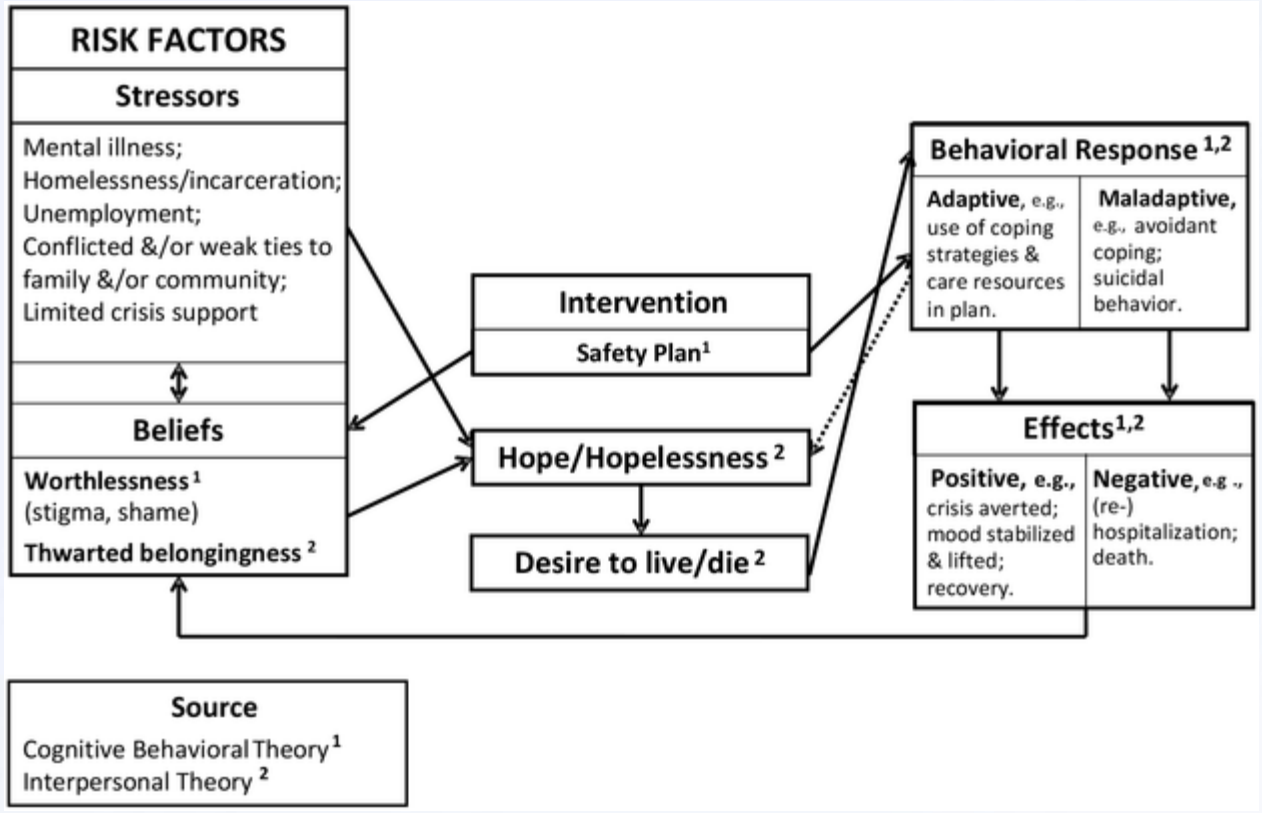
# SAFE VET Qualitative Study: Part II: VA Staff Interviews

- 94% felt SAFE VET was helpful for Veterans and staff
  - 85% reported it increased connection to services
  - 54% reported it decreased suicidal behavior
  - 37% reported it increased Veteran self-efficacy in responding to suicidal crises
  - 80% believed it help to provide support, advocacy and a sense that Veterans were cared for
  - 24% reported it improved comprehensiveness of care
  - 33% thought it helped staff
  - 19% reported increased comfort in discharging at risk Veterans from the ED

Chesin, Stanley, Haigh, Chaudhury, Pontoski, Knox & Brown (2015). Manuscript in preparation.

# Qualitative Study #2: Kayman et al, 2015

## Proposed Model of SPI Mechanism and Interviewed 20 Veterans at baseline and 1 month



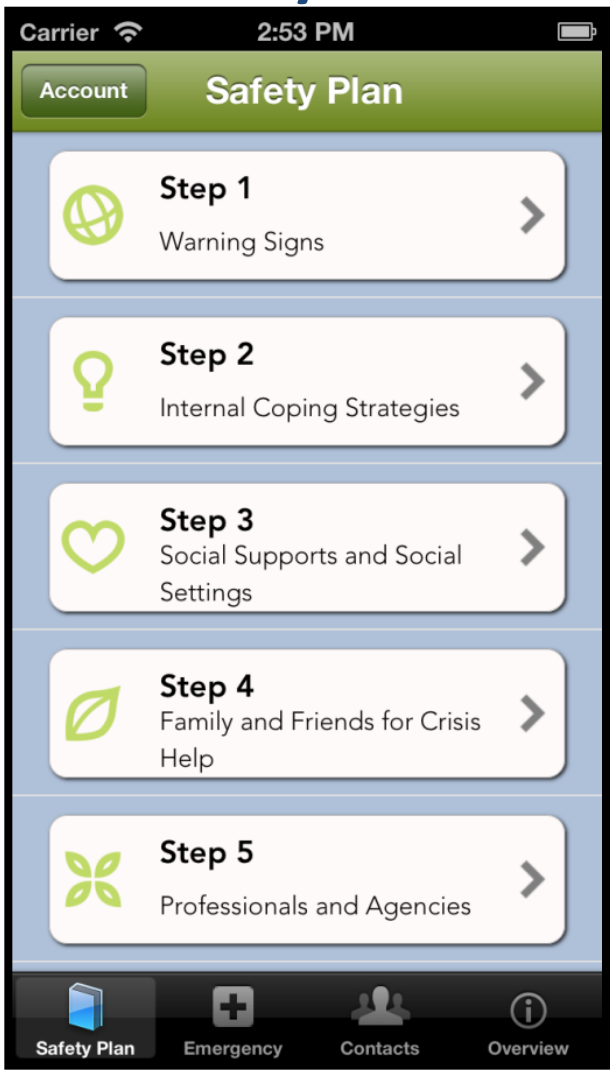

Kayman, D. J., Goldstein, M. F., Dixon, L., & Goodman, M. (2015). Perspectives of suicidal veterans on safety planning: Findings from a pilot study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 36*(5), 371-383. http://dx.doi.org/10.1027/0227-5910/a000348

# Veterans' Perspectives on SPI

| Category | Perspectives elicited |
|---|---|
| Helpful aspects of making plan | Visibility of doctor's concern. |
| | Collaboration with doctor (made veteran feel less alone). |
| Unhelpful aspects of making plan | Thinking, talking, and writing about warning signs (i.e., because these activities stimulate urges toward self-harm). |
| Expectations concerning plan utility | Range of responses: |
| | Positive: Will be good to have hotline and other emergency contact information all in one place, and to have a list of activities that are still enjoyable. |
| | Negative: Doubt that strategies outlined will work; anger at suggestion that such strategies might work; strongly held belief that veteran's doctor is the only person with whom the veteran would want to talk. |
| Reported experience with plan (between baseline and follow-up) | Range of responses from daily use to no use at all and/or loss of hard copy. |
| | Symptom reduction: |
| | Through cognitive reframing: List of enjoyable activities reinforced idea that life is not all bad. |
| | Through success in self-soothing by methods listed on plan. |
| Barriers to use of plan | External: |
| | Sparseness of veteran's social network ("no-one to call"). |
| | Inadequacy and/or inaccessibility of favored strategies and contacts, especially on nights and weekends (most likely crisis times). |
| | Difficulty of keeping track of hard copy. |
| | Lack of privacy in which to read hard copy. |
| | Lack of privacy in which to practice self-soothing strategies listed. |
| | Internal: |
| | Social withdrawal. |
| | Adherence to avoidant style of coping. |
| | Depression-related lethargy, amotivation. |
| | Belief that burden of using plan is too great to carry alone. |
| Facilitators to use of plan | Recall of doctor's wise advice. |
| | Treatment after plan construction. |
| | Discussion of plan at follow-up visits. |
| | Sharing of plan with supportive others, to increase likelihood that they will ask how veteran is feeling and recognize and act on signs of trouble. |
| Ways to improve plan | Maximize individualization of plan. |
| | Offer plan in compact and/or mobile formats. |
| | (See Table 3 for ways to enrich content of each step.) |

Safety Net

# Additions to SPI: Safety Plan Smartphone Mobile App




Barbara Stanley, Ph.D.

Gregory K. Brown, Ph.D.

Sponsors: New York State Office of Mental Health and Columbia University

# Safety Plan Intervention Rating Scale
(Brown & Stanley, 2013)

- **General Safety Plan Intervention Skills for Clinicians**
  - Rationale for Development of a Safety Plan
  - Collaboration and Active Participation
  - Utilizing the Safety Plan
- **Constructing Each Step of the Safety Plan for Clinicians**
  - Identification of Key Warning Signs
  - Internal Coping Strategies
  - Socialization and Social Support Strategies
  - Contacting Family or Friends Who May Offer Help
  - Contacting Professionals and Agencies
  - Making the Environment Safe
  - Location, Barriers and Likelihood of Use
- **Rating of Patient Skills to Understand and Use the Safety Plan** (Ratings: 0,1,2)

# Treatment Development with SPI:
## Mindfulness-based CT for Suicide Prevention (MBCT-S)

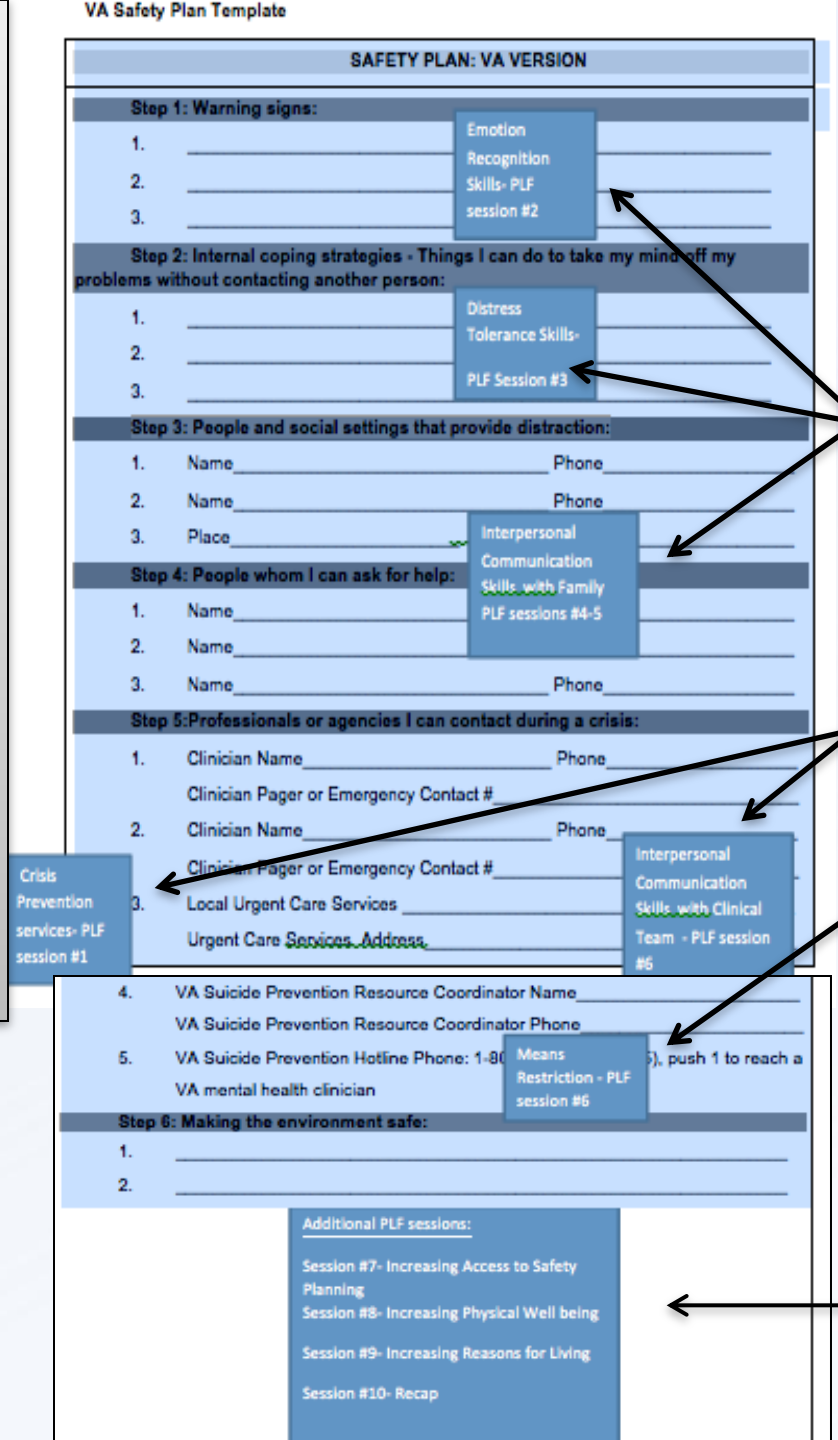
- Developed by Lyons VA group: Interian, Kline, Latorre, Chesin, Stanley (IASR, October, 2015)
- MBCT-S
  - 10 sessions (2 individual sessions + 8 group sessions)
  - 2 individuals sessions
    - Safety Planning Intervention (SPI: Stanley & Brown, 2012)
    - Formulating rationale of mindfulness skills as a coping tool
    - Can be applied during hospitalization
  - 8 group sessions of MBCT with adaptations for Suicide prevention
  - Monthly maintenance group sessions
  - Combination of SPI and MBCT cultivates:
    - immediate skills to cope with emergent crises
    - Longer-term skills to achieve alternative ways of experiencing the mental states that spiral into suicide crises

# Project Life Force: Group Treatment to develop skills for effective use of SPI

- Developed and under testing at the Bronx VA
- Manual drafted
- PI: Marianne Goodman

**Project Life Force:**
**Safety Planning Group Treatment Intervention**

*10 sessions
*Combines emotion regulation skill based, and psychoeducational approaches
* Maximize suicide safety planning development and implementation.


VA Safety Plan Template

SAFETY PLAN: VA VERSION

Step 1: Warning signs:
1. _____
2. _____
3. _____

Emotion Recognition Skills- PLF session #2

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:
1. _____
2. _____
3. _____

Distress Tolerance Skills- PLF Session #3

Step 3: People and social settings that provide distraction:
1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____

Interpersonal Communication Skills with Family PLF sessions #4-5

Step 4: People whom I can ask for help:
1. Name_____
2. Name_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:
1. Clinician Name_____ Phone_____
Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
Urgent Care Services Address_____

Crisis Prevention services- PLF session #1

Interpersonal Communication Skills with Clinical Team - PLF session #6

4. VA Suicide Prevention Resource Coordinator Name_____
VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-80[illegible]), push 1 to reach a VA mental health clinician

Means Restriction - PLF session #6

Step 6: Making the environment safe:
1. _____
2. _____

Additional PLF sessions:

Session #7- Increasing Access to Safety Planning
Session #8- Increasing Physical Well being
Session #9- Increasing Reasons for Living
Session #10- Recap

Outline of "Project Life Force (PLF)" session content corresponding to steps of the safety plan

Additional PLF sessions

Goodman, Perlick, Dixon & Stanley, ISSPD, October, 2015

# Adapting SPI for Violence Prevention: Bullying Prevention Plan

- Safety plan for youth who bully others which aims to prevent future bullying/ cyberbullying behavior
- Targets urges to bully instead of suicidal urges
- Used throughout Israel currently (Klomek, Sourander & Stanley, 2014)

VA | U.S. Department of Veterans Affairs

# Problem Solving: Creating an Action Plan

## An Intervention for Veterans with Moderate to Severe TBI

**Lisa A. Brenner, Ph.D.**

Rocky Mountain Mental Illness, Research, Education and Clinical Center (MIRECC)
University of Colorado, School of Medicine, Department of Psychiatry

ROCKY MOUNTAIN MIRECC

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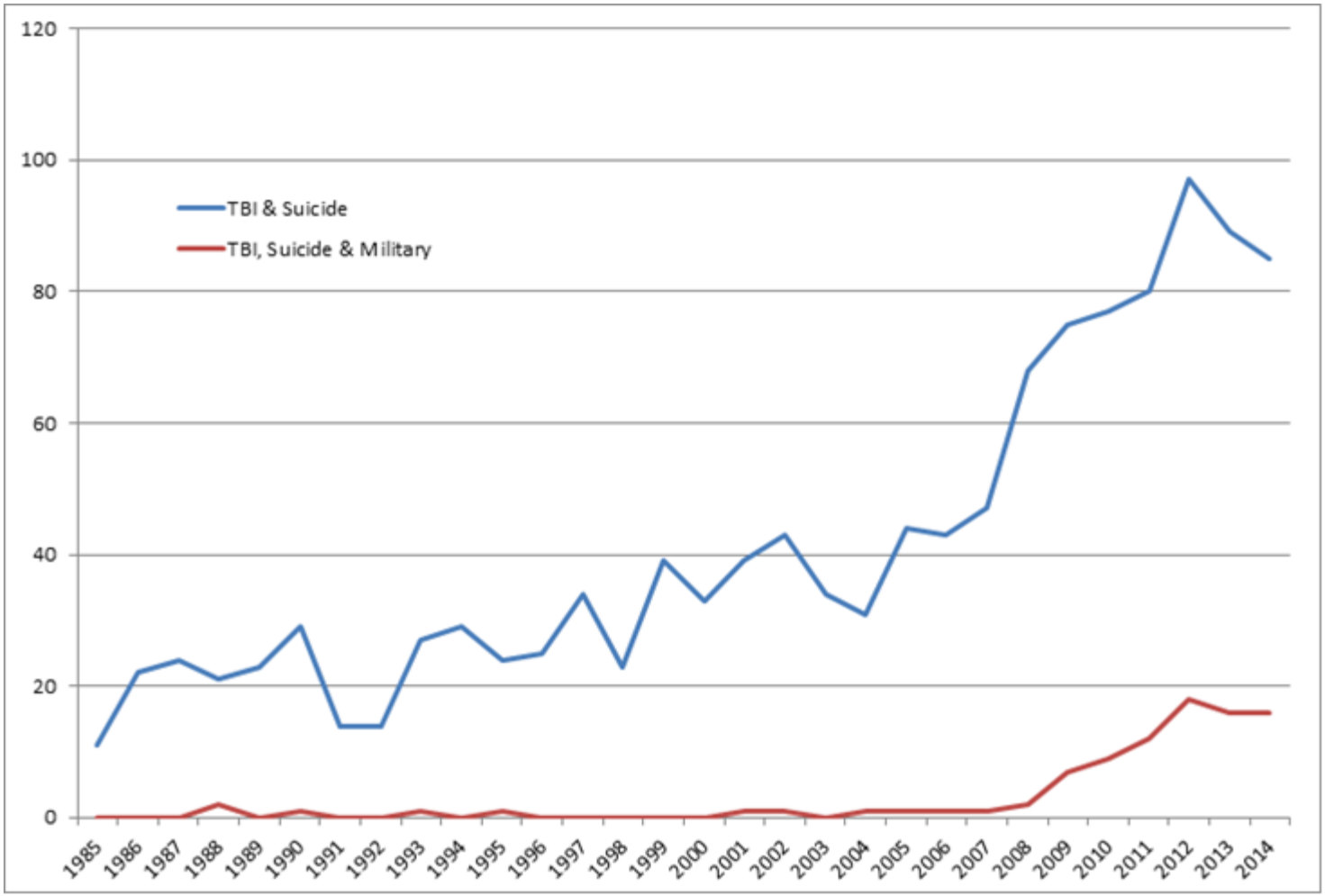
# TBI: Suicide & Military



# Problem Solving:

# Creating an Action Plan

*Veterans' Version*

Lisa Brenner, PhD, ABPP (Rp)

with Beeta Homaifar, PhD

Lindsey Monteith, PhD

Sean Barnes, PhD

Adam Hoffberg, MHS

Georgia Gerard, LCSW

Problem Solving Therapy Strategies

↓

Facilitate Safety Planning (Action Plan)

# Small Groups (2 to 3 Veterans) – 10 Sessions (2 hour)

# Take Home Messages for Today and Everyday

*Session 1 - Introduction to Problem Solving*

- People approach problems differently
- There are specific steps that you can use to solve a problem
  - **A** = **A**ssess
  - **B** = **B**rainstorm
  - **C** = **C**onsider and **C**hoose
  - **D** = **D**evelop a Plan and **D**o it
  - **E** = **E**valuate
  - **F** = **F**ight on!
- **Stress** makes it hard to solve problems
- During a **crisis** is not a good time to solve a problem
- Planning ahead can help you cope with a **crisis**
- Use your **Action Plan** to prevent **Warning Signs** from snowballing into **crises**

*Session 2- Recognizing & Identifying Triggers, Warning Signs & Crises*

- A **crisis** is when we:
  - Feel overwhelmed
  - Feel like everything is spiraling out of control
  - Can't make good decisions
- **Triggers** are things that upset or unsettle us such as:
  - Places/events
  - Things
  - People
- **Triggers** can range from mild to severe
- **Triggers** can lead to **Warning Signs**
- **Warning Signs** are thoughts, feelings, physical sensations, and behaviors
- **Warning Signs** can let you know that a **crisis** is on the way

**Session 2:**

**Recognizing & Identifying Triggers, Warning Signs & Crises**

# Take Home Messages for Today and Everyday

*Session 4- PASTA: A Strategy to Help with Triggers & Warning Signs*

- Pause, Aware, Slow Down, Think & Act (PASTA)
- PASTA can help you Pause when you become Aware of a trigger or a warning sign
- Slow Down using slow down techniques, Think & Act—
- PASTA by using your Action Plan before a crisis overwhelms you
- PASTA is something you can do in your daily life to handle everyday stresses
- If you rush to ACT, your opportunity to problem solve is in the PAST
- Use PASTA when you feel triggered

*Session 5- Unhelpful Thinking & Problem Solving*

- Some thoughts are **helpful** and other thoughts are **unhelpful** and can make us feel worse
- **Unhelpful thoughts** can make it hard to problem solve
- **Unhelpful thoughts** can lead to feelings of hopelessness or depression

*Session 6- Thoughts are Thoughts*

- You can:
  - Do things to lessen the impact of **unhelpful thoughts**
  - Do things to come up with more **helpful thoughts**
  - Come up with more helpful ways to think about problems

# Feasibility and Acceptability Data

**Phase I. PST-SP Results**
Demographics of Participants (n=14)

| Demographic and Military (n=14) | n (%) |
|---|---|
| Age- Mean (SD) | 51.9 (14.7) |
| Age-Median (range) | 54.5 (30-72) |
| Gender | |
| Male | 12 (85.7%) |
| Female | 2 (14.3%) |
| Race (n=13) | |
| Caucasian | 11 (84.6%) |
| Other | 2 (15.4%) |
| Marital Status | |
| Married | 6 (42.9%) |
| Single | 5 (35.7%) |
| Divorced/Separated | 3 (21.4%) |
| Education | |
| Some college or associate degree | 7 (50.0%) |
| Bachelor, graduate or professional degree | 7(50.0%) |
| Employment (n=13) | |
| Retired or Not Employed | 9 (69.2%) |
| Unemployed | 4 (30.8%) |
| Student | 2 (14.3%) |
| Branch | |
| Army | 4 (28.6%) |
| Air Force | 6 (42.9%) |
| Navy | 1 (7.1%) |
| Marines | 1 (7.1%) |
| Multiple | 2 (14.3%) |
| Deployed | 10 (71.4%) |
| Combat (n=12) | 4 (33.3%) |
| Mean Months in the Military (n=13) | 96.9 (53.6) |
| Median Months in the Military (n=13) | 104 (20-198) |
| Currently Homeless | 2 (14.3%) |

# Baseline Beck Hopelessness Scale

**Baseline BHS score (n=14)**

| | |
|---|---|
| Mean (SD) | 14.1 (3.1) |
| Median (range) | 14 (9-19) |

# Attendance

**Total Number of Sessions Attended by PST group (n=16)**

| Number of Sessions Attended | n (%) |
|---|---|
| 0 | 2 (12.5%) |
| 3 | 1 (6.3%) |
| 6 | 1 (6.3%) |
| 8 | 1 (6.3%) |
| 9 | 4 (25.0%) |
| 10 | 7 (43.8%) |

# Client Satisfaction

**Post Assessment Client Satisfaction Questionnaire-8 scores (n=13)**

| Item | Anchors | Mean | SD | Median | Range |
|---|---|---|---|---|---|
| Quality of Services | Excellent (4) to Poor (1) | 3.8 | 0.38 | 4.0 | 3-4 |
| Kind of Service | Yes, Definitely (4) to Definitely Not (1) | 3.4 | 0.87 | 4.0 | 1-4 |
| Needs Met | Almost All (4) to None (1) | 3.2 | 0.69 | 3.0 | 2-4 |
| Recommend to Friend | Yes, Definitely (4) to Definitely Not (1) | 3.7 | 0.63 | 4.0 | 2-4 |
| Help Satisfaction | Very Satisfied (4) to Quite Dissatisfied (1) | 3.3 | 1.11 | 4.0 | 1-4 |
| Deal with Problems | Great Deal (4) to Make Things Worse (1) | 3.5 | 0.66 | 4.0 | 2-4 |
| Overall Satisfaction | Very Satisfied (4) to Quite Dissatisfied (1) | 3.3 | 1.11 | 4.0 | 1-4 |
| Return to Program | Yes, Definitely (4) to Definitely Not (1) | 3.7 | 0.63 | 4.0 | 2-4 |
| | Total | 27.8 | 4.78 | 29.0 | 14-32 |

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**Co-Authors and SAFE VET PIs:**

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- Lisa Brenner, Ph.D.
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