Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01	
EP6 - Evidence-based resources for safety planning, and follow up care upon discharge	
Tools	**Brief Description**
Safety Planning Intervention (SPI) **Authors:** Barbara Stanley and Gregory K. Brown **Settings:** ED, trauma centers, crisis hot lines, psychiatric inpatient units, and other acute care settings. **Availability:** Free **http://suicidesafetyplan.com/About_Safety_Planning.html**	The **Safety Planning Intervention (SPI)** is an innovative and brief treatment, for suicidal patients evaluated in the ED, trauma centers, crisis hot lines, psychiatric inpatient units, and other acute care settings. The SPI is a collaborative effort between a treatment provider and a patient and takes about 30 minutes to complete. The basic steps include (a) recognizing the warning signs of an impending suicidal crisis; (b) using your own coping strategies; (c) contacting others in order to distract from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the availability of means to complete suicide. (Stanley & Brown, 2011) This intervention can be used in the context of ongoing outpatient treatment or during inpatient care of suicidal patients. SPI has been determined to be a best practice by the Suicide Prevention Resource Center. (www.sprc.org). In this paper, the SPI is described in detail and a case example is provided to illustrate how the safety plan may be implemented: Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk Cognitive and Behavioral Practice, Volume 19, Issue 2, May 2012, Pages 256-264 http://suicidesafetyplan.com/About_Safety_Planning.html http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog_Beh_Practice.pdf A recent large-scale cohort comparison study (Stanley B, et al. 2018) found that SPI+ was associated with a reduction in suicidal behavior and increased treatment engagement among suicidal patients following ED discharge and may be a valuable clinical tool in health care settings. Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776 https://www.ncbi.nlm.nih.gov/pubmed/29998307

Safety Planning Guide: A Quick Guide for Clinicians ©2008 Barbara Stanley and Gregory K. Brown **Settings:** Behavioral Health Care, Outpatient Mental Health **Availability:** Free **http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians** or **Safety Planning website**	This quick guide for clinicians may be used to develop a safety plan—a prioritized written list of coping strategies and sources of support to be used by patients who have been deemed to be at high risk for suicide. The authors strongly recommend that the guide be used after reviewing the Safety plan treatment manual to reduce suicide risk. You can learn more about safety planning through the authors' Safety Planning website.
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version By Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. **Populations:** Military Service Members and Veterans **Settings:** All VA settings **Availability:** Free **http://www.sprc.org/resources-programs/safety-plan-treatment-manual-reduce-suicide-risk-veteran-version**	The **Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version** was developed by Stanley & Brown, 2008 and is intended to be used by VA mental health clinicians, including suicide prevention coordinators, as well as other VA clinicians who evaluate, treat, or have contact with patients at risk for suicide in any VA setting. The manual provides a detailed description of how VA clinicians and patients may collaboratively develop and use safety plans as an intervention strategy to lower the risk of suicidal behavior. The manual identifies 6 steps for **Developing a Safety Plan** and outlines the rationale, instructions and examples of each step. Step 1: Recognizing Warning Signs Step 2: Using Internal Coping Strategies Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis Step 5: Contacting Professionals and Agencies Step 6: Reducing the Potential for Use of Lethal Means The manual further describes key activities for **Implementation of the Safety Plan:** • Assess for likelihood that the plan will be used and problem solving if there are obstacles: • Evaluate if the proposed safety plan format is appropriate to the veterans' capacity and circumstances • Review plan periodically The manual underscores the safety plan as one component of comprehensive care of the suicidal individual that is used in

	conjunction with other important components which include risk assessment, appropriate psychopharmacologic treatment, psychotherapy and hospitalization. **Evidence:** Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776 Currier, Glenn W. et al. Rationale and study protocol for a two-part intervention: Safety planning and structured follow-up among veterans at risk for suicide and discharged from the emergency department. Contemporary Clinical Trials, Volume 43, 179 – 184 Barbara Stanley, Gregory K. Brown, Glenn W. Currier, ChelseaLyons, Megan Chesin, Kerry L. Knox, "Brief Intervention and Follow-Up for Suicidal Patients with Repeat Emergency Department Visits Enhances Treatment Engagement", *American Journal of Public Health* 105, no. 8 (August 1, 2015): pp. 1570-1572.
Patient Safety Plan Template By Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. **Settings:** Primary Care, Outpatient Mental Health **Availability:** Free **http://www.sprc.org/resources-programs/patient-safety-plan-template**	The **Patient Safety Plan Template** is a fill-in-the-blank template for developing a safety plan with a patient who is at increased risk for a suicide attempt**.** **Populations:** Adults, Young Adults Ages 18 to 25 Years, Military Service Members and Veterans http://www.sprc.org/sites/default/files/resource-program/Brown_StanleySafetyPlanTemplate.pdf
Safety Planning Intervention for Suicide Prevention online education course From, New York State Office of Mental Health and Columbia University	The **Safety Planning Intervention for Suicide Prevention** is a free, online course from the New York State Office of Mental Health and Columbia University designed for education and training of behavioral health care practitioners the courses focus is on strategies of effective care/treatment and safety planning. The course describes the Safety Planning Intervention tool and how it can help individuals, explains when to work with individuals to create a safety plan, and describes the steps in creating a safety plan. https://www.integration.samhsa.gov/images/res/SBQ.pdf

	Recommending Organizations: 1. New York State Office of Mental Health 2. Suicide Prevention Resource Center http://www.sprc.org/strategic-planning/finding-programs-practices 3. Zero Suicide initiativehttp://zerosuicide.sprc.org/toolkit
Caring for Adults with Suicide Risk – A Consensus Guide for Emergency Departments (the ED Guide) **Populations:** Adults **Settings:** Emergency Departments **Author:** Suicide Prevention Resource Center (SPRC) **Availability:** Free **http://www.sprc.org/ed-guide**	The **ED Guide** is designed to assist emergency department (ED) providers with decisions about the care and discharge of patients with suicide risk to improve patient outcomes after discharge. The guide includes: • A Decision Support Tool • Brief ED-based Interventions • A Discharge Planning Checklist • Patient-centered Care Guidelines It can help answer the following questions: • Can this patient be discharged or is further evaluation needed? • How can I intervene while this patient is in the ED? • What will make this patient safer after leaving the ED? The guide also includes references to a comprehensive set of external resources which can be accessed via hyperlinks in the guide. A **Quick Guide** version of **the ED Guide** is in Appendix A. The authors recommend providers read the complete version before using the Quick Guide. **http://www.sprc.org/sites/default/files/EDGuide_full.pdf** **http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf** **Recommending Organizations:** 1. Suicide Prevention Resource Center 2. SAMHSA **Evidence/ Development:** The **ED Guide** was developed with extensive input from a consensus panel of experts from emergency medicine and suicide prevention organizations. Recommendations in the ED Guide were developed using an iterative process that included both reviews of the literature and expert panel consensus.

Counseling on Access to Lethal Means (CALM) **Populations:** Adults, Youth **Settings:** All **Author:** Online version - Suicide Prevention Resource Center (SPRC) **Availability:** Online - Free **https://training.sprc.org/enrol/index.php?id=3**	**Counseling on Access to Lethal Means (CALM)** is a free, online course from the Suicide Prevention Resource Center about how to reduce access to the methods people use to kill themselves. It covers who needs lethal means counseling and how to work with people at risk of suicide—and their families—to reduce access. While this course is primarily designed for mental health professionals, others who work with people at risk for suicide, such as health care providers and social service professionals, may also benefit. This online course was developed in collaboration with Catherine Barber, director of the Means Matter Campaign at the Harvard Injury Control Research Center, and Elaine Frank, a co-developer of the original in-person CALM workshop. **Recommending Organizations:** 1. Suicide Prevention Resource Center 2. SAMHSA 3. Zero Suicide Initiative http://zerosuicide.sprc.org/toolkit/engage#quicktabs-engage=1 4. Harvard Injury Control Research Center, Means Matter **Evidence:** Johnson, R.M., Frank, E.M., Ciocca, M., & Barber, C.W. (2011). Training mental health care providers to reduce at-risk patients' access to lethal means of suicide: Evaluation of CALM Project. Archives of Suicide Research, 15(3), 259-264. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21827315 Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., . . . Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, *3*, 646–659. Stone, D. M., Holland, K. M., Bartholow, B., Crosby, A. E., Davis, S., & Wilkins, N. (2017). *Preventing suicide: A technical package of policies, programs, and practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Zero Suicide Institute (2018). Engage: Reducing Access to Lethal Means. Retrieved from http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/ENGAGE%20LETHAL.pdf

Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports. **Authors:** Riblet N, Shiner B, Watts, BV, Mills P, Rusch B, Hempbill RR J Nerv Ment Dis. 2017 Jun;205(6):436-442. **Setting:** Inpatient mental health unit **Availability:** PUBMED https://www.ncbi.nlm.nih.gov/pubmed/28511191	To examine the high risk for death by suicide after discharge from an inpatient mental health unit, this 2017 publication presents a review of root cause analysis reports of suicide within 7 days of discharge from across all Veterans Health Administration inpatient mental health units between 2002 and 2015. Findings: There were 141 reports of suicide within 7 days of discharge, and a large proportion (43.3%, n = 61) followed an unplanned discharge. Root causes fell into three major themes including challenges for clinicians and patients after the established process of care, awareness and communication of suicide risk, and flaws in the established process of care. The authors conclude that flaws in the design and execution of processes of care as well as deficits in communication may contribute to post discharge suicide. Furthermore, while policies mandate mental health follow-up within 7 days of discharge, the risk for suicide in the week after discharge may be the greatest in the first few days after discharge. Inpatient teams should also be aware of the potentially heightened risk for suicide among patients with unplanned discharges. Need for additional research to better understand the drivers of unplanned discharge and whether they may have a role in suicide risk is indicated.