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Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk

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The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

Assessing risk for suicide is a crucial component of evaluations aimed at treatment disposition and planning for individuals with psychological problems. Although clinical practice guidelines have been published for conducting suicide risk assessments in emergency settings (American Psychiatric Association, 2003), current standards of care do not include providing brief psychosocial interventions for suicidal patients in the emergency department (ED) or other acute care settings (Allen, Forster, Zealberg, & Currier, 2002). Typically, when suicidal patients are evaluated in the ED and hospitalization is not clinically indicated, they are provided with a referral for outpatient mental health treatment (Allen et al., 2002).

The "assess and refer" approach can be disconcerting to patients and their families as well as to clinicians making disposition plans, and such concerns may be exacerbated by the potential for dire consequences associated with not hospitalizing patients who may actually need it. Adding to the anxiety of discharging patients who are experiencing some measure of suicidal feelings is the fact that many suicidal individuals do not attend recommended outpatient treatment following the ED visit (Craig et al., 1974; Krulee & Hales, 1988; Litt, Cuskey, & Rudd, 1983; Rudd, 2006). Intervening in the ED with suicidal individuals is important because between 11% and 50% of attempters refuse outpatient treatment or drop out of outpatient therapy very quickly (Kessler, Berglund, Borges, Nock, & Wang, 2005; Kurz & Moller, 1984). Furthermore, up to 60% of suicide attempters attend only 1 week of treatment postdischarge from the ED (Granboulan, Roudot-Thoraval, Lemerle, & Alvin, 2001; Kurz & Moller, 1984; Litt et al., 1983; O'Brien, Holton, Hurren, & Watt, 1987; Piacentini et al., 1995; Spirito, Stanton, Donaldson, & Boergers, 2002; Trautman, Stewart, & Morishima, 1993). Of those suicide attempters who attend treatment, 38% terminate within three months (Monti, Cedereke, & Ojehagen, 2003), a statistic that is particularly troubling because the first three months following a suicide attempt is when individuals are at the highest risk of additional suicidal behavior (Monti et al., 2003).

Thus, conducting a brief "treatment" when the suicidal patient is present in the ED may be valuable and is consistent with the way in which most medical conditions are addressed in the ED. Treatment of acute medical problems in the ED most often includes some form of immediate intervention.

Keywords: suicide; suicide prevention; safety plan; safety plan intervention; suicide-related coping

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Clinicians are beginning to recognize the ED setting as an opportunity to provide brief interventions for mental health problems (D'Onofrio, Pantalon, Degutis, Fiellin, & O'Connor, 2005; Rotheram-Borus, Piacentini, Cantwell, Belin, & Song, 2000). For example, D'Onofrio and her colleagues developed a 10- to 15-minute intervention approach—Screening, Brief Intervention, and Referral to Treatment (SBIRT)—to counsel problem drinkers who visit the ED. The SBIRT intervention includes: (a) a screening component to quickly assess the severity of substance use and identify the appropriate level of treatment, (b) a brief intervention focused on increasing insight and awareness regarding substance use and motivation toward behavioral change, and (c) a referral for those identified as needing more extensive treatment.

We have developed a similar, innovative and brief treatment, the Safety Planning Intervention (SPI), for suicidal patients evaluated in the ED, trauma centers, crisis hot lines, psychiatric inpatient units, and other acute care settings Stanley, B. & Brown, G. K. (with Karlin, B., Kemp, J. E, VonBergen, H. A.) (2008). The SPI has its roots in CT tested by Brown et al. (2005), further expanded by Stanley & Brown (2006) and then adapted for use by high suicide risk Veterans (Stanley & Brown, 2008a) and depressed, suicidal adolescents in CBT for Suicide Prevention (CBT-SP) (Stanley et al., 2009). SPI has been determined to be a best practice by the Suicide Prevention Resource Center/ American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org). Furthermore, this intervention can be used in the context of ongoing outpatient treatment or during inpatient care of suicidal patients. In this paper, the SPI is described in detail and a case example is provided to illustrate how the safety plan may be implemented.

Rationale for the Safety Planning Intervention (SPI) as a Clinical Intervention

Recognizing that, despite best efforts, some patients will not seek treatment following an emergency evaluation for a suicidal crisis, and further recognizing that there is an inevitable lag between an ED evaluation and outpatient mental health appointments, we suggest that the ED visit or other acute care setting may serve as a valuable opportunity to conduct a brief intervention that may reduce further suicidal behavior. Furthermore, given that suicidal crises may be relatively short-lived and have an ebb and flow pattern, an intervention that assists patients in coping with such crises may be particularly useful, even if the intervention is only used for a brief period of time until the crisis diminishes. For example, the effectiveness of means restriction is largely based on the fact that suicidal thoughts tend to subside over time and that making it more difficult for patients to act on these thoughts would be a helpful preventive measure (Daigle, 2005). Similarly, if patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, then the risk for suicide is likely to decrease.

Similar approaches to addressing acute suicidal crises have been developed by others, predominantly in the context of ongoing outpatient or inpatient care, but not as stand-alone interventions. For example, Rudd and his colleagues developed the crisis response plan that emphasizes what patients will do during a suicidal crisis (Rudd, Joiner, & Rajab, 2001). The crisis response plan is part of a cognitive behavioral therapy intervention that is aimed at reducing suicide risk. It involves helping patients to identify what triggers the crisis, use skills to tolerate distress or regulate emotions, and, should the crisis not resolve, access emergency care. Specifically, the crisis response plan is a series of therapeutic interventions that ensures the safety of the patient by removing access to lethal means; initiating self-monitoring of the suicidal thoughts, feelings, and behaviors; targeting symptoms that are most likely to interrupt day-to-day functioning; targeting hopelessness and sense of isolation, reinforcing the commitment to treatment and solidifying the therapeutic relationship. Similarly, David Jobes uses a safety plan approach in the context of his approach, Collaborative Assessment and Management of Suicidality (CAMS), a psychotherapeutic approach for managing suicidal patients, in both outpatient and inpatient settings (Jobes, 2006). The CAMS safety plan focuses on whom to call during a suicidal crisis and cleansing the environment of means to commit suicide.

Both safety plans and crisis response plans have been used as therapeutic strategies in the context of other short-term, empirically supported treatments that have been found to reduce suicide risk, such as cognitive therapy (Brown et al., 2005; Wenzel, Brown, & Beck, 2009) or cognitive behavior therapy for suicide prevention (CBT-SP; Stanley et al., 2009). However, to our knowledge, the use of a safety planning intervention as a single-session, stand-alone intervention for emergency care settings has not been explicitly described. Yet other novel targeted interventions have been proposed. Rotheram-Borus et al. (2000) tested an ED intervention for suicidal adolescents that involved psychoeducation about the importance of treatment in suicidal teens for both the ED staff and the patients. Kruesi et al. (1999) and McManus et al. (1997) developed psychoeducation programs that stressed the need to restrict access to means when there was a suicidal adolescent in the home. Sneed, Balestri, and Belfi (2003) adapted dialectical behavior therapy (DBT) skills in a single-session format for the ED. Despite these proposed interventions, the standard of "assess and refer" approach to care remains.

While other efforts at safety planning have been described in the literature, the SPI is unique in that it is a systematic and comprehensive approach to maintaining safety in suicidal patients. Prior efforts have primarily focused on a single aspect of safety (e.g., means restriction or

emergency contacts). Furthermore, the explicit focus on utilizing internal coping and distracting strategies as a step in an emergency plan to deal with suicidal urges is not typically an aspect of most safety plan efforts even though it is an aspect of therapies targeting suicidal feelings (e.g., CT and DBT).

Safety Planning vs. No-Suicide Contract

Another type of brief intervention that is provided for suicidal patients is a "no-suicide contract." This intervention is a written or verbal agreement between the clinician and patient requesting that the patient refrain from engaging in suicide behavior. The SPI is quite different from a no-suicide contract intervention given that the no-suicide contract does not necessarily provide detailed information about *how* patients should respond if they become suicidal.

A no-suicide contract usually takes the form of asking patients to promise not to kill themselves and to contact professionals during times of crisis (Stanford, Goetz, & Bloom, 1994). In contrast, the safety plan is *not* presented to patients as a no-suicide contract. Despite the anecdotal observation that no-suicide contracts may help to lower clinician anxiety regarding potential suicide risk, there is no empirical evidence to support the effectiveness of no-suicide contracts for preventing suicidal behavior (Kelly & Knudson, 2000; Reid, 1998; Shaffer & Pfeffer, 2001; Stanford et al., 1994). To our knowledge, there are no randomized controlled trials (RCTs) that have examined the efficacy of no-suicide contracts for preventing suicide or suicide attempts. There have been a few studies that have examined the clinical utility of no-suicide contracts, but findings have been inconsistent (Drew, 2001; Jones, O'Brien, & McMahon, 1993; Kroll, 2000; Mishara & Daigle, 1997). The methodological problems with these studies and the lack of RCTs have led to the conclusion that there is no empirical support for the efficacy of this intervention. (see Rudd, Mandrusiak, & Joiner, 2006). Clinical guidelines also caution against using no-suicide contracts as a way to coerce patients not to kill themselves, as it may obscure the determination of the patients' actual suicidal risk (Rudd et al., 2006; Shaffer & Pfeffer, 2001). For example, patients may withhold information about their desire to kill themselves for fear that they will disappoint their treating clinicians by violating the contract. Rather, the SPI is presented as a strategy to illustrate *how* to prevent a future suicide attempt, and identifies coping and help-seeking skills for use during times of crisis.

Methods

Intervention Description

The SPI, a very brief intervention that takes approximately 20 to 45 minutes to complete, provides patients with a prioritized and specific set of coping strategies and sources of support that can be used should suicidal thoughts reemerge. The intent of the safety plan is to help individuals lower their imminent risk for suicidal behavior by consulting a predetermined set of potential coping strategies and a list of individuals or agencies they may contact; it is a therapeutic technique that provides patients with more than just a referral at the completion of the suicide risk assessment during an emergency evaluation. By following a predetermined set of internal coping strategies, social support activities, and help-seeking behaviors, patients have the opportunity to evaluate those strategies that are most effective. While we recommend that the interventions be followed in a stepwise manner, it is important to note that if a patient feels at imminent risk and unable to stay safe even for a brief time, then the patient should immediately go to an emergency setting. Furthermore, some patients may feel that they cannot or do not wish to use one of the steps in the safety plan. In this instance, they should not feel that they must do so as the intent of the safety plan is to be helpful and not a source of additional stress or burden.

The SPI is best developed with the patient following a comprehensive suicide risk assessment (cf. American Psychiatric Association, 2003). During the risk assessment, the clinician should obtain an accurate account of the events that transpired before, during, and after the recent suicidal crisis. Patients typically are asked to describe the suicidal crisis, including the precipitating events and their reactions to these events. This review of the crisis facilitates the identification of warning signs to be included in the safety plan and helps to build rapport. Consistent with an approach described by Jobes (2006), a collaborative stance is most effective for developing the safety plan. The basic components of the safety plan include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts as a means of distraction 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 potential use of lethal means. The first five components are employed when suicidal thoughts and other warning signs emerge. Reducing access to means is discussed after the rest of the safety plan has been completed, often with the aid of a family member or friend, for an agreed upon period of time. Each of these steps is reviewed in greater detail below.

Recognition of Warning Signs

The first step in developing the safety plan involves the recognition of the signs that immediately precede a suicidal crisis. These warning signs include personal situations, thoughts, images, thinking styles, moods, or behaviors. One of the most effective ways of averting a suicidal crisis is to address the problem before it fully

emerges. Examples of warning signs include feeling irritable, depressed, hopeless, or having thoughts such as, "I cannot take it anymore." Similarly, patients can identify problematic behaviors that are typically associated with suicidality, such as spending increased time alone, avoiding interactions, or drinking more than usual. Generally, more specifically described warning signs will cue the patient to use the safety plan, than warning signs that are more vaguely described.

Internal Coping Strategies

As a therapeutic strategy, it is useful to have patients attempt to cope on their own with their suicidal thoughts, even if it is just for a brief time. In this step, patients are asked to identify what they can do, without the assistance of another person, should they become suicidal again. Prioritizing internal strategies as a first-level technique is important because internal strategies enhance patients' self-efficacy and can help to create a sense that suicidal urges can be mastered. This, in turn, may help them feel less vulnerable and less at the mercy of their suicidal thoughts. Such activities function as a way for patients to distract themselves from the crisis and prevent suicide ideation from escalating. This technique is similar to those described in DBT (Linehan, 1993), a cognitive behavioral therapy for suicidal individuals with borderline personality disorder that instructs patients to employ distraction techniques when they are experiencing intense urges to make a suicide attempt. Examples of these coping strategies include going for a walk, listening to inspirational music, going online, taking a shower, playing with a pet, exercising, engaging in a hobby, reading, or doing chores. Activities that serve as "strong" distractions vary from person to person and, therefore, the patient should be an active participant in identifying these activities. Engaging in such activities may also help patients experience some pleasure, sense of mastery, or facilitate a sense of meaning in their lives. However, the primary aim of identifying and doing such activities is to serve as a distraction from the crisis.

After the internal coping strategies have been generated, the clinician may use a collaborative, problem-solving approach to ensure that potential roadblocks to using these strategies are addressed and/or that alternative coping strategies are identified. If patients still remain unconvinced that they can apply the particular strategy during a crisis, other strategies should be developed. Clinicians should help patients to identify a few of these strategies that they would use in order of priority; the strategies that are easiest to do or most likely to be effective may be listed at the top of the list.

Socialization Strategies for Distraction and Support

If the internal coping strategies are ineffective and do not reduce suicidal ideation, patients can utilize socialization strategies of two types: socializing with other people in their natural social environment who may help to distract themselves from their suicidal thoughts and urges or visiting healthy social settings. In this step, patients may identify individuals, such as friends or family members, or settings where socializing occurs naturally. Examples of the latter include coffee shops, places of worship, and Alcoholics Anonymous (AA) meetings. These settings depend, to a certain extent, on local customs, but patients should be encouraged to exclude environments in which alcohol or other substances may be present. In this step, patients should be advised to identify social settings or individuals who are good "distractors" from their own thoughts and worries. Socializing with friends or family members, without explicitly revealing their suicidal state, may assist in distracting patients from their problems and their suicidal thoughts; this strategy is not intended as a means of seeking specific help with the suicidal crisis. A suicidal crisis may also be alleviated if patients feel more connected with other people or feel a sense of belongingness.

Social Contacts for Assistance in Resolving Suicidal Crises

If the internal coping strategies or social contacts used for purposes of distraction offer little benefit to alleviating the crisis, patients may choose to inform family members or friends that they are experiencing a suicidal crisis. This step is distinguished from the previous one in that patients explicitly reveal to others that they are in crisis and need support and assistance in coping with the crisis.

Given the complexity of deciding if patients should or should not disclose to others that they are thinking about suicide, the clinician and patient should work collaboratively to formulate an optimal plan. This may include weighing the pros and cons of disclosing their suicidal thoughts or behavior to a person who may offer support. Thus, for this step, someone who may help to distract patients from their suicidal urges may not be the best person for assisting patients with a suicidal crisis when suicidal thoughts are disclosed. Patients should be asked about the likelihood that they would contact these individuals and whether these individuals would be helpful or could possibly exacerbate the crisis. If possible, someone close to the patient with whom the safety plan can be shared should be identified and should be named on the plan. It should be noted that sometimes patients are unable to identify someone because they may not feel comfortable sharing the plan with family or friends.

Professional and Agency Contacts to Help Resolve Suicidal Crises

This component of the plan consists of identifying and seeking help from professionals or other clinicians who could assist patients during a crisis. The clinicians' names and the corresponding telephone numbers and/or locations are listed on the plan and may be prioritized. Patients are instructed to contact a professional or agency

if the previous strategies (i.e., coping strategies, contacting friends or family members) are not effective for resolving the crisis. If patients are actively engaged in mental health treatment, the safety plan may include contact information for this provider. However, the safety plan should also include other professionals who may be reached, especially during nonbusiness hours. Additionally, contact information for a local 24-hour emergency treatment facility should be listed as well as other local or national support services that handle emergency calls, such as the national Suicide Prevention Lifeline: 800-273-8255 (TALK).

The safety plan emphasizes the accessibility of appropriate professional help during a crisis and, when necessary, indicates how these services may be obtained. The clinician should discuss the patients' expectations when they contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so. Patients may be reluctant, at times, to contact professionals and disclose their suicidality for fear of being hospitalized or being rescued using a method that is not acceptable to them. As with the other components of the plan, the clinician should discuss any concerns or other obstacles that may hinder patients from contacting a professional or agency. Only those professionals whom patients are willing to contact during a time of crisis should be included on the safety plan.

Means Restriction

The risk for suicide is amplified when patients report a specific plan to kill themselves that involves a readily available lethal method (Joiner et al., 2003). Even if no specific plan is identified by patients, a key component of the safety plan intervention involves eliminating or limiting access to any potential lethal means in the environment. This may include safely storing and dispensing of medication, implementing firearm safety procedures, or restricting access to knives or other lethal means. In developing a safety plan, means restriction is addressed after patients have identified ways of coping with suicidal feelings because, if they see that there are other options to acting on their suicidal urges than committing suicide, they may be more likely to engage in a discussion about removing or restricting access to means. Depending on the lethality of the method, the manner in which the method is removed or restricted will vary. Generally, clinicians should ask patients which means they would consider using during a suicidal crisis and *collaboratively identify ways to secure or limit access to these means.* Clinicians should routinely ask whether patients have access to firearms, regardless of whether it is considered a "method of choice," and make arrangements for securing them. For methods with lower lethality (such as drugs or medication with a low level of toxicity), clinicians may ask patients to remove or restrict their access to these methods themselves when they are not experiencing a crisis. For example, if patients are considering overdosing, having them ask a trusted family member to store the medication in a secure place might be a useful strategy.

The urgency and importance of restricting access to a lethal method is more pronounced for highly lethal methods. For methods of high lethality, such as a firearm, asking patients to temporarily limit their access to such means themselves by giving it to a family member or other responsible person may be problematic, as patients' risk for suicide may increase further as a result of direct contact with the highly lethal method. Instead, an optimal plan would be to restrict patients' access to a highly lethal method by having it safely stored by a designated, responsible person—usually a family member or close friend, or even the police (Simon, 2007). Patients who are unwilling to remove their access to a firearm may be willing to limit their access to the firearm by having a critical part of the firearm removed or by using a gunlock and having the gunlock key removed. Clinicians should also be aware that restricting access to one lethal method does not guarantee patients' safety because they may decide to use another one. The specific behaviors necessary to make the patients' environment safer should be noted on the safety plan and the length of time (e.g., 1 month, 2 weeks) that this restriction should be in place can be noted.

Implementation of the Safety Plan

It is important to note that the SPI should be administered in a collaborative manner with patients. The coping strategies, external supports and triggers to suicidal urges are generated together by the clinician and patient and the patient's own words are used in the written document. The collaborative nature of this intervention is essential to developing an effective safety plan. A clinician-generated list of coping strategies is unlikely to be helpful to a patient in the absence of knowing what strategies are most compelling for the individual. Similarly, "typical" triggers to suicidal feelings are not useful if they do not have personal relevance. On the other hand, the patient is not left alone to struggle with identifying his or her triggers and best means for coping. Instead, clinicians can offer suggestions and inquire in a supportive manner to help the patient complete the intervention.

After the SPI is complete, clinicians should assess the patient's reactions to it and the likelihood he or she will use the safety plan. One strategy for increasing patient motivation to use the safety plan during a crisis is to ask the patient to identify the most helpful aspects of the plan.

If the patient reports or the clinician determines that there is reluctance or ambivalence to use the plan, then the clinician should collaborate with the patient to *identify* and *problem solve* potential obstacles and difficulties to using the safety plan. Role playing the use of the SPI may be helpful if clinicians have sufficient time available and the patient is willing to engage in this exercise. Once a patient indicates his or her willingness to use the safety plan during a crisis, then the original document is given to the patient to take with him or her and a copy is kept in the medical record. The clinician also discusses where the patient will keep the safety plan and how it will be retrieved during a crisis. This may include making multiple copies of the plan to keep in various locations or changing the size or format of the plan so that it could be stored in a wallet or electronic device that is easily accessible. In order to increase the likelihood that the safety plan would be used, the clinician may consider conducting a role-play during which the patient would describe a suicidal crisis and then would provide a detailed description of locating the safety plan and following each of the steps listed on the it.

Training

Clinicians with a wide range of backgrounds (e.g., nurses, psychologists, primary care physicians, psychiatrists, social workers) can be trained to implement the SPI. The typical training includes: (a) reading the safety plan manual (Stanley & Brown, 2008a), reviewing the brief instructions (Stanley & Brown, 2008b) and the safety planning form; (b) attending a training in which the intervention, its rationale and evidence base are described; and (c) conducting role-plays to practice implementing the intervention.

Adaptation for Special Settings and Special Populations

The SPI was developed to be used in settings where emergency services or acute care services are provided, such as EDs, trauma units, crisis hot lines, or medical emergency response units. In addition, the SPI may be used as a part of ongoing mental health treatment in outpatient settings for individuals at risk for suicidal behavior. In this context, safety plans may be revised over time as new coping skills are learned, as new risk factors and precipitants are identified or as the social network changes. We propose that the SPI may be useful in other settings where psychiatric, medical, or psychosocial services are provided, such as inpatient psychiatric settings, military or correctional settings. For these settings, the SPI has to be adapted to acknowledge the limited availability of coping strategies and people who can be enlisted. Institutional staff may require specialized training for determining when patients should be encouraged or coached to follow their safety plan and when a higher level of observation or other external precaution should be implemented.

It is recognized that the application of the SPI will vary depending on the population as well. For example, when developing safety plans with adolescents, it may be important to identify key adults who may become part of the plan. Adolescents are able to aid in determining which family members or other responsible adults are more likely to have a calming and positive influence. Some family members, particularly those with whom the adolescents have frequent conflicts, may not be good candidates to enlist as contacts on the safety plan. Family members can also be coached to help the adolescent use the safety plan. In addition, special care must be taken when helping the adolescent identify individuals other than family members who may offer support and distraction from the suicidal crisis.

Safety Plan Intervention: An Illustrative Case Example

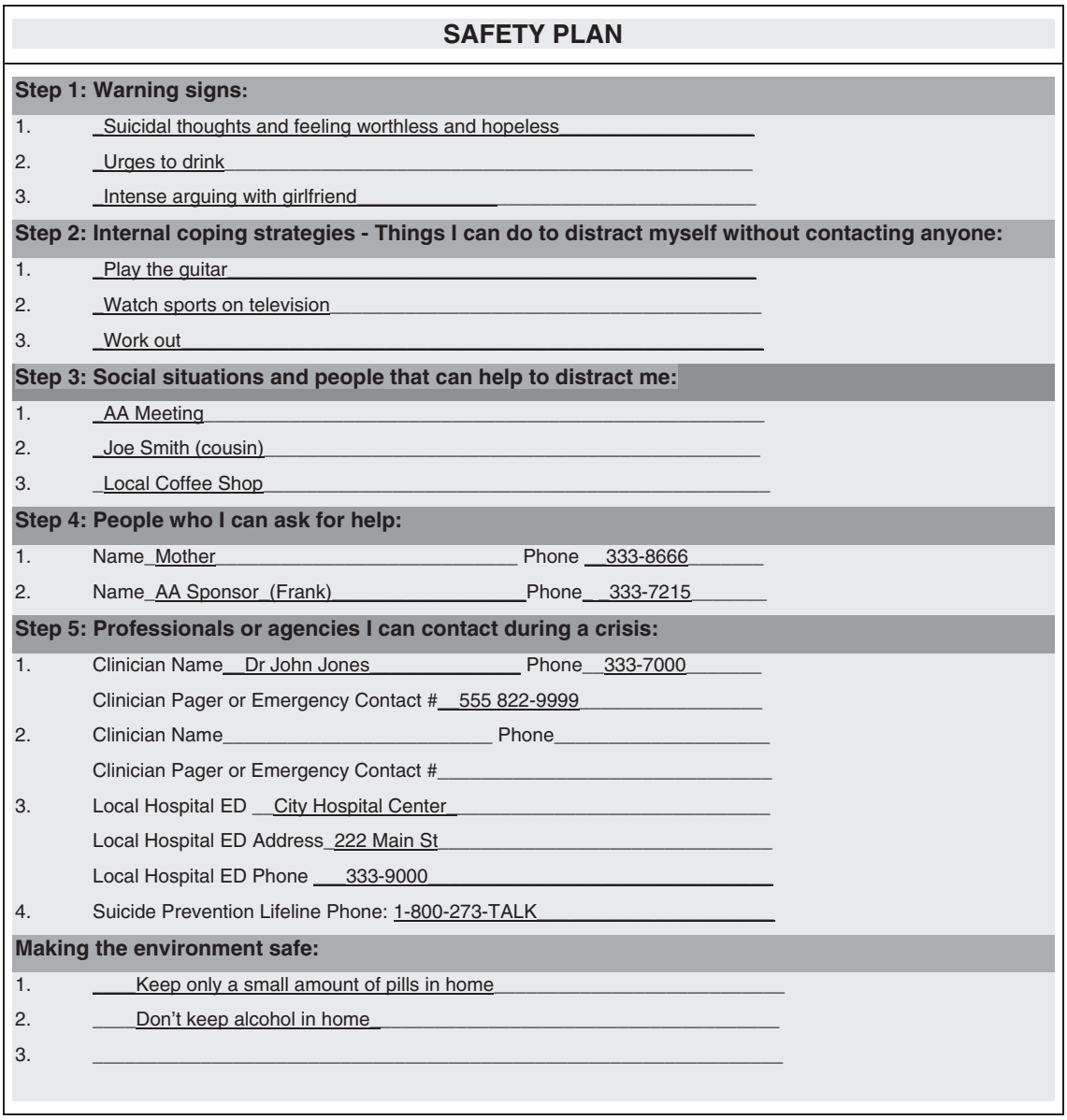
A 28-year-old divorced male and father of two young children presented at the local hospital ED following a suicide attempt. The patient became depressed 2 months ago after his paternal grandfather died from pancreatic cancer. The patient, who cared for his grandfather during his illness, was fired from his job due to excess absences. In the past month, the patient began seeing a psychiatrist at the local community mental health clinic for depression.

During ED evaluation with the psychiatry resident, the patient stated that he "felt down" and sometimes wondered whether "life was not worth living." He described that the onset of his depression coincided with his grandfather's death and loss of his job. Most recently, he stated that he had thoughts of killing himself following several intense arguments with his girlfriend who was considering leaving him because he was out of work. After the most recent argument, the patient impulsively ingested 4 to 6 (325 mg) tablets of acetaminophen and six 12-ounce beers with the intention of dying. However, immediately after he swallowed the pills, he thought about his two young children, realized he did not want to die, and went to the ED. He had no prior suicide attempts and no psychiatric admissions. Upon clinical interview, the resident found the patient's mood to be depressed. The patient reported feeling hopeless, especially about resolving the conflict with his girlfriend and finding a job, but denied any current thoughts of wanting to kill himself or plans to do so. He regretted that he had made the attempt and stated that he realized he "could never do this to his children." He denied hallucinations, delusions, and homicidal ideation. His tentative diagnoses were major depressive disorder and possible alcohol

abuse disorder. His blood alcohol level, 8-panel drug test, acetaminophen and liver function test results were within normal limits. The patient reported a history of "problems with drinking" in the past but, until the suicide attempt, had been abstinent for the past year, having found AA meetings to be very helpful.

The resident consulted with the attending psychiatrist about whether the patient should be admitted for a psychiatric hospitalization or discharged with a referral to his local mental health clinic. The patient's risk for suicide was determined to be moderately high but not at imminent risk. Based on the consultation, the patient was discharged and scheduled for an appointment with his psychiatrist the next day. The patient agreed to attend daily AA meetings and increase contact with his AA sponsor. The patient's motivation to continue psychiatric treatment was ambivalent but he said he would attend the scheduled follow-up appointment. While it was determined that the patient could be safely discharged from the ED, the resident remained uneasy about the disposition.

This case illustrates a frequent clinical scenario in the ED. As is the case with most ED interviews with a suicidal patient, the interaction focuses on suicide risk assessment and treatment disposition. We propose that the ED is



SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3.

Figure 1. Safety Plan Example.

ideally suited for implementation of a very brief psychosocial intervention that may increase the safety of this patient and similar patients, particularly during the interval between ED visit and follow-up appointments.

Figure 1 shows the safety plan that was developed for the patient. The patient explicitly identified suicide ideation, arguing with his girlfriend, urges to drink and feelings of hopelessness and worthlessness as personal warning signs. His internal coping strategies included working out, playing the guitar, and watching sports on television. Social distractors, where suicidal feelings are not revealed, included attending AA meetings, going to the local coffee shop, and talking with a cousin with whom he felt close. The patient then identified his mother and his AA sponsor as people in his support network with whom he could talk if he were in a suicidal crisis again.

In addition, his current psychiatrist's name and contact information was listed as was the local ED and the suicide prevention hot line number. The plan was written in a collaborative manner with the ED physician. A copy was placed in the patient's chart and the patient was given a copy on discharge. The patient stated that he would make another copy so that he could keep one copy in his bedside stand and one copy in his wallet.

Discussion

Patients evaluated for suicide risk in EDs and other emergency settings for whom hospitalization is not clinically indicated are often offered the same disposition as nonsuicidal outpatients (Schulberg, Bruce, Lee, Williams, & Dietrich, 2004; Spirito et al., 2002). The management and treatment of suicidal patients in outpatient settings can be burdensome and anxiety-provoking for clinicians and may diminish their motivation to treat these patients. Although protocols have been developed for managing suicidal crises in outpatient settings (Jobes, 2006; Rudd, 2006, Stanley et al., 2009; Wenzel et al., 2009), these strategies have been developed as part of ongoing and longer-term treatment. Brief crisis interventions, such as safety planning, may be especially useful when the opportunity for longer-term care is limited or, alternatively, as an adjunct to treatment.

The SPI is a promising intervention to mitigate risk of suicide when evaluating and treating patients who are at increased risk for suicide. It can serve as a valuable complement to risk assessment, particularly for those patients who do not require psychiatric hospitalization. The SPI has several advantages. It is both easy to learn and easy to utilize. Staff can be trained readily, and in our clinical experience, the safety plan intervention is easier to learn than conducting a comprehensive risk assessment. Furthermore, it may be incorporated into the treatment of suicidal individuals, regardless of the clinician's theoretical perspective.

This intervention has been used clinically by the authors (e.g., Stanley et al., 2009) and has been used as part of other evidence-based psychotherapy interventions in clinical trial research. Its efficacy as a stand-alone intervention is currently being evaluated by us in an urban ED and nationally in a Department of Veteran Affairs clinical demonstration project. We describe only one format or version of a safety plan and recognize that other formats may be useful as well.

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