Safety Planning with Suicidal Patients:

Understanding the Process and "Supercharging" Therapeutic Outcomes

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1

General Introduction

- Suicidal ***crises*** tend to ebb and flow quickly (e.g., Simon et al., 2001; Stanley & Brown, 2012).
- People are unable to think clearly when in crisis.
- Strategies that have historically been recommended for helping patients manage acute crises include:
  - "No suicide contracts"/"Contracting for safety"
  - "Stabilization plans"
  - "Safety plans"
  - "Crisis response plans"
- These terms are ***not necessarily*** interchangeable.

2

"No Suicide Contracts"

- Patients "solemnly promise" that they will not directly harm themselves *under **any** circumstances* (Leahy et al., 2012, p. 36).
- Qualitative feedback from **practitioners** (e.g., Farrow et al., 2002) suggests that they find these contracts to be:
  - "Protective" against suicide/malpractice
  - Useful for risk determinations
  - "Empowering" for patients
- **In reality**, these contracts have been shown to be:
  - **NOT** protective against **either** (e.g., Rudd et al., 2006; VA/DoD, 2013)
  - **NOT** useful for risk determinations, given patient experiences of "coercion" (e.g., Farrow et al., 2002)
  - **"**Intimidating" and "disempowering" per **patient report** (Farrow et al., 2002)

3

"Safety Planning"/ "Crisis Response Planning"

- These interventions are ***philosophically different*** from no-suicide contracts.
- Practitioners work with patients to collaboratively determine what they **can do** during future crises.
- Different variations of this intervention have been discussed in literature. But, **all** overlap on general domains emphasized:
  - Identifying "triggers"
  - Engaging internal coping
  - Decreasing isolation
  - Learning when and how to access professional resources
  - Making the environment safe

4

"Safety Planning" (Cont.)

- Safety planning/crisis response planning is included as a key part of most suicide-focused approaches/treatments, including:
  - Brief Cognitive Behavioral Therapy (e.g., Rudd, 2012)
  - Cognitive Therapy for Suicidal Patients (Wenzel et al., 2009)
  - Collaborative Assessment and Management of Suicidality (Jobes, 2006)
  - Post-Admission Cognitive Therapy (Ghahramanlou-Holloway et al., 2012)
- It has also been used as a **single session intervention** for both civilians (Stanley & Brown, 2012) and Veterans (e.g., Knox et al., 2012; Stanley & Brown, 2008) in both inpatient and outpatient settings (Rings et al., 2012).

5

"Safety Planning" (Cont.)

HOWEVER:

- Not all patients "buy into" these interventions.
  - Anecdotal evidence suggests that some patients do not know ***why*** this intervention was recommended or ***how*** a "piece of paper" will keep them safe.
  - *This feedback is consistent with previous reports from patients who presented to the ER following a suicide attempt and who did not feel they received adequate information about treatment options (e.g., Cerel et al., 2006).*
- Also, anecdotal ***clinician*** *feedback* suggests that some approach this as a mandatory task that has to be completed.

6

How Can Clinicians Make This Process Feel Therapeutic?

- Set the stage by catching patients' "suicide stories" and "living narratives"
- Reduce suicide-specific shame
- "Sell" the intervention in an **idiosyncratic** manner
- Plan specific steps in a way that illustrates why ***this individual patient*** would find them useful.

7

Setting the Stage

- Clinicians are generally encouraged to complete a comprehensive, nuanced risk assessment before shifting into safety planning (Matarazzo et al., 2014; Stanley & Brown, 2012).
- Information obtained from a risk assessment that clarifies patients' idiosyncratic "**stories**" about their **suicidal crises** and their **reasons for living** is particularly useful for "selling" and completing this intervention.

8

Catching the "Suicide Story"

- Suicide "stories" emphasize life variables and internal/external factors that triggered, fueled, and ultimately ended someone's suicidal crisis (e.g., Michel & Valach, 2011).
- To catch the "story," practitioners are encouraged to:
  - Verbally and nonverbally convey openness for and interest in ***any suicide specific-content***.
  - *Genuinely* praise patients for disclosing this information.
  - Use concrete techniques when patients lack insight into relevant parts of their story. Such techniques include:
    - Beginning with the major "decision point" associated with increased suicide risk and working "backwards in time" (Stanley et al., 2013)
    - Functional analyses of suicidal crisis (activating events, beliefs, consequences)
    - Chain analysis (Linehan, 1993; Rizvi & Ritschel, 2013)
    - Imagining the index suicidal crisis as if it were happening right now (Wenzel et al., 2009)

9

Catching the "Living Narrative"

- Conversely, understanding the story of what makes a patient's life worth living can help practitioners find "hooks" for implementing this intervention.
- Suicidal patients may struggle to identify reasons for living (e.g., Malone et al., 2000), so practitioners may find it helpful to assess several domains, like:
  - Enjoyable activities
  - Future-focused plans/goals/wishes
  - Personal/religious beliefs against suicide
  - "Cons" of Suicide
  - ***Personal values and sources of meaning***
- If patients cannot identify reasons for living despite being prompted, then practitioners might consider using the acceptance and commitment therapy stance of "***In our pain we find our values, in our values we find our pain***" as a way to tap values that have not been identified.

10

Reducing Suicide-Specific Shame

Two evidence-based interventions for alleviating shame (Finn, 2014) may be particularly useful when transitioning from risk assessment to safety planning:

1. Directly confront/challenge shame

- Honestly, empathically, and authoritatively tell patients that experiencing suicidal ideation or making a suicide attempt ***does not mean*** that they are inherently "broken," "bad," or "worthless" (or other self-labels identified)
  - Eye contact makes such statements especially powerful.

11

Reducing Suicide-Specific Shame (Cont.)

2. Reframe the "story"

- Instead, suggest that suicidal thoughts reflect ***significant pain/struggle***, and that such thoughts are ***completely normal*** given the patient's broader "story."
  - Provide idiosyncratic examples to illustrate this
  - *"**Anyone** with that context would think about hurting/killing himself"*
- Further reframe by providing an alternative explanation for why ***this patient*** is struggling.
  - Neurobiological overview

12

Setting the Stage: Conclusions

- Understanding a person's suicide specific "stories" allows you to:
  - Gauge and reduce their shame in this area
  - Empathize with their their pain ***and*** their reasons for living (Orbach, 2001; Jobes, 2006)
  - Suggest a "new story" using contextual information and relevant psychoeducation
  - Introduce a safety planning intervention in a ***personally significant way*** that ***gives hope for wiring in this "new story"***
- These gains are most likely maximized when the preceding discussion is:
  - Open and nonjudgmental
  - Collaborative in nature
  - Treated in such a way that the patient is considered the "expert" of his or her distress (e.g., Jobes, 2006)

13

Planning Specific Steps

Remember:

Different variations of safety plans/crisis response plans have been discussed in literature. But, ***all*** overlap on general domains emphasized:

- ***Identifying "triggers"***
- ***Engaging internal coping***
- ***Decreasing isolation***
- Learning when and how to access professional resources
- ***Making the environment safe***

14

Planning Specific Steps (Cont.)

- ***Identifying "triggers"***
- Engaging internal coping
- Decreasing isolation
- Learning when and how to access professional resources
- Making the environment safe

15

Identifying "Triggers": Introduction/Process

- Identifying personal "triggers" and "warning signs" can allow patients to become more aware of factors that start/precipitate suicidal crises.
- This process may, in turn:
  - Boost their confidence in their ability to manage crises
  - Further reduce their suicide-specific shame
  - Increase their overall psychological flexibility, as this information will increasingly allow them to ***respond***, not ***react*** to crises

16

Identifying "Triggers": Concrete Strategies

- Much of this information will directly come out of the suicide story previously identified.
- Practitioners can engage patients in this step by asking one of the following questions:
  - *How will you know when you should use your safety plan?*
  - *What are some signs that make you think a crisis is coming?*
  - ***NOTE***: Some patients may prefer different wording for these factors than "warning signs" or "triggers." Practitioners should consciously choose to adopt the verbiage that patients prefer.

17

Identifying "Triggers": Barriers (Cont.)

Patients might say that they are not sure what their warning signs are.

If this happens, clinicians can:

- Suggest possible warning signs from the completed risk assessment
  - *I noticed X. When X happens, how do you feel?*
  - *Have you noticed X before when in crisis?*
- Ask about **behaviors** specifically
  - *How do you know you're not feeling well?* ***What do you do?***
- Encourage patients to ask supportive others whether they have noticed "signs" along these lines
  - *Is there anything someone else would say could be a sign that something's wrong or that you're in crisis?*
  - *Do they ever say you act differently when things are really bad?*

18

Planning Specific Steps (Cont.)

- Identifying "triggers"
- ***Engaging internal coping***
- Decreasing isolation
- Learning when and how to access professional resources
- Making the environment safe

19

Enhancing Internal Coping: Introduction/Process

- Patients who manage suicidal crises independently before contacting other people may feel more self-confident and find this intervention more useful over time (Stanley & Brown, 2012).
- Guidelines for enhancing internal coping often recommend that patients list as many strategies as they can think of that they could use to relax, distract, or soothe themselves (e.g., Linehan, 1993; Stanley & Brown, 2012).
  - ***HOWEVER***, applying strategies like distraction in an ***unfocused manner*** when experiencing suicidal ideation can be associated with a rebound effect (e.g., Najmi & Wegner, 2008).
  - In contrast, applying distraction or other strategies in a ***focused manner*** seems to make this rebound effect less likely.

20

Enhancing Internal Coping: Concrete Strategies

- Clinicians should help patients identify ***personally meaningful*** strategies and plan how to implement them in a ***focused, consistent manner***.
  - *Where?*
  - *When?*
  - *How?*
    - ❑ "*Walk*" vs. "*Walk for 20 minutes in X park*"
- Gauge patients' likelihood of ***actually*** using specific strategies through questions like "*How likely do you think you would be to use this during a time of crisis?*"
  - It can be useful to quantify this question (e.g., using a 0 – 10 scale) and to only include skills on a crisis response plan that meet a certain cutoff score (e.g., 8 or 9 on that scale).

21

Enhancing Internal Coping: Concrete Strategies (Cont.)

- **Values-based activities** or activities associated with **personal meaning** should be especially emphasized.
  - Patients may be more likely to engage in values-consistent strategies ***even when not in crisis*** because they are personally meaningful.
  - Such repetition can boost mood and maximize the chance that these activities are also used in crisis.
  - Ideas for such activities can come from the "living narrative."

22

Enhancing Internal Coping: Barriers (Cont.)

Practitioners should consider proactively gauging barriers that might emerge for patients with this step.

This can be done with a question like "*What might stand in the way of your thinking of these activities or actually doing them in a crisis?*"

23

Enhancing Internal Coping: Barriers (Cont.)

Patients might say that they do not have any coping skills.

If this happens, clinicians can:

- Suggest ideas by referencing reasons for living and/or values identified during the risk assessment.
- Draw from the patient's past successes, asking a question like "*Have you ever dealt with hard times in the past? What did you do then?*"
- Build on recent experiences, if applicable.
  - Patients who experienced suicidal ideation but did not make a suicide attempt could be asked *"What helped you before this most recent crisis?"*
- Use a list of activities for brainstorming, like the dialectical behavior therapy pleasant events list (Linehan, 1993), and identify some which are personally meaningful.

24

Planning Specific Steps (Cont.)

- Identifying "triggers"
- Engaging internal coping
- ***Decreasing isolation***
- Learning when and how to access professional resources
- Making the environment safe

25

Decreasing Isolation: Introduction/Process

- If patients are unable to mitigate crises on their own, all forms of safety planning/crisis response planning suggest that they should take steps to reduce isolation in some way.
- Ideas for reducing isolation that patients should consider include:
  - Going to locations they enjoy
  - Going to locations where people are but where they (the patients) can be anonymous (e.g., coffee shops)
  - Going to personally meaningful locations
  - Contacting people they enjoy being around/talking to
  - Contacting people whom they can ask for help
  - Accessing professional resources, if no other strategies/contacts/places are available or accessible

26

Decreasing Isolation: Concrete Strategies

- Specific questions practitioners can use to elicit people and places for this step include the following:
  - *Is there anyone that you just enjoy being around?*
  - *Is there anyone who you try to keep up on how they have been doing?*
  - *Is there anyone that you value providing support for? (e.g., kids, grandkids, nieces/nephews, friends, etc.)*
  - *Are there places that you can go that you find personally meaningful?*
  - *Among your family or friends, whom do you think you could contact for help during a crisis?*
  - *Is there anyone who supports you even when you're at your "worst"?*
  - *Is there anyone you feel that you can talk to when you're under stress?*

27

Decreasing Isolation: Concrete Strategies (Cont.)

- For each person or place listed, clinicians should ask about the likelihood that patients would actually access this resource and screen for contentious ("triggering") relationships.
  - The strategy suggested quantifying patients' likelihood of contacting specific people or going to specific places can be used here as well (e.g., 0-10; using options rated "8" or higher).
- Although patients may have phone numbers memorized or included in their phones, they should always be encouraged to write numbers down on their plans.
  - Having numbers written down allows for an option to remain useful even if patients' cannot access their cell phones or if they are not thinking clearly.

28

Decreasing Isolation: Concrete Strategies (Cont.)

- If patients are able to identify supportive others (people they would ***actually*** ask for help), then clinicians should encourage them to share their safety plan with them and explain why they are using it.
  - Patients might be very hesitant to do this, and *it is ultimately their choice*.
  - Connecting with another person in this manner can significantly reduce the shame of needing a "safety plan" and increase their sense of accountability for using it.

29

Decreasing Isolation: Barriers (Cont.)

Patients might say that they do not have anyone they can connect with.

If this happens, clinicians can:

- Gently gauge the validity of this statement using Socratic Questioning, particularly if their report is not consistent with what was noted during the risk assessment.
  - If patients truly do not have access to supportive others, clinicians should normalize their experience and emphasize places for distraction and professional resources instead.
  - A similar approach can be adopted if patients say that they do not want to "burden" supportive others.

30

Decreasing Isolation: Barriers (Cont.)

Patients might say that they do not want anyone who knows them to know they are suffering.

If this happens, clinicians can:

- Gently gauge the utility of this approach using Socratic Questioning.
- If patients remain consistent in not wanting to contact others, clinicians ***should not insist that they do***. Instead, they should validate the patients' preferences and emphasize places for distraction and professional resources instead.

31

Decreasing Isolation: Barriers (Cont.)

Patients might say that they prefer to isolate when distressed.

If this happens, clinicians can:

- Gently gauge the utility of this approach using Socratic Questioning and relevant psychoeducation.
- Determine whether there are "safe," "de-escalating" places they might be willing to access.
- If patients remain consistent in wanting to isolate after taking these steps, clinicians ***should validate and accept*** their preferences.

32

Planning Specific Steps (Cont.)

- Identifying "triggers"
- Engaging internal coping
- Decreasing isolation
- Learning when and how to access professional resources
- ***Making the environment safe***

33

Changing the mindset: Lifeline and lethal means safety

1) **Always provide Lifeline number**
2) **Always discuss access to lethal means**
3) **Verify that means have been secured**
4) **Consider providing your own number**

34

Making the Environment Safe: Introduction/Process

- Means restriction is emphasized in guidelines for safety planning/crisis response planning because of the short-term nature of acute suicidal crises (e.g., Stanley & Brown, 2012) and because of its effectiveness at both the population (e.g., Mann et al., 2005) and individual levels (e.g., McManus et al., 1997).
- Means restriction can help patients feel physically "safer" in their environments, but additional strategies that help them feel like their environments are more "***livable***" and ***supportive*** or ***nurturing*** (Matarazzo et al., 2014) should also be considered.

35

Reducing Access to Lethal Means: Concrete Strategies

- Clinicians can begin discussing means restriction by asking the following questions (*if this information was not obtaining during the risk assessment*):
  - *What means do you have access to that you might use to make a suicide attempt (or to kill yourself)?*
  - *Can we **work together** to develop a plan that can limit your access to these means?*
- Bryan et al. (2011) suggest the following strategies for making this process more collaborative:
  - Providing appropriate psychoeducation for patients (and supportive others, as necessary) about the need for means restriction
  - Emphasizing patient control
  - Giving a variety of options to ensure that patients' choices are respected

36

Making the Environment Safe: Concrete Strategies

- To help patients develop a more "***livable***" environment, practitioners could suggest the following:
  - Creating a hope kit/survival kit (e.g., Wenzel et al., 2009).
    - If patients are willing to develop a hope or survival kit, it may be helpful to discuss the following:
      - The kind of box patients would want to use, and whether they want to adorn it in any particular way
      - What they will put in it
      - Where they will put it
  - Placing multiple copies of the completed plan in accessible areas.
  - Emphasizing patient suggested values, and making a specific plan for planting reminders of reasons for living around the home (e.g., *"I will cut out and hang up the pictures of the places I want to visit that I saw in Backpacker Magazine"*).

37

Reducing Access to Lethal Means: Barriers (Cont.)

Patients may say that they are unable or unwilling to reduce their access to lethal means.

If this happens, clinicians can offer alternative options, including:

- Storing the means in a place that is difficult to access
- Locking up the means and leaving the key in another location
- Giving primary access to another person during periods of distress
- Placing visual cues of specific reasons for living (e.g., sticky notes, pictures, coping cards) on or near lethal means

38

Finishing and Discussing the Plan

- After a safety plan/crisis response plan is created, practitioners should gauge:
  - Patients' questions about, thoughts about, and/or reactions to the process
  - Aspects of the plan that patients consider helpful and unhelpful
  - Patient likelihood of using the plan as a whole
    - Some patients may benefit from "rehearsing" a crisis where they would need the plan and imagining themselves using it successfully (Stanley & Brown, 2012; Wenzel et al., 2009)
  - Where patients will to keep their plan(s)
    - As suggested previously, patients should be encouraged to keep multiple copies in easily accessible areas.
      - *Where will you find this most useful?*
      - ***What modalities*** *(e.g., paper, phone application) would be most useful)?*
  - Patient likelihood of reviewing the plan over time

39

General Conclusions

- Safety plans/crisis response plans ***are not treatment***, but they can be extremely therapeutic.
- Sell the intervention in a ***personally meaningful way*** that makes sense given ***this patient's*** unique ***story***.
- Emphasize internal and external coping strategies that are ***personally meaningful***.
- Decreasing isolation does ***not*** have to involve talking to other people.
- Making the environment safe can (and should) go above and beyond limiting access to lethal means.

40

Thank you!

Questions or Comments? Please contact:

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41