

Safety Planning for Suicide Prevention

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Opinion statement

The Safety Plan was developed to help individuals at risk of suicide to prevent and/or manage suicidal crises. The risk of suicide is elevated for people with serious mental illness, that is, a mental illness that interferes with the ability to carry out one or more major life activities. Serious mental illness makes it difficult to think clearly, make decisions, and take positive action. In other words, it impairs executive functioning. A wide variety of diagnoses, including depression (unipolar or bipolar), borderline personality disorder, post-traumatic stress disorder, and schizophrenia, are associated with this kind of impairment. A Safety Plan in easy reach reduces the burden of problem-solving when a crisis is looming and the ability to think clearly is impaired. There is no need to figure out what to do to interrupt a darkening mood, because strategies that may help are already written out. There is no need to look up emergency contact information, because it has already been compiled. Essential as this information can be, a well-constructed Safety Plan is more than just a list of strategies and contacts. When the items are individualized and described in detail, they can be potent reminders of cherished memories, simple pleasures that give comfort, and people who care who are in reach and can be counted on to respond when needed. In other words, a well-constructed Safety Plan can reassure its owner that s/he is neither helpless nor alone. Since 2008, the construction of a Safety Plan has been mandated for every patient at risk of suicide at every facility under the auspices of the Department of Veterans Affairs (VA). Today, 8 years since the issuance of this mandate, VA clinicians have not only become accustomed to developing and reviewing Safety Plans in the medical record but also, as this review will suggest, begun to discover for themselves how helpful a Safety Plan can be. As it is not yet known which patients

(e.g., with respect to age, sex, or diagnosis) are likeliest to benefit, or whether the impact varies with the timing of its construction (e.g., at time of discharge, or the day before), setting, (e.g., in the emergency department or the inpatient unit), and/or mode of delivery (e.g., in group or individual sessions), these and other questions that aim to optimize Safety Plan effectiveness merit further investigation.

Introduction

History Suicide is among the ten leading causes of death in the USA [1]. The suicide rate in 2014 was the highest since 1986: 13 per 100,000 people. Since 1999, suicide rates have been rising in every age group, and since 2006, they have doubled, from 1 to 2 % per year [1]. A look at the raw numbers is even more startling. In 1999, there were 29,199 suicides and in 2014, 42,773, an increase of 46 %.

Suicide rates among US military veterans have risen as well. Until 2006, suicide rates (adjusted for age and gender) were lower for veterans than for adult civilians; however, by 2014, death by suicide was 21 % more likely for veterans than for their adult civilian counterparts [2]. In 2014, an average of 20 veterans died by suicide each day [2]. In particular, suicide rates for younger veterans (18–29) and for veterans ages 30–39 increased sharply between 2001 and 2014, while rates for civilians in these age groups remained stable [2]. The number of non-fatal suicide attempts among recipients of VA services increased as well, even after the nationwide implementation of a multi-faceted program for suicide prevention by the Department of Veterans Affairs: while 700 such attempts were reported for August, 2012, nearly 900 were reported for August, 2014 [2].

These findings highlight the urgency of developing and evaluating interventions for the prevention of suicide. The need may be especially acute for an intervention suitable for use by individuals for whom treatment is available but not acceptable [3]. To the extent that mental health problems are viewed as weaknesses or moral failings, rather than as injuries or illnesses, it can be difficult for anyone to acknowledge them or to commit to treatment. Mental health stigma diminishes the self-respect of individuals with mental health problems and may be especially acute for veterans because of the centrality of resilience in military culture [4]. Stigma also can jeopardize current employment or prospects for future employment [5].

Treatment overview Patients at risk of suicide have been treated with a variety of approaches, some of which have

demonstrated effectiveness in randomized clinical trials, e.g., intensive case management [6, 7], dialectical behavior therapy (DBT) [8], interpersonal psychotherapy [9, 10], and cognitive behavior therapy (CBT) [11, class II]. As these have been described elsewhere, this review will focus on the Safety Plan in the formats reported to date in a small but growing body of literature.

The Safety Plan originated as the crisis plan component of a ten-session series of CBT sessions for persons who had recently made a suicide attempt [11, class II]. The VA Safety Plan is co-constructed by a veteran and a clinician. In six steps (see Fig. 1), the veteran identifies the thoughts and beliefs that come to mind prior to a suicide attempt and devises specific adaptive strategies for countering and reframing them. At each step, the veteran is encouraged to list items that reflect his/her personality, interests, and circumstances.

The time required for the plan construction encounter can be as little as 15 minutes or as many as 60 minutes; a more typical time frame is 30–40 minutes. Once the plan is completed, it becomes part of the veteran's medical record. The veteran takes a copy home for use in self-care, that is, to avert or safely contain suicidal crises.

At VA facilities, the Safety Plan has most often been used as a stand-alone, one-on-one intervention, but it also has been tried as a group intervention (e.g., for psychiatric inpatients) and as a component of a multi-part intervention (e.g., Safety Planning in the emergency department, followed up with case management by telephone). Recent VA-based studies on these approaches are summarized below. Also summarized is a recent review of the integration of Safety Plans in mobile mental health applications (apps) that either include or are dedicated in their entirety to suicide prevention.

Safety plan construction in the emergency room, with telephone follow-up A substudy conducted as part of a larger clinical demonstration in five geographically dispersed VA facilities examined service utilization outcomes after emergency room (ER) visits for 96

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).	

Fig. 1. Safety Plan treatment manual to reduce suicide risk: veteran version. Washington DC: US Department of Veterans Affairs [12].

suicidal individuals who had had two such visits in a 6-month period [13, class IV]. On the first ER visit, the veteran received usual care. The second ER visit, which included Safety Planning, was followed up with supportive telephone calls from the study clinician who collaborated with the patient on plan construction in the ER. Each call included brief assessment of risk for suicide, review and revision of the Safety Plan, and identification and resolution of barriers to treatment. The first call was made within a week of the veteran's discharge from the ER. Additional calls were made weekly until the veteran attended his or her first two appointments for outpatient mental health or substance abuse treatment [14•]. Utilization of behavioral health services was significantly greater after receipt of this dual-component intervention than after receipt of usual ER care [13, class IV].

Safety planning in groups In light of the therapeutic advantages of group work (e.g., normalization of experience), the Suicide Prevention Team at the Denver VA Medical Center decided to invite psychiatric inpatients to participate in group sessions dedicated to Safety Planning [15•, class IV]. The group meets once weekly for 60 minutes. Two clinicians co-facilitate. On the scheduled day, the care team selects the veterans who are appropriate for inclusion and the group's facilitators meet individually with each of them to introduce themselves, explain the purpose of the group, and invite the veteran's participation. Even though it takes only one session to construct a Safety Plan, veterans are invited to attend as many sessions as they like. Though quantitative outcome data are not shown, changes observed over time among group participants are described. Some veterans not only amended their Safety Plans but also chose to increase their contributions to the group discussion and the support they gave to other members of the group.

The group does not replace the other mental health services the veteran receives as an individual inpatient. After the group session, the treating clinician meets privately with each participant to review the Plan and make sure that s/he is comfortable with it and understands how to use it.

Another example of Safety Planning in groups is Project Life Force (PLF), a novel, manualized, multi-session intervention targeting suicidal veterans. Developed by Dr. Goodman and recently piloted with funding from the VA Office of Rehabilitation Research

and Development, the intervention supports the initial construction of the Safety Plan while also aiming to engage the veteran in a group of peers and in an ongoing process of amending and individualizing the plan and applying it to everyday life. The intervention's multi-session format also facilitates VA-mandated monitoring for high-risk veterans.

PLF draws on several approaches to treatment: CBT, DBT, skills training, and psychoeducation. PLF groups meet weekly for 10 weeks. Group participants learn skills for distress tolerance, emotion regulation, and interpersonal effectiveness and incorporate them in their respective plans. The intervention also includes training in the use of a Safety Plan mobile app, in order to maximize each veteran's access to the plan and encourage timely utilization of plan content.

Promising preliminary findings (not yet published) from this pilot study—in particular, from an initial qualitative analysis of interviews with PLF participants—suggest that the intervention is both feasible and acceptable. Participants stated that social connection and coping with suicidal urges had improved and that depressive and lonely feelings had diminished. Participants also reported that their utilization of the Safety Plan had increased.

Safety plan utilization by recently hospitalized veterans A qualitative study [16•, class IV], conducted in New York City with a small sample of suicidal veterans (see Table 1), aimed to explore whether and how Safety Planning affected engagement in self-care in the first few weeks after discharge from an inpatient unit, a time of heightened risk for suicide. Two brief interviews were conducted with each of the 20 patients, the first at the time of discharge and the second approximately a month later. Asked at follow-up whether and how they had made use of the plan, some veterans reported not having used it at all. Others said that they looked at it whenever they felt unwell or that they reviewed the plan every day at certain times (e.g., on waking). Asked what had been most useful about having a Plan, some veterans reported that they had reduced their symptoms by using coping strategies, as suggested in the second step. Some used strategies listed on the plan. Others had searched online for ideas, and still others had applied skills learned in outpatient treatment. Some also kept notes on their progress: problems that came up and strategies that helped. For some, it was calming simply to look at the list of activities on the plan, as this

Table 1. Demographic characteristics of interviewed veterans

Age	Mean = 38 (range 23–55)	N (%)
Sex	Male	11 (55)
	Female	9 (45)
Race/ethnicity	Hispanic	11 (55)
	African-American	4 (20)
	Caucasian (non-Hispanic)	3 (15)
	Asian	1 (5)
	Unknown	1 (5)
Employment status	Unemployed/disabled	10 (50)
	Employed (by self or other)	6 (30)
	Full-time student	2 (10)
	Unknown	2 (10)
Marital status	Single/never married	9 (45)
	Divorced	5 (25)
	Married/engaged	4 (20)
	Unknown	2 (10)
Diagnosis (at T1) ^{a, b}	PTSD	10 (50)
	MDD	9 (45)
	Substance abuse	6 (30)
	Other anxiety	5 (25)
	Bipolar disorder	4 (20)
	Psychotic disorders	3 (15)

^aPatients may have more than one diagnosis

^bStudy data do not distinguish between primary and secondary diagnoses

reminded them that there still were things they liked to do and that they still could experience enjoyment.

Another use for the plan was to share it with friends and family members, not only to inform them of its content but also to enlist their support in applying the strategies and using the resources listed. Veterans hoped that sharing the plan would make it easier for friends and family members to talk with them, e.g., to ask about their well-being and to reach out when they seem withdrawn.

Some veterans reported that the experience of collaborating with a clinician on plan construction had helped them feel cared for and less alone. This finding led the first author to seek support from the VA Patient Safety Center of Inquiry for Suicide Prevention (PSCI-SP) to conduct a quality improvement (QI) project during the summer of 2015. Its purpose was to learn about Safety

Planning encounters from the perspective of clinicians. A brief description of the project appears immediately below, under the heading “Clinicians’ Perspectives on Safety Planning.” The clinicians’ recommendations for practice are summarized next under the heading “Treatment: Intervention Procedures.”

Clinicians’ perspectives on safety planning The 12 participants in this VA-funded QI project were members of suicide prevention teams stationed at VA facilities situated either in New York City (Manhattan, Brooklyn, and the Bronx) or in neighboring counties in New York (Suffolk and Westchester) or New Jersey (Essex and Somerset). Examples of their responsibilities include the review of the medical records of suicidal veterans, co-construction of

Safety Plans with them, dissemination of the intervention to other clinicians and clinicians-in-training, and consultation on individual cases.

To facilitate the participation of the suicide prevention specialists, interviews were scheduled well in advance and conducted on station. All six were conducted by the first author, three in small groups, and three one-on-one. The interview script was structured to take an hour at most to com-

plete. The questions elicited recommendations for clinical practice that were illustrated with richly detailed accounts of Safety Planning encounters. Digital audio recordings of the interviews were transcribed by Ms. Wilsnack, who also assisted the first author in the analysis. The section entitled “[Treatment: Intervention Procedures](#)” presents the recommendations obtained from the suicide prevention specialists.

Treatment: Intervention Procedures

Overview

Since 2008, the VA has required the construction of a Safety Plan for every veteran who presents with either (a) a suicide attempt or (b) serious suicidal ideation with plan and intent. For admitted patients, the Plan is to be completed prior to discharge. For outpatients, the Safety Plan is to be constructed on the first visit after the attempt or the ideation is reported. As noted above, it is not yet known which patients (e.g., with respect to age, sex, or diagnosis) are likeliest to benefit from Safety Planning or whether setting (e.g., group versus individual, inpatient versus outpatient) and/or timing of plan construction (e.g., on admission, at time of discharge, or some other point) affects its acceptability or impact in positive or negative ways.

As noted above (in the “[Introduction](#)” section), the VA Safety Plan (shown in Fig. 1) is co-constructed by a veteran and a clinician in a face-to-face encounter that typically takes 30 to 40 minutes. The veteran then takes a copy home for use in self-care, that is, to avert or safely contain suicidal crises. The Plan also becomes part of the veteran’s medical record.

The suicide prevention specialists who took part in the QI project described above recommended that the Plan be reviewed with the veteran and updated as needed on subsequent visits to the outpatient clinic. Keeping contact information current is vitally important not only to the veteran but also to clinicians because access to this information in the medical record saves precious minutes in the emergency room (or at other moments of crisis) when the veteran may not have a mobile phone in hand or may find the phone too difficult to use. A change that many veterans make in their Plans is to remove contacts—a change that merits clinical exploration because it can denote instability in the veteran’s support network. The suicide prevention specialists further recommended that the progress note for the review of the Safety Plan include such information as how the veteran is feeling, whether s/he has a copy of the Plan, the extent to which s/he finds the Plan helpful (or irrelevant), and the changes made.

The safety plan encounter

Despite the brevity and seeming simplicity of the Safety Plan format, the suicide prevention specialists agreed that collaborating with the

veteran to individualize the Plan requires the investment of considerable clinical skill. This investment is well rewarded when the Safety Planning encounter increases the clinician's understanding of the veteran, lends focus to the risk assessment, and suggests ways to strengthen the overall treatment plan.

The suicide prevention specialists emphasized that some veterans need added prompts to fully grasp the meaning of a step and respond to it in ways that are both personal and pragmatic. For example, a plan for securing and/or removing weapons, if any, is a good starting point for step 6 (making the environment safe), but additional prompting may be needed to identify and address other hazards in the patient's environment. For example, what did the veteran use in past suicide attempts? What can the veteran do to steer clear of places, things, and situations that trigger dark moods? In this regard, might it be helpful to the veteran to keep the Safety Plan handy? What if the only coping strategies the veteran mentions are simply impractical at certain seasons or times of day (e.g., taking a walk during a storm or playing loud music after midnight)? What if the veteran's preferred coping strategy (e.g., drinking alcohol) is one that is likely to cause harm?

The suicide prevention specialists also recommended that clinicians look for clues to a veteran's state of mind in the way in which s/he responds to the steps. For example, a veteran's inability to verbalize anything s/he might do to feel better, or safer, may signify hopelessness, which is hypothesized to drive the desire to die [16•, class IV]. Someone whose remarks are unresponsive to the questions, or whose responses are sarcastic, may be feeling defensive and distrustful. Responses that sound too pat and shallow may indicate that the individual is too distracted to engage seriously in Safety Planning. For example, the last hours before discharge home may strike the patient as the wrong time to have a deeply personal discussion with potential to stir up intense feelings.

Safety plans in mobile applications for suicide prevention

A recent review [17•] summarizes app cost, features, and content. Of the 49 suicide prevention apps found to contain best practices and/or evidence-based strategies, 14 (28.6 %) allowed users to create Safety Plans. Though the Safety Plans found in these apps were similar to each other in content (e.g., inviting the user to list coping strategies), they differed from one another in some features (e.g., whether contact information could be imported from the address book, whether content could be protected with a password or personal identification number, or whether the app could use location data from the phone to help the user find the nearest mental health resource).

Questions for further study

Since responsibility for Safety Plan construction does not rest solely with specialists in suicide prevention, interviewing other clinicians

who collaborate with patients on Safety Planning might help to identify “best practices” for particular settings, such as emergency departments, substance abuse treatment programs, and services for the homeless. Through such interviews, it should be possible to identify the Safety Planning practices that clinicians have found most helpful in increasing patient stability and safety.

To gather stronger evidence on the impact of Safety Planning, it will be necessary to conduct multi-site studies that follow larger numbers of at-risk patients for 6 months or more. To identify similarities and differences in patterns of Plan use, it might be fruitful to compare individuals with Plans in hard copy only, individuals with Plans in mobile formats, and recipients of multi-component interventions that include Safety Planning and other promising approaches, such as the Hope Box [18].

Conclusions

1. The Safety Plan template is a framework for a brief, yet crucial conversation that otherwise might be difficult to start or sustain. While the Plan construction encounter is too brief to replace an in-depth risk assessment, it can elicit clinically relevant information while also helping to engage the patient in treatment and/or self-care. Additional prompts may be needed to obtain rich and useful information from the patient, but prompting is a skill with which clinicians are familiar as a result of their training.
2. A difference between the Safety Plan and most other take-home instructions is that the Safety Plan is the product of collaboration between patient and clinician. This collaborative process is a unique opportunity to demonstrate caring. While caring is always a positive value, its relevance and resonance may be especially strong in suicide prevention, since the belief that no one cares is common among persons who are suicidal.
3. Media attention to the issue of suicide prevention may prompt some patients and family members to ask clinicians for information and advice about suicide prevention apps. Especially since the apps vary widely in quality, with some too generic and others high in potential for harm, it makes sense for clinicians to prepare ahead of time for such questions and also to ask patients what apps, if any, they are using. Recommendations should be confined to apps that have received high ratings for content.
4. Even though Safety Planning cannot yet be labeled an “evidence-based practice,” its acceptance by clinicians is growing, and it remains a subject of intense research interest.

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Compliance with Ethical Standards

Conflict of Interest

Jaime Wilsnack and Marjorie F. Goldstein declare that they have no conflicts of interest.

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Human and Animal Rights and Informed Consent

This article does not contain any studies with human or animal subjects performed by any of the authors.

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