Suicide Prevention Webinar: Implementing the Safety Planning Intervention in Your Organization – Guidance on NPSG 15.01.01 (EP 6) effective July 1, 2019

6:00 - 7:00 am (Hawaii)

8:00 - 9:00 am (Alaska)

9:00 - 10:00 am (PT)

10:00 - 11:00 am (MT)

11:00 am - noon (CT)

noon - 1:00 pm (ET)

September 9, 2019

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Webinar Audio – Information & Tips

- Audio is by VOIP only – use your computer speakers or headphones to listen
- There are no dial in lines
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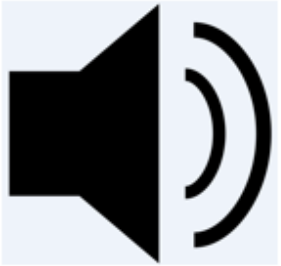

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Background

- National Patient Safety Goal 15.01.01 (EP6), effective July 1, 2019 requires counseling and follow-up at discharge, such as safety planning
- Suicide prevention safety planning is more than filling out a form
- This webinar focuses on Implementing the Safety Planning Intervention (SPI)
- SPI, developed by Barbara Stanley PhD and Gregory K. Brown PhD is recognized as a best practice by the Suicide Prevention Resource Center and is evidenced-based (Stanley et al, 2018).

Reference
Stanley B, et al. "Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department." JAMA Psychiatry, 2018;75(9):894-900.

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Session objectives include:

1. Describe the rationale for the Safety Planning Intervention and the evidence supporting its use
2. Describe the types of healthcare settings, timing and appropriate candidates for the intervention
3. Provide an overview of the clinical tasks involved in conducting the Safety Planning Intervention
4. Describe potential barriers and facilitators for successful implementation
5. Recommend resources for further dissemination and implementation

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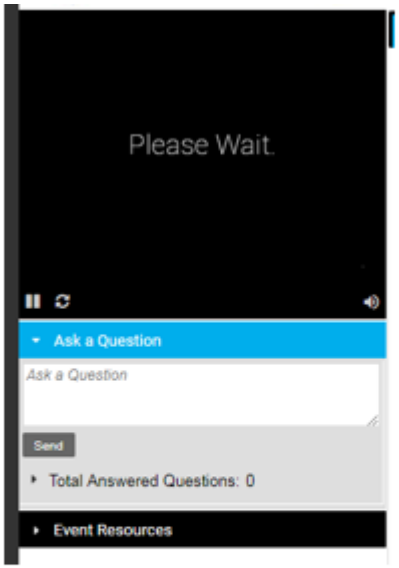

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This program is designed to be interactive.

- All participants are connected in listen-only mode
- Ask questions through the Ask a Question pane
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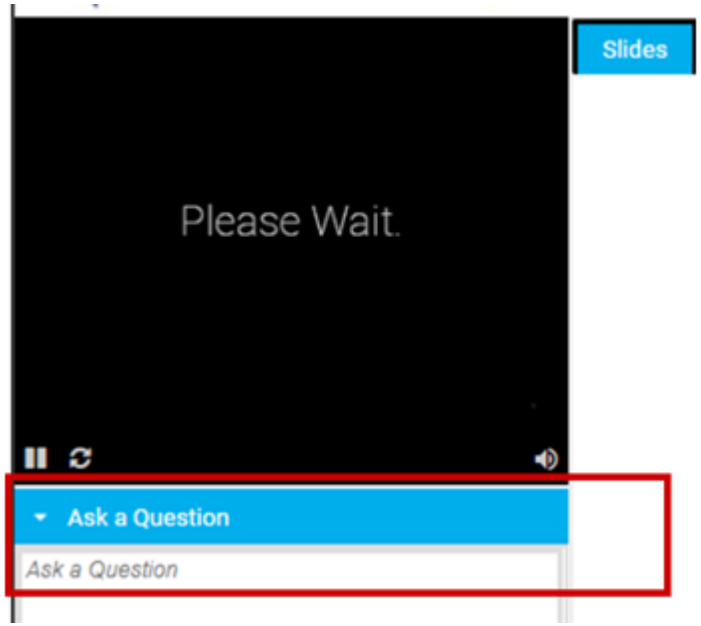

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Suicide Prevention Webinar: Implementing the Safety Planning Intervention

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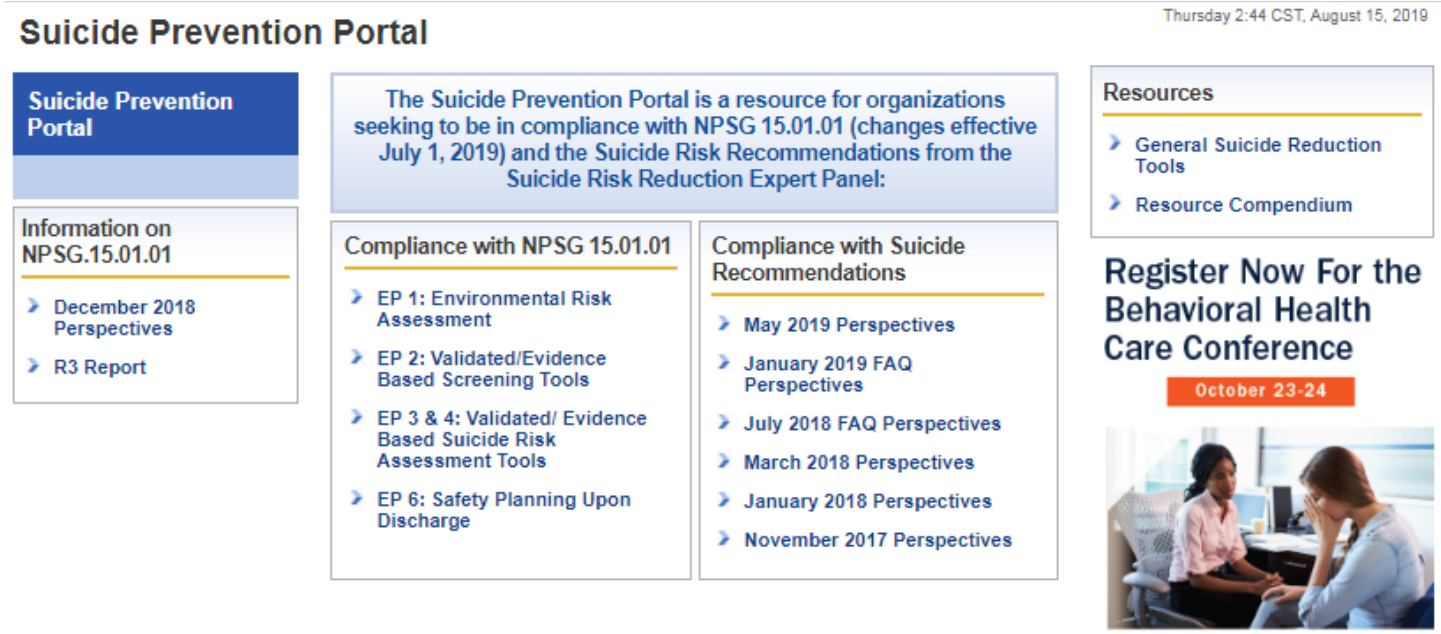

Follow-up materials including the slide deck, recording, and Q&A will be found at this link within several weeks of this session

https://www.jointcommission.org/topics/suicide_prevention_portal.aspx

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Disclosure Statement

These staff and speakers have disclosed that neither they nor their spouses/partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity:

- Stacey Paul, MSN, RN, APN/PMHNP-BC, Project Director, Clinical, Standards and Survey Methods
- Gregory K. Brown, PhD, University of Pennsylvania's Perelman School of Medicine
- Barbara Stanley, PhD, Columbia University Medical Center
- Christine Moutier, MD from the American Foundation for Suicide Prevention

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Science Permeating Societal Views

- Scientific field growing
- Public awareness increasing, stigma diminishing
- Suicide prevention movement gaining strength, ppl personally affected speaking out
- Consensus on effective strategies at community and clinical levels

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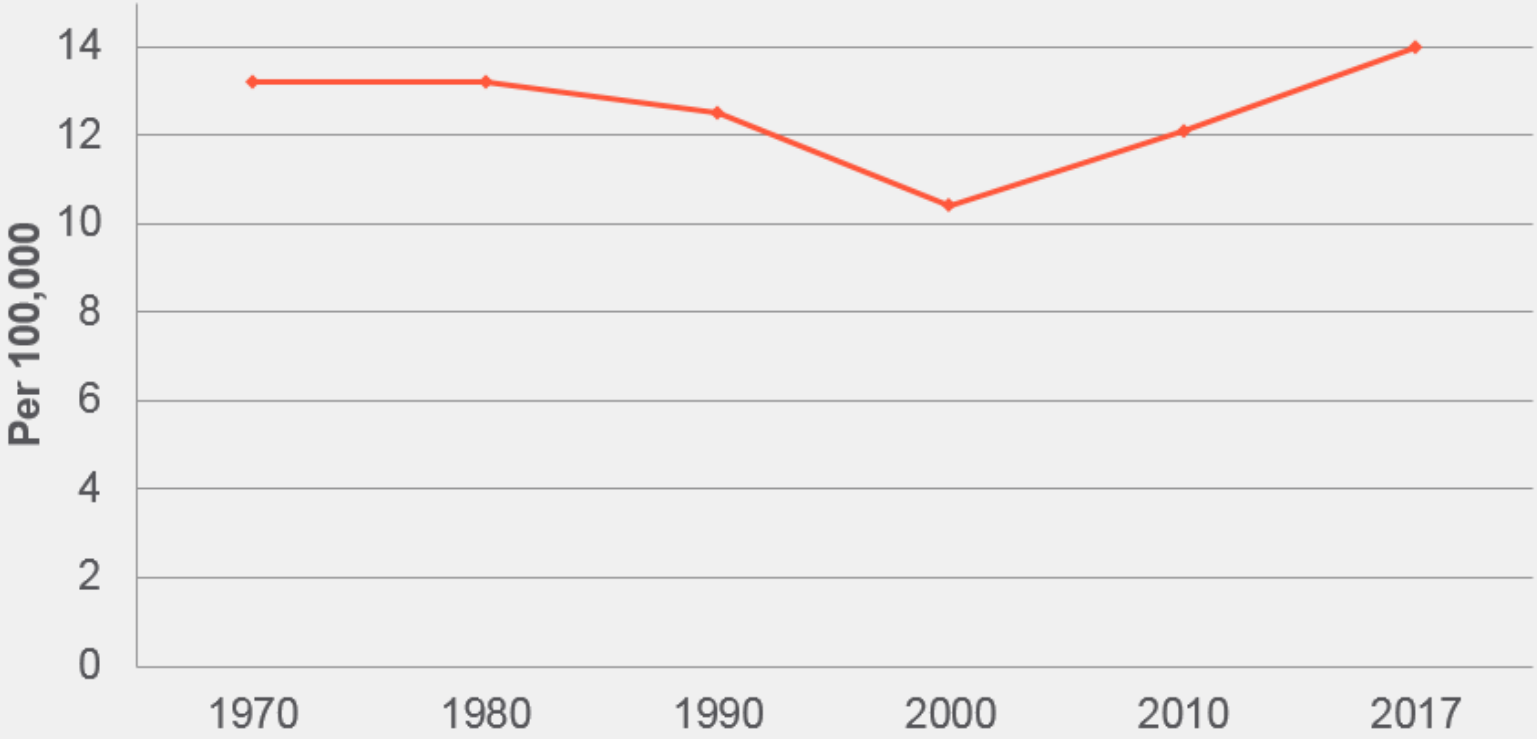
US Suicide Rate (1970–2017)



Suicide rates listed are age-adjusted rates.

Centers for Disease Control and Prevention. Data and Statistics Fatal Injury Report for 2017. Accessed March 1, 2019.

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Suicide
is a **health**
issue.

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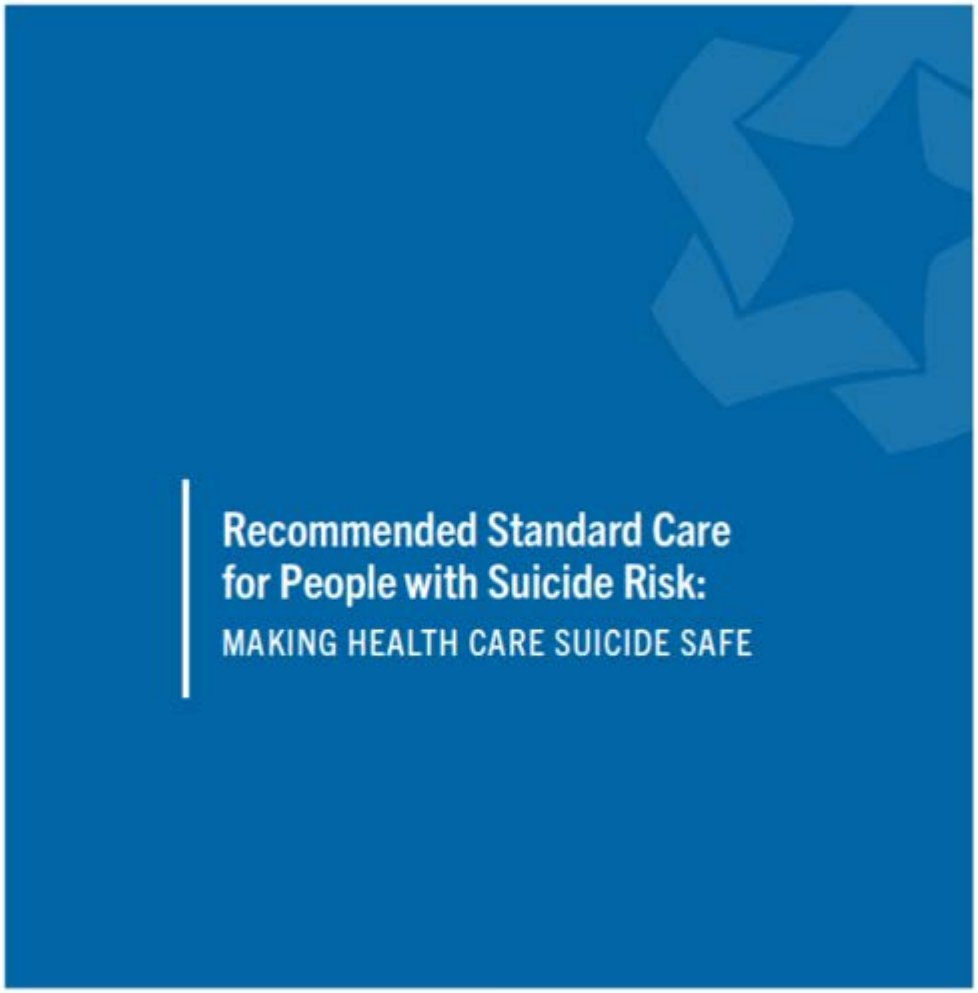

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

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RELEASED JULY 1, 2019
The Joint Commission National Patient Safety Goal 15.01.01

The new NPSG for suicide prevention includes:

- Clear steps for general hospitals and BHOs to take
- Emphasis on organization's SP *program* rather than just screening or referral
- 7 elements of performance (EPs)

www.jointcommission.org/topics/suicide_prevention_portal.aspx

TJC National Patient Safety Goal 15.01.01

Elements of Performance (EPs)

1. Environmental risk reduction
2. Screening for SI - all patients in BH settings and those w/ primary psychiatric conditions in general hospital or ED settings
3. SRA that goes beyond solely assessing SI
4. Care plan and documentation
5. Written policies for all of the above, as well as for reassessment, monitoring, staff training
6. Counseling - as part of clinical care and discharge planning
7. A process for ensuring ongoing quality

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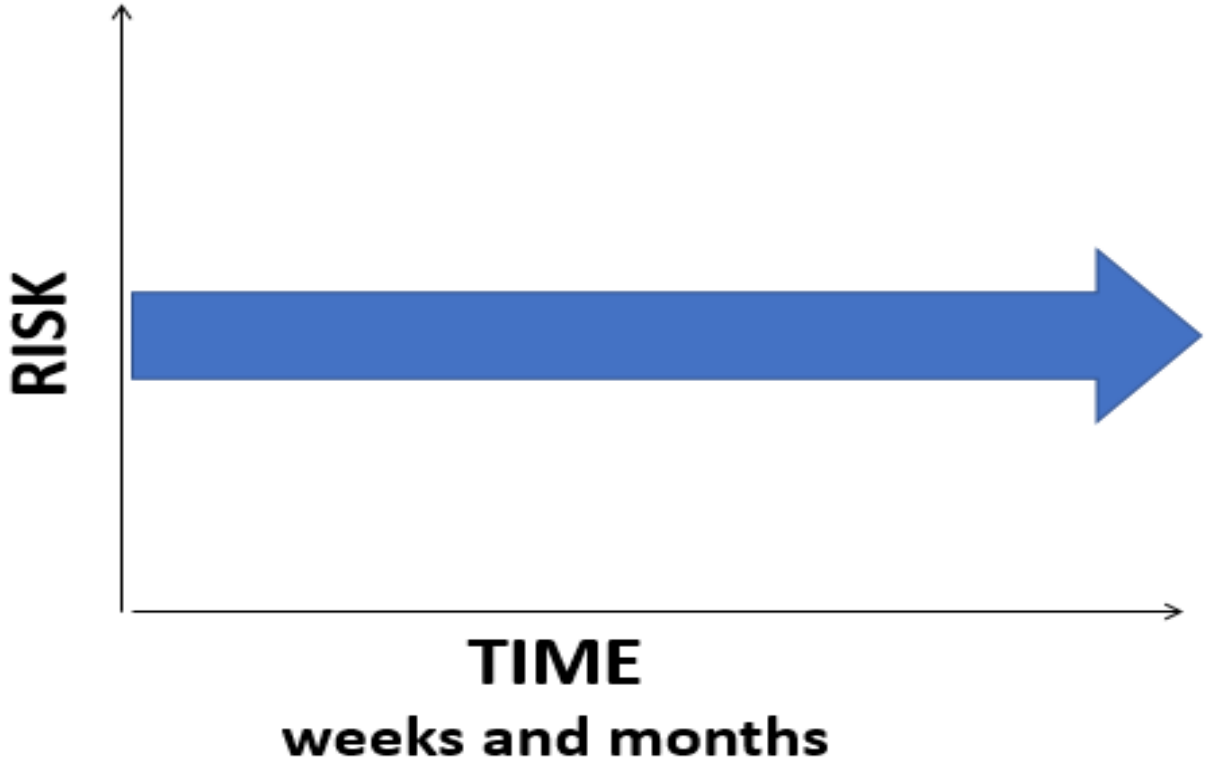
Elevated, More *Chronic* Suicide Risk

e.g., Depression, SUD, PTSD, Hopelessness, Persistent, Severe Stressors:

Treatment: Disorder-specific and Suicide-specific Psychotherapy, Psychotropic Medication



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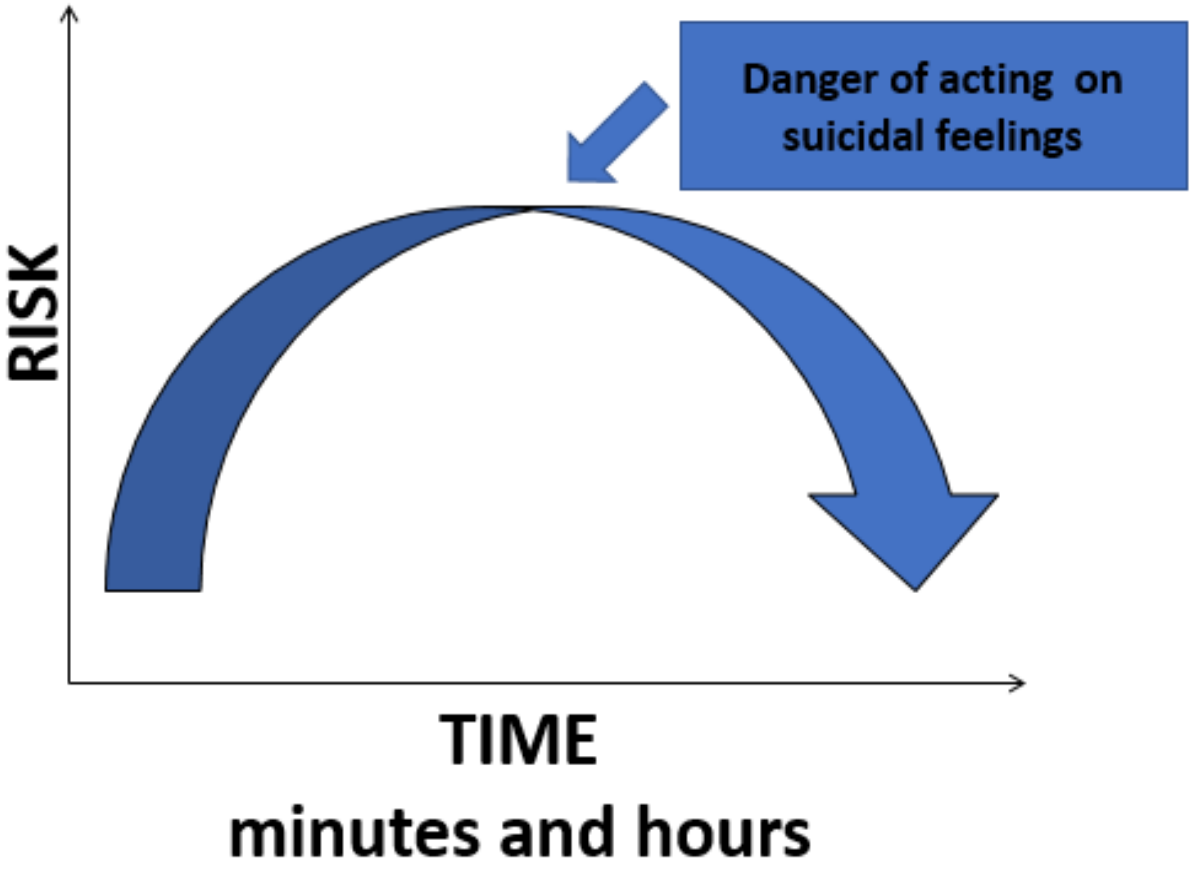
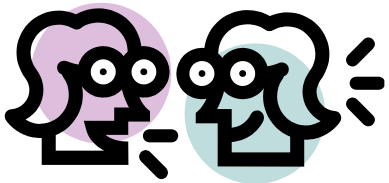
Acute Suicide Risk Fluctuates Over Time:

Treatments: Brief Crisis Interventions, Fast-acting Medications, Emergency Care



Safety Planning Intervention Approach

- Individuals may have trouble recognizing when a crisis is beginning to occur
- Problem solving and coping skills diminish during emotional and suicidal crises
- Therefore, a predetermined strategy for coping can mitigate suicidal crises
- The clinician and patients (and their family, if applicable) work together to develop better ways of coping during crises that uses the patient's own words



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Fire Safety: Stop, Drop and Roll

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Plane Safety Measures

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The Safety Planning Intervention

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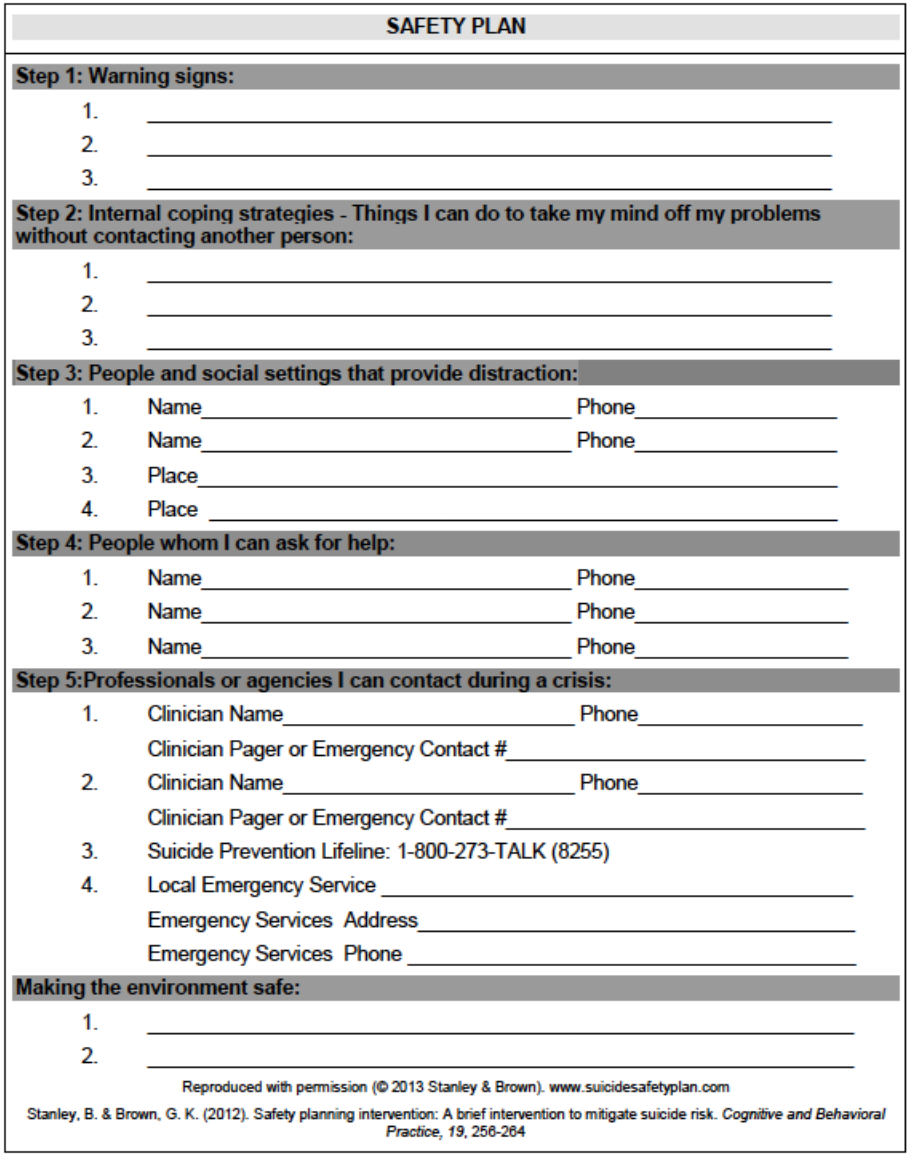
- Brief clinical intervention for suicidal patients
- Prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis to prevent suicide and suicide attempts
- Starts "within self" strategies and builds to seeking help from external resources including EDs



SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

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 #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

Reproduced with permission (© 2013 Stanley & Brown). www.suicidesafetyplan.com

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256-264

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Cognitive and Behavioral Practice 19 (2012) 256-264

Cognitive and Behavioral Practice

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Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk

Barbara Stanley, *Columbia University College of Physicians & Surgeons and New York State Psychiatric Institute*
Gregory K. Brown, *University of Pennsylvania School of Medicine*

The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

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R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Requirement	NPSG 15.01.01, EP 6: BHC: Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide. HAP: Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
Rationale	Studies have shown that a patient's risk for suicide is high after discharge from the psychiatric inpatient or emergency department settings. Developing a safety plan with the patient and providing the number of crisis call centers can decrease suicidal behavior after the patient leaves the care of the organization.
Reference*	Stanley B, et al. "Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department." *JAMA Psychiatry*, 2018;75(9):894-900.

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Research

JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

Author Audio Interview

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades; middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

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Safety Planning Intervention Effectiveness Results

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- Safety Plans administered in the ED to patients who were experiencing a suicidal crisis but did not require hospitalization (moderate risk)
- Structured Follow up phone calls to assess risk and review and revise the safety plans (SPI+)
- Enrollment: N=1,640, Mean age = 48 (SD=14), 88% men

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). *JAMA Psychiatry*

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Project Design

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

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). *JAMA Psychiatry*

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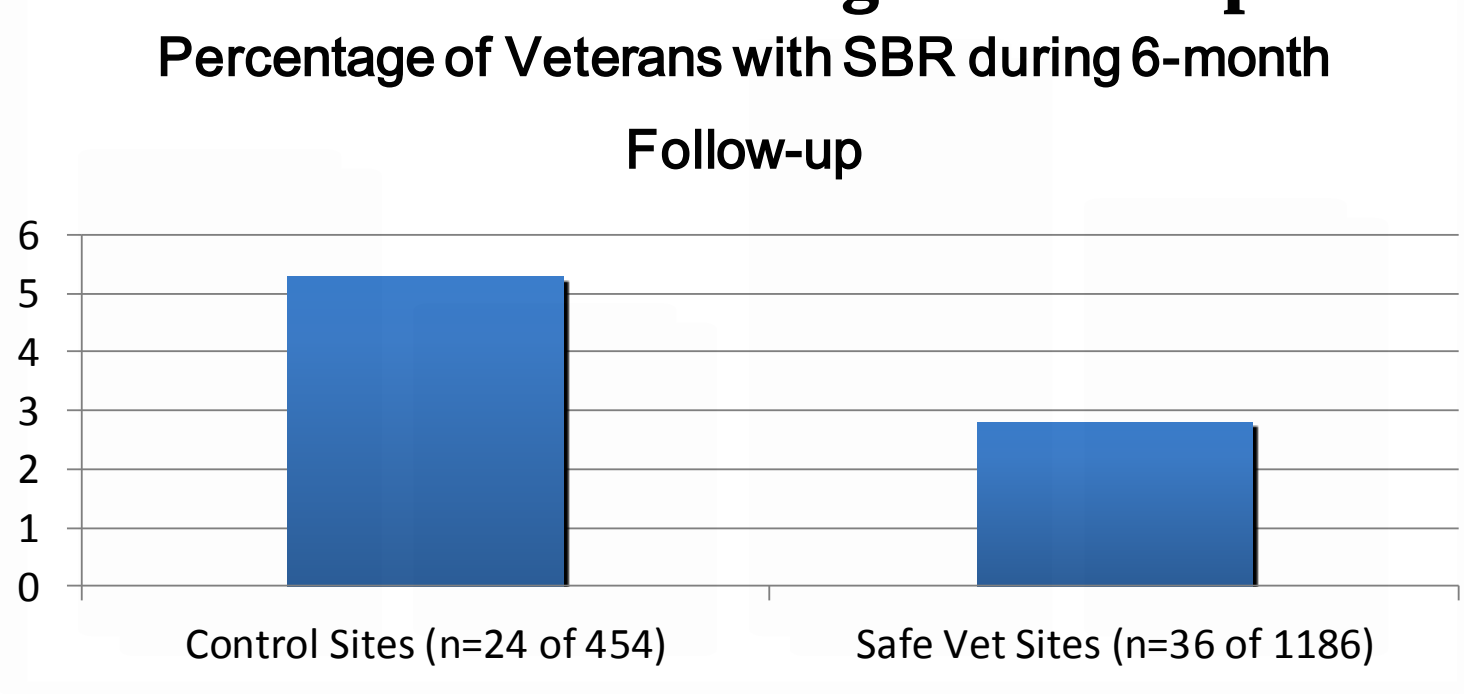
Does SPI+ help to decrease suicidal behavior?

Suicide Behavior during follow-up



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

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

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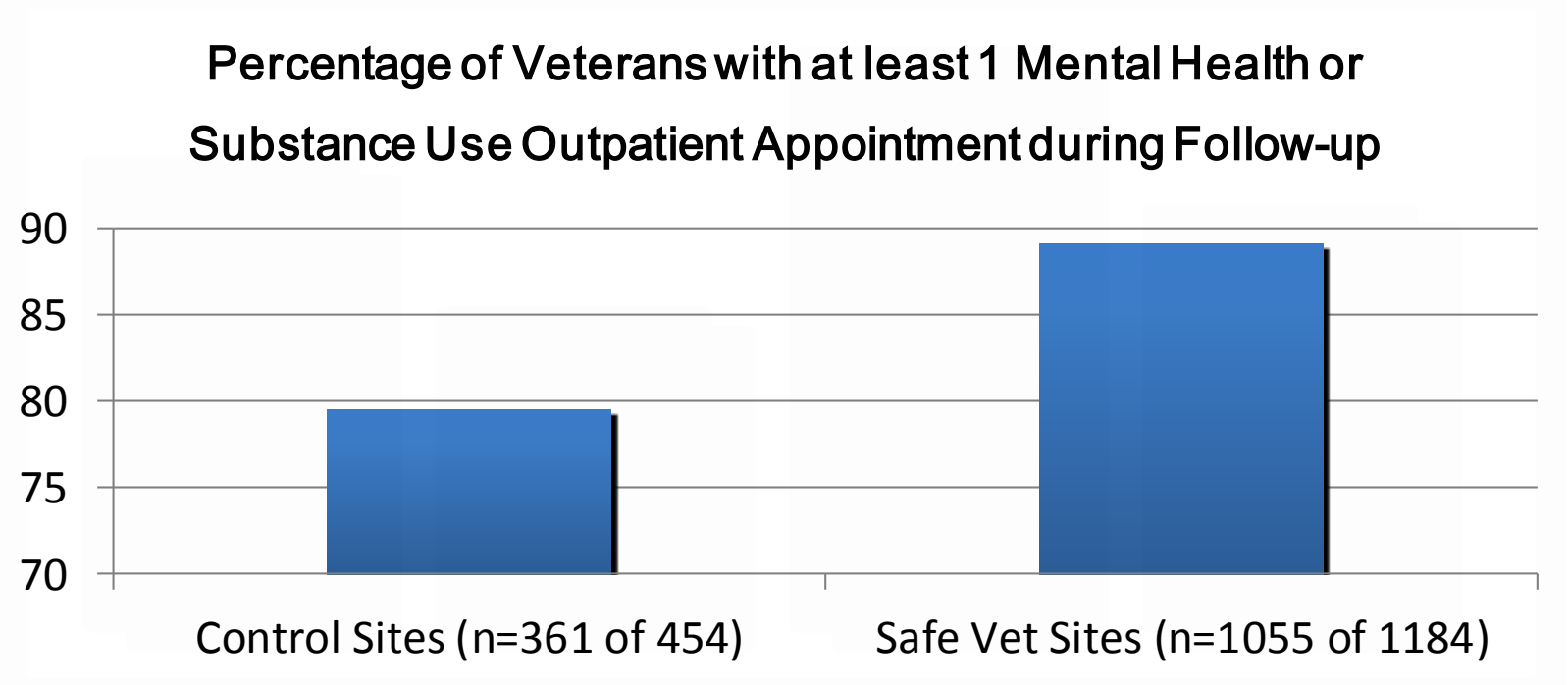
Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). *JAMA Psychiatry*

Does SPI+ help to increase outpatient treatment?

Engagement during follow-up



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

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). *JAMA Psychiatry*

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Safety Planning Settings and Timing

- Appropriate settings are wherever suicidal patients are found in the healthcare system:
  - EDs
  - Inpatient units
  - Outpatient behavioral health care
  - Primary care
- When should safety planning be done?
  - Usually following a suicide risk assessment
  - When the patient is able to engage in a clinical intervention: not intoxicated, psychosis does not interfere, and does not require immediate rescue

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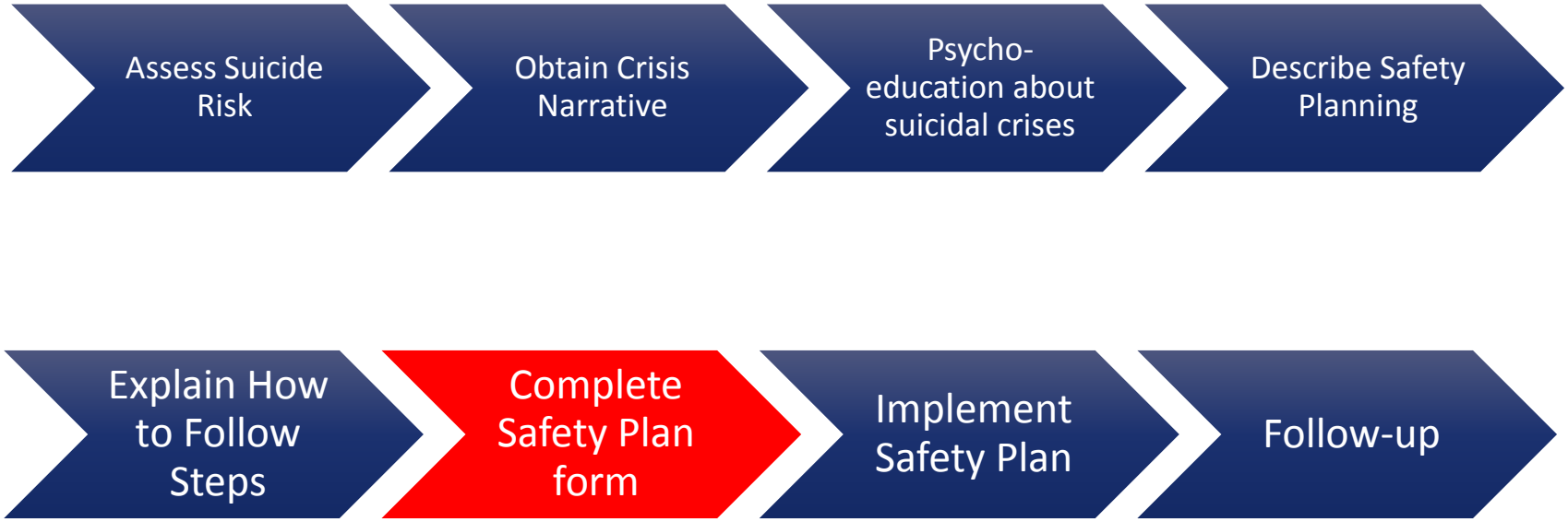
Safety Planning Intervention Tasks

The Safety Plan Intervention involves more tasks than simply completing the Safety Plan Form!



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Task 1. Identify if Patient is a Candidate for Safety Planning: Target Populations

- Individuals who have...
  - History of suicidal behavior including:
    - Suicide attempts
    - Interrupted attempts by self or others
    - Made preparation for suicide
  - Recent history of serious suicidal ideation
  - Otherwise determined to be at risk for suicide
- Children, Adolescents, Adults and Older Adults

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Task 2. Conduct Narrative Interview of the Recent Suicidal Crisis

- Ask the patient to describe in greater detail what had happened that led to the specific suicidal behavior or crisis
- Inform the patient that this will help the clinician to understand the timeline of events from their perspective
- Focus on the recent warning signs not historical vulnerabilities

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Be Attentive to Critical Components of the Narrative that Correspond to the Risk Curve

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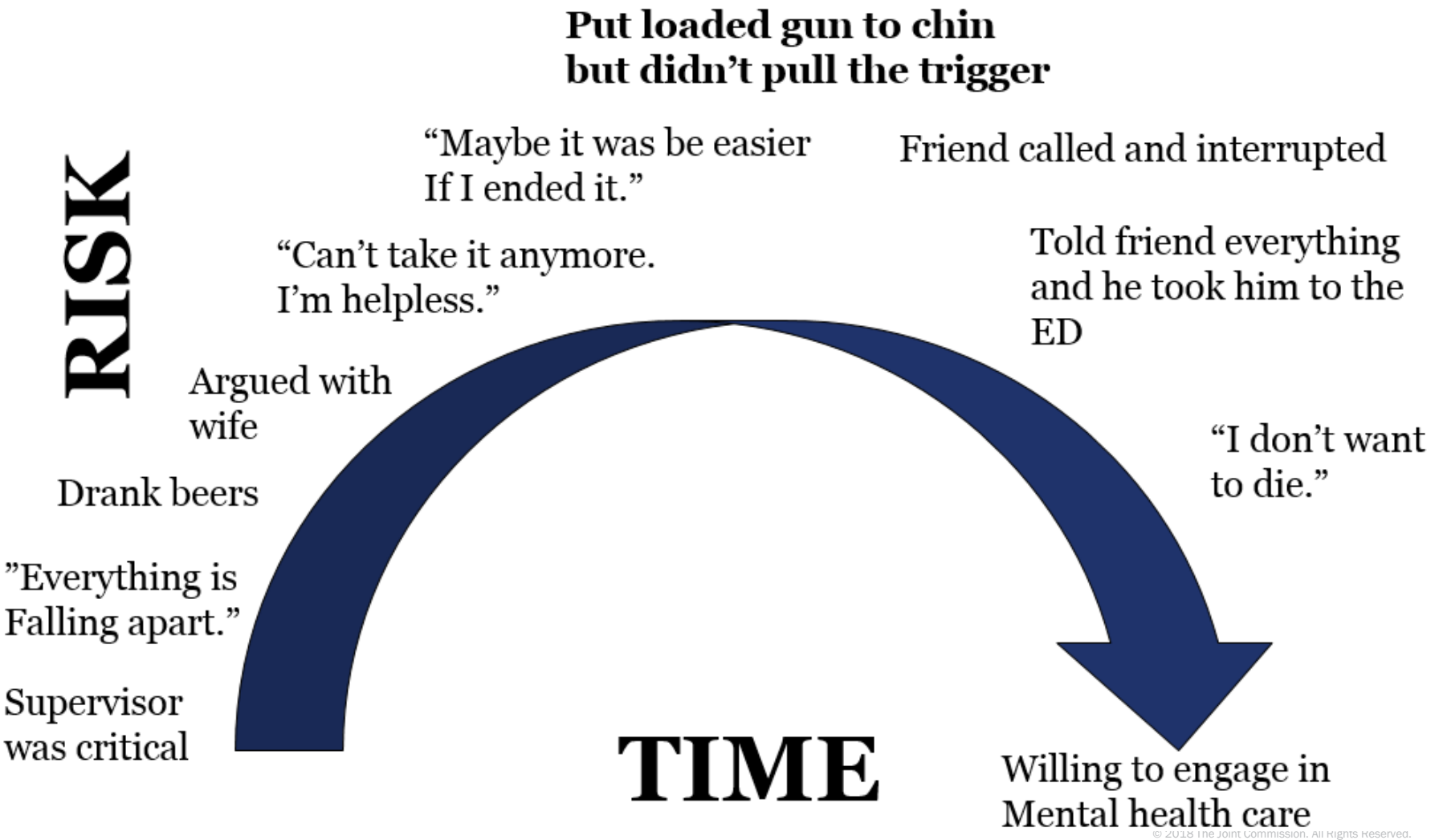
Suicide Risk Curve: Case Example



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Task 3. Provide Psychoeducation about Suicidal Crisis

- Explain how suicidal feelings are temporary and do not remain constant
- Describe how suicidal risk increases and then decreases over time and that pain is time-limited. This helps patients see an end of the crisis that occurs naturally without acting on suicidal feelings

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Task 4. Describe Safety Planning

- Introduce the safety plan form and explain how identifying warning signs provides an opportunity to cope before acting on suicidal urges
- Explain that the Safety Plan form is a tool to help patients follow a pre-determined set of strategies to avert a suicidal crisis

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Task 5. Provide an Overview of Safety Planning Form 1/2

1. Warning signs
2. Internal coping strategies: Things to do to take my mind off of my problems without needing to contact another person
3. People and social settings that provide distraction
4. People who I can ask for help
5. Professionals or agencies to contact during a crisis
6. Make the environment safer by reducing the potential for use of lethal means

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Task 5. Explain How to Use the Safety Plan Form 2/2

- Explain how to progress through listed plan steps:
- Go through steps sequentially
- If a step is not helpful, then go to the next step
- If suicide risk has subsided after following a step, then the following step is not necessary
- If patients feel that are in danger of acting on suicidal feelings, then steps can be skipped to reach out for professional help

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Task 6. Completing the Safety Plan Form

- Explain the rationale for each step
- Collaboratively brainstorm responses for each step
- Obtain feedback on the likelihood of completing each response listed
- Assess barriers and problem solve ways to address them

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Task 6. Completing the Safety Plan Form

- Do not simply give individuals the Safety Plan form to complete by themselves!

- Instead, use a collaborative approach to brainstorm ideas, obtain feedback and revise responses as needed

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Overview of Safety Planning: 6 Steps

1. Warning signs
2. 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 resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

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Example: Identifying Internal Coping Strategies (STEP 2 on the SPI form)

- Explain how distracting oneself from the suicidal thoughts helps to lower imminent risk
- Ask "What have you done in the past to take your mind off your suicidal thoughts without contacting another person? What activities could you do by yourself to help take your mind off of your problems even if it is for a brief period of time?"
- Suggest some distracting activities if patients cannot think of any

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Example: Identifying Internal Coping Strategies (STEP 2 on the SPI form)

- For each strategy, ask, “How likely do you think you would be able to do this during a time of crisis?” or “Is it feasible?”
- If doubt about use is expressed, 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 and identify alternative coping strategies that are more feasible

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Task 7. Implementation of the Safety Plan

- Review the entire Safety Plan
- Explain how to use the form
- Provide a copy/copies of the Safety Plan and discuss the location(s)
- Assess the likelihood that they will actually use the safety plan when the warning signs are noticed
- Discuss barriers to using the safety plan
- A family member or other support person may also be provided with a copy of the Safety Plan with the patient's permission

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Task 8. Follow-up: In Person or by Phone

- Assess current risk and determine whether immediate rescue is needed
- Assess whether the Safety Plan was used; if so, determine if it was helpful and discuss any reasons it was not helpful
- Discuss any barriers to using the Safety Plan
- Revise the Safety Plan as needed
- Facilitate treatment engagement; discuss obstacles

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Using a No-Suicide Contract instead of Safety Planning

No Suicide Contract

I, *Jane Doe*, hereby agree that I will not harm myself in any way, attempt suicide or die by suicide.

If I believe that I'm in immediate danger of killing myself, I will call 911, etc.

Patient Signature: *Jane Doe*

Clinician Signature: *John Smith*

Problems with no-suicide contracts:

- May provide a false sense of assurance to the clinician if the patient signs the contract
- Patients often perceive that the contract serves as a way to protect the clinician or the institution
- No Suicide Contracts are not protective in malpractice suits and there is limited evidence supporting their use; not really a contract
- No Suicide Contract asks patients to promise to stay alive without telling them *how* to stay alive (other than calling emergency numbers, if provided)

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Lessons Learned: Quality Matters!

- Chart review was conducted for VA patients who were flagged as high risk (Gamarra et al., 2015)
  - Safety plans were mostly complete and of moderate quality, although variability existed

- An additional VA study of safety plans in medical records found that the quality of safety plans was low (Green et al, 2018)
  - Higher safety plan quality scores predicted a decreased likelihood of future suicide behavior reports

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Issues to Consider for Successful Implementation

- Time: How much time is actually needed to the intervention?
- Organization Readiness: Who will do this? (social worker, psychiatrist, nurse practitioner)
- Training: Are resources available for staff training on how to do safety planning?
- Quality: What is the quality of completed safety plans? Describe some poor examples and how poor quality is associated with suicidal behavior
- Learn how to apply safety planning in different settings and how to address site-specific barriers

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Patient Reactions: Qualitative Study

- *I would definitely recommend doing safety planning..... I would tell them that it saved my life.....”*

- *Gave me the opportunity to more clearly define signs, when my mood is beginning to deteriorate and when to start taking steps to prevent further worsening...”*

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

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

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For further information on the Safety Planning Intervention including staff training and certification contact:

Barbara Stanley, PhD: DrBarbaraStanley@gmail.com

and

Gregory K. Brown, PhD: GregBrownDE@gmail.com

http://www.suicidesafetyplan.com

Questions?

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Additional Resources

- Joint Commission's Suicide Prevention Portal - https://www.jointcommission.org/topics/suicide_prevention_portal.aspx

- Safety Planning Intervention Videos *(visit links below)*
  - Safety Planning Intervention | Part One
  - Safety Planning Intervention | Part Two
  - Safety Planning Intervention | Part Three
  - Safety Planning Intervention | Part Four

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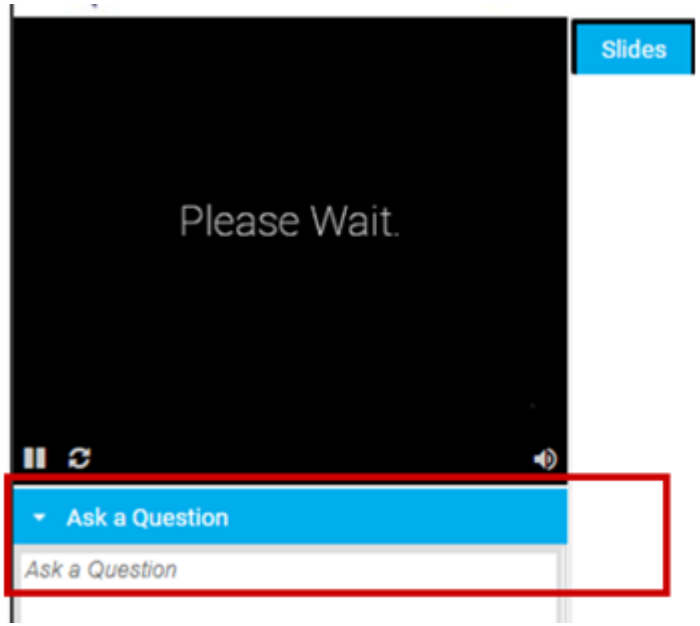

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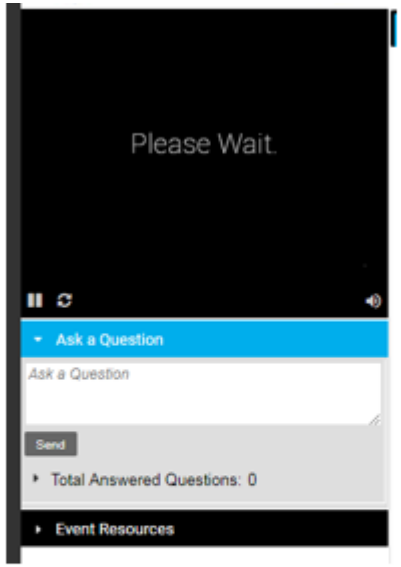

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Suicide Prevention Webinar: Implementing the Safety Planning Intervention

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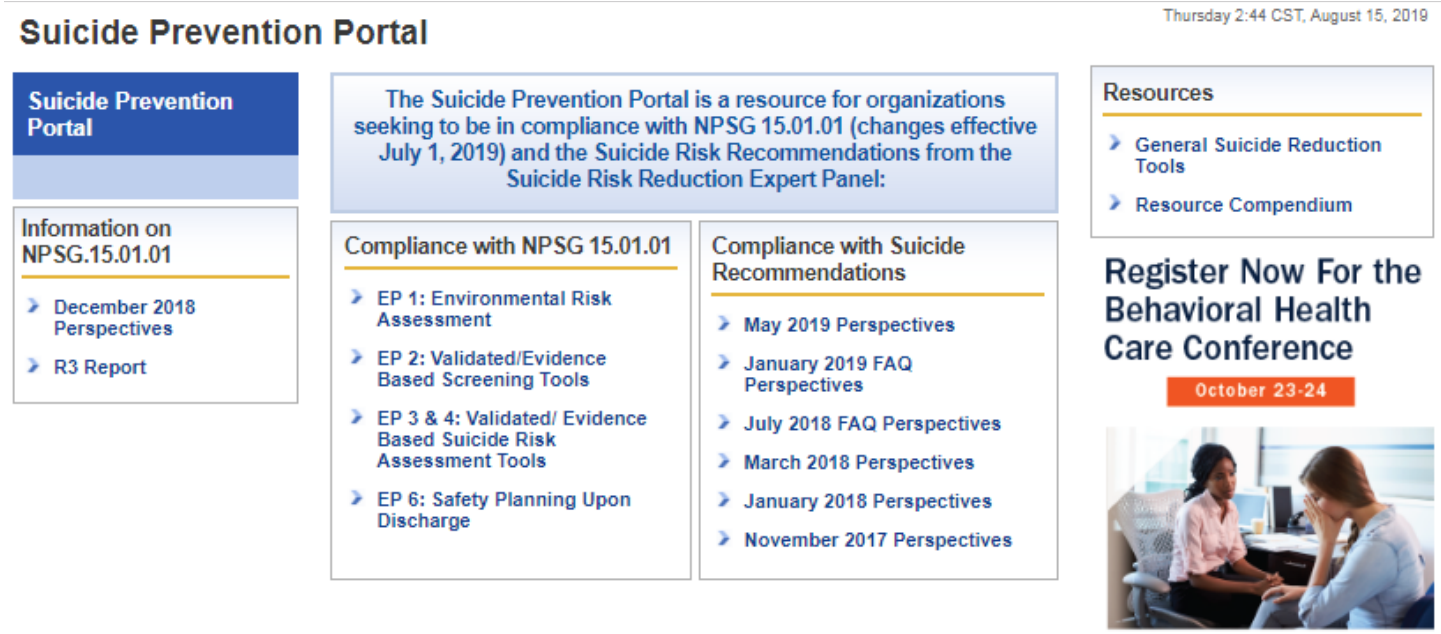

Follow-up materials including the slide deck, recording, and Q&A will be found at this link within several weeks of this session

https://www.jointcommission.org/topics/suicide_prevention_portal.aspx

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Session Evaluation Survey

You will receive an automated email that will direct you how to access an evaluation survey.

We use your feedback to inform future content and assess the quality of our sessions.

The evaluation closes in 2 weeks.

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