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Presente(s)r: Lisa Brenner, Gregory Brown, Barbara Stanley

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Molly: Here we are at the top of the hour, so at this time I would like to introduce our speakers. Joining us today, we have Dr. Lisa Brenner. She’s the Director of the Rocky Mountain Mental Illness Education and Clinical Center and a Professor at the University of Colorado. Joining her today is Dr. Gregory Brown. He’s a Research Associate Professor in the Department of Psychiatry and the Director for the Center for the Prevention of Suicide at the Pearlman School of Medicine of the University of Pennsylvania and Psychologist at VISN 4 Mental Illness Research, Education and Clinical Center. Also joining us today is Dr. Barbara Stanley. She is the Professor of Medical Psychology in the Department of Psychiatry, at Columbia University and Director of Suicide Prevention Training, Implementation & Evaluation at the Center for Practice Innovations at New York State Psychiatric Institute. I’d like to thank all of our presenters for joining us today and at this time, Dr. Brown, can I turn it over to you?

Dr. Brown: Sure thing.

Thank you. Excellent. We’re good to go.

Dr. Brown: Good to go. Thank you everybody. I’m Greg Brown and I’ll be presenting the first part of this Webinar. Thank you everybody for joining and I’m joined my esteemed colleagues, Lisa Brenner and Barbara Stanley who will also be talking.

Just want to mention that we have no conflict of interest to disclose; that this presentation is supported in part by the Department of the Veteran’s Affairs, the Department of Defense, and the Military Suicide Research Consortium. We want to add that our research and comments here do not necessarily the reflect the use of the government or the VA.

We are going to be talking about three objectives. The first is to discuss the empirical evidence supporting the use of safety planning intervention to help veterans manage suicidal crises. The second will describe qualitative data of veterans and staff experiences in using safety planning. The third is we will discuss ways in which safety planning has been adapted or incorporated into other interventions.

As you most of you know the safety plan intervention is a written list of prioritized coping strategies and resources for use during a suicidal crisis. I’m not going to go through the safety planning intervention detail, assuming all of you have been very familiar with it. Although, I will point out the manual that was originally written in 2008 is available at the bottom of the screen, as well as published version of it that Barbara and I published in 2012 in Cognitive Behavioral Practice. The safety planning consists of six steps that generally go from internal to external resources for support, which is described in detail in the manual and in the publication.

There’s a lot of ways we can evaluate safety planning such as has been used throughout the VA and throughout the country. We decided to evaluate safety planning in the Emergency Department (ED) setting, by and large because a lot high-risk patients come through the ED.

In 2008, a blue-ribbon panel of veteran suicide was convened and recommended the development and implementation of the ED-based intervention for suicidal veterans who were discharged from the ED. VA leadership responded to this recommendation and developed a clinical demonstration project called the Suicide Assessment and Follow-up Engagement Veteran Emergency Treatment project or SAFE VET for short, and that is described in a publication by Knox and Colley in 2012. The traditional ED strategy for high-risk patients was to do a suicide assessment and either to admit, observe or discharge and refer the patient for follow-up care. The SAFE VET proposed a revised ED strategy where a brief intervention was conducted after the suicide risk assessment for high-risk patients, and then for those patients who are discharged and subsequently referred, to add a follow-up component until they were engaged in care. This is generally done with patients who would not be deemed to be at such high risk that they would be admitted to the hospital or these are patients who would be in the more moderate risk range and could be safely discharged.

The SAFE VET intervention, in addition to safety planning, also included structured follow-up calls, and these were conducted by a project clinician who also conducted the safety plan intervention in the ED. During these calls, which are about 20 minutes in the length, the clinician would assess suicide risk, review and revise the safety plan if it was used and if it wasn’t used, why not, remind them of upcoming mental health appointments and discuss and problem-solve barriers to attending those appointments, and provide additional referrals if needed including rescue. These calls were made approximately 72 hours following discharge from the ED and weekly thereafter until the veteran was engaged in care.

In SAFE VET project we asked several questions. The prominent ones were: Is the safety plan and structure follow-up intervention provided by project clinicians at the SAFE VET sites associated with a lower percentage of patients with suicide behavior reports for six months following the ED visits than the control sites? Then we also wanted to know whether the SAFE VET intervention was associated with greater attendance to at least one mental health or substance outpatient visit for six months following the ED visit it controls and associated with fewer days to the first mental health or substance abuse appointment it controls.

There were five VA EDs that participated in this project. We used a cohort comparison design, so we selected four VA EDs that did not provide a SAFE VET intervention that were matched on, whether they were urban, suburban versus rural; whether they were similar number in the number of psychiatric ED evaluations for a year; and whether they had an inpatient psychiatric unit available at the VA. We also extracted medical record data for the six months prior and six months post the index ED visit. These mainly included the suicide behavior reports that are available on CPRS as well as mental health and substance use services data.

We included those veterans who sought medical evaluation at a VA ED who were eligible for VA services, who were age 18 years or older, who are identified as being at risk for suicide based upon presenting complaint and/or the assessment of an ED clinician and who were discharged from the ED; that is hospitalized patients were excluded. Then for the SAFE VET site they must have met with the SAFE VET project clinician and agreed to receive the safety plan.

We enrolled 1,186 veterans at the following VA site listed there, you can see. We also enrolled 454 veterans at the control site. You can see there the VAs there that were also in the project. So, we recruited a total of 1,640 veterans. In terms of the data or the results, you can see that the number who received the safety plan intervention was about 99.3% of the patients received the safety plan intervention in the SAFE VET sites, whereas 23% of the veterans received safety plan intervention in the control site.

In terms of the follow-up calls that were made at the SAFE VET sites, almost 90% received at least one follow-up call; had actually engaged a follow-up call. The mean number of calls was 3.7, which ranged from zero calls to 26 calls, and the mean number of attempted calls, but who were not contacted, was 3.4 calls. The mean number of days between the first and last completed call was 43.5 days, and that ranged from zero all the way up to 307 days.

These were major findings for the project that addressed our questions. The percentage of veterans with the suicide behavior report during the six-month follow-up showed a significant difference. We found that people who were at the SAFE VET sites had a significantly lower number of suicide behavior reports than those at the control sites. We found that if you were in the SAFE VET sites, you were about half as likely to have a suicide behavior report than if you were at the control site. It went from about, from the controls about a 5.1%, 5.2% of patients who had a suicide behavior report, to about a 2.8% of veterans who had a suicide behavior report in the control site during the six-month follow-up.

We also looked at the percentage of veterans with at least one mental health or substance use outpatient session during the six-month follow-up. See here that you were about twice as likely to have at least one outpatient session, about 89% did so. They were in the SAFE VET site whereas in the control site it was about 79%. So, this was also a significantly stated difference. This is actually attending the appointment, not having a scheduled appointment.

In terms of how quickly people got into care, the SAFE VET sites have significantly fewer days to the first attended mental health or substance use outpatient visit than the control sites. If you look at the mean number of days to the first appointment, there was 39.2 days for patients who were in the SAFE VET site and 58.6 days for those patients in the control site.

We also had a DOD funded research study to rigorously evaluate the SAFE VET demonstration project. In this project we enrolled a sub-sample of veterans. It shows 238 veterans from the clinical demonstration project from both the SAFE VET ED sites and the control ED sites. These veterans agree to complete research assessments at baseline at one, three and six months post baseline. There’s a detailed description of the study protocol by Courier and Colleagues there in Contemporary Clinical Trials.

As part of this project we did look at suicidal-related coping. This is a newly-developed measure. It’s not new anymore, because we had developed it in 2010, but this is a 21-item self-report Likert scale. We wanted to look at suicide-related coping and we didn’t find a good measure at the time, so we developed our own. These are 21 items that range from zero, strongly disagree, to four, strongly agree; that have a high internal consistency.

When you look at the factor structure we find two factors. The first factor tends to get at more internal coping strategies, or general coping strategies as you can see by the items there, and the second factor was not internal coping strategies, a little more on the external side such as limiting access to weapons or other ways to hurt yourself and being able to recognize the warning signs.

When we look at the mean scores on this measure, we saw a consistently significant difference between the SAFE VET patients and the control patients. This measure was administered after the patients in the SAFE VET site received the safety plan intervention, so it’s not before they received it, so that’s why you’re seeing that difference at month zero. Both groups did increase over time and there was a significant group by time interaction in \_\_\_\_\_[00:13:38]. So what this shows is that suicide coping was different and much higher in the SAFE VET site improved over time and the main facts be protective of subsequent suicide behaviors.

Okay, I’m going to turn it over to Barbara Stanley, who is going to walk us through the qualitative study of SAFE VET.

Barbara Stanley: Good afternoon everybody. So, as part of our SAFE VET project, we conducted a qualitative study of both veterans of who received the intervention and staff who were either present in the ED and who may not have delivered the intervention themselves, but were part of the system which was delivered. We also interviewed the people who ended up doing the delivery of the intervention. We thought that both of these were important to do both the staff and veteran interviews, because especially for the staff interviews, which I’ll talk about in a minute. We were changing practices within the ED and EDs have a set way of practicing and the idea of adding an intervention into the ED system was novel and we had heard in advance that this would be perceived as very burdensome and not very feasible.

First, I’m going to talk a bit about the veteran interviews. What we did was we contacted 100 veterans following participation in SAFE VET to assess the feasibility and acceptability of them. We did a typical kind of transcription and developed decoding system based on common things and looked for frequency of responses. For the safety plan questions, which is what I’m going to be talking about here today, the overall reliability was high.

Next slide. This is just some of the results that we found. This is the manuscript that in press in Psych Services now. Is the safety plan acceptable and feasible? The first thing that we wanted to know is did they recall doing a safety plan. This is not a small question because people are in the ED. There is a lot going on. There are typically under stressful conditions.

We were glad to see that all of the people who we interviewed had, in fact, remembered that they did a safety plan. Almost all of them were satisfied with the safety plan, and in fact, 88% of them could even identify where it was currently. This could be several months to a couple years after having had the intervention. For those that used the safety plan, that 61% who reported having reported used the safety plan. We had a number of people who did the safety plan, knew they did the safety plan, were happy with it, but in fact never had to use it. So 61% said they did use it.

We had them identify what did they think was the most helpful about the safety plan. I have to say this was a little surprising to me. 52% said that the social contacts and places for distraction, in other words, using people and social places as a means of coping and distraction, not actually reaching out for support and telling somebody that you’re in a crisis, was seen as very helpful, by 52% of the people. 47% saw that social support and identifying who those people were for crisis help was helpful. 45% said contacting professionals was helpful. 27% said having internal coping strategies was helpful. You can see that people really thought that knowing the social support network was really very helpful for them and having that in mind.

Next slide. Then we asked people about keeping the safety plan static or changing it and 20% reported making changes to the safety plan either on their own or with a professional. We asked people about using, knowing that they needed to use the safety plan and not using it, and why might that be. 18% said they chose not to use the safety plan when they in fact needed it, and there were just a small number of reasons why. They thought that there was a strategy that was not on the safety plan. They felt too distressed. A very small number. This is one of the concerns we had when we developed the safety plan, and people will have this question for us. Well, will people remember to use the safety plan if they’re upset? Only a very small number felt too distressed to use it. A couple people thought that it wouldn’t help or didn’t want to appear weak, and therefore rely on something outside themselves.

I think that the good news here is that the vast majority of people who felt they needed it, did use it, and that 5% who used the strategy that wasn’t on the safety plan thought that if the clinician works with them, they could identify them going forward, to put that safety plan on the strategy should they need it again. So it’s just that kind of those last three categories, how do we do more work to reach out to them?

Next slide. Now I’m going to turn to talk a little about the qualitative interviews with the staff. As I said, we thought that this was very important to get staff reactions to this. The way we actually did this was we hired the equivalent of suicide prevention coordinators. We called them acute services coordinators to go into the ED. What we said to them was go into the ED, this is what your job is, to implement this, and figure out how to do that. So each VA ED ended up implementing it in probably a little bit different way. Each VA did end up implementing it very successfully.

We were very pleased to see that almost everybody, 94% of the staff thought it was helpful for both the staff and for veterans. 85% reported that they thought it increased connections of services, and that was probably owing to the part of the intervention that we’re not talking about today, which is the follow-up phone calls that we did. 54% thought it decreased suicidal behavior, and in fact that’s what our data shows.

Our data also shows that it does increase connection to services. 37% reported that an increase in veteran self-efficacy in responding to suicidal crises. In fact, that’s one of the things that’s very important, that veterans feel not so much at the mercy of their suicidal feelings, that they have a plan of action. 80% believed that it helped to provide support and advocacy in the sense that veterans were cared for. Many veterans talked about feeling cared for. 24% said that it reported comprehensiveness of care, which is really has to do with doing an intervention in the ED and then following up by phone call.

The staff said that it helped them, a third of them, and then 19% reported increased comfort in discharging at-risk veterans from the ED. This is actually one of the goals that we think is important in doing an intervention. We really don’t want to hospitalize people who don’t need to be hospitalized, and if we can give them something else in the ED that will increase their safety, then we do want to discharge them. I would say the figure of 19% is still a little low, but perhaps as more people, as the intervention gets integrated into routine care, and there is success with discharging suicidal veterans, that this number would increase.

Next slide. Okay, now I want to turn for a minute and just talk about another qualitative study that was published by Deb Cayman from the Bronx VA. Their group published this very recently. There is the reference at the bottom of the slide. What I thought was very interesting in this manuscript is they proposed a model, a safety planning mechanism, and so you kind of take a look at where they think the safety plan fits into helping people cope.

Next slide. So they interviewed veterans, 20 veterans at baseline, when they got the safety plan and then one month later. I’m not going to go over all these things. I just want to point out a few things to you. They asked people what were the helpful aspects; what were unhelpful aspects, and so forth. One of the things that I think is very important to point out that people thought that the collaboration with the doctor was very important. It made them feel less alone.

The reason that I’m pointing this out is because there is a tendency to, because safety planning is templated, to over time, more or less have it become such a routine, that it becomes more of a form to fill out than an intervention to do. So, kind of the collaborative part of any part of clinical intervention, like CAMs or CDT, that it becomes more just like okay, so this format let’s do, or you do this, or I’ll do this. So here a veteran is pointing out that really the collaboration is a key part of the intervention, and I think that it’s really important not to lose sight of that.

Then at the bottom, there’s only a couple things I want to point out here, and I would really recommend this article to you. There was a discussion of the plan at follow-up visits and that facilitates the use of the safety plan. Just not letting it drop was seen as really important. Ways to improve the plan. There were a couple things that I think were really important to point out here. Maximize individualization of the plan and offer the plan in compact or in mobile format.

Unfortunately, these two things kind of go against each other. When you have these kind of mobile formats, they tend to be a drop down with drop down menus. Pick this, pick that, pick this as your kind of coping or who you’re going to contact. That actually flies in the face of the other comment about making them individualized. So, the app that Greg and I developed, which I’ll show you in a minute, is an app but it retained the text format which makes it not as easily usable, but it really addresses this thing that we think is really important, which is to have the plan individualized.

Next slide. So this is the plan, the app that Greg and I developed with the support of the New York State Office of Mental Health and Columbia University. You can see that it parallels the steps on the safety plan. We have a button to push for emergency contact. People can link up with their contacts in their address book. It’s available both on iTunes and Android. There’s no charge for it.

Next slide. So there’s been a lot of interest in how do you identify a good safety plan. Greg and I developed a safety plan intervention rating scale that we have available. It assesses both the general intervention, the safety plan intervention skills, and then it assesses the success of each step of the safety plan and how it was constructed. It’s a simple grading scale with rating zero, one and two and we sum them over the course of the assessment. So, we will often use this when we do trainings to assess how well a role-play was done, and you can use this, of course, to assess written safety plans, too. For the part about having to do with each step was constructed.

Next slide. I’m just going to end now by mentioned a couple treatment developments that are happening with the safety plan intervention. The first is a group at the Lyon’s VA. This was presented at the IASR Conference in October. It’s called Mindfulness-based CT for Suicide Prevention. This is a combination of MBCT and it integrates safety planning into the intervention. There are two individual sessions in which safety plans is done and revisited and what mindfulness based treatment is all about, and then eight group sessions where mindfulness is taught. The thinking is that the combination of the safety plan intervention and MBCT will kind of take two sides of suicidal problems. One is the immediate skills to cope with a crisis, so that’s where the safety plan intervention comes into play. Then the MBCT helps to develop longer-term skills to retrieve alternative ways of experiencing mental states to prevent spiraling into crises.

Next slide. A project that is now being done at the Bronx VA with Marianne Goodman as the principal investigator. Marianne has taken a really interesting project of safety planning, where she’s doing a group treatment to develop skills for effective use of the safety plan.

Next slide. This is a complicated side, but I think it kind of captures the treatment. It’s ten sessions. It’s designed as a group treatment, and it combines and takes each step of the safety plan and identifies the skills needed to effectively use that step and then teaches those skills to the individual. Then there are a few additional sessions that make the treatment a ten-session treatment.

Next slide. Finally, this is a non-VA project. Safety planning was adapted for violence prevention. A colleague of mine, Annette Clemmek[ph.] in Israel had the idea taking the safety plan intervention and adapting it for use who bully others. So the target behavior in the minor is identifying is urgence to bully. Not to be bullied. It’s the bullier. Then uses the safety plan in a very similar way that the safety plan for preventing suicidal crisis is used.

Okay, so now that kind of finishes up my part of this presentation, and I’d like to turn it over to Lisa Brenner.

Lisa Brenner: Hi. I’m going to talk about specifically about a modification we made using safety planning which we call an action plan in this case. When Dr. Stanley spoke before about the idea that perhaps that some individuals may have challenges regarding remembering to use the safety plan or may have kind of cognitive challenges around implementing, we really wanted to provide some scaffolding and some practice in repetition with the different steps and decided to work on wrapping safety planning around problem solving. So, we created a problem-solving safety plan intervention. This is specifically for veterans with moderate to severe TBI.

Next slide. With the disclaimer that was presented before. This work was also supported by the Military Suicide Research Consortium, and we are very grateful for the support they provided.

Next slide. One thing in particular, and I’m not going to get too far into this, there has been, as you can see from this slide, would fit all Pub-Med articles on suicide and TBI, since 1985. I’ll have you notice that the first line there is 20, so not so many. We went along like that for many, many years, and suddenly there has been an explosion from my world, although I think compared to other literatures this is still small of research regarding suicide and TBI, particularly in the military population, however, to date, there has only been one intervention that has actually been studied. So we have a dearth of interventions for this very high-risk group. The other intervention, Window to Hope, which was initially trialed in Australia and we actually had a second trial here with positive findings, which I’m not going to be talking about today. I think I’m going to be talking about that on webinar in the future. We also wanted to have another intervention, something else that could be used that may build off stuff that we’re already using here in the VA. That was the impotence for us creating this intervention.

Next. What the intervention is called is Problem-Solving, Creating an Action Plan. This is a very veteran-focused intervention in that there is a lot of veteran specific language in it. But actually creating a civilian version, it would not be hard, and we’re actually doing that for our colleagues in Australia who passed us Window to Hope. So certainly something can easily be adapted for civilian population.

As I said before, the focus is really using problem-solving therapy strategies, and using those to facilitate safety planning which we call action planning throughout the group, and as you’ll see, it’s a very iterative process, in which they work on a safety plan at the beginning but then they learn specific problem-solving skills that they use augment a safety plan. It’s really wonderful. We had them continuing to build these safety plans over the course of the intervention, and the kind of breadth and depth of the plans really was beautiful to see over time, the growth of the plans.

Next. So, like Windows of Hope. This is a small group intervention. When we say group, sometimes people think eight people small, or seven people small, we’re actually talking two to three veterans, and what that does is provides a lot of space for these folks who do have moderate to severe TBI, time and space to talk and review, but also does provide the opportunity for peer-support and peer-feedback. It’s the best of all possible worlds.

It’s a ten-session, two hours per session intervention. Usually the first hour, and this is more concrete than it really was, but the first hour was really focused on a new problem-solving strategy or technique or skills or psychoeducation, and the second hour is really set applying that to safety planning. So you’ll see I’ve got the sessions outlined here. We started with an introduction to problem solving. Then we really spend the second session recognizing and identifying triggers, warning signs, and crises. Then as you can imagine we focus quite a bit the first step of safety planning, and it goes on like this.

Next slide. You can see specifically on helpful thinking and problem solving, really recognizing thoughts, brainstorming ideas, and every week as we’re doing this we’re using it directly to inform the safety plan and how to expand the safety plan, when to use the safety plan in real life, practicing using the safety plan, practicing the safety plan even when people are not in total crisis so that they actually can remember to do it when they are in crisis.

Next slide. Then really using the safety plan then also to help identify problems in folks lives and then developing problem-solving strategies to decrease the need to use the safety planning. It worked great.

Next slide. We really did, in each session, focus on specific take-home messages for today and every day. These were iterated and re-iterated throughout. You can see here, for example, session one, these were the take-home messages, for example, people approach problems differently. There are specific steps used to solve a problem.

We used a number of mnemonics and things to help folks remember the different strategies that we’re using. The idea that 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 and using your action plan to prevent warning signs from snowballing into crises. So I think that can give you an example of how we took both the problem-solving strategies and the safety plan and put them together.

Next slide. Another example was PASTA. And PASTA, we had a different mnemonic for that. This was actually a mnemonic that a veteran thought of for Pause, Aware, Slow Down, Think and Act, and using this as a specific strategy to deal with triggers and warning signs, again pairing safety planning with the problem-solving steps and folks did not have any trouble remembering PASTA. That was something we were able to talk about quite a bit. Using these strategies to help the veterans with cognitive impairments really latch onto the ideas and bring them into their everyday life.

Next slide. So we ran this group. We had 14 participants. This is the feasibility and acceptability study, so we developed the manual and did a feasibility and acceptability. As you can see, this is kind of mostly male, around 50 year olds, married, some married, some single. Really mixed education and military service. All of them with moderate to severe TBI.

Next slide. They came into the study with moderate helplessness scale scores. Folks came in and they’re having a pretty hard time. People often say to me, can you folks with moderate to severe TBI to stick through a process? Can you get them to come to sessions? Can they understand what’s going on? Will they like it? Will they learn? They have moderate to severe brain injury and the reality is this distress group as you’ll see on the next slide, actually 75% of them made it to nine or ten sessions. So, this was great.

Actually, one of the groups I ran, actually both, I had 100% attendance at both groups. One of the groups I had a very mixed cohort. We had an OIS veteran, had a Vietnam veteran who got to work together. Each of them had different strengths and weaknesses but some similar backgrounds, but some very different backgrounds. It was just a great experience having them be in it together.

Next slide. For our first outcome in terms of acceptability we gave the clients a satisfaction questionnaire which asked a number of questions about how folks about the interaction and you can see the folks were either satisfied or very satisfied on all elements and we felt like this was great. We’re in the process right now of modifying this a little bit. It’s going to be piloted in Australia next, and we’re also going to be working on a larger RCT here.

Next slide. I think Barbara, Greg and I and our colleagues, there was a large group of individuals who have contributed to all the projects we talked about, but particularly for SAFE VET. We have to our phone calls on Friday morning for SAFE VET and I think we started the phone calls when my kids were barely born, and now they’re about to graduate from high school, but we’re still working together and it’s taken a village to get this study and all big studies going, so we want to make sure everybody is acknowledged here and thank everybody for helping us get this done.

Next slide. More acknowledgements.

Next slide. Also, I want to encourage folks will have, I know we already had information about this webinar on the Myrick website. I think we tweeted about it, I know we did on our Myrick website, so we’d love to hear from you on twitter about this and thanks for the opportunity, I think we’re going to open it up to questions now, right Molly?

Molly: Thank you, yes we do have lots of great pending questions. I know a lot of our audience joined us after the top of the hour. So, to submit your question or comment, please use the question section of the go-to webinar dashboard that’s on the right-hand side of your screen. Just click the plus sign next to the word “questions”, that will open up the dialog box and you can submit it there.

So we’ll go ahead and start at the beginning…

Q. Is it possible to determine whether or not SAFE VET reduced rate and incidents of suicide among enrollees as compared to a general rate?

Lisa: I think, Barbara or Greg, do you want me to answer that just real quick?

Barbara: Yes, please.

Lisa: Okay. This is always a very challenging question when it comes to suicide prevention research, because although every death by suicide is, of course, very, very serious. The overall kind of numbers make it very challenging to study. We are in the process of pulling down attempts and death data for the cohort and will hopefully have that to present in the very near future. Part of that has been creating enough time and space for unfortunate events to happen also. Greg and Barbara I’m not sure you if you want to add to that.

Barbara: Nope. That’s fine.

Greg: No. That’s good. Thank you.

Lisa: Okay.

Molly: Thank you for that reply. The next question, “what is the difference between a SAFE VET site and a control site?”

Greg: Okay. This is Greg. I’ll tackle that one. The SAFE VET site we hired project SAFE VET clinicians who went into the site and got everybody to start safety planning. At the time, safety planning was not done in the VA EDs, at least at this particular sites. So we did a lot of education and integration of safety planning into the site, and then the SAFE VET clinicians adhere to a pretty rigid protocol for doing follow-up services. Follow-up services are often provided by the VA as our usual care, but we had a very strict policy about how often these calls were to occur and what was to be covered in the calls. The other thing is that the control site, at the time, were not using safety planning by and large in the EDs although 23% were, and that were the primary difference. So the SAFE VET site had safety planning plus the routine follow-up calls and the control sites basically did not.

Barbara: This is Barbara. One other thing that I would mention here is that in SAFE VET who is specifically targeted were moderate to high risk veterans. We kind of assumed that if the veteran was high-risk when they were evaluated in the ED that they would be hospitalized. What we were interested in was targeting this middle group where if you’re scared and you don’t have anything else to give them that they would be hospitalized, or you would let them go and not hospitalize them and keep your fingers crossed. It’s this moderate risk group. So, it’s not a surprise that people weren’t doing safety planning with this group because this group would typically not be targeted for a safety plan intervention.

Molly: Thank you both for those replies. The next question we have. “Why is there such a big sample size difference between the SAFE VET sites and the control sites, and was this unbalanced design taken into account during data analysis?”

Greg: These were the sites that we were able to group during the period of the clinical demonstration project. This was a pretty, we identified people in the control sites based on the medical record data. So this is all the people who met those inclusion criteria and it just happened to be what it was. We tried to match people for the same size and whether it was urban or rural and so, but this just turns out to be the way it was. This has occurred at the same point in time that the SAFE VET sites were then rolling out the project.

This is also a time in the VA, if you remember back in 2008 where there were a lot of new programs and changes coming out. That was the initiation of the two \_\_\_\_\_[00:47:49] coordinators and all the other associated programs that have had tremendous success in the VA. So we wanted to make sure we controlled for time and so that we weren’t comparing the sites that were not in time. We did look at site differences of course and didn’t find that was significant between the sites. We did control for that in the analyses. Barbara, did you want to add anything?

Barbara: Yeah. Just I think, the only other thing I would say is I understand the point about the difference in the sample sizes, but given the size of the sample, the fact that we have different numbers really shouldn’t make that much difference in terms of the data analysis.

Molly: Thank you both for those replies. The next question. “This is very interesting. Thank you for the presentation. I was wondering if we could know the number of VA staff interviews which were conducted and if these were semi-structured or in-depth views? Also is there a bit more context about VA staff felt the safety plan decreased suicidal behavior in veterans?”

Barbara: I don’t remember exactly the number. I think it was 45 staff members that we interviewed, and we interviewed staff in all of the EDs that were in the SAFE VET site so we interviewed the acute services coordinator, the person who was responsible for implementing the intervention, and then fanned out from there, so we interviewed the ED docs and the social works in the ED, the staff in the ED. In terms of how they thought the intervention worked, I would say we didn’t really get that much information about how they thought it worked, other than it helped keep them safe by giving them something to do instead of acting on their suicidal feelings. Greg or Lisa, do you want to add anything else?

Greg: Yeah, these interviews were semi-structured, so they were the same open-ended questions that were given to all the staff. The interviews lasted about an hour sometimes more. We gathered a lot of information that we used and developed the coding process.

Molly: Thank you both. Next one. “In your experience can nursing staff without clinical mental health training effectively complete the plans? Do you have a resource for individuals who may not be trained in psychotherapy or suicide prevention?”

Lisa: This is Lisa. I’ll start there. I mean I think that what we probably, and I’m not sure what Greg and Barbara, what they would say about this, but I think that somebody who has clinical skills, and nursing certainly falls in that category, could certainly learn how to do safety planning particularly in ED setting. It just depends on how committed the person is to learning how to do it and then engaging with the process around it. I think safety planning can be a very wonderful intervention for the ED and as you saw with some of the interventions, can be incorporated into a much more complex clinical process. In my mind, it would really be a part of kind of trying to decide how expensive it was going to be and what the main function would be. Greg and Barbara, I’m curious what you would say also.

Barbara: I would say, yes, nurses can be trained. In fact, they have been trained for a project that Greg and I are working on implementing safety planning in non-VA EDs; that’s one of the groups we are training. The thing I would say is that it is much easier to learn how to do a good safety plan with somebody than it is to learn how to do a risk assessment. It seems like the role of a nurse in this process would be after the person has been judged, as the patient as this is the level of risk, either they need the hospitalization or they don’t need the hospitalization, and then they are given over to the nurse to do the safety plan. I think the biggest thing would be for a nurse or any other professional working with somebody is doing the safety plan is to not assume that they know what the right answers are, and not assume that the patient can do it all by themselves. Greg, do you have anything else?

Greg: No that sums it up pretty well.

Lisa: I think the main thing that we keep iterating over and over again is that we really want this to be a personalized intervention for folks, so even though the steps themselves may be very straight forward, that really taking the time and having the kind of interaction with the veteran that makes it personal to them is key.

Molly: Thank you all very much. “Do the small group sessions reduce the rate or instance of suicide as described by Dr. Brenner?”

Lisa: That is a question I would love to be able to get the funding to be able to answer for you. So you will have to stay tuned for that. Right now we’ve got folks coming and being very engaged in the process. I’m hopeful.

Molly: Thank you. “I’m wondering what the presenters’ thoughts are on suicide risk assessments. There are quite a few available. Do you all have any favorites?”

Barbara: Well, in full disclosure Greg and I are authors on the Columbia Suicide Severity Rating Scale, which is very popular and is widely used. So the thing that I would say about it is that the CSSRS is good and instead of talking about what risk assessment measures to use, what I would say to you is these are the things I would look for in any risk assessment. Does it measure ideation? Does it measure behavior? And does it measure the associated risk factors with suicidal behavior? Because, one of the important things to remember is someone could deny suicidal ideation, and you’re not necessarily home-free. So you want to make sure you’re assessing other things too. Greg?

Greg: We had just published an article in Journal of Clinical Psychiatry on looking at the differences between if you use a standardized research measure like the Columbia, which was traditionally developed as a research measure, but since then expanded, to just doing routine suicide risk assessments in the ED not using a standardized measure. What we found was some discrepancies. By and large, people were similar in their assessments when we looked at concordance of the identification of suicide behaviors, but there was some important differences. One of them was that clinicians in the ED sometimes did not identify suicide behaviors whereas in the research interviews that they did do, and this kind of pushes the idea; that no matter what measure, no matter what you do in the ED, it’s probably a good idea to use some type of standardized screening method, so it’s just not at the whim of the clinician that’s doing the assessment; there’s some other structured way that you’re doing the assessment in addition to the clinical interview.

Lisa: I would add to that too. In the Myer we’ve been working on something that I think very much with what Greg and Barbara are talking about. It’s called Therapeutic Risk Management. We have a number of tools available regarding that. I think the Columbia is a great measure or tool to use to help identify, but within therapeutic risk management, really making some determinations about acute and chronic risk and also what the level of care needed at this point is. This is a resource and we’ve been talking quite a bit about it and have a lot of printed materials that can be pulled down from the \_\_\_\_\_[00:57:20] website and also in terms of the National Consult Service.

This is a great time for me to remind folks that we do have a National Consult Service, so any VA clinicians that are working with veterans that are challenging or they’d like to consult with people who think about this all the time, we’re here and available, and information about the National Consult Services also on the Rocky Mountain and Myrick website. The kind of thinking about risk management and risk assessment, something that I know, Bridgett M\_\_\_\_\_[00:57:51] and \_\_\_\_\_[00:57:57], do all the time and talk about all the time and will be happy to talk you through this with a specific case if you are interested in learning more about this.

Molly: Excellent. Thank you so much. “How do peer specialists do this safety training?” I’m sorry. “How do peer specialists do this safely planning?” I’m assuming it might be “safety planning”.

Lisa: It seems like the response that would be similar, although I think peer specialists come with different skill sets, so if the peer specialists had some clinical background in skill sets, I think it’s an interesting question to talk about kind of how much they can help engage with safety planning. Also some very important parts about safety planning is having people know what your safety plan is and having people that you can and be a part of your safety plan. I certainly think that peer supports would be excellent individuals identified on safety plans and would be wonderful folks to help us implement them in real time in the real world. I think there’s a number of roles that peer supports could play, and some of it’s about thinking about that more clinically. Right away I feel very strongly that peer supports absolutely are part of the important safety net of safety planning.

Barbara: So, I think I could just add that in New York State we are just getting under way a project in which we are looking at the role, just started with doing focus groups for suicide attempt survivors to look at what would be their experience being kind of a safety plan helper and would they, in their experience, would they think that this would be helpful to them. That is the movement to incorporating suicide attempted survivors into helping the actively suicidal is very, very strong, and we think that we want to see how they can be used as adjuncts with safety planning.

Greg: Our experience was, as a safety plan was rolled out in VA, is that patients were teaching other patients to do it, so I think it’s a matter of whether VA wants them to or not, they ended up doing it. It’s a matter of, can peer support individuals be trained to a level of competency to administer the safety plan intervention. That I think has yet to be determined in a study or as part of a training program.

Molly: Thank you. We just have one pending question. “Great presentation. Can you offer some examples of safety plan coping strategies that even depressed or withdrawn suicidal individuals may distract, relax and connect with others?”

Lisa: Go ahead, Greg.

Greg: Yeah, we find there’s quite a bit of difference in the strategies, and we could name some that people do use like taking a walk, taking a hot shower, playing with pets, and watching a specific type of show, going to movies...There’s a whole host of things. What I’m concerned about is though is just making suggestions to people that are kind of broad suggestions. It’s so important that these strategies are tailored to the person. What’s distracting to one person is not necessarily or effective for somebody else. When we do the safety plan intervention, we like to pull as much of the information from the individual that’s doing it as possible. Work with them and ask questions like, “Well, what have you done in the past to keep yourself safe or what have you done in the past that helps calm you down or take your mind off your problems?” and kind of work from there. You could develop lists and some people have done that but this comes at a price or cost of going down a checklist, which I don’t think is an effective way to do a safety plan.

Lisa: I’ll just add one other thing. When I try to get people to think about this, even if they are depressed, I will say, “what do you do, what activity have you ever engaged in that is so engrossing that for an hour of time of can pass and you don’t even notice the passage of time?” Everybody can think of something like that. So that’s kind of a way to help people begin to think about it for themselves if they are coming up against a wall.

Molly: Thank you for that reply. We have lots of people writing in saying “thank you for this excellent session” and people are wondering if they can get these slides. Yes, you already have a link to the slides. Just go to the reminder email you used this morning to get into the session and there’s a live link there. Also, you’ll all receive a follow-up email two days from now with a link leading to the recording and to the slides. If you cannot find your email from this morning, you can email cyberseminar@va.gov and I can send you a copy of the slides.

Thank you very much Drs. Brenner, Brown and Stanley. We really appreciate you lending your expertise to the field, especially on such an important topic, and of course, thank you to our attendees for joining us. Thank you to Steve Dobscha, Barb \_\_\_\_\_[01:03:57], and the teams for getting this series going and continuing on. We do have a suicide prevention cyber seminar every second Tuesday of the month at 3:00 p.m. Eastern, so please keep an eye on your emails for a registration announcement for the next one.

At this place I’m going to close out the session. Please take a moment to fill out the feedback survey. It’s just a few question, but we look very closely at your responses and it helps us to improve sessions we’ve already provided as well as gives us ideas for new topics to facilitate. Thank you once again to our presenters and to our attendees. This does conclude today’s [01:04:33] cyber seminar.

Have a great day everyone.