Questions from ‘CDP Presents: The Safety Planning Intervention for Reducing Suicide Risk’ Webinar 9/20/2017, answered by presenter: Greg Brown

Thank you for these questions and for your interest in safety planning. Responses to the question are indicated using a bold font.

1. *Is this the form that is in CPRS?*

   The CPRS safety plan template may or may not be similar to the form. Facilities may have adapted the form for their own use.

2. Would you issue this during a current suicidal ideation episode or to plan for future episodes where therapist isn't present?

   The Safety Plan Intervention is primarily a suicide prevention tool. The safety plan can be completed with patients who are actively suicidal unless they need to be rescued.

3. At what time would you use the safety plan

   The time to use the safety plan is whenever the patient recognizes his or her personal warning signs that indicate that a crisis is occurring or escalating.

4. What do you do when people have such poor social support they can't name anyone to serve as distractors (step 3)?

   It is okay to list acquaintances who may provide distraction. The people listed on step 3 do not necessarily need to be close friends or family members. Also, social places can also be listed that provide distraction.

5. Can you address responses to those clients who respond, "I have no one"

   Sometimes people report that they do not have family members or friends who can provide help during a suicidal crisis (Step 4). I would first empathize with the client’s situation. Then consider lay professionals who may serve in this role such as an AA sponsor, peer specialist, chaplain or clergy, etc. If there is absolutely no one who can be identified, it might be helpful to identify this as a future goal for the patient (identifying people who might serve in this role in the future). Clients, of course, should be instructed to proceed to Step 5 if no one is listed in Step 4.

6. If someone is contemplating suicide I am concerned that telling them to go into a crowd of people may lead to innocent bystanders interacting with someone in crisis which may lead to others getting hurt

   Each item that is listed on the safety plan should be carefully vetted by the clinician to make sure that it will be feasible and helpful in reducing risk. If being around other people in a public setting is likely to increase risk, then this response should not be listed on the safety plan.

7. I agree with concern (mentioned earlier) about using the public/other people as distractions. I think it is very important to talk to client about the risk of disappointment in them if they do not succeed in making the client "feel better." There is risk of taking it out on them when they don't realize the client's distress, which a client may interpret as "nobody cares what happens to me." Important to remind that steps are not guaranteed to work, they must remind themselves to move on to the next step, not do something about the step that is not working, like taking it out on them or teaching them a lesson, etc.

   Reaching out for help from family and friends is something that should always be considered. In vetting people that are listed on the plan, it is crucial that the feasibility and helpfulness of doing so be ascertained, e.g., "Do you think this is someone who you would feel okay in reaching out for help? Do you think that could help you during a crisis? What is the likelihood of this occurring? Can you think of any roadblocks in asking others for help?" I completely agree that it is important for expectations to be realistic when seeking help and patients should be informed that if that doesn't work, then to proceed to the next step (contacting an agency or professional).

8. I am new to the agency I'm interning at. I wonder if they have an SPI form, if not, do you know where I can access one?

   www.suicidesafetyplan.com

9. Is there a specific SPI form for working with youth?

   Not really. The main change to the form is list "adults" to contact on Step 4 so that kids will not go to other kids for help. Some people have developed forms that contain the same content but are formatted in a way that is more appealing to kids.

10. Does this safety plan have a translation to Spanish?

    Yes, the Safety Plan has been translated into Spanish. Please contact gregbrown@pennmedicine.upenn.edu.

11. Most of us therapists in the VA are in Clinics that are not set up for emergency calls as we're often in session or what have you. Should we then not put ourselves as one of the mental health professionals to contact?

    That is up to you. If you list yourself as someone to be contacted, it is important to include the time of day that you are likely to be available and what to do if you are unable to return a call within a specific period of time.

12. Step 6: When soldier have guns? How safe environment?

    Weapon removal or pin removal is just one of the strategies that may be used. If there is concern that a Military Service Member may have access to other firearms, then additional precautions should be taken such as using Buddy Watch or Unit Watch until the Service Member can be safety transported to a safer environment or alternative level of care.

13. As clinicians what should we do when clients (either military or civilian) are adamant that they will not give up their firearm?

    If the client is allowed to legally own a firearm, then it is important that clients understand the rationale for making the environment safer (i.e., increasing the amount of the time it takes to obtain access to a firearm will likely decrease the likelihood that someone will act impulsively). As mentioned during the webinar, it may be helpful to review the pros and cons of weapon removal or what removing access to the firearm means to them. Consider alternative ways of making the environment safer other than weapon removal (e.g., trigger locks and giving the key to someone else). Be knowledgeable about your local, state and federal laws on removing or transferring firearms.

14. Is there a safety storage place that is a public/common building for people to store their guns/weapons instead of keeping them at home? Renata Kadlcek: ...like lockers?

    Many self-storage facilities allow storage of firearms in storage units or lock boxes. Some gun shops and shooting ranges rent lockers for a fee. Some law enforcement departments do offer temporary storage of firearms. Be sure that the firearms are not loaded when stored and use gun locks or locked gun cases.

15. I have sometimes found it helpful to see if the person will remove themselves from the means (eg stay with a friend or family member's place) if they are not ready to remove the means themselves. I am curious about what is recommended when client's have difficulty identifying warning signs or being present, such as dissociation, etc.?

    Sometimes clients report that the urge to kill themselves happens "out of the blue." It is important for clients to understand that they need learn to recognize when warning signs occur so that they know when to use the safety plan. Clients who are encouraged to describe their story within the context of a strong therapeutic alliance are more likely to be forthcoming than in situations when rapport is not that good. Asking clients to recall the specific events leading up to the crisis or asking them to engage in a guided imagery task may help with recall. Clients may be more likely to notice a shift in mood, physical sensations or changes in their behavior than becoming aware of their thoughts.

16. Is there "an app for that?" Could be really helpful. Buttons that call preprogrammed #s built right in, etc.

    Yes. www.my3app.org

17. Are there published research articles on burnout for those who conduct many safety plans (e.g., Suicide Prevention Coordinators in VA, ER and crisis call staff, etc.)?

    Not to my knowledge but it sounds like such a manuscript would be quite helpful. There have been articles published on dealing with burnout among mental health professionals, in general.