[ Captioner is ready and standing by ]

 Hello. Thank you for joining. This presentation will begin in approximately three minutes.

Good afternoon. Welcome to today's webinar entitled the safety planning intervention to reduce suicide risk, by SAMHSA. My name is Kelle Masten, and I would like to thank you all for joining us. Before we introduce today's presenters, today's webinar is being recorded. The recording, along with the PowerPoint presentation slides will be available on the national council's website at WW.the nationalcouncil.org and WWW dot NASMHPD.org within three to five days. For participants only audio is being streamed through your computer speakers with no need to connect by phone unless necessary. If you're having any technical details, write it in the Q & A pod. Please type your questions. At the end of the presentation we will ask as many questions as we can. The PowerPoint slides are available at the top of the screen where it says PowerPoint presentation for you to download. Please click on upload file. At the end of the webinar we ask that you take a moment -- a letter of attendance will be available for you to download on your own when we switch to the evaluation screen. The letter can be found at the top of the screen where it says letter of attendance. If you have any questions, my email address will be available at the top of the screen during the evaluation as well. I would like to thank SAMHSA for allowing to us share this information with you today and, again, thank you for joining us. I will now turn it over to flankery Peterson, senior management for the national council of behavioral health.

Thank you. Today's presenters are doctors Barbara Stanley and Gregory brown. Dr. Stanley is a professor of medical psychology, department of psychiatry. She is also a research scientist in the division of mow leg cue lar energy where she is a principal investigator and coinvestigate or. Her research focuses on borderline personality disorder including assessment and intervention with suicidal individuals, clinical factors rel vents to suicidal behavior and neurobiological and biobehavioral influences. She oversees the suicide prevention training. With her colleague Dr. Gregory brown she developed the safety planning. Dr. Stanley is a member of the learn foundation for suicide prevention and the president of the New York michael phelps regional clap ter. She is on the executive committee of international academy of suicide research and editor in chief of their official journal. She also serves on several journal editorial boarding, the author over 200 publications and has received several awards. Dr. Gregory brown is an expert in suicide prevention whose work has brought advances in the treatment of suicidal individuals and develop innovative targeted interventions designed to reduce vulnerability factors in high risk populations and evidence-based treatment. Specifically Dr. brown is a developer along with his colleagues of two clinical interventions for individuals at risk for suicide including safety planning intervention. The safety planning intervention is an evidence-based prevention strategy and widely disseminated in healthcare settings. He also is one of the interventions cognitive therapy for suicide prevention. Dr. brown is the principal investigator and research grant from American foundation for suicide prevention and the department of veterans affairs and the author of numerous publications and has received several awards for his contributions. Currently serves on the scientific advisory board. With that, I would like to welcome today's presenters and hand it over to Dr. Stanley although will get us

 started. Dr. Stanley, I think you might still be on mute.

Hello, everybody. I'm Barbara Stanley and I'll be presenting today with my colleague Greg brown. I would like to briefly go over the learning objectives as we get started here. So what we would like to do is just give you a basic overview of the safety planning intervention and talk about some of the challenges and perhaps over potential solutions in doing safety planning, particularly in the pop lake with SMI. We're going to talk a little bit about some of the research on safety planning and I will talk about some of the adaptations and the challenges in doing safety planning with individuals who have serious mental illness. So I am going to talk a bit about the background for safety planning and then Greg is going to talk about you know, the how to do it, the nuts and bolts of safety planning and then we'll end by talking about some cases doing safety planning with people with SMI. One of the really important things to remember is that suicide risk varies with time. It does not remain constant with anybody, including those with serious mental illness. So we call this curve that is presented here as the suicide risk curve. When we do safety planning with people, we show them this curve and it's really actually important to show this curve because what you can see here is that if somebody doesn't act on their suicidal feelings on the urges, the risk comes back down, and so it's really important to remind people that their risk doesn't remain constant. So at the beginning here of the curve we see that there is a point at which there is -- the risk escalates. Some people it goes up smoothly like this. Others it goes up slowly and then quickly. Others, it's a very low rise. For here we show the urges to make a suicide attempt or to kill oneself escalates and what we want to do is to help people identify whether there are warning signs so that they can start to enact their emergency plan, in other words, to pull out the safety plan and begin to use it so they don't act on their suicidal feelings. So spending a bit of time on this because this risk curve serves as the basis for psychoeducation for people who are suicidal and as a clinician, on this it's important that you explain this to the suicide hall individual, so we identify what the warning signs are here and that is the indication that the person who is suicide mal needs to pull out their safety plan and begin to use it. The important thing to know if a person doesn't know what their warning signs are, they're not going to know they're in a suicide hall crisis and they're not going to know to pull out the safety plan. Okay. So what is the safety plan? It's actually pretty simple but it turns out that it is not the simplest intervention to do. So the safety plan starts with a list of warning signs that you would have identified with the person. It's this part of the curve here. What are the warning signs and it goes on to say okay, when these warning signs are present, what are the thoughts, feelings, behaviors that are associated with being in a suicide hall crisis and so we identify those warning signs when the warning signs are present. That means we go to steps two, three, four and five in that order, and then we'll talk a little bit about step six, which is making the environment safe later. So who is good to use the safety plan with, this intervention with? So anybody who is at increased risk for suicide is a candidate for a safety plan, but its important to remember that we should not be doing a safety plan with people who need immediate rescue and this is mostly people who you're speaking with over the phone, who you're not in contact with at the month. So we've done a lot of crisis training with the hotline. If somebody has called into a crisis hotline, but the crisis hotline workers will do safety plans but if that person is in danger of making the suicide attempt right at that moment, so, for example, has a gun and they're holding on to the gun and they can't tell you they're going to put the gun away, that person is not appropriate for a safety plan. You have to do what you need to do to rescue them to save their life. So other people who are eligible or good candidates for safety plan are people who have had a history of suicidal behavior, including people who have had aborted attempts. In other words, had false starts, taken pills out, thought about taking them, putting them in front of them on the table and deciding not to do it. That would be an aborted attempt or people who have made preparations for suicide or people who have made suicide attempts. Also, people who have had serious suicidal ideation like had thoughts of killing themselves and have made a plan and have had intent but didn't act on it. They are good candidates for doing this. So, in other words, anybody who has had a suicide hall crisis. But

 in addition, I talk about people who may not be appropriate at least at that moment. There are two categories that I think are really important to think about, people who are in some way or another intoxicated, so they have had a lot of alcohol onboard and their cognition is clear, same with people have recently used substances and who are still under the influence, so you can't do an intervention like this with somebody who needs clear cognition and you can't do it unless they have clear cognition and they are not clear. The other group that is very difficult to do a safety plan with is somebody who is acutely psychotic at the moment and maybe made a suicide attempt recently where they were acting on the basis of a command hallucination, so it's very hard to do a safety plan with somebody who can't think about what their warning signs are because in their mind they may not have a warning sign because it was a command to them. So I'll return back to this a little bit later. So the approach that we take here is that people may have trouble recognizing when a crisis is beginning to occur. So that's why we put the big emphasis on having people tell their story, their narrative of their suicidal crisis, even if it's sketchy in their mind so we can help them identify their warning sign. We emphasize that because we don't want people to be way high up on that risk curve before they start to think about oh, my goodness, I'm going to kill myself. I'm going to make a suicide attempt. So we emphasize identifying warning signs prior to or at the very beginning of a crisis. The other part of our approach here is we know that problem solving and coping skills diminish during an emotional crisis or during an emergency of an sort. We're in the not great problem solvers when the fire alarm is going off in our building. Do we do this first. What do we do second. So we need a plan in place. A third thing that's really important is this is an intervention and I put -- I made this a big I, capital I for intervention. Although you walk away with the form and the clinician fills out the form, it is not just a form to be filled out. You have to think of this as a clinical intervention. The thing I say to clinicians, if you're going to think about this as a form to be completed, don't bother. This is a clinical intervoangs and the client and the clinician have to work together to complete this intervention and you'll see why as we go through this. I used the example of of a fire alarm. This is a firefighter explaining to , what do you do. We know this is a rare event that one would catch on fire just like we hope you sidal crises are rare events but the consequences of whatnot to do are dire. Even though it's a rare event, it's a bad event. We want to make sure people know what to do. This is how we talk to people about about having a safety plan. We don't want you to think about what to do in an emergency. We want you to have lap plan. So I'm saying these words to you as the attendees here but these are the exact workeds that we say to the people that we are doing the safety plan with, so we explain all of this so there is a bit of psychoeducation that goes along with doing a safety plan for -- with our

 clients. So the safety plan, the way we have developed it is step wise. It goes from strategies that are simply by yourself. What do you do on your own to diminish your crisis all the way up to going to the emergency room. So we really like people to think about what they clan do completely on their own first and this is not rocket science. These are simple distraction strategies. We put a lot of emphasis on distraction to get people through the crisis. If we have time later I can talk about more. It starts within self- Sometimes people have a lot of support in their environment. Sometimes they have very little or none. So we work with them. The thing that we also tell people is look, we have this plan for you that's step wise. Don't think you have to go through it in lock step manner. You go from one step to the next but if you don't have the patience to try it and feeling in a crisis, you go on to the next step. If you have somebody in outpatient care, you can do the safety plan in one session and then you should be looking at it or visiting it over time or revising it based on new information, based on if they used it and certain things worked, certain things didn't work. Okay. So I'm going to talk a little bit about some of the data that supports doing safety planning and this is just one example. There are other examples of support showing that this type of approach is helpful with suicidal individuals. This happens to be the biggest, largest sample. So we did a study, project, it was a demonstration project where we implemented safety planning and it's important to note here it was not safety planning alone. So we did safety planning in the emergency department with follow-up phone calls and two people who were seen in the emergency department for suicide crisis. So they came in either having made the suicide attempt having aborted or interrupted attempted or they have suicidal ideation and the physician in the emergency department interviewed the patient and decided that that person did not require hospitalization and so typically what do we do with people like that. We would say, okay. You don't need hospitalization. You are free to go and we would often -- the standard would be to give them a referral and have them go see their -- if they have a clinician on the outside or give them a referral to a new clinician. We thought this was a pretty dangerous circumstance where somebody comes in and makes a suicide attempt, we know that if they made a suicide attempt or had a suicidal crisis, they are at risk of having another attempt in the next two to three months. We decided to try this intervention and so we did the safety plan and did the follow-up plans until people got seated in treatment. At the time we did this project it was a long time before people got -- were able to get care in the outpatient department in the VA because they were so overburdened. And so we wanted people to get something while they were waiting for an outpatient appointment. So what did we find? We saw that -- so we had several sites that had the intervention that we call the safe bed intervention which includes safety planning plus follow up phone calls. In our article we call it SPI plus. We found that in fact giving SPI a plus was associated with 45% fewer suicidal behavior over the next six months. It was not great in the control group but we pretty much have the number of suicide behaviors. In addition, we found that people who had this intervention were more likely to get into outpatient care. So that we thought was pretty important tend increased the odds significantly. Now we also did a mediation analysis and saw it was not so much the intervention but that there was a mediation, that the people that -- in other words, we did the intervention and getting outpatient treatment. It was a direct impact of the intervention on suicidal behavior. So this is numbers, but I like to give people the flavor of what participants what clients who had the intervention have told us. So we did a qualitative study where we interviewed people. So this is a couple examples of what people said to us. So one person said it gave me the opportunity to more clearly define the signs when my mood is beginning to deteriorate and when to start taking steps to prevent further worsening. This is exactly what we would hope for in terms of somebody being able to identify their warning signs. Another person said how has the safety plan helped me. It saved my life or than once. This actually has been a recurring comment that we've gotten from participants who have had the safety plan. So I will turn it over to Greg in a minute but I want to just stress here if we look at the steps in doing the safety plan, you'lled in in the parching arrow, it says to complete safety plan and so there are a bunch of things that need to happen, several steps that need to occur before you actually do the safety plan form completion and so this is why we stress so much that this is a process between a clinician and a client. You can't just give the form to the person and say, okay, here is the form. Fill it out. I understand you've had a suicide attempt. Here's the form for you to do by yourself. And so I think I can turn it over to you, Greg, now and you can talk about this slide and the follow-up slides.

Thank you, bar bra. hi, everyone. I'm Greg brown. As Barbara mentioned, I'm going to go over kind of each of these blue flags really and go over the red flag in detail with a focus on how to actually do it. You'll see while the end product of the safety plan is relatively simple as it should be because people need simple instructions when this crisis, the process of getting there is actually a clinical process. There's why I want to spell it out in a little more detail. After you do your risk assessment and term this person is appropriate for safety planning, we do what's called the narrative interview which is part of the risk assessment. We asked individuals to tell their story about a recent suicidal crisis. It could be an episode of ideation or it could be a suicide attempt or behavior. It doesn't matter as long as there's a story behind it. We want to help people identify their warning signs, how the crisis escalated and de-escalated, so it really makes this clear that the risk for suicide fluctuates over time. So it also really helps to do this to establish rapport and a working alliance with the person you're speaking to. If you really take the time to listen to people, their going to be much more open and receptive to collaboration, so we think this is a really important step for a number of reasons. So when you're doing the narrative part, you're asking people things like can we talk about your overdose in a little more detail. I'd like to hear exactly what happened, what led up to you taking the pills and then I kind of shut up. Being a good listener, maybe lean forward a little bit. Maybe do some summaries and ask a few questions if the story sun clear but I basically trust the patient will tell me exactly how they got from the warning sign to the top of the curve and beyond. So as you're doing this, you want to be -- use your skills and just emphasize and validate their

 feelings. Sop here's an example of what I mean. As I'm listening to people, I'm thinking about the timeline as if it's a movie shot, movie screen and start thinking about what were their feelings, what were their thoughts, all of those bond around in my head. This is a soldier who was state side and his wife had left him several months ago because he was working a lot and would come home and kind of watch tv and not participate with the family that much and was not involved in chores or helping out with the kids and the wife got discouraged. She left and moved to another state to live with her parents who could provide the emotional support. So he was very angry about this that she had abandoned this and he had to move out of his house or where he was staying and help couldn't find a place where he could keep the dogs. She took the dogs, so he was really feeling alone. The chief reaction he had is I thought this would never come to this and this began to affect his work. He began to become irritable at work and then he would snap at his peers and then he would withdraw and this was noticeable behavior. So his commander one day called him the into his office and really laid into him about him being irresponsible and not doing a good job with working with coworkers and he was taken aback. The commander even asked about his home life and the fact that things were going well at home but he didn't open up to his commander about that. So he's driving home and he has the thought what is he going to do when everything starts falling apart. He got home and cracked open a few beers to chill out. He said well, I'll just call my wife and tell her what happened and get some advice but it turned quickly into an argument, the blame game and he was feeling overwhelmed and at the end of the call just began it have a lot of emotions going on a lot of rambling thoughts that would happen and some of these thoughts include I can't take it anymore. I don't know what to do. I feel helpless. Myless went down the toilet. That led to suicide. Maybe this would be easier if I just ended it. Everything would be fixed and he got his gun that he kept in his night stand next to his bed loaded and brought it down to the kitchen table and was cleaning it and working with it and would put it up to his chin thinking about pulling the trigger, but during that period of time -- we're only talking about a few minutes here, his buddy called and he had heard about what happened at work that day and he broke down and told a friend everything and the buddy said, hang on. Put the gun down. I'm coming right over and -- to help you and I will be there, just hang on. So the friend dashed over and he stayed overnight and brought him into the clinic the next day and he told the clinician there that help didn't want to die afterall. He wanted to get help. So if we take that story and put it on the suicide risk curve, you can see on the left side of the curve, the activating event really started with supervisor was critical. We know his wife leaving to separating maybe upped his risk some. So this curve is the top of that, but the key saying everything is falling apart, the drinking, the beer, the wife, putting the loaded gun to his chin. You can see on the other side how the risk comes down, telling his story to the point he was willing to engage in treatment. This only happened in a period of a couple hours. It was not a lengthy period of time. When I work with patients, I actually draw the curve, put the things on the curve so people can see clearly how their story maps on to a suicide risk and it's essential in identifying suicide risk. So educate people about the crisis that it doesn't remain constant. It's relating to the curve. Your risk went up, maybe for a period of time, couple of hours and then started coming back down. So the risk comes and goes. At that point you can introduce the safety plan method to help recognize warning seens and take action to keep the curve from escalating and to see how it comes down. Usually at this point, once you understand the suicide risk surf, I'll say what we want to do is help you develop an emergency plan for you that's going to work in crises like this so you never get to the point of holding that gun in your hand again and wanting to pull the trigger. So the way we're going to do that is through a sheer Reese of steps that are organized beginning with warning signs and go from internal coping strategies to external coping strategies and so on and we'll filthies out together as a team with the brainstorming ideas and breaking sure that it's really going to work with you. So I set the stage for how we're supposed to be talking about this so it's communicated that I'm not just giving him the plan to fill out on his own, nor am I directing the person on how to do a safety plan. We're working as a team together. So when I'm going over this ail say it's a series of steps and you progress. If you recognize the your warning sign and you pull out your safety plan, start following what you listed if you do what your enturnal coping strategies were, you kind of stop. You're done. Your crisis is over. You can wrap things up and go on about your day, but if you find that you tried some of the internal coping strategies and they're not helpful, then you go to the next step and keep working the safety plan until you get to the point where it's needed. You can call the national crisis lifeline or go to the ED or call a provider who can help you with the risk. But the idea is once that doesn't work, you go to the next step fssments that doesn't work, you go to the next step and so on. You don't have to go through all the steps if you're feeling an acute crisis. You go directly to the ED. You don't have to work the steps first before going to the ED if not appropriate. So coming backs to the beginning of the safety plan, I will explain how to go through each of the steps briefly. The first step is to identify the warning signs. The important point here is know that it's important to become aware of your warning signs so you can take action, work your plan before the crisis escalates. Once people start going down a path to the point where they're ready to pull a gun out, there's not a lot of opportunity to intervene, so if you back up in the chain of events and intervene sooner that will probably work better. So the other point it's very simple. It's important to know your warning signs. When we first started doing this, people would explain the safety plan intervention. People would have a safety plan. They would come back in a crisis. Well, did you use your safety plan. They would say no. Why not. Well, because I forgot, and so, forgetting to use the safety plan is a barrier. We have to make sure the signs are specific and jump out at you. You explain the purpose. You can go back here on this suicide risk charge. You can see here. You say, well, how about the supervisor was critical as the warning sign. That's what we call an external warning sign or trigger and that's okay to use the trigger but the problem with the trigger, it's not often very specific and the supervisor would be critical and you're not suicidal. So we refer to use some reaction to the external event, usually a thought or behavior. So we have the next thing that happens. Everything is falling apart. That's the thought he had. That's a really good warning sign because it's specific. So you keep going up the curve here looking for other warning signs and identifying them and vetting them in a similar manner.

Greg, can I say one thing if you go back to that curve.

Oh, sure.

You notice Greg knew a lot about the suicidal person, that led up to -- that occurred before the supervisor was critical that he had been having trouble with his wife over time and that things weren't going well, so that part doesn't go, that is kind of a, you know, like president ground on which the crisis

 occurred, but you'll notice that doesn't appear as a warning sign here. It's the part where -- like the minutes or hours before the crisis developed into where it gets extremely serious, so it isn't like we start back on this curve weeks or days. It's hours, minutes before the event occurs. That's all I wanted to say.

Yes. Thank you, Barbara. It's important to be specific. So if you're talking in Jeanne ralts, you'll never

 general

 ties. Okay. So identify the warning signs. What were they and if they're not very specific, if they say, well, when I get depressed, say well how often do you get depressed. I'm depressed every day. Are you going to use your safety plan every day. No. That's a warning sign. You have it a lot. You're not going to use the warning signs because you're not in crisis. The person says well when I get depressed I feel helpless and alone. Okay. Is that when you begin top feel suicide am and they say yes. That sounds like a really good warning sign there. That's how you identify it. You can tell there's a lot of back and forth conversation that happens and this is true throughout filling out the safety plan. That's why it takes 30 to 45 minutes to do it. You can't do it in 10 minutes because you would have no way of brainstorming or veght the response. The second step on the safety plan once people have filled it out is to identify internal coping strategies. This is as Barbara said, one of distraction, that, the idea here is if you don't think about your problems that are causing the suicidal crisis or don't think about suicide, your risk is going to go down and so the idea here is to kind of put your suicidal crisis aside and do something elsewhere you -- it's going to be incompatible or thinking about suicide but it doesn't necessarily have to be something that is calming and or pleasurable. It just has to be distracting. And so sometimes doing things like playing video games, or running or exercising, they are not calming activities. They're busy activities. The point is they take people's mind off the coping strategy. The reason we go here first, people who are suicidal are often aon and often don't feel like reaching out for help. Sometimes people can manage some suicidal thoughts on their own without having to call the crisis hotline or go to the ED. It's not like we're saying the crisis hotline isn't helpful. They most certainly are but we're trying to empower the patient to use their own resources to help them cope with the crisis and we think that's really important. So when you're doing identifying distracting activities, you want to make sure you're identifying strong distracttors that will be helpful. You will vet them in the same way you vet the warning signs and identifying any barriers and problem solve. So you may say, well, what has he done in the past to distract you from your problems or thinking about suicide and usually people come up with some pretty good things just off the top of their head. They're willing to talk about it. Sometimes they don't and you have to brainstorm with them a little more and make suggestion but often they do readily come up with things and so then you're off and running so. You want to make sure that you vet the response and make sure it's specific and individualized. So if somebody says, well, I like to play video games when I am in a crisis because I really am focused on the video game, you can write down do video games but that's not terribly individualized. It's likely the person will not do. It so what kind of games do you get into. Well, I play football on video games. It really takes me outside myself. Time pass. Well, playing video football games. That's a much better response. Are you able to access the video game easily and they'll say yes. Is it something you would be willing to do in the middle of the night, yes. Do you think it will work. Yes sho. you're done. Sometimes people come up with things that aren't very helpful or vague. This doesn't sound like a

 good distracter for you, can you think of something else. Once you've listed several internal coping strategies, the next one is social settings. So here we explain to patients that this is people as distracters, to people you hang out with that you have a good time with that take you outside yourself, the time passes, that provide a positive influence in your life, do some brainstorming with the patient to come up with some friends or family or acquaintances that they may have in fair natural environment. The other thing, they don't have any friends. They can always go somewhere where there's other people. This might be places that could be like the beach, the coffee shot, the mall, the grocery store, the AA meeting. Wherever there's people around that you can be a people watcher or interact with people that probably will be a great distracter. You do the same thing there. You want to make sure you vet the responses like you do with internal coping strategies and ask them is this a good place, realistic. You want to make sure it's a healthy place. One person says I go to the bar and drink S that distracting? It's distracting but it probably increases your risk because you will be disinhibited, more likely to do something to harm yourself. It doesn't sound like that would be the best option. Can you think of another place to go where there's people around. So you do that kind of thing. So for each response, you ask is it feasible and address any bear requires. You do that for each and every response in the safety plan. In that isn't helpful, then you may identify family members or friends who, on step four, can help with the crisis. These are people who the patient would go to for help, tell them they're in crisis, tell them they need their support, ask them to spend some time with them and help them out and this is sometimes in the ED setting or more difficult step for people to do because they often don't have healthy social networks but if you come up with at least one person that will be really helpful. And you do the same thing here. You vet the response. You ask them, you know, how likely do you think you'll be able to reach this person S this person going to be helpful. What might get in the way and so on, making sure that you also note, you may ask them is this somebody who you would be willing to share the safety plan with so they can help you in a crisis. That's always a big question to ask. Okay. If that family member or friend is not helpful, the next step is top identify a professional in the person's healthcare system or an agency where they can go for help. Again, this is often what people do when people are doing a crisis intervention. They give the numbers to the crisis hotline or tell them where to go to the ED and else that kind of it. You have no idea whether the person is actually going to call the hotline, go the ED or tell their therapist they're suicidal. A lot of times they don't want to tell them because they may send them to the hospital or feel like they let them down. It's important to identify what those things that might get in the way and work with them a little bit. You can also ask them to contact a provide per, or try calling the national crisis lifeline and see how that works. Finally, the last step in the safety plan, this is not something you do in crisis. This is something you do before the crisis but that's making the environment safe per. We call this lethal means counseling or lethal means safety. We want to identify the method the person used while they were in crisis or thinking about suicide and develop an action plan for make the environment safer and having not as quick access to that method and the idea here is the same as distraction, really, how do we extend the period of time that you get to the method so that the crisis has time to subside. Maybe you have second thoughts. Even if it's only 15 minutes that 15 minutes can be an important period of time that the person could have second thoughts about acting on their feelings and decide not top and decide not to follow their safety plan. Anything you can do to remove access, ready access to lethal means and extend the time to obtaining it the better. We talk about lethal means and that it will make it less likely that people will act on their suicide hall thinking. So if somebody says they're thinking about overdosing, then we talk about ways that they meet be able to have not as much access to the medication. People, of course, need their medication but at the same time it's a danger, so you have to come up with ways of safely storing the medication. Sometimes it involves getting rid of the medication or having a family member help out with medication distribution. Whatever the method is, you go through the same type of problem solving discussion to try to determine what is going to make the environment

 safer. We always ask about firearms. In the United States firearms is such a lethal method and the number one method among men to kill themselves. Men are the most common, especially older men are much more likely to kill themselves. Ask about firearms. It could be a sensitive topic. If you say it in a way this is a standard question I ask everybody because I'm really concerned about access to firearms because it happens so quickly and lethal, do you have a firearm that you have access to for support or protection and if they answer yes, then I'll ask how many do you have. Where's the lock, ammunition lock all the questions that come after that. It is important to be aware of the state law involving fire harm ownership in case you're in a position of wanting to counsel someone on how to safely store the firearm. We'll get into more detail about that, but get some advice or get some training. So often people are ambivalent about getting rid of their methods about suicide and to deal with that am biv lens

 ambivalence and pros and

 cons. This is a very effective method for dealing with access to a lethal weapon. People sometimes keep that method in their back pocket just in case they are feeling suicidal again and want to weigh it out. Sometimes, they're reluctant to leave it out. Okay. You might also point out the part about involving others and making the environment safer. You have a family member or person that can help carry out the plan. That's better than having the patient do it themselves. Make sure that plan is written down and make sure you follow up with the person to make sure the plan was executed. So, finally, the implementation of the plan. That's next to the last flag. You want to review the entire plan, make sure this works for the person. If any coping strategies aren't helpful, try the next step. If it's working, they can stop. Make sure they have a copy of the safety plan and discuss where to keep it because if they don't have ready access to that safety plan, they're not going to use it. Sometimes people will make multiple copies of their safety plan and put it in their purse, wallet, pocket, night stand, the place where they keep the gun, so they seat safety plan if they're reaching for their weapon. So it's an important discussion. Timely, the likelihood that they're going to use the plan and any barriers to its use. Sometimes people take a picture of it or enter it on an app. The most important thing is that it's readily available. If you take a picture, on my phone I've got thousands of pictures, you want to be able to find that picture. You're not going to scroll through hundreds of pictures to find it. Okay. Finally once the person is on their way and feel confident they're going to use it is to have a follow-up conversation and ask a person if they found it helpful, what's working for you. What's not working for you. So and always review the access to lethal means and whether that was actually executed. So finally you can see that doing a high quality safety plan is important. If you just give the form, there's been several reviews, studies done. Both of these are in the VA with coded safety plans on how individualized they were and whether or not they were addressed in the medical record, the one if 2015 found most safety plans were complete and moderate quality although there was a lot of variability. The most significant part is in the medical records but not addressed in the medical records. There was a second study done by green at the VA. How individualized or accurate or on target the responses were. They rated quality and they rated completeness, and they found the quality rating was associated with a decreased likelihood of suicide behavior reports within a six-month period. So quality is really important when you're doing this and using it in your institution or in your setting and so it's important to have an on going review of a safety plan to improve quality. I'm going to toss it back to Barbara to go over suicide risk in psychotic illness.

So I will do this quickly so we have some time for questions. So we already know that suicide it a sick risk in individuals with psychotic illness. About 4% to 107% of people who have schizophrenia die from suicide. So we think that in general people with serious mental illness have a or good candidates for having a safety plan. So psychosis in and of itself is definitely not a contraindication for doing a safety plan, but often there are challenges or obstacles that exist within the clinician as opposed to the suicide individual with SMI for doing a safety plan. So what are some of the indications for doing a safety plan for people who have psychotic illness. So, first, as you're doing the safety plan, if you want to do it in that particular moment, you have to assess the degree of reality testing and cognitive capacity at that particular moment. It doesn't mean that they can't -- so you play decide, no, they don't have got reality testing. It doesn't mean the next day or two weeks later that you couldn't do a safety plan, so if the person is psychotic at the moment, they have a poor reality testing and they're extremely disorganized and they're suicidal, they're probably not great candidates for doing a safety plan if you think about having to engage that person and the kind of process that Greg just described, is probabliment that likely. But when you are doing it, some of the adjustments that you can make are thinking about using simple concrete language with them, accent baseline delusional thinking if it is not directly related to suicidal ideation and where possible and this is true with people with first episodes, involving family or other significant people in the process. So that's really very important, especially when you have someone with psychotic illness who is living with their family. So here is an example of Mr. V who is a 40-year-old man with chronic schizophrenia, recent loss of list mother leaving him sad, loanly and overwhelmed. When speaking to him, he said he has recently thought about killing himself. So whales

 what's the obstacle here. Does he have access to a gun or other lethal means. Has he made a plan and what's his current reality testing. So in this example his delusions have not worsened and he's not more disorganized in his baseline. He's thought of ways of hurting himself and expressed a wish to be with his mother. That's common that people would have that kind of wish. He express as wish for help and his reality testing is intact. So this is a very good candidate for a safety plan despite being psychotic. He generated simple warning signs like feeling sad, thinking about his mother, crying. He had no ways of distracting himself or turning to other people and he concretely focused on step six, specifically how to keep himself away from the bridge. Every time I think about the bridge, I go to the park instead. This is Mr. G, a 25-year-old man with schizophrenia. He had multiple high lethal ti suicide attempts, and psychosocial stressors, coming to the clinic saying help wants to kill himself using a gun. Again, these are the questions you would ask, does he have access, does he have a plan, what provoked this and reality questions. When questioned he doesn't have a gun he talked about his neighbors who refuse to low of him aown and he said suicide is probably the only way out. So this person is not a grate candidate at this particular moment to do a safety plan because he says he has access to lethal weapons and he has a past high lethality suicide attempt. The thing that does make him a or candidate is that he's disorganized and he has worsening delusions directly linked to suicidal thoughts and thinking about suicide as the only option. So if you think about how would you engage this person in warning signs and distracting himself, he probably would not be able to do it. So one of the things I would like to end with, when we think about people with psychotic illness, there are basically two kind of paths to suicide that we see. Often they are depressed in the same kind of way that people without psychotic illness get depressed. They feel hopeless. So those people are very good candidates for the most part for getting a safety plan. The other group of people are people who have things like are either delusional and their delusions are tied new their suicide at or have commanded a louse

 hallucination. Suicide warning signs. When I have had somebody who is like that, what I will often work with them on is a safety plan that is a little bit different where they could people -- and this happens to be clinically the way I have talked about it with my patients where I will help them notice when their thinking is going off track and for some reason thinking about their thinking going off track seems to be acceptable to the patients I've worked W I don't know if it's true for the listeners here, but -- so we then develop a safety plan, like what are the warning signs that your thinking is going off track and then use the safety plan for that. So I think I will end here and give you some time to ask additional questions, if we can go back to the question that you started out with. Thank you for listening.

Thank you so much. Now is the time if you have a question, you can enter your question in the Q&A pod on the screen and we'll try to get as many questions as possible. One question we received earlier in the presentation that I will start off with is asking can you speak to those individuals with substance abuse disorder and how can you use the same skillsets and tools to prevent overdose deaths?

So that's a great question. So I'm assuming you mean overdose deaths that are not suicidal? I'm not sure. But when somebody has serious problems with substance use the place safety planning can be helpful is when they have stopped using substances and they are fighting urges to use. Some people have taken the safety plan and instead of having it be about having suicide, have it be about urges to use, so what are the warning signs andenact the steps in the same way. I'm not sure if that's what the question meant. Greg, do you have any thoughts?

If the warning sign is using drugs and they become high or really intoxicated to the point they're cognitively impaired, then the safety plan is no good. That's why Barbara said to back up and start talking about urges or warning signs to used use the safety plan in that manner. Any questions?

Thank you.

Another question we received focused on adolescence. Are there any adaptations or considerations you would recommended when applying or working with an adolescent. Is there a youngest age that this intervention is appropriate for.

So we developed this first in the form it is now in a project we were doing with adolescents. That project we were doing safety planning with

 kids as young as 12. There are a couple of things that are adaptation. Number one doing -- not including kids as people they turn to for help as people on the safety plan, so, you know, if you remember, people use it in two places as distracttors and for support. So we never want to put another adolescent in that spot. We don't want to burden an adolescent with having to take care of someone who is suicidal. We tell the adolescent at the beginning that we're going to do this together. Often we'll do it alone with the adolescent but we'll share it with their family members, usually one of their parents. So we tell them at the tweak give the child fair warning, if they want to put things as distracters that they know their parent would get up set about or angry about and tell them they shouldn't use, we share it with the parent and do the same time of psychoed with the party as we did with the adolescent and help to enlist them in using the safety plan. Someone who was working with me, who is adapting this intervention for children that are younger than 12, so she's doing a more pick

 toral type of

 intervention.

Do you bleach only licensed clinicians should be in this role in terms of developing or implementing safety interventions with clients or could a knowledgeable peer specialist fill the role?

Greg, do you want to answer that one? Maybe Greg is muted. So, yes. There is no reason that a peer specialist, if they're trained shouldn't be able to do it. As a matter of fact, I'm working with the firefighters union, and they are developing a training to teach firefighter pierce how to do safety planning with other firefighters and you can think about certain groups where it would be much more palatable to them to do this with a peer than it would be to do it with a

 clinician.

Another question, if a exesion is promoting safety plans -- however for our webinar it takes 35 to 40 minutes to develop. Are there other recommendations for how to develop safety plans.

So that is true that the joint commission is promoting it. One of the things that take time in doing a safety plan is to get the narrative, the story of the person and the actual part of the safety plan is going through the steps much briefer so it could be done through mean restrictions, mean counseling, can be done in about 20 minutes. So what I would say is in the emergency department, the clinician already has the background information. They already have the suicide story of the patient, so that's the 20 minutes, the narrative related 20 minutes in a certain way like shooting count toward the safety plan. The other thing I would mention with Ed Budreau we developed a safety plan that kind of helps the clinician do this in the emergency department. We only did feasibility testing on that. We don't have efficacy data on that, but there are -- it's an interesting idea about how to get things done in a way that requires to do a safety plan that requires less of the clinician time.

Thank you. A couple comments that we rereceived. The safety plan appears similar to the crisis plan. Are you familiar with that plan. Should a person have both or would that be due duplicative.

The rep is really great but it's different than this. If you look at what the crisis plan is and at least my understanding of it, it has to do with how do you know when somebody else should take over for you. The safety plan is almost like the opposite of that like when you're having trouble. The crisis plan is when I'm having trouble and I can't be doing X, Y and Z on my on anymore. So it seems to me it's a little different. I think there's a utility for both of these. One other thing I would mention is that for everybody with psychotic illness you can see how having doing a rap plan or engaging rap is very useful but it would only be for a subset of people with psychotic illness, those or suicide pal you would do a safety plan they're only for -- the safety plan is only for a subset where the rap would be for everybody with psychotic

 illness.

Thank you. Another question we received is requesting if we start with say the planning first or do you work mon establishing a relationship and getting an individual to engage and participate and then follow-up with the safety planning.

 Yes. That's the point of the narrative interview is alliance interviewing, especially that adolescent who may not be engaging. May say things like this happened in the past. I made a mistake. Life goes on. We think the more you can engage them, the better the safety plan is to develop.

Thank you. A couple questions asking if you're familiar with the my three app, the safety plan tool and do you recommend it.

I had not used the my three app but I am familiar with it. It does closely mirror the safety plan as we developed it but I do not know of research on my three. I'm aware of it. There's been an explosion of safety planning apps in the last few years. The jury is still out about the effectiveness of the app, but there are studies in progress. I would just be very careful because apps get buried on a phone just like you lose pieces of paper. As long as the person is going to be able to use the app and find it, use it, that's my biggest concern. I'm sure as time goes on there will be more studies supporting or not supporting its use.

thank you. I think we have time for one more question before we wrap up today's webinar and the question that came in earlier asked for folks who have been in the field for a while, what are some things that we should work to unlearn regarding safety planning interventions based on recent research.

I'll let Barbara answer this but I have to say with the sue side risk curve, clinicians often cope mingle acute suicide risk from the most distant cases and they focus more on the distal crone eke factors rather than the acute risk and people get sidetracked, so I think it's important to first address how you're going to keep the person safe during an acute ris and the person with SMI, do that first and once that's done, you have a good safety plan, then go back and dress the longer term risk factors. In doing the interview, they often get

 sidetracked.

So I would add to that. I think there is an asum son that if we take care of the primary problem that suicide ality that we don't have to address it. The person comes in and they say that they're not suicidal at the moment but they have all of these other problems going on and we put that but they have had a suicide attempt in the past and we put that aside because they are not suicidal in the moment, we put it aside and don't think about it. It can sneak up on you if you don't think about keeping it front and center. One other thing that somebody had asked about twice, wanted to in the question box that I wanted to address had to do with what about people who are thinking about suicide for a long time. So this is actually a very common problem, that there are people, not just with schizophrenia but I've work lad lot with patients with borderline personality disorder who are chronically suicidal. It's when they flip, when it escalates from this kind of baseline suicidal level to going up past that baseline. So it requires a lot of fine tuning and detective work on the part of the clinician to help the patient understand -- okay. So you're walking around always feeling suicidal but you're not always acting on your suicidal feelings. What gets you from thinking about it to actualing actually acting on it. That is the closest that we can get to

 that.

Thank you. I think with that we're at time, so I will pass this off to Kelle to wrap us up.

thank you, Flannery.

I would like to thank Dr. Barbara Stanley and Dr. Greg brown. I will switch to a short evaluation and ask that you take time to fill this out. If you would like a letter of attendance, feel free to download one on your own at the top of the screen where where it says letter have you attendance. Again, thank you for joining us and enjoy the rest of the afternoon. [ Event concluded ]