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Safety Plan Treatment Manual to Reduce Suicide Risk:

Veteran Version

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Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version

Introduction

This manual describes a brief clinical intervention, safety planning, that can serve as a valuable adjunct to risk assessment and may be used with veterans who have made a suicide attempt, have suicide ideation, have psychiatric disorders that increase suicide risk, or who are otherwise determined to be at high risk for suicide (cf. Stanley & Brown, 2008). This manual is intended to be used by VA mental health clinicians, including suicide prevention coordinators, as well as other VA clinicians who evaluate, treat, or have contact with patients at risk for suicide in any VA setting.

A safety plan is a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that veterans can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides patients with something more than just a referral at the completion of suicide risk assessment. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, veterans can determine and employ those strategies that are most effective.

The purpose of this manual is to provide a detailed description of how VA clinicians and patients may collaboratively develop and use safety plans as an intervention strategy to lower the risk of suicidal behavior. This approach is consistent with the Recovery Model, which views veterans as collaborators in their treatment and fosters empowerment, hope, and individual potential.

Developing a Safety Plan

Safety plans should typically be developed following a comprehensive suicide risk assessment (see Suicide Risk Assessment Guide Reference Manual and VA Assessment Pocket Card, 2007). During this risk assessment, the clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis (this may be a suicide attempt or increased/chronic suicide ideation). During this part of the intervention, patients have the opportunity to “tell their story” about the crisis. This description may include the activating events as well as the patients’ reactions to these events. This discussion helps to facilitate the identification of the warning signs to be included on the safety plan as well as the identification of specific activities that may have been used to alleviate the crisis.

Consistent with an approach described by Jobes (2006), collaboration is often improved when the clinician and patient can sit side-by-side, use a problem solving approach, and focus on developing the safety plan. Given that collaboration and the therapeutic alliance is paramount for developing safety plans and engaging patients in treatment, the safety plan should be completed using a paper form with the patient (see the Safety Plan form and corresponding Safety Plan Brief Instructions in the Appendix). Information from the safety plan may then be entered using the computerized template once the session has ended or the safety plan may be scanned into the electronic medical record. In general, safety plans should consist of *brief instructions using the patient’s own words* and should be *easy-to-read*.

The basic components of the safety plan include (1) recognizing warning signs that are proximal to an impending suicidal crisis; (2) identifying and employing internal coping strategies without needing to contact another person; (3) utilizing contacts with

people as a means of distraction from suicidal thoughts and urges. This includes going to healthy social settings, such as a coffee shop or place of religion or socializing with family members or others who may offer support *without discussing suicidal thoughts*; (4) contacting family members or friends who may help to resolve a crisis and with whom suicidality can be discussed; (5) contacting mental health professionals or agencies; and (6) reducing the potential for use of lethal means. Patients are instructed first to recognize when they are in crisis (Step 1) and then to follow Steps 2 through 5 as outlined in the plan. If following the instructions outlined in Step 2 fails to decrease the level of suicide risk, then the next step is followed, and so forth.

Step 1: Recognizing Warning Signs

Rationale: The first step in developing the safety plan involves the recognition of the signs that immediately precede a suicidal crisis. These warning signs can include personal situations, thoughts, images, thinking styles, mood, or behavior. One of the most effective ways of averting a suicidal crisis is to address the problem before it emerges fully.

Instructions: In order to do this, patients should be helped to identify and, just as importantly, to pay attention to their warning signs. In helping veterans to identify these signs, the clinician may ask: "*How will you know when the safety plan should be used?*" Alternatively, patients may be asked to identify what they experience when they start to think about suicide or encounter extreme distress. The specific warning signs will vary from patient to patient and may include one or more of the following domains: thoughts, images, thinking processes, mood, or behavior. These warning signs are then listed on the safety plan *using the patient's own words*.

Examples: ***Thoughts:*** "I am a failure." "I don't make a difference." "I am worthless." "I can't cope with my problems." "I can't take it anymore." "Things aren't going to get better."

Images: "Flashbacks."

Thinking Processes**:** "Having racing thoughts."

Mood: "Feeling irritable." "Feeling down." "Worrying a lot."

Behavior: "Spending a lot time by myself." "Avoiding other people." "Not doing activities that I usually do." or "Using drugs."

Step 2: Using Internal Coping Strategies

Rationale: After patients have identified the signs that are associated with a suicidal crisis, they are asked to list some activities that they could employ without needing to contact other people. Such activities function as a way to help patients take their minds off their problems and prevent suicide ideation from escalating. Given that the most effective activities will vary from person to person, the veteran should be an active participant in generating these strategies. The specific strategies may or may not include skills that were learned during therapy. As a therapeutic intervention, it is useful to have patients try to cope on their own with their suicidal feelings, even if it is just for a brief time.

Instructions: There are several steps for identifying internal coping strategies including (a) the identification of coping strategies, (b) the likelihood of using such strategies, and (c) the identification of barriers and problem solving.

Identification of coping strategies: Patients may be asked, "*What can you do on your own if you become suicidal again, to help yourself not to act on your thoughts or*

urges? What activities could you do to help take your mind off your problems even if it is for a brief period of time?" The coping strategies should include specific behaviors that the patient could do without contacting another person.

Assess the likelihood of using such strategies: After some internal coping strategies have been generated, the clinician should obtain specific feedback. For example, the clinician might ask, "*How likely do you think you would be able to do this step during a time of crisis?*"

Identification of barriers and problem solving: If patients express doubt about their ability to implement a specific step on the safety plan, then the clinician may ask, "*What might prevent you from thinking of these activities or doing these activities even after you think of them?*" The clinician may use a collaborative, problem solving approach to ensure that potential roadblocks to using these strategies are addressed and/or that alternative coping strategies are identified. If veterans still remain unconvinced that they can apply the particular strategy during a crisis, other strategies should be developed. The clinician should help patients to identify a few of these strategies that they would use in order of priority; the strategies that are the easiest to do or most likely to be effective may be listed at top of the list.

Examples: Internal coping strategies may involve engaging in a wide variety of specific behaviors such as going for a walk, praying, listening to inspirational music, going online, taking a shower, playing with a pet, exercising, engaging in a hobby, reading, or doing chores.

Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support

Rationale: When the internal coping strategies are ineffective and do not reduce suicidal ideation, patients should identify key social settings and people in their natural social environment who may help take them outside themselves and distract them from their suicidal thoughts and urges. This may be either individuals, such as friends or family members, or may be healthy social settings in which socialization occurs naturally. Examples of the latter include coffee shops or places of religion. These settings depend, to a certain extent, on local customs but veterans should be encouraged to exclude environments in which alcohol or other substances may be present. In this step, when contacting others, veterans should be advised to identify social settings or individuals who are good "distractors" from their own thoughts and worries. This step is not for reaching out to others for specific help with the suicidal crisis. Socializing with friends or family members without explicitly informing them of their suicidal state may assist in distracting patients from their problems including distracting them from their suicidal thoughts. A suicidal crisis may also be alleviated if veterans feel more connected with other people.

Instructions: Patients are instructed, specifically, to reach out to these individuals or to go to these social settings if engaging in the internal coping strategies in the second step does not resolve the crisis. It is important to ask patients to list several people and/or settings, in case the first choice is unavailable. Thus, the list is prioritized, and phone numbers and/or locations may be included. It is important to remember the both individuals and safe places where they have the opportunity to be around others, such as coffee shops, may be included. It may be helpful to ask*, "Who*

helps you feel good when you socialize with them?" or "Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings." or "Where can you go where you'll have the opportunity to be around people in a safe environment?"

Examples: Identify individuals who are friends or acquaintances with whom the patient has a cordial, noncontroversial relationship or, if few friendships exist, identify places where casual social contacts may occur, e.g. local coffee shop. (Places where substance use takes place are generally not a good choice.)

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

Rationale: If the internal coping strategies or social contacts for purposes of distraction and connection offer little benefit to alleviating the crisis, veterans may choose to inform family members or friends that they are experiencing a suicidal crisis. This step is distinguished from the previous step in that veterans explicit identify that they are in crisis and need support and help.

Instructions: The clinician may ask: "*Among your family or friends, who do you think you could contact for help during a crisis?*" or "*Who is supportive of you and who do you feel that you can talk with when you're under stress?*" Given the complexity of deciding if patients should or should not disclose to others that they are thinking about suicide, the clinician and patient should work collaboratively to formulate an optimal plan. This may include weighing the pros and cons of disclosing their suicidal state to a person who may offer support. Thus, veterans may choose to enlist individuals who may help to distract themselves as indicated in Step 3 as well as individuals who will

assist in managing a suicidal crisis as indicated in Step 4. For both of these steps, patients should be asked about the likelihood that they would contact these individuals and to identify potential obstacles and problem solve ways to overcome them. If possible, someone close to the patient with whom the safety plan can be shared should be identified. This person should be named on the plan. Sometimes it is not possible for veterans to identify someone, or they may not feel comfortable sharing the plan with his family or friends. It is **not** mandatory that veterans identify a friend or family member who will have access to the safety plan. It is important to remember that the safety plan is intended to be helpful and supportive and not a source of additional stress or burden.

Examples: Spouse/partner, sibling, parent, close friend, clergy

Step 5: Contacting Professionals and Agencies

Rationale: The fifth step consists of professionals or other clinicians who could assist veterans in a time of crisis and the corresponding telephone numbers and/or locations. Patients are instructed to contact a professional or agency if the previous strategies (i.e., coping strategies, contacting friends or family members) are not effective for resolving the crisis.

Instructions: As with the other steps of the safety plan, the list of professionals or agencies may be prioritized. If patients are actively engaged in mental health treatment, the safety plan may include the name and phone number of this provider. However, the safety plan should also include other professionals who may be reached especially during non-business hours. The safety plan emphasizes that appropriate professional help is accessible in a crisis and, when necessary, indicates how these services may be obtained. As mentioned previously, patients may be reluctant to

contact professionals and disclose their suicidality for fear of being hospitalized or rescued using a method that is not acceptable to them. The clinician should discuss the veterans' expectations when they contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so. As with the previous steps, the clinician should discuss any concerns or other obstacles that may hinder the veteran from contacting a professional or agency. Only those professionals whom the veteran is willing to contact during a time of crisis should be included on the safety plan. Questions here might be, "*Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers?"*

Examples: Primary mental health clinician, other mental health clinician, 24-hour local urgent care services facility or emergency department, and the VA Suicide Prevention Hotline: 800-273-TALK (8255). *Please note that the VA Suicide Prevention Hotline is staffed by trained mental health clinicians who are well versed in veterans' concerns. This service is available 24 hours a day, 7 days a week. Upon calling, veterans will be instructed to press "1" on their telephone keypads in order to be routed to the veteran-specific call center in Canandaigua, NY. Veterans may also choose not to identify themselves as veterans when using the hotline.* In some settings or circumstances when access to urgent mental health or medical care is limited (or not appropriate), then the clinician and patient may decide to include calling 911 on the safety plan.

Step 6: Reducing the Potential for Use of Lethal Means

Rationale: The risk for suicide is amplified when patients report a specific plan to kill themselves that involves a readily available lethal method. Even if no specific plan is

identified by the veteran, a key component in a safety plan involves eliminating or limiting access to any potential lethal means in the patient's environment. This may include safely storing medication, implementing gun safety procedures, or restricting access to knives or other lethal means.

Instructions: Depending on the lethality of the method, implementing the decision to remove or restrict the method will vary. The clinician should ask patients which means they would consider using during a suicidal crisis and *collaboratively identify ways to secure or limit access to these means*. The clinician should routinely ask whether the veteran has access to a firearm (such as a handgun, rifle or shotgun), whether or not it is considered a "method of choice" and make arrangements for securing the weapon. For methods with lower lethality (such as drugs or medication with a low level of toxicity), the clinician may ask veterans to remove or restrict their access to these methods themselves before they are in crisis. For example, if patients are considering overdosing, having them ask a trusted family member to store the medication in a secure place might be a useful strategy. The urgency and importance of restricting access to a lethal method is more pronounced for highly lethal methods. For methods of high lethality, such as a firearm, asking veterans to temporarily limit their access to such means themselves and give it to a family member or other responsible person is problematic, as the veterans' risk for suicide will increase further due to direct contact with the highly lethal method. Instead, an optimal plan would be to restrict the veterans' access to a highly lethal method by having it safely stored by a designated, responsible person—usually a family member or close friend, or even the police (Simon, 2007). The clinician should also be aware that restricting access to a lethal method does not guarantee patients' safety because they may decide to use another method. If

veterans report any other methods or specific plans for suicide, then these means should also be secured or the access to these means should be limited. The specific behaviors necessary to make the patients' environment safer should be noted on the safety plan. The clinician can ask veterans, *"What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?"* and *"How can we go about developing a plan to limit your access to these means?"*

Implementation of the Safety Plan

Assess for likelihood that the plan will be used and problem solve if there are obstacles: After the safety plan has been completed, the clinician should assess the veterans' reactions to it and the likelihood they will use the safety plan in general. The clinician may ask: *"How likely is it that you will use the safety plan when you notice the warning signs that we have discussed?"* If patients report or the clinician determines that they are reluctant or ambivalent to use it, then the clinician should collaborate with them to identify and problem solve potential obstacles and difficulties to using the safety plan. The clinician may ask: *"What might get in the way or serve as a barrier to your using the safety plan?"* For specific barriers that are identified, the clinician may say: *"Let's discuss some ways to deal with this problem(s) so that you will be able to use the safety plan when it would be the most helpful for you."* For example, some veterans may feel that they may have trouble reaching out to others for help. The clinician should help veterans identify what is likely to stand in the way of asking for help and ways to minimize this obstacle. They may also refuse to use their safety plan because they find the name of the strategy, "Safety Plan," to be offensive. In this instance, the clinician would work with the veterans to find an alternative name such as "Plan B" or "Action Plan" that they may find has a more neutral connotation. Once patients indicate that they are willing use the safety plan during a crisis, then the original document is given to them to take with them and a copy is kept in the medical record. The clinician also discusses where veterans will keep the safety plan and how it will be retrieved during a crisis.

Evaluate if the proposed safety plan format is appropriate to the veterans' capacity and circumstances: In some circumstances, the clinician may determine that

the format of the safety plan is not appropriate for a particular veteran. For example, if the veteran has cognitive impairment that makes it impossible to follow the plan as put forth in this manual, or for any other reason the veteran is unable to follow a plan on his or her own, the clinician should adapt the approach to the veteran's needs. The implementation of the safety plan should always be made using good clinical judgment that involves an assessment of the appropriateness for any given safety plan methodology. Thus, the format of the safety plan may be adapted depending upon the personal needs of the patient. For example, the Safety Plan form that is provided in the Appendix includes 3 items to be listed under each subheading. In practice, more than 3 items may be listed. However, regardless of the format that is chosen, the most important feature of the safety plan is that it is readily accessible and easy to use. That is, lengthy and complex safety plans are less likely to be used by veterans during a crisis.

Review plan periodically: The Safety Plan should be periodically reviewed and discussed and possibly revised by the clinician and veteran after each time it is used. The plan is <u>not</u> a static document. It should be revised as veterans' circumstances and needs change over time.

The safety plan is one component of comprehensive care of the suicidal individual: Brief crisis interventions, such as safety planning, may be especially useful when the opportunity or circumstance for longer-term care is limited. While safety planning is a useful intervention with veterans at risk for suicide, it is important to consider safety planning as one component of comprehensive care for veterans who are suicidal. Other important components include risk assessment, appropriate psychopharmacologic treatment, psychotherapy and hospitalization

Safety planning protocols have been developed for managing suicidal crises in outpatient mental health settings (see Jobes, 2006; Linehan, 1993; Rudd, 2006; Wenzel, Brown, & Beck, in press; Stanley et al., 2008) as part of ongoing and longer-term psychotherapy treatment. In that context, safety plans are used as part of ongoing mental health treatment in outpatient settings and are revised during subsequent visits as new coping skills are learned or as the social network is expanded.

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Appendix

VA Safety Plan Form

VA Safety Plan: Brief Instructions

SAFETY PLAN: VA VERSION

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. Local Urgent Care Services ____________________
   Urgent Care Services Address____________________
   Urgent Care Services Phone ____________________
4. VA Suicide Prevention Resource Coordinator Name____________________
   VA Suicide Prevention Resource Coordinator Phone____________________
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. ____________________
2. ____________________

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

VA Safety Plan: Brief Instructions*

Step 1: Recognizing Warning Signs

__ Ask "*How will you know when the safety plan should be used?"*

__ Ask, "*What do you experience when you start to think about suicide or feel extremely distressed?*"

__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"*

__ Ask *"How likely do you think you would be able to do this step during a time of crisis?"*

__ If doubt about using coping strategies 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 ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.

__ Ask *"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"*

__ Ask patients to list several people and social settings, in case the first option is unavailable.

__ Ask for safe places they can go to do be around people, e.g. coffee shop.

__ Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.

__ Ask *"Among your family or friends, who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*

__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.

__ Ask *"How likely would you be willing to contact these individuals*?"

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.

__ Ask *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers?"*

__ List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255))

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.

__ For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.

__ Restricting the veterans' access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

*See Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008) for a full description of the instructions.