Welcome to the ASPI Consultant Training!

We will begin at the top of the hour.

In the meantime, some housekeeping…

1) **For AUDIO, dial into VANTS.**
   1-800-767-1750; Code 19270#

2) **Please mute your phones and computer (make sure the speaker icon on the top of the Adobe screen is gray, not green. *6 toggles the mute on & off.**

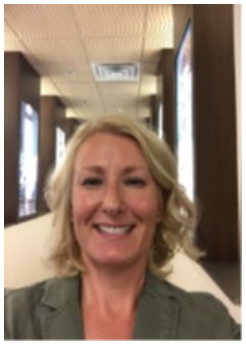
3) **Please do NOT place the call on hold. Hang up and dial back into the call.**

4) **Type your LAST NAME into the Chat pod in the middle on the right side.**

5) **Slides and handouts can be downloaded from the Files pod in the bottom right below and on the SharePoint.**

6) **Please type Questions and Comments in the Chat anytime during the Training.**





Safety Planning Intervention: Consultant Training Workshop

Gregory K. Brown, Ph.D.
Barbara Stanley, Ph.D.
Wendy Batdorf, Ph.D.

Advanced Safety Planning Intervention Training Program
Office of Mental Health and Suicide Prevention
Department of Veterans Affairs

Final: 6-20-19

Housekeeping & Attendance

- **Welcome!**
- **Use only your phone for audio**
  - Mute your phone and computer speakers
- **Do not place the phone line on hold**
- **Please use the Chat for questions, comments, or responses**
- **Do not text or respond to emails during this session**
- **If you haven't already done so, please type your LAST NAME name in the chat pod**

Acknowledgements

- This presentation was developed by Gregory K. Brown, Ph.D., Barbara Stanley, Ph.D. and Wendy H. Batdorf, Ph.D. (2019) for providers who are participating in the Advanced Safety Planning Intervention (ASPI) Training Program.
- Sponsored by the Office of Mental Health and Suicide Prevention, Department of Veterans Affairs Central Office.

VA ASPI Training Program
Office of Mental Health and Suicide Prevention

Training Program Staff	Role
Dr. Wendy Batdorf (Contact)	ASPI Training Program Coordinator
Drs. Greg Brown and Barbara Stanley	ASPI Master Trainers and Subject Matter Experts
Dr. Kristine Day	ASPI Program Manager
Drs. Chris Crowe, Nate Kimbrel, Mandy Kumpula, Kristin Powell, Kristine Day, Wendy Batdorf, Greg Brown, Barbara Stanley, Jeff Hoerle	ASPI Training Program Workgroup and Program Evaluation Team
Sheena Sharma	ASPI Program Administrator

VA ASPI Training Consultant Team

Name	Degree	Email	VISN and Location
Kaily Cannizzaro	PsyD	Kaily.cannizzaro@va.gov	19; RM MIRECC
Robert "Corey" McCulloch	PhD	Robert.McCulloch@va.gov	22; San Diego
Melissa Pinson	PhD	melissa.pinson2@va.gov	17; Corpus Christi
Hilary Montano	PhD	hilary.montano@va.gov	6; Hampton VA Virginia Beach COBC
Georgia Gerard	LCSW	Georgia.Gerard@va.gov	19; RM MIRECC
Suzanne McGarity	PhD	Suzanne.McGarity@va.gov	19; RM MIRECC
Megan Harvey	PhD	Megan.Harvey2@va.gov	19; RM MIRECC
David Kapelle	LCSW	David.kapelle@va.gov	20; Puget Sound
Gloria "Gia" Maramba	PhD	gloria.maramba@va.gov	21; Palo Alto HCS
Meghan Campos	LCPC	Meghan.Campos@va.gov	17; Texas Valley Coastal Bend HCS
Elyssa Kushner	PsyD	Elyssa.Kushner@va.gov	4; Philly VAMC

Introduction of the ASPI Training Consultants

In less than a minute:

- **Your name**
- **Where you work**
- **What you want to get out of this training**

ASPI Consultant Training Agenda

Day 1: Tuesday, June 18th, 2019		
12:00 – 12:15pm ET	Welcome and Introductions	Drs. Wendy Batdorf, Gregory Brown, Barbara Stanley
12:15 – 1:30pm ET	Overview of the ASPI Training Program Pilot; ASPI Consultant Responsibilities and Program Logistics	Drs. Batdorf & Brown
15-minute Break		
1:45 – 4:20pm ET	Training in the VA Safety Planning Intervention	Drs. Brown & Stanley
4:20 – 4:30pm ET	Question and Answer; Wrap up	Group
Day 2: Wednesday, June 19th, 2019		
12:00 – 12:05pm ET	Welcome	Drs. Batdorf, Brown, Stanley
12:05 – 1:45pm ET	Review of the Safety Planning Intervention Rating Scale-Veterans Affairs (SPIRS-VA) and Safety Planning Intervention Scoring Algorithm-Veterans Affairs (SPISA-VA)	Drs. Brown & Stanley
15-minute Break		
2:00 – 4:20pm	Review of ASPI Session and Calibration to Rating Scale	Drs. Brown & Stanley
4:20 – 4:30pm	Question and Answer; Wrap up	Group
Day 3: Thursday, June 20th, 2019		
12:00 – 12:05 ET	Welcome	Drs. Batdorf, Brown, Stanley
12:05 – 1:45pm	Experiential Training Role-Plays	Group
15-minute Break		
2:00 – 4:00pm	Experiential Training Role-Plays	Group
4:00 – 4:30pm	Question and Answer, Wrap up, Next Steps	Group

VA ASPI Consultant Training Workshop Learning Objectives

1. Provide an overview of the ASPI Training Program
2. Describe the rationale for the Safety Planning Intervention
3. Describe how to collaboratively develop a safety plan
4. Describe how to evaluate the clinician fidelity to the Safety Plan Intervention

Background/Development

- **Eliminating Veteran suicide is VA's top clinical priority**
  - Approximately 20 Veterans die by suicide every day
  - The VA Secretary has requested all VA staff be involved in efforts to end suicide
  - VA has already released:
    - Comprehensive Suicide Risk Evaluation (CSRE) Toolkit, which is a unified strategy for suicide risk screening and evaluation
    - CPRS Safety Planning Template and Manual
  - Plans are underway within VA for:
    - Pilot program for Cognitive Therapy for Suicide Prevention (CT-SP; Brown et al., 2005)

Clinical Practice Guidelines (CPG)

- **CPG for Assessment and Management of Patients at Risk for Suicide (currently under revision) recommends:**
  - Safety Planning developed collaboratively with the patient should be part of discharge planning for all patients identified as high risk for suicide
    - CPRS Safety Planning Template and Manual were recently released within VA
  - Treatment should include Evidence-based Treatment/Management
    - Evidence-based treatment/management of the underlying condition (e.g., SUD, MDD, Psychosis, Schizophrenia, Bipolar Disorder, PTSD, TBI, Chronic Pain, Medically unexplained symptoms)
      - EBP Programs offer trainings in EBPs for treatment of many of the noted underlying conditions
    - Interventions that directly and specifically address the potential suicidality (e.g., CT for Suicide Prevention and Problem Solving Therapy)
      - CT-SP (2-day workshop, without consultation) currently offered through Center for Deployment Psychology
      - CT-SP currently being piloted, based on a Telemental Health (TMH) Hub model, within two VISNs

Limitations of Current VA Efforts

- **CPRS Safety Planning Template and Manual**
  - Training consists of webinar, with no consultation component
  - The literature suggests a consultation component is critical for development of quality safety plans (Green et. al, 2017)
- **CT-SP TMH Hub Pilot**
  - Challenges regarding model (low base rates/accessibility to training cases)
  - Any future effort to develop CT-SP within EBP Program will be informed by their pilot

EBP Program Plans

- **EBP Program Direction for Treatment Approach**
  - *Short term*: Develop Advanced Safety Planning Intervention (ASPI) training, with consultation, as a means of having a broader reach and maximum impact that would reach more clinicians and Veterans relatively quickly
  - *Long term*: Consider developing CT-SP training program in the future, pending outcome of CT-SP pilot within VA
- **Alignment with VA priorities**
  - Consistent with VA priority to decrease suicidal and self-injurious behaviors in Veterans
  - Aims to increase provision of CPG-concordant care for prevention of suicide
  - Designed to enhance existing training resources, including VA's web-based Suicide Prevention Safety Planning training

Rationale for Development of ASPI Training

- **Although widely implemented within VA, safety planning quality varies**
  - Gamarra et al. (2015) found that, for those Veterans flagged as high risk for suicide, safety plans were mostly complete and of moderate quality, but significant proportion had no evidence of ongoing review or utilization of safety plan in treatment
  - Green et al. (2017) found that quality of VA safety plans was low; safety plans of higher quality predicted decreased likelihood of future suicide behavior reports
- **Findings of low quality and incomplete safety plans highlights the need for additional training in administration of Safety Planning Intervention (SPI)**
- **VA recently developed and released a template and an updated manual for SPI for Veterans**
- **However, simply providing non-interactive training materials is likely not sufficient for improving the quality of safety planning**
- **We propose that advanced training in the safety planning intervention will offer competency-based training in safety planning, beyond that currently available in VA, that may reduce suicidal behaviors**

ASPI Training Program

- **For VA providers who regularly encounter Veterans at elevated risk for suicide**
- **Blended learning training model involves:**
  - Interactive, web-based didactic training that includes demonstration videos
  - Experiential exercises that include individualized feedback from expert consultants
  - Evaluation of safety planning administration using standardized patient role plays and standardized rating measures

- **ASPI Training Program Learning Objectives:**
  - Teach the rationale and clinical implementation of developing Safety Plans with Veterans
  - Tailor Safety Plans for Veteran-specific issues and across diverse populations
  - Evaluate VA providers in the application of the SPI to promote competency and fidelity
  - Promote safety planning as a clinical intervention and promote ongoing implementation post-training

ASPI Training Model

- **ASPI Training Model includes four components:**

Component	Activity	Duration
Program Orientation	• 1 hour	• 2 times provided
1: Didactic Training	• Live, 3-hour webinar • Completion of Safety Planning Template Training	• 4 hours total completed during a 2-week window
2: Experiential Training	• 2 weekly, 2-hour calls	• Completed during a 2-week timeframe
3: Participant Evaluation	• 1 hour, 1:1 evaluation with Training Consultant	• Completed within 1 month of completing Experiential Training
4: Follow-Up Evaluation	• 1 hour, 1:1 evaluation with Training Consultant	• Completed 3 months after Participant Evaluation

- **Successful completion of all four components will allow inclusion on ASPI Provider Roster**

ASPI Training Model (cont.)

Component 1: Didactic Training

- Upload a de-identified patient safety plan for review
- Attend the 1-hour Program Orientation
- Complete the 1-hour Suicide Safety Planning Training course in TMS
- Read the *Safety Planning Intervention Manual: Veteran Version*
- Attend and participate in the ASPI Webinar (3 hours)

Component 2: Experiential Training

- Briefly review core SPI skills
- Practice implementing SPI skills using interactive role play and group discussion
  - Each role play is 40 minutes, with 20 minutes for feedback provided by the Consultant and other participants on the call
  - Each training participant will have an opportunity to role-play a safety plan in the role of Provider
  - The Consultant will rate each participant's role play using the Safety Planning Intervention Rating Scale-Veterans Affairs (SPIRS-VA)
  - Consultants will also rate the written plan using the Safety Planning Intervention Scoring Algorithm-Veterans Affairs (SPISA-VA)
  - These measures will be used to provide individualized feedback to participants

ASPI Training Model (cont.)

- **Component 3: Participant Evaluation**
  - One hour role-play session in which each participant is individually evaluated on the development of a safety plan, including the written plan
  - Each training participant is evaluated by different Consultant than the one who conducted Component 2
    - 40-minute role play with the training Consultant acting in the role of a "standardized patient"
    - 10 minutes for Consultant to provide a competency rating using the SPIRS-VA (evaluation of the process of safety plan implementation); participant completes the written safety plan for the standardized patient
    - Consultant provides a rating of the written patient safety plan using the Safety Planning Intervention Scoring Algorithm-Veterans Affairs (SPISA-VA)
    - 10 minutes for feedback and provision of scores
  - If participant demonstrates competency by achieving a passing score on the SPIRS-VA, move to Component 4 for the follow-up evaluation (with a different Consultant)
  - If participant does not demonstrate competency, Consultant provides individualized feedback to participant regarding area(s) requiring further development. Participant may be reassigned to a new group to restart Component 2

ASPI Training Model (cont.)

- **Component 4: Follow-up Evaluation**
  - Scheduled 3 months after Component 3 evaluation
  - Evaluation is same structure is that described in Component 3 above; those who achieve or exceed the competency benchmarks on both measures are added to ASPI Roster
- **Post-Training**
  - Once completion of all requirements is confirmed and all program evaluation measures are completed in the Portal, each training participant will be added to the VA ASPI Provider Roster and a Record of Completion acknowledging their status will become available in the portal.
  - Highly skilled providers with supervisory and/or teaching experience may be nominated by their training consultant to apply to become an ASPI training consultant *after* all program requirements have been met.

ASPI Training Program Evaluation Plan

- **Changes in safety planning knowledge and intent to use safety planning skills** (Pre-training and after Component 2).
- **Changes in training participant competency in safety planning (after Components 3 and 4).**
- **Changes in adherence to written patient safety plan criteria over the course of the training** (Pre-training, Components 3 and 4).
- **Participant feedback on the didactic and experiential components of the ASPI training program, including technology, program staff, Experiential Consultant** (after Component 2).
- **Participant feedback on the implementation of safety planning at 3-month post-training follow-up, including barriers and facilitators to safety planning, estimated rates of safety planning, follow-up reviews of safety plans** (timing TBD).
- **Proportion of training participants who successfully complete the requirements of the training program** (after pilot cohort completes Component 4).

Potential Future Analyses

- Comparison of rates of patient suicidal behaviors during 3-month follow-up period of ASPI training participants with the rates of patient suicidal behaviors of a matched cohort of therapists and patients who did not participate in the ASPI training
- Association between levels of competency and adherence in safety planning of the training participants and rates of patient suicidal behaviors

SPI Implementation

- **Multidimensional, top down and bottom up approach to promote adoption and sustainability**
- **OMHSP EBP website**
- **ASPI SharePoint site**
  - ASPI Provider Roster
- **Systematic Program Evaluation**
- **Safety Plan Note Templates (CPRS)**
  - Facilitate standard clinician documentation of delivery
  - Promote fidelity in delivery of EBPs
  - Facilitate measurement-based care
  - Reduce protocol drift over time
  - Allow for direct measurement of EBPs
    - Which is of interest to many internal and external VA stakeholders including Congress, OIG, OMB, IOM, and others
  - SP Template instructions available on the **ASPI SharePoint**

ASPI Training Program Requirements for Completion

- **Complete Component 1: Didactic Training**
  - Attend Program Orientation
  - Upload previously completed de-identified, written patient safety plan in ASPI Data Portal
  - Complete SPI Template Training Course in TMS and upload certificate in Data Portal
  - Attend and participate in the ASPI Webinar
  - Read the *Safety Planning Intervention Manual: Veteran Version*
- **Complete Component 2: Experiential Training**
  - Attend and participate in 2 ASPI Experiential Calls
  - Complete one SPI role-play and one written safety plan
- **Complete Component 3: Participant Evaluation**
  - Complete one SPI role-play and one written safety plan
  - Obtain a passing score of **14 or greater (78%) on both Part II and Part III** of the Safety Planning Intervention Rating Scale-VA (SPIRS-VA)
- **Complete Component 4: Follow-Up Evaluation**
  - Complete one SPI role-play and one written safety plan
  - Obtain a passing score of **14 or greater (78%) on both Part II and Part III** of the Safety Planning Intervention Rating Scale-VA (SPIRS-VA)
- **Complete all program evaluation measures per the schedule in the ASPI Data Portal**

ASPI Program Logistics

- **Skype**
  - Used for weekly calls
  - Provides a conference line
  - Can use screen share, whiteboard, and other features
  - Basic instructions on the ASPI SharePoint site
- **ASPI Data Portal**
  - Web-based tool for participants, consultants, and program administration
    - Approved for use by VA Networks and Security Operations Center (VANSOC)
  - Enter all program evaluation and patient measures
  - Portal instructions are available on the ASPI SharePoint site
    - Participant and Consultant versions
  - Training Consultants and Participants should enter data promptly and not wait until the end of the training.

ASPI Program Logistics (cont.)

- **Where is the portal?**
  - Available only within VA firewall and is accessible through remote access (VPN)
  - Link: http://vaww.mirecc.visn6.va.gov/tmportal/
- **ASPI Program team will add each Training Consultant and Training Participant in the Portal**
  - Each participant will update their profile, ensuring their name, VA email, physical address, and phone number are current
- **Consultant Training and Portal Demonstration will occur on an upcoming ASPI TC call**

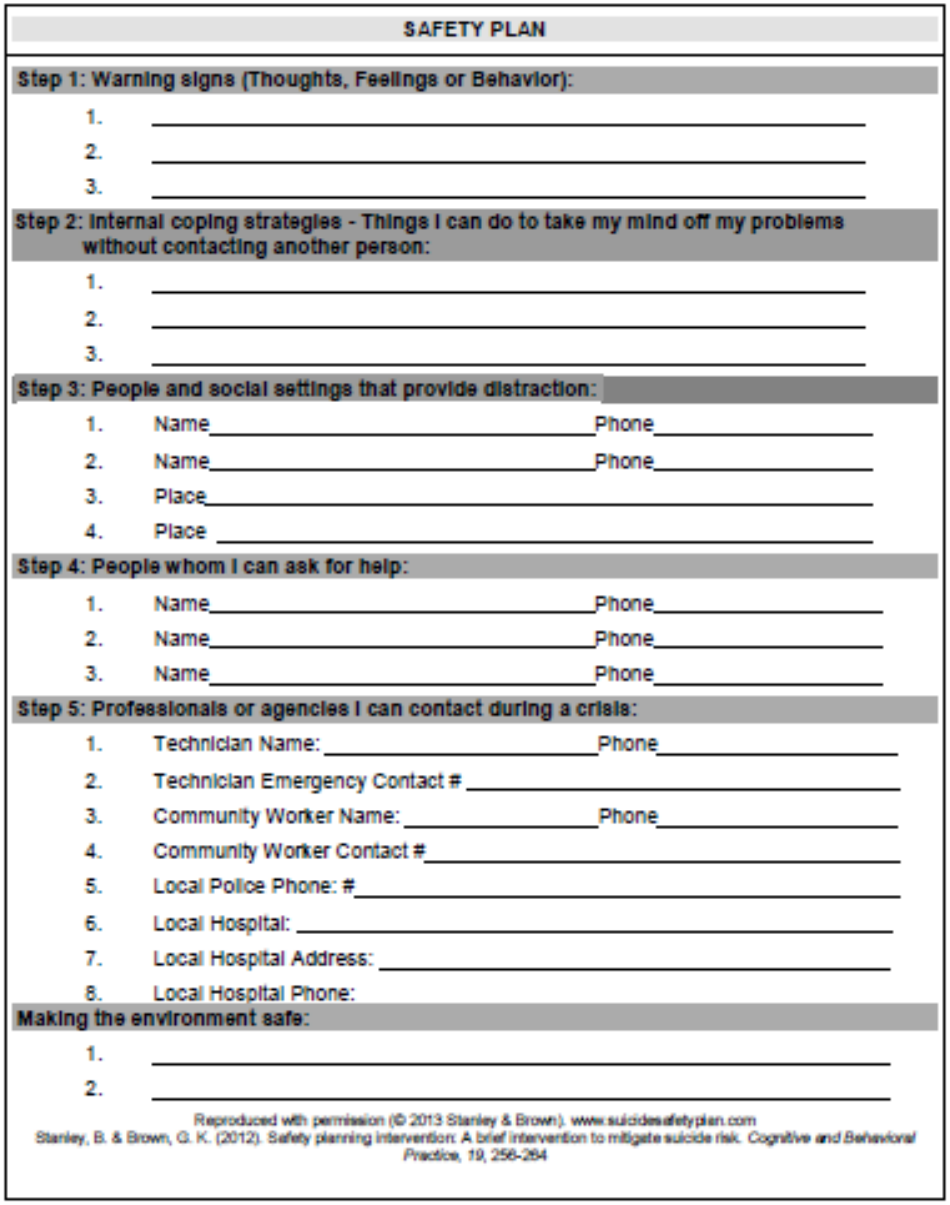
ASPI Consultant Resources

- **ASPI Training Program SharePoint site**
  - Program forms, procedural guides, articles, etc.
- **ASPI Training Consultant Handbook**
  - Please do not distribute to others outside of the ASPI Training Program
- **ASPI Training Consultant Calls**
  - 2nd and 4th Tuesdays beginning July 9th
  - Only for Training Consultants (attendance required)
  - Frequency may be adjusted after pilot completed

SAFETY PLANNING INTERVENTION

Safety Planning Intervention

- **Brief clinical intervention that results in a prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis**
- **Stanley & Brown (2012). *Cognitive and Behavioral Practice***



SAFETY PLAN

Step 1: Warning signs (Thoughts, Feelings or Behavior):

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

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

1. Technician Name: _____ Phone_____
2. Technician Emergency Contact # _____
3. Community Worker Name: _____ Phone_____
4. Community Worker Contact #_____
5. Local Police Phone: #_____
6. Local Hospital: _____
7. Local Hospital Address: _____
8. Local Hospital Phone:

Making the environment safe:

1. _____
2. _____

Reproduced with permission (© 2013 Stanley & Brown). www.suicidesafetyplan.com
Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256-264

JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades; middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

Author Audio Interview

Safety Planning Intervention: VA Study

- Safety Plans administered in the ED to patients who were experiencing a suicidal crisis but did not require hospitalization (moderate risk)
- Structured Follow up phone calls to assess risk and review and revise the safety
- Enrollment: N=1,640, Mean age = 48 (SD=14), 88% men

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018).

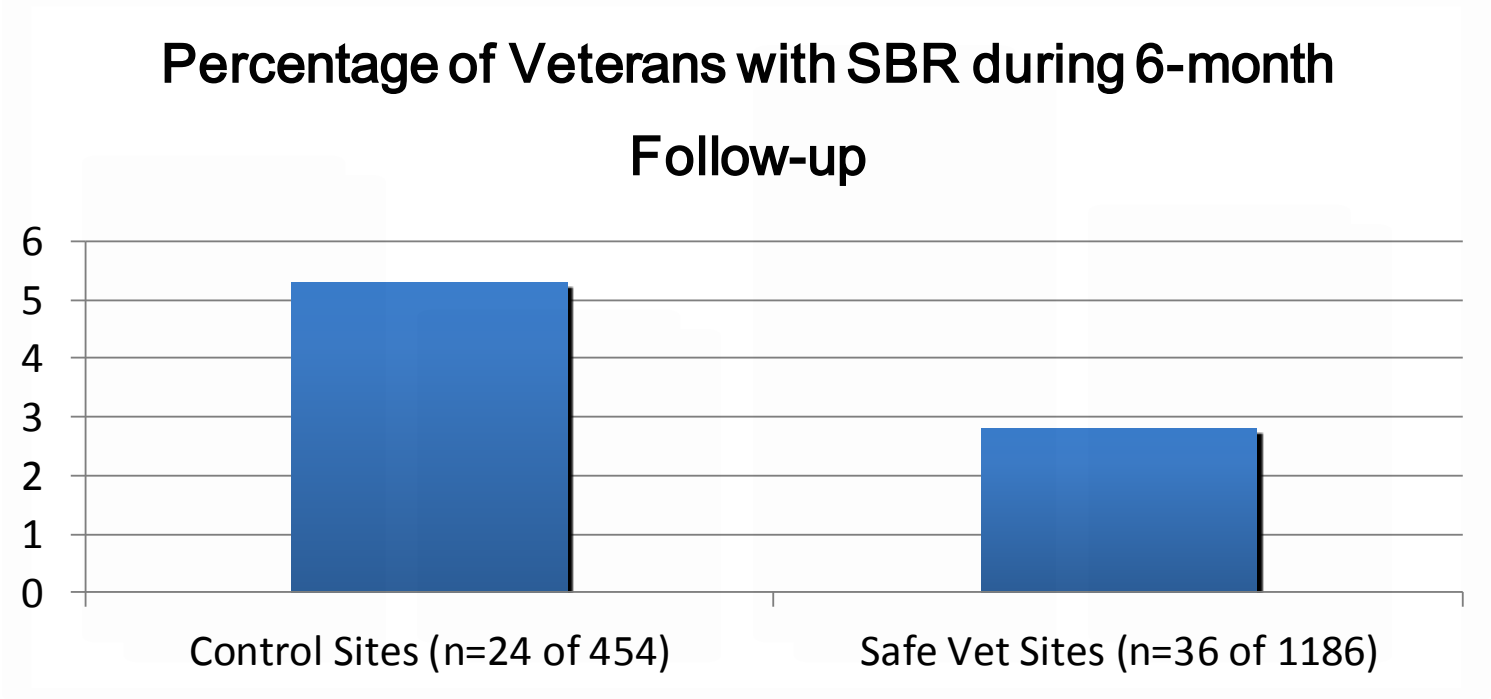
Project Design

- **Selected 5 VA EDs that provided the SPI+ intervention**
- **Cohort comparison design: 4 VA EDs that did not provide SPI+ and that were matched on:**
  - Urban/suburban vs. rural
  - Similar number of psychiatric ED evaluations per year
  - Presence of an inpatient psychiatric unit at the VAMC
- **Medical record data were extracted for the 6 months prior to and 6 months following the index ED visit**
  - Suicide Behavior Reports
  - Mental Health and Substance Use Services

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018).

Does SPI+ help to decrease suicidal behavior?

Suicide Behavior Reports (SBR) During Follow-up



$\chi 2(1, N = 1640) = 4.72$, $p = .029$; OR = 0.56, 95% CI: 0.33, 0.95

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). JAMA Psychiatry

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Requirement	NPSG 15.01.01, EP 6: BHC: Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide. HAP: Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
Rationale	Studies have shown that a patient's risk for suicide is high after discharge from the psychiatric inpatient or emergency department settings. Developing a safety plan with the patient and providing the number of crisis call centers can decrease suicidal behavior after the patient leaves the care of the organization.
Reference*	Stanley B, 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.

Lessons Learned: Quality Matters!

- **Fidelity to Safety Planning involves more than simply completing a piece of paper, the safety plan form.**
  - Also involves taking a collaborative and understanding approach to addressing painful experiences.
- **A comprehensive chart review was conducted for VA patients who were flagged as high risk (Gamarra et al., 2015).**
  - Safety plans were mostly complete and of moderate quality, although variability existed.
  - A significant proportion of the patient charts had no explicit evidence of ongoing review or utilization of the safety plan in treatment.
- **An additional study of VA safety plans in medical records found that the quality of safety plans was low (Green et al, 2018).**
  - Higher safety plan quality scores predicted a decreased likelihood of future suicide behavior reports.

VA Initiatives to Improve Quality of Safety Plans FY18-19

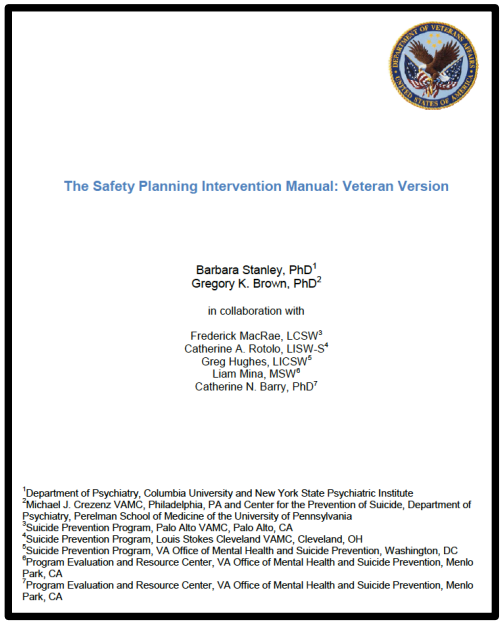
1. Launched VA Advanced Safety Planning Intervention Training Program
2. Enhanced VA medical record Safety Plan template and paper form
3. Updated and expanded VA Safety Planning Intervention manual
4. Adapted measures of fidelity (competency and adherence) for the Safety Plan Intervention in VA

National Standardized Safety Plan Note Template

- Provides detailed instructions and tips for completing the VA Safety Plan template for improving collaboration and specificity of coping strategies and resources
- Improves VHA's ability to monitor and analyze appropriate use and timing of safety plans
- Provides the option for Veterans to decline safety planning (or specific aspects), document the reason for refusal and ensure updated current address and emergency contact information
- Provides specific instructions about access to guns, opioids, and other lethal means and action plans to improve safety
- Enhancements to assessing safety contacts and sharing of safety plans with others
- Availability of training to use the template: Suicide Safety Planning Training (TMS Course #36232)

Safety Planning Intervention Manual: Veteran Version (2018)

- **Revision and expansion of the 2008 VA manual**
- **Detailed description of how VA providers and Veterans collaboratively develop and use Safety Plans as an intervention to lower risk**
- **Corresponds to VA Safety Plan note template**
- **Provides an explicit rationale for each aspect of the intervention**
- **Focuses on how to conduct a narrative interview of the suicidal crisis, how to introduce safety planning, how to use the plan and how to review safety plans during follow-up visits**
- **Includes VA provider-Veteran dialogue to illustrate the intervention**


The Safety Planning Intervention Manual: Veteran Version

Barbara Stanley, PhD[1]
Gregory K. Brown, PhD[2]

in collaboration with

Frederick MacRae, LCSW[3]
Catherine A. Rotolo, LISW-S[4]
Greg Hughes, LICSW[5]
Liam Mina, MSW[6]
Catherine N. Barry, PhD[7]

[1]Department of Psychiatry, Columbia University and New York State Psychiatric Institute
[2]Michael J. Crezenz VAMC, Philadelphia, PA and Center for the Prevention of Suicide, Department of Psychiatry, Perelman School of Medicine of the University of Pennsylvania
[3]Suicide Prevention Program, Palo Alto VAMC, Palo Alto, CA
[4]Suicide Prevention Program, Louis Stokes Cleveland VAMC, Cleveland, OH
[5]Suicide Prevention Program, VA Office of Mental Health and Suicide Prevention, Washington, DC
[6]Program Evaluation and Resource Center, VA Office of Mental Health and Suicide Prevention, Menlo Park, CA
[7]Program Evaluation and Resource Center, VA Office of Mental Health and Suicide Prevention, Menlo Park, CA

Stanley, B. & Brown, G. K. with MacRae, F., Rotolo, C. A., Hughes, G., Mina, L. & Barry, C. N. (2018). *Safety Planning Intervention Manual: Veteran Version.* Washington, D.C.: United States Department of Veterans Affairs.

Safety Planning Intervention Rating Scale for VA (SPIRS-VA)

- Detailed protocol for evaluating provider competency of the Safety Planning Intervention
- Ratings are based on audio/video recordings or live observation
- Educational tool for providing detailed feedback on the strengths and weaknesses when implementing safety planning
- Useful for assessing changes in competency over time
- Using behavioral anchors, items are rated as:
  0 = "Not Present," 1 = "Inadequate,"
  2 = "Satisfactory," 3 = "Excellent"
- Summary Scores:
  - **Part I (no score)**
  - **Part II Total Score (General Safety Planning Skills)**
  - **Part III Total Score (Constructing Each Step of the Safety Plan)**
  - **Global Score (Overall Quality)**
- Interpretation Guidance: Competency determined by scoring 78% correct on both Parts II and III.

Safety Planning Intervention Rating Scale for VA (SPIRS-VA)

Part I. Pre-Safety Plan Intervention (No Score)

1. Performing a Suicide Risk Assessment
2. Assessing Appropriateness for Safety Plan

Part II. General Safety Plan Intervention Skills (Maximum Score: 18)

1. Obtained a Description of a Recent Suicidal Crisis
2. Reviewed the Suicide Risk Curve
3. Provided a Rationale for the Safety Plan
4. Safety Planning as a Collaborative Process
5. Explained How to Follow the Steps of the Safety Plan
6. Location, Sharing, Barriers, and Likelihood of Use

Part III. Constructing Each Step of the Safety Plan (Maximum Score: 18)

1. Warning Signs
2. Internal Coping Strategies
3. Socialization and Social Support Strategies
4. Contacting Family or Friends Who May Offer Help to Resolve a Crisis
5. Contacting Professional or Agencies
6. Making the Environment Safer

Safety Planning Intervention Scoring Algorithm for VA (SPISA-VA)

- **Detailed protocol for evaluating the quality and completeness of written safety plans**
- **Each response is evaluated for degree of completeness, personalization, and accuracy**
- **Detailed ratings for Step 6: Making the environment safe (e.g., firearm safety, access to opioids, providing a copy of the plan, contacts for safety check)**
- **Summary Scores:**
  - Total Quality Score
  - Total Completeness Score
  - Safety Plan Global Impression Score

Safety Planning Intervention Scoring Algorithm for VA (SPISA-VA)

Example:

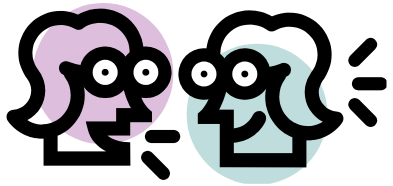
Select one score for each line	No Text Present (0 pts)	Text Present: Not Personalized (1 pt each)	Text Present: Somewhat Personalized (2 pts each)	Text Present: Highly Personalized (3 pts each)
STEP 1: Warning Signs				
Step 1 Examples:	Blank	"Stressed"	"Sad"	"I can't take it anymore."
Step 1: Warning Signs, Row 1 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 2 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 3 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 4 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 5 Is any text present?	0	1	2	3
Step 1 Overall Quality Rating	0	1	2	3

Target Population for Safety Planning Intervention

- **Individuals at increased risk for suicide but *not* requiring immediate rescue**
- **Patients who have…**
  - History of suicidal behavior including:
    - Suicide attempts
    - Interrupted attempts by self or others
    - Made preparations for suicide
  - Recent history of suicidal ideation
  - Otherwise determined to be at risk for suicide

Safety Plan Intervention Approach

- Individuals may have trouble recognizing when a crisis is beginning to occur
- Problem solving and coping skills diminish during emotional and suicidal crises
- The clinician and patient (and their family, if applicable) work together to develop better ways of coping during crises that uses the patient's own words
- Over-practicing skills using a predetermined set of skills may improve coping capacity



Fire Safety: Stop, Drop and Roll

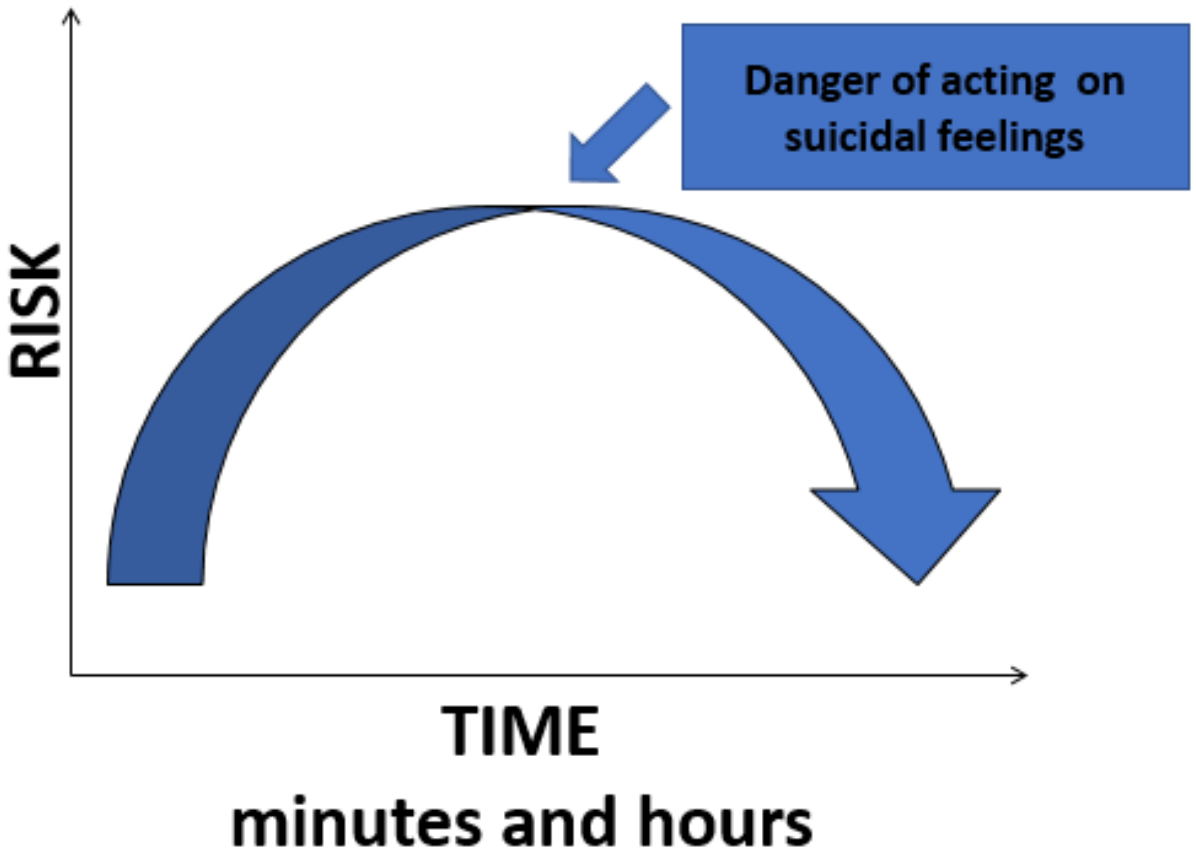
Elevated, More *Chronic* Suicide Risk

e.g. Depression, SUD, PTSD, Hopelessness, Persistent Stressors:

Treatment: Disorder-specific and Suicide-specific Psychotherapy, Medication

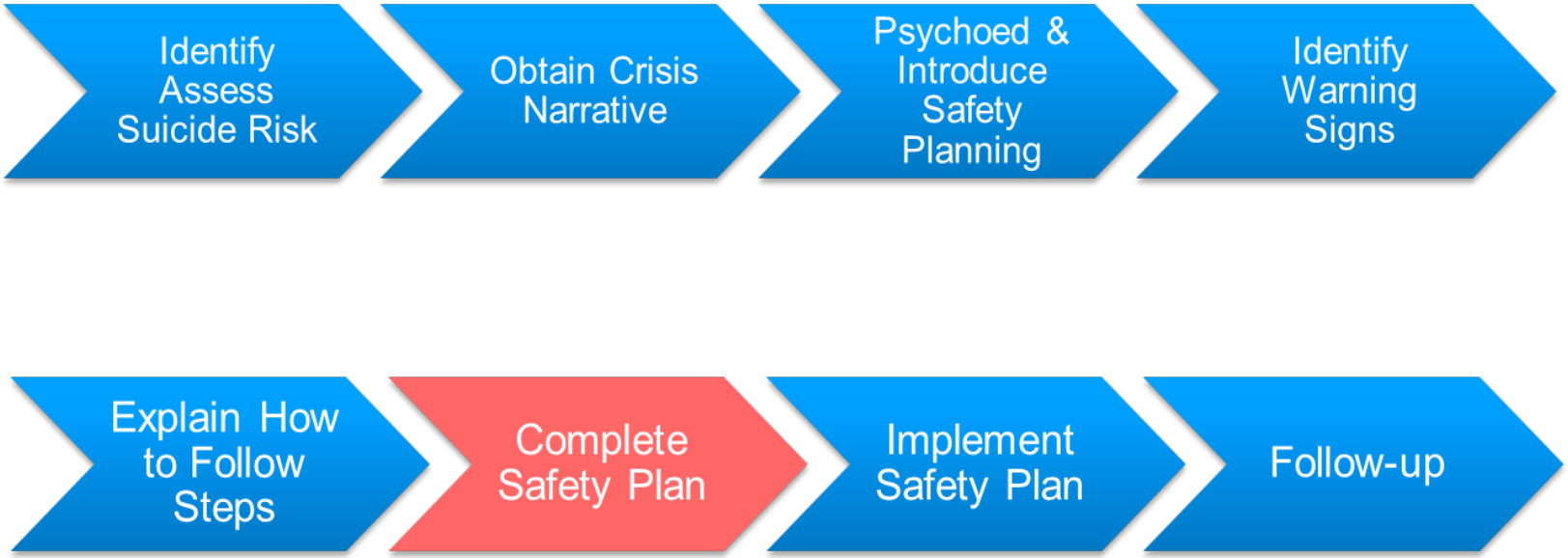
Acute Suicide Risk Fluctuates Over Time:

Treatments: Brief Crisis Interventions, Fast-acting Medications, Emergency Care



Safety Plan Intervention Tasks

The Safety Plan Intervention involves more tasks than simply completing the Safety Plan Form

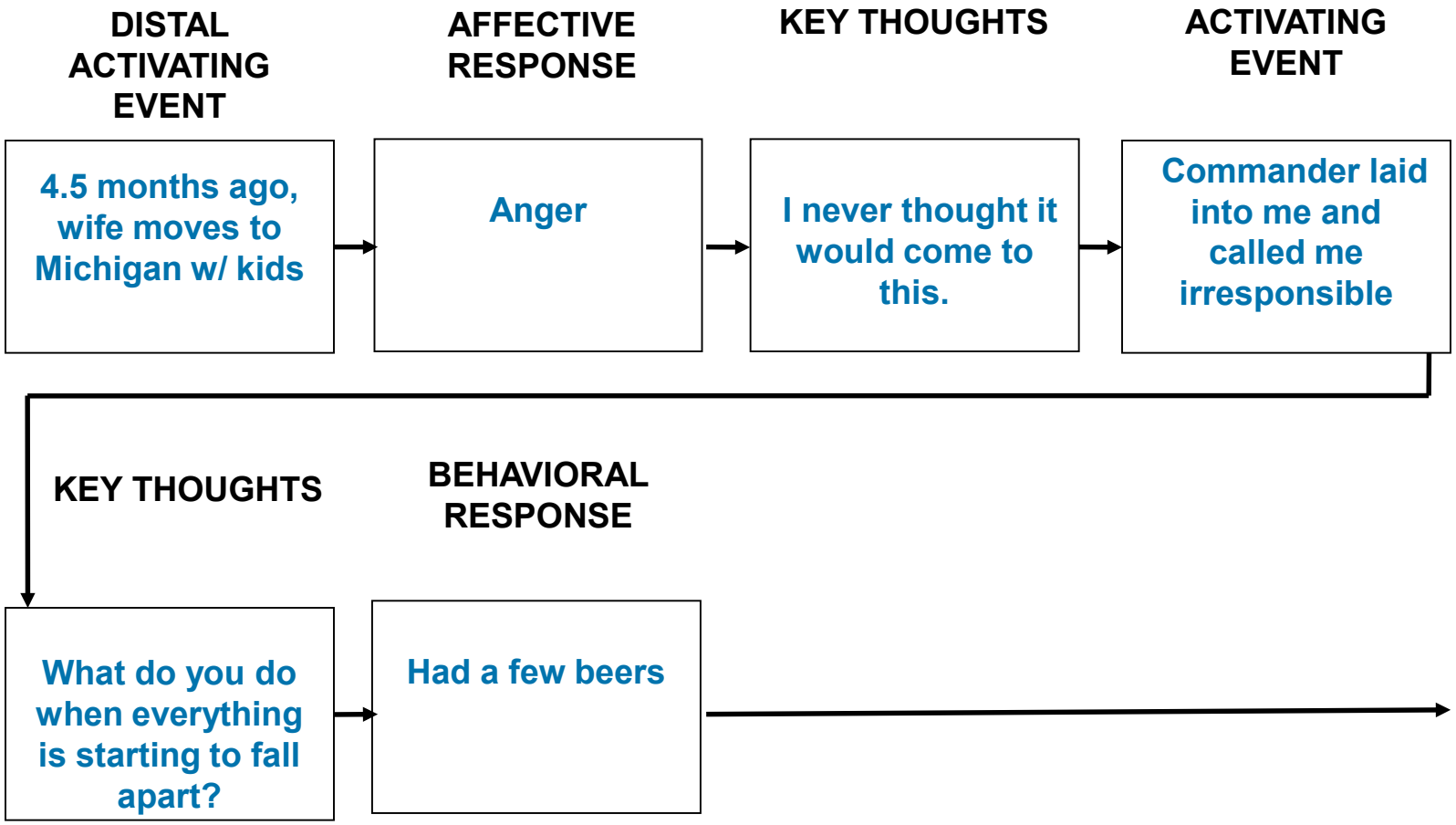


Goals of the Narrative Interview for SPI

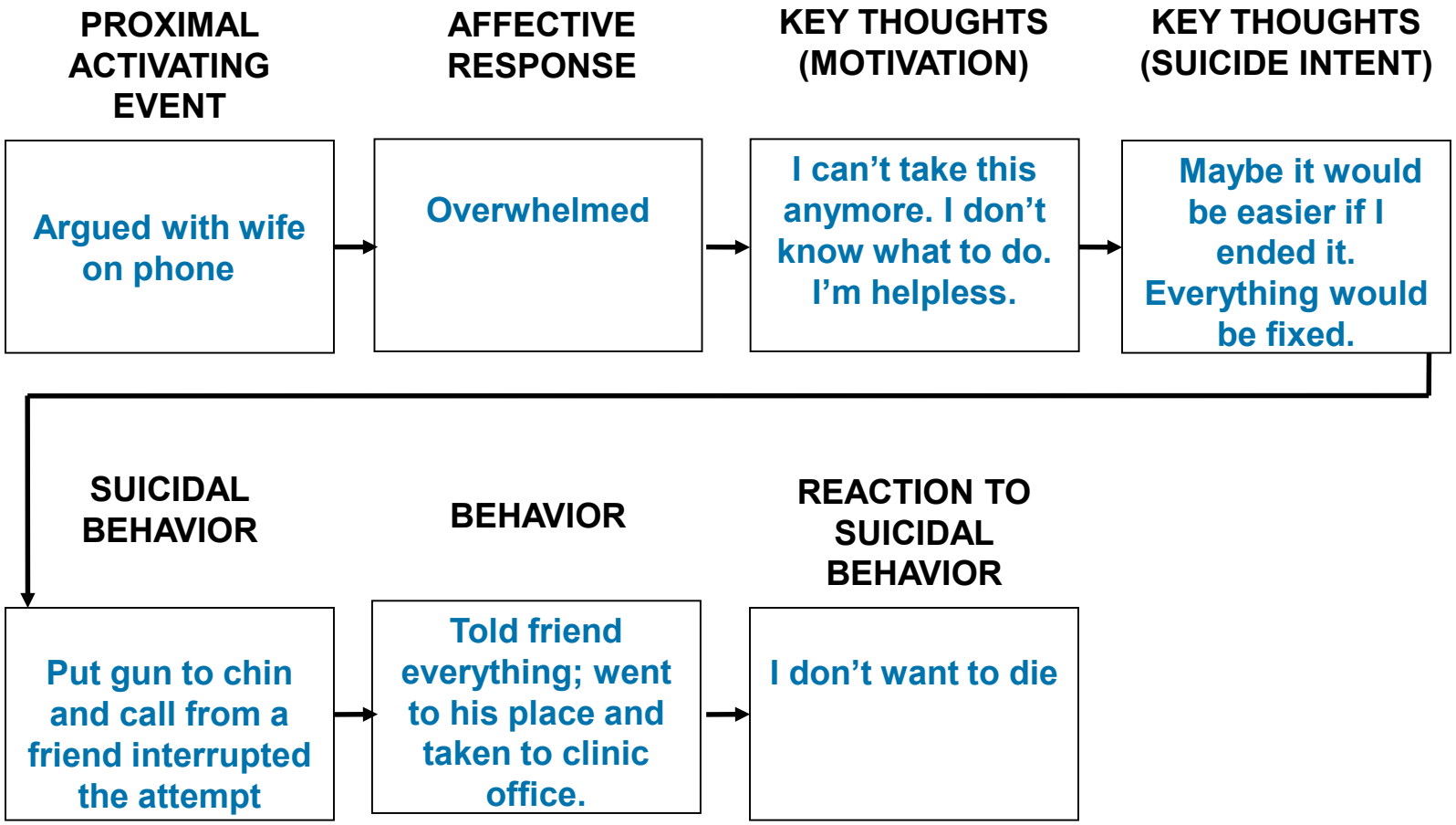
1. To help individuals to "tell their story about how they came to end their lives." Focus on a specific suicidal crisis and less on historical vulnerabilities; Help to build rapport and feel understood
2. To help individuals to identify the events (triggers) and personal warning signs that indicated the beginning or escalation of the crisis
3. To help individuals describe how suicidal risk increases and then decreases over time; unbearable pain is time-limited
4. To help individuals understand how identifying key aspects of suicide risk provides an opportunity for the individual to cope before acting on suicidal urges

Suicide Risk Curve: Critical Components

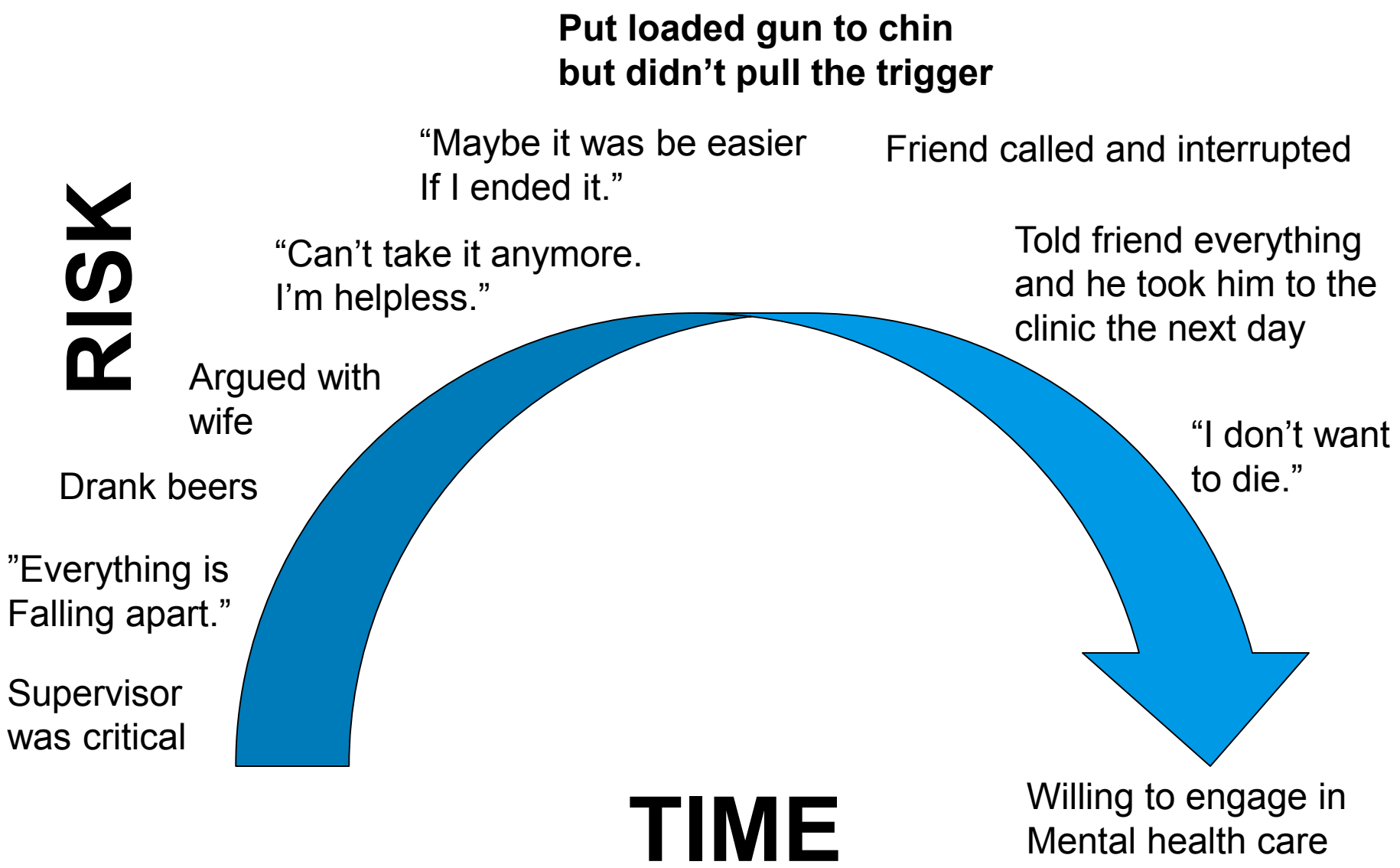
Timeline of Suicide Attempt: Example



Timeline of Suicide Attempt: Example



Suicide Risk Curve: Case Example



Provide Psychoeducation about the Suicidal Crisis

Goal:

- **Explain how suicidal feelings are temporary and do not remain constant. This will help the individual to see an end of the crisis that occurs naturally without acting on suicidal feelings.**

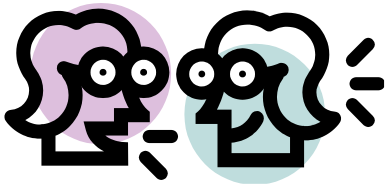
Introduce Safety Planning

- Introduce the safety plan as a method for helping to recognize warning signs and to take action to reduce risk or keep it from escalating.
- Use the suicide risk curve and patient narrative to illustrate how suicidal thoughts come and go; that suicidal crises pass and that the safety plan helps not act on feelings, giving suicidal thoughts time to diminish and become more manageable.
- Explain how using the strategies enhances self-efficacy and a sense of self control.

Introduce the Safety Plan Form

- Explain that the Safety Plan form is a tool to help patients follow a pre-determined set of strategies to avert a suicidal crisis
- Explain that the best Safety Plans are individualized, easy-to-read, and use the Veteran's own words
- Explain that completing the Safety Plan form is a collaborative process with both the Veteran and provider work together as a team
- Collaboration can be improved if the Veteran and provider sit side-by-side and complete the paper form before entering it in the medical record

Narrative Interview of the Suicidal Crisis



Role Play

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Explain How to Follow the Steps

- Explain how to progress through each step listed on the plan. If following one step is not helpful in reducing risk, then go to the next step.
- Explain that if the suicide risk has subsided after a step, then the next step is not necessary.
- Explain that the patients can skip steps if they are in danger of acting on their suicidal feelings.

Identify Warning Signs

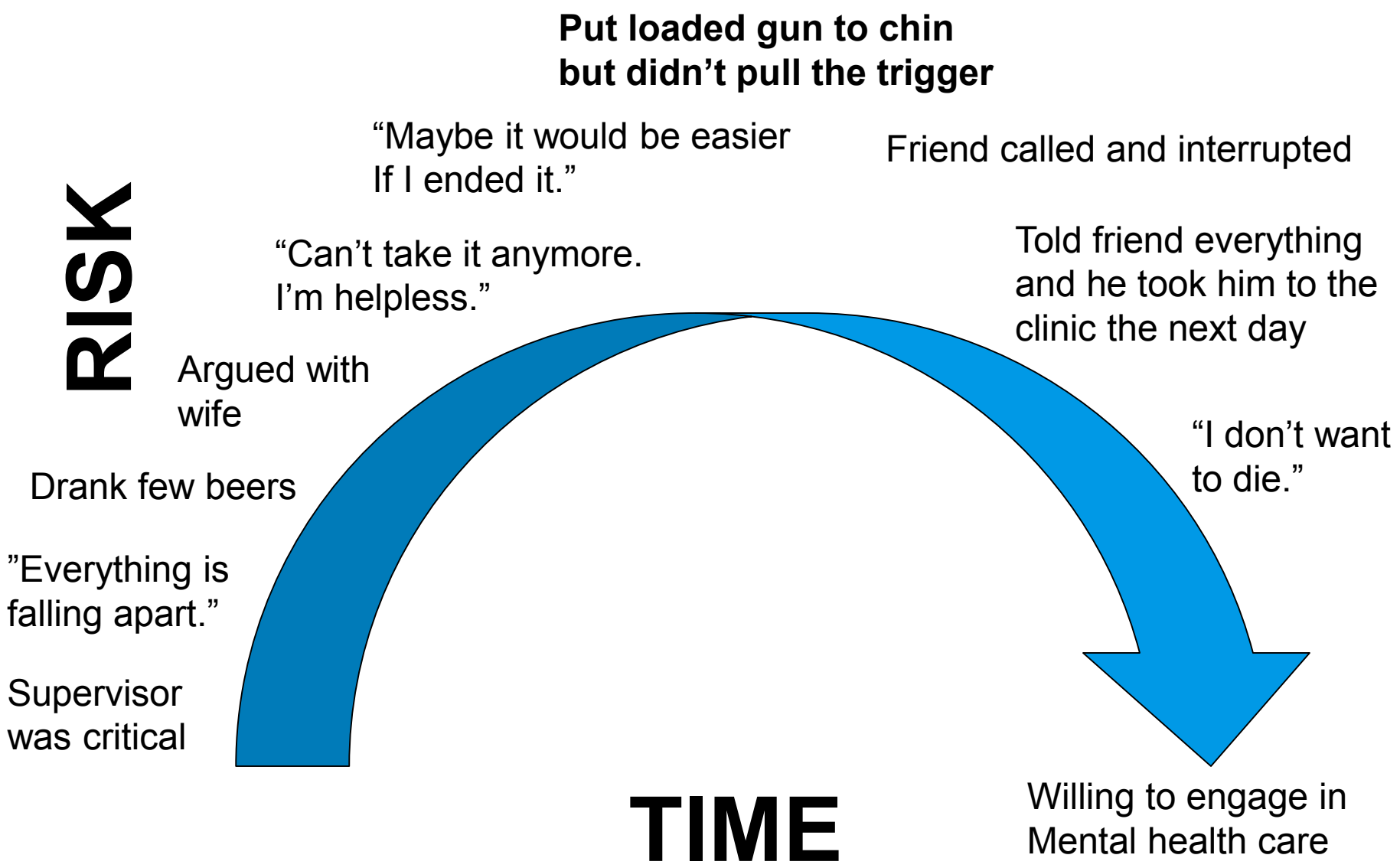
GOALS:

1. **Identify personal warning signs that marked the beginning or worsening of the crisis.**
2. **Understand how identifying warning signs and change in risk provides an opportunity to cope before acting on suicidal urges.**
3. **To serve as a reminder to use the safety plan and evaluate its usefulness (e.g., specificity, feasibility, etc.)**

Identify Warning Signs
(STEP 1 on the SPI form)

- Inform individuals that the purpose of identifying warning signs is to help them to recognize when the crisis may escalate so that they know to refer to their plan and take action to reduce risk.
- Ask, “What were the warning signs that you experienced during the crisis that you told me about? How will you know you are in crisis and that the safety plan should be used?”
- If the warning signs are vague, say, “Let's try to be more specific." Explain that it is important to be specific so that they are more likely to recognize the beginning of the crisis. Use their words or images.

Suicide Risk Curve: Case Example



TIP: Identifying Specific vs Vague Warning Signs

- **After identifying the warning signs, the clinician may ask, “Do you think you will be able to recognize when any of these warning signs occur? Will you remember to retrieve your Safety Plan? Does it need to be more specific?**

TIP: Identifying Internal Versus External Warning Signs

- Warning signs should be specific internal events
- Internal events such as thoughts and emotions as well as behaviors that the Veteran engages in, offer greater specificity and are more likely to indicate an impending crisis than an external event
- External events happen from time to time and often do not provoke suicidal feelings
- When Veterans identify an external event as a warning sign, ask, “What is your reaction to that event that leads you to feel like a crisis is about to happen or get worse?”

Identify Internal Coping Strategies

GOALS:

1. **Explain that the purpose of internal coping strategies is to help take the individual's mind off of one's problems to prevent worsening of suicidal thoughts and prevent making a suicide attempt without contacting other people**
2. **Help the individual identify specific internal coping strategies – the best strategies are simple and easy to do**
3. **Obtain feedback from the individual about the likelihood of using strategies**
4. **Identify barriers and problem-solve ways to overcome them**

Identify Internal Coping Strategies (STEP 2 on the SPI form)

- Explain how distracting oneself from the suicidal thoughts helps to lower risk
- Ask "What have you done in the past to take your mind off your suicidal thoughts without contacting another person? What activities could you do by yourself to help take your mind off of your problems even if it is for a brief period of time?"
- Provide suggestions if individuals cannot think of any distracting activities

Identify Internal Coping Strategies (STEP 2 on the SPI form)

- Ask "How likely do you think you would be able to do this during a time of crisis?" or "Is it feasible?"
- If doubt about use is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to address potential roadblocks and identify alternative coping strategies that are more feasible.

TIPS: Internal Coping Strategies

- **Identifying Specific Rather Than More General Coping Strategies**
  - Activities that are vague are less likely to be used or helpful than specific ones and the clinician should work with the Veteran to do so.
  - Identifying activities that are meaningful, enjoyable, soothing or offer hope are helpful as long as they serve as effective distractors from one's problems.
- **Endorsing Productive Distracting Activities**
  - Do not endorse distracting activities that are likely to increase suicide risk such as "having a few drinks", "sharpening knives", "cleaning my firearms", etc.

Identify Social Contacts and Social Settings

GOALS:

1. **Instruct the individual to use Step 3 if Step 2 does not resolve the crisis or lower risk.**
2. **Identify other people and social settings that provide distraction from the crisis**
3. **Obtain feedback from the individual about the likelihood of actually doing these activities**
4. **Identify barriers and problem-solve ways to overcome them**

Identify Social Contacts and Social Settings (STEP 3 on the SPI form)

- Explain that if Step 2 does not lower risk, then go to Step 3
- Ask "Who can you contact who helps you take your mind off your problems or helps you feel better? You don't need to tell these people that you are feeling suicidal. We just want to identify people who can take your mind off your problems even for a brief time."

Identify Social Contacts and Social Settings (STEP 3 on the SPI form)

- Ask, “What public places, groups, or social events help you to take your mind off your problems or help feel better?”

- “Sometimes when people are feeling really upset, they don’t want to talk to other people. However, sometimes just getting out and being in a place around other people can help. Can you think of places you could go where you wouldn’t have to be alone?”

Identify Social Contacts and Social Settings (STEP 3 on the SPI form)

- For each response, ask, “How likely do you think you would be able to do talk with someone/go somewhere during a time of crisis?” “Is it feasible and safe?”

- If doubt about use is expressed, ask, “What might stand in the way of you thinking of contacting someone or going to a social setting?” Identify ways to resolve roadblocks or identify alternatives.

TIPS: Social Contacts and Social Settings

- **Encourage Healthy Social Contacts**
  - The Veteran should be encouraged to exclude places or contacting other people in which alcohol or other substances may be present or are likely to increase risk
- **Identify Specific Rather than Vague Places, Groups or Events**
  - Identify specific places that are readily accessible and frequently available. Social activities that require advanced planning are not typically helpful

Identify Family Members or Friends

GOALS:

- **Instruct the individual to use Step 4 if Step 3 does not resolve the crisis or lower risk.**
- **Explain that the next step on the Safety Plan involves contacting and telling a trusted family member or friend that they are in crisis and need support.**
- **Help the individual to distinguish between persons who are distractors (Step 3) and persons who can help to resolve the crisis (step 4).**
- **Obtain feedback from the individual about the likelihood of actually contacting others**
- **Identify barriers and problem-solve ways to overcome them**

Identify Family Members or Friends (STEP 4 on the SPI form)

- Explain that if Step 3 does not lower risk, then go to Step 4.
- Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress or feeling suicidal?"
- Ask, "How likely do you think you would be able to reach out to each person?"
- If doubt is expressed about contacting others, ask, "What might get in the way of reaching out to this person? Resolve roadblocks or brainstorm others to contact.

TIPS: Identify Family Members or Friends

- **Disclosure of No Support**
  - Consider other interventions to address social isolation or social skills, such as social skills training, peer support, intensive referral for mutual help, group therapy, behavioral activation, activity scheduling, etc.
- **Encourage Sharing the Safety Plan with Others**
  - If possible, someone close to the Veteran with whom the Safety Plan can be shared should be identified if the Veteran is willing to do so. The Veteran may ask family members or friends for help in using or following the Safety Plan if they observe that the Veteran is in crisis

Identify Professionals and Agencies

GOALS:

- **Instruct the individual to use Step 5 if Step 4 does not resolve the crisis or lower risk.**

- **Explain that Step 5 consists of professionals or agencies who can provide assistance to the individual during a crisis.**

- **Assess the likelihood that the individual will contact each professional or professional service listed on the plan.**

Contact Professionals or Agencies (STEP 5 on the SPI form)

- **Explain that if Step 4 does not lower risk, then go to Step 5.**
- **Ask "Who are the mental health professionals or professional peer support who should be included on your safety plan?"**
  - Examples: Primary mental health provider, other mental health providers, primary care provider, peer support professional
- **Ask, "Are you aware of the Veterans Crisis Line?" If so, have you ever used it? How did it go?"**
- **Ask, "If you need to go to an urgent care center or emergency department, where will you go?"**

Contact Professionals or Agencies (STEP 5 on the SPI form)

- **Assess the likelihood that the Veteran will contact each professional or professional service listed on the plan.**
- **Identify potential barriers to seeking professional help or services and assist in problem solving these barriers.**
- **Some Veterans may be reluctant to contact professionals and disclose suicidal thoughts for fear of being hospitalized or rescued using a method that is not acceptable.**
  - It may be helpful to describe a range of interventions or services that may be offered if when reaching out for help with hospitalization being one type of care that may be offered.

Making the Environment Safer

GOALS:

- **Individuals may have already disclosed a method or plan during the suicide risk screen. If not, assess whether the individual has thought about a method or developed a specific suicide plan.**
- **Explain that having easy access to lethal means places the individual at greater risk for suicide and does not allow enough time to use the coping strategies or sources of support listed on the Safety Plan.**
- **For each method that is identified, determine the individual's access to the lethal means and collaborate to find voluntary options that reduce access to the lethal method and make the environment safer.**

Making the Environment Safer
(STEP 6 on the SPI form)

- **Express concern about the patient's safety.**

- **Explain that making the environment safer will help to lower risk of acting on suicidal feelings (delays urge to act on suicidal thoughts)**

- **For some patients who attempt suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes**
  - Explain that the longer it takes to obtain or use a potentially lethal method, the lower the risk to impulsively act upon the suicidal urges

Making the Environment Safer
(STEP 6 on the SPI form)

- For each lethal method, ask "What can we do to make the environment safer?"
- Ask, "How likely are you to do this? What might get in the way? How can we address the obstacles?"
- Be aware of the potential view that having access to a lethal mean to kill oneself may be a strategy used to cope with crises.
- If doubt is expressed about limiting access, ask, "What are the pros of having access to this method and what are the cons? Is there an alternative way of limiting access so that it is safer?"

TIPS: Lethal Means

- **Discussing Lethal Means.**
  - When a Veteran declines to disclose ownership of lethal means, explore the concerns.
  - Reassure the Veteran that reducing access to means is a highly effective strategy to prevent suicide. A delay in accessing means can provide the individual time to calm and apply the steps in their safety plan.
- **Ensuring Comprehensive Discussion of Lethal Means.**
  - Do not limit the discussion of lethal means to the one that the Veteran identifies as most likely.
  - Limiting access to any means immediately available is important even if the Veteran states that particular means would not be used.

Strategies for Medication Safety

- Inquire about whether an individual has an excess of medication and make a plan to easily dispose of it
- Use of weekly pill boxes. Pill bottles can then be stored out of sight or potentially locked up and managed by someone else.
- Stickers with the National Lifeline number on pill boxes or bottles
- Keep copies of a safety plan or visual reminders of reasons for living with pill boxes or bottles

Examining Pros and Cons

Throwing out my extra meds

Pros	Cons
Staying on track in treatment; If I kill myself, treatment won't help	I would be giving in to what others tell me
It would make my family feel better	I won't have them if I need them
It might make it more "out of sight, out of mind"	

Keeping my extra meds

Pros	Cons
It gives me a sense of control and power	It's tempting to have them in the house
I won't have to worry about collecting them again if I want to kill myself	My mom would keep nagging me about it

Discussing Access to Firearms

- **68% of male and 41% of female Veteran suicides were firearm-related***
- **About 90% of firearm-related suicide attempts are fatal, as compared to approximately 5% of suicide attempts by all other mechanisms combined****

***VHA Office of Suicide Prevention, August 3, 2016. Suicide among veterans and other Americans 2001-2014.**

****CDC WISQARS Deaths from death certificates; nonfatal incidents from national sample of hospital emergency departments**

- **The clinician should routinely ask whether the Veteran has access to a firearm whether or not it is considered a "method of choice."**
- **Ask, "Do you have access to firearms?"**
  - If so, ask, "How are the firearms and ammunition stored?

Strategies for Firearm Safety: Off-Site Storage

- During high-risk periods, temporary off-site storage may be the safest option. Note: There is significant state variability in laws regulating firearm transfers.
- Friend or relative (provided they aren't prohibited from possessing firearms)
- Storage facility (Ammunition must be stored separately)
- Police departments (Some police departments will store temporarily at no charge)
- Pawn shops (Pawning the guns for a very small loan amount is reliable storage option; interest fees of ~15-20% monthly)
- Gun stores or gun clubs (Some may offer free or inexpensive storage options for people they know)

https://www.mirecc.va.gov/lethalmeanssafety/safety/

Strategies for Firearm Safety: On-Site Storage

- **Any step(s) that increase the time and distance between a suicidal impulse and a gun will reduce suicide risk.**
- **A locked gun poses a lower suicide risk than an unlocked gun, no matter who holds the key**
- **An unloaded gun (ammunition stored separately) poses a lower suicide risk than a loaded gun.**
  - Store guns unloaded
  - Store ammunition out of home
  - Store guns and ammunition separately
  - Lock the gun
  - Store gun in safe
  - Disassemble the gun

https://www.mirecc.va.gov/lethalmeanssafety/safety/

Strategies for Firearm Safety: On-Site Storage

Brochure

Cable lock

Trigger lock

Lifejacket

Lockbox

Safe/Cabinet

https://www.mirecc.va.gov/lethalmeanssafety/safety/

Strategies for Firearm Safety: On-Site Storage

Involving others in on-site storage of firearms:

- **Give the lock key to someone else**
- **Asking someone to change safe combination**
- **Temporarily disassemble gun and store components (e.g., firing pin) with someone else**

https://www.mirecc.va.gov/lethalmeanssafety/safety/

Involving Others in Making the Environment Safer

- Assess the potential helpfulness of involving specific persons
- Assess whether the person is capable of carrying out the plan
- When possible, discuss plan with other persons and patient together
- Follow-up with other person to ensure completion of plan

Implementation of the Safety Plan

GOALS:

- **Review the entire Safety Plan with the Veteran**
- **Explain that if the coping strategies in any step are unhelpful, then the person should try the next step on the Safety Plan until the risk for suicide decreases.**
- **Advise that it is not necessary to follow all the steps before reaching out for help. If individual does not feel that he or she can stay safe, encourage the individual to go to the hospital or call the VA Crisis Line.**
- **Provide a copy of the Safety Plan and discuss its location(s).**
- **A caregiver or family member may also be provided with a copy of the Safety Plan with the Veteran's permission.**

Implementation of the Safety Plan

- Ask, “Here is a copy of this Plan. Where would you like to keep it to help remind you of the steps you can take to keep yourself safe?”
- Ask, “How likely is it that you will use the safety plan when you notice the warning signs that we have discussed?”
- Ask, “What could keep you from using your safety plan when you start to feel suicidal?”
- Ask, “How can you remind yourself the importance of using your safety plan if you forget or don’t feel like it?”
- Ask, “Would it be helpful to you to share a copy of your safety plan with anyone?”

Safety Contacts

- If the clinician is unable to reach the them and is concerned about their safety, the clinician would like to contact someone who may be able to provide information about their location and well-being.
- The clinician should ask the Veteran if there is a family member, friend, or other trusted person who can be contacted to inquire about the Veteran's safety.
- The name and contact information of the Safety Contact(s) should be noted as well as storing a signed Release of Information form in the Veteran's file.
- The clinician may also note if the Veteran refuses to designate a Safety Contact

Safety Plan Pocket Card:
Rationale, React, Remove, Review & Revise (5 R's)

Rationale for Safety Plan

Explain:

- How suicidal crises come and go and identify warning signs (link to individual's own experience)
- How the Safety Plan helps to prevent acting on suicidal feelings
- How the Safety Plan is a series of steps – go to the next step if the current step is not helpful

React to the Crisis to Decrease Suicide Risk

Collaborate to:

- Understand the reasons for each step
- Brainstorm ideas for each coping strategy or resource
- Be specific
- Improve feasibility/remove barriers

Remove Access to Lethal Means

Work together to develop an action plan to:

- Limit access to preferred method or plan for suicide
- Limit access to firearms

Review the Safety Plan to Address Concerns

Obtain feedback to assess:

- Helpfulness and likelihood of using Safety Plan
- Where to keep the Safety Plan and when to use it

Revise at Follow-up Visits

Ask:

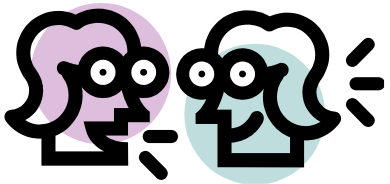
- Do you remember the last Safety Plan you developed?
- Have you actually used your Safety Plan?
- Was the Safety Plan helpful for preventing you from acting on suicidal urges? If not, why not?
- How can the Safety Plan be revised to be more helpful?

Gregory K. Brown, PhD & Barbara Stanley, PhD (2017)

Review and Revision of Previously Completed Safety Plan

- Determine if the safety plan has been used.
- Ask individual to retrieve safety plan for review with you.
- Determine what has been helpful and what isn't helpful.
  - If not, why not? (forgetting to use it, how to use it or where to find it)
- Revise plan as indicated---remove unhelpful items, discuss with individual what may be more helpful. Both the clinician and the suicidal individual notes the changes on the plan. Consider sending the suicidal individual a revised plan if the revisions are extensive.
- Always review access to means and whether there is a need to remove means.

Safety Planning Intervention



Role Plays

ASPI Consultant Training Agenda

Day 2: Wednesday, June 19th, 2019		
12:00 – 12:05pm ET	Welcome	Drs. Batdorf, Brown, Stanley
12:05 – 1:45pm ET	Review of the Safety Planning Intervention Rating Scale-Veterans Affairs (SPIRS-VA) and Safety Planning Intervention Scoring Algorithm-Veterans Affairs (SPISA-VA)	Drs. Brown & Stanley
15-minute Break		
2:00 – 4:20pm	Review of ASPI Session and Calibration to Rating Scale	Drs. Brown & Stanley
4:20 – 4:30pm	Question and Answer; Wrap up	Group
Day 3: Thursday, June 20th, 2019		
12:00 – 12:05 ET	Welcome	Drs. Batdorf, Brown, Stanley
12:05 – 1:45pm	Experiential Training Role-Plays	Group
15-minute Break		
2:00 – 4:00pm	Experiential Training Role-Plays	Group
4:00 – 4:30pm	Question and Answer, Wrap up, Next Steps	Group

Safety Planning Intervention Scoring Algorithm for VA (SPISA-VA)

Date of Rating: ____/____/_____ Source of Written Safety Plan: ☐ Patient ☐ Role play

Timepoint of Rating: ☐ Pre-didactic (Component 1) ☐ Experiential (Component 2)
☐ Participant Evaluation ☐ Follow-Up Evaluation

Instructions: The SPISA-VA is used for evaluating the quality and completeness of written safety plans. Each line is scored according to the descriptors provided below. Each Step receives an Overall Quality rating that takes into account the line item scores. The Overall Quality rating for each step indicates the "average" rating for each line that contains text. The Total Quality score is the average of Overall Quality Ratings for all six steps. A Total Completeness score is the sum of the number of nonzero responses.

SPISA-VA

Scoring Instructions for each line:	Definitions:
0 points if text is Not Present	**Not Present** – no written text
1 point if response was Not Personalized	**Not Personalized** – "boilerplate" or generic; no mention of specific people, places, activities, etc.; a vague response; any response that is entered on the wrong step (e.g., "call friend" recorded on Step 2)
2 points if response was Somewhat Personalized	**Somewhat Personalized** – some specific information included
3 points if response was Highly Personalized	**Highly Personalized** – specific and detailed information directly relevant to and/or provided by the Veteran

SPISA-VA

Select one score for each line	No Text Present (0 pts)	Text Present: Not Personalized (1 pt each)	Text Present: Somewhat Personalized (2 pts each)	Text Present: Highly Personalized (3 pts each)
STEP 1: Warning Signs				
Step 1 Examples:	Blank	"Stressed"	"Sad"	"I can't take it anymore."
Step 1: Warning Signs, Row 1 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 2 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 3 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 4 Is any text present?	0	1	2	3
Step 1: Warning Signs, Row 5 Is any text present?	0	1	2	3
Step 1 Overall Quality Rating	0	1	2	3

SPISA-VA

Select one score for each line	No Text Present (0 pts)	Text Present: Not Personalized (1 pt each)	Text Present: Somewhat Personalized (2 pts each)	Text Present: Highly Personalized (3 pts each)
STEP 2: Internal Coping Strategies				
Step 2 Examples:	Blank	"Reading"	"Reading a biography"	"Reading the latest Abraham Lincoln book."
Step 2: Internal Coping Strategies, Row 1 Is any text present?	0	1	2	3
Step 2: Internal Coping Strategies, Row 2 Is any text present?	0	1	2	3
Step 2: Internal Coping Strategies, Row 3 Is any text present?	0	1	2	3
Step 2: Internal Coping Strategies, Row 4 Is any text present?	0	1	2	3
Step 2: Internal Coping Strategies, Row 5 Is any text present?	0	1	2	3
Step 2 Overall Quality Rating	0	1	2	3

SPISA-VA

STEP 3: Social Contacts and Social Settings				
Step 3 Examples:	Blank	"Someone I hang out with"; "Shopping mall"	"My friend"; "Big Name Coffee Shop"	"My best friend Chad"; "YMCA on Cherry Street"
Step 3: Social Contacts, Row 1 Is any text present?	0	1	2	3
Step 3: Social Contacts, Row 2 Is any text present?	0	1	2	3
Step 3: Social Contacts, Row 3 Is any text present?	0	1	2	3
Step 3: Social Contacts, Row 4 Is any text present?	0	1	2	3
Step 3: Social Contacts, Row 5 Is any text present?	0	1	2	3
Step 3: Social Contacts, Row 6 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 1 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 2 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 3 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 4 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 5 Is any text present?	0	1	2	3
Step 3: Social Locations, Row 6 Is any text present?	0	1	2	3
Step 3 Overall Quality Rating	0	1	2	3

SPISA-VA

Select one score for each line	No Text Present (0 pts)	Text Present: Not Personalized (1 pt each)	Text Present: Somewhat Personalized (2 pts each)	Text Present: Highly Personalized (3 pts each)
STEP 4: Family and Friends for Crisis Support				
Step 4 Examples	Blank	"Someone I hang out with"	"My friend"	"My Uncle Dave"
Check if Veteran chooses not to disclose distress to friends or family.	Declined	If this item is declined, proceed to Step 5		
Check if Veteran describes a lack of family or friends.	Declined	If this item is declined, proceed to Step 5		
Step 4: Social Contacts for a Crisis, Row 1 Is any text present?	0	1	2	3
Step 4: Social Contacts for a Crisis, Row 2 Is any text present?	0	1	2	3
Step 4: Social Contacts for a Crisis, Row 3 Is any text present?	0	1	2	3
Step 4: Social Contacts for a Crisis, Row 4 Is any text present?	0	1	2	3
Step 4: Social Contacts for a Crisis, Row 5 Is any text present?	0	1	2	3
Step 4 Overall Quality Rating	0	1	2	3

SPISA-VA

STEP 5: Professionals and Agencies				
Step 5 examples	Blank	"VA staff person"	"My counselor"	"Dr. Snow"
Step 5: Professionals for a Crisis, Row 1 Is any text present?	0	1	2	3
Step 5: Professionals for a Crisis, Row 2 Is any text present?	0	1	2	3
Step 5: Professionals for a Crisis, Row 3 (Urgent Care or Emergency Department) Is any text present?	0	1	2	3
Step 5: Professionals for a Crisis, Row 4 (VA site-specific emergency #) Is any text present?	0	1	2	3
Step 5 Overall Quality Rating	0	1	2	3

SPISA-VA

Select one score for each line	No Text Present (0 pts)	Text Present: Not Personalized (1 pt each)	Text Present: Somewhat Personalized (2 pts each)	Text Present: Highly Personalized (3 pts each)
STEP 6: Making the Environment Safe				
Step 6 Examples	Blank	"No guns" "No alcohol"	"Get rid of unused medication"	"Lock up my firearm and ammunition and give the keys to my brother"
Step 6: Making the Environment Safe, Row 1 Is any text present?	0	1	2	3
Step 6: Making the Environment Safe, Access to firearms answered?	No (proceed to next item)	Yes		
If answer marked Yes, was **firearm safety** discussed?	No	Yes		
Step 6: Making the Environment Safe, Access to firearms answered?	No (proceed to next item)	Yes		
*If answer marked Yes, was a **gunlock** offered?*	No	Yes		

SPISA-VA

Step 6: Making the Environment Safe, Access to opioids answered?	No (proceed to next item)	Yes		
*If answer marked Yes, was **opioid safety** discussed?*	No	Yes		
Step 6: Making the Environment Safe, Access to opioids answered?	No (proceed to next item)	Yes		
*If answer marked Yes, was **naloxone prescription** offered?*	No	Yes		
Step 6: Making the Environment Safe, **Social Contacts for a Safety support**, Is any text present?	No	Yes		
Step 6: Making the Environment Safe, **Follow-up date**, Is any text present?	No	Yes		
Step 6: Making the Environment Safe, **Current Physical Address**, Is any text present?	No	Yes		
Check if Veteran declined to provide this information	Declined			

SPISA-VA

Step 6: Making the Environment Safe, **Copy of Safety Plan Provided**, Is any text present?	No	Yes		
Check if Veteran declined to provide this information	Declined			
Step 6: Making the Environment Safe, **Contact for Safety Check**, Is any text present?	No	Yes		
Check if Veteran declined to provide this information	Declined			
Step 6 Overall Quality Rating	0	1	2	3

SPISA-VA

Total Quality Score *(Average of Overall Quality Ratings for all 6 steps)*	
Total Completeness Score *(Sum of the number of lines with text present)*	

Safety Plan Global Impression Score

Select one of the following ratings of the overall quality of the safety plan as a global impression

0=Poor	1=Mediocre	2=Satisfactory	3=Good	4=Excellent
☐	☐	☐		☐

Safety Planning Intervention Rating Scale for VA (SPIRS-VA)

Date of Rating: ____/____/_____ Source of Written Safety Plan: ☐ Patient ☐ Role play

Type of Observation: ☐ Audio ☐ Video ☐ Live Observation

Time Point of Rating: ☐ Experiential (Component 2) ☐ Participant Evaluation (Component 3)
☐ Follow-up Evaluation (Component 4) ☐ Other: _____

Directions: This measure is to be used by a trained rater when reviewing an audio or video recording or during a live observation of the Safety Planning Intervention. Items are scored in the following manner:

0 = "Not Present," 1 = "Inadequate," 2 = "Satisfactory," and 3 = "Excellent"

Please indicate the numerical rating that most closely matches the behaviors demonstrated by the clinician and do not leave any items blank.

Part I. Pre-Safety Plan Intervention

Was a suicide risk assessment performed? ___Yes ____No ___Unknown

Is the patient appropriate for Safety Plan (at risk and no rescue required)? ___Yes ___No

SPIRS-VA

Part II. General Safety Plan Intervention Skills

1. Obtained a Description of a Recent Suicidal Crisis

0 **Not Present** – Clinician did not ask the patient to describe a recent suicide crisis or ask about specific events that were proximal to a suicidal crisis.

1 **Inadequate** – The clinician asked the patient to describe a suicidal crisis. However, the clinician: (1) did not focus on a specific, recent suicidal crisis that was associated with an increased risk for suicide; (2) did not ask the patient to describe what was happening when the crisis started so that warning signs could be identified; (3) did not identify specific thoughts, feelings and behaviors that occurred before and during the crisis; (4) did not obtain enough information about the specific crisis so that it is clear that the risk for suicide escalated and then diminished over time.

2 **Satisfactory** -- The clinician asked the patient about most of the following aspects of the suicidal crisis: (1) to briefly describe a specific, recent suicidal crisis that was associated with an increased risk for suicide; (2) to describe what was happening when the crisis started so that warning signs could be identified; (3) to identify specific thoughts, feelings and behaviors that occurred before and during the crisis; (4) to obtain enough information about the specific crisis so that it is clear that the risk for suicide escalated and then diminished over time.

3 **Excellent** – The clinician asked the patient about all of the following aspects of the suicidal crisis: (1) to briefly describe a specific, recent suicidal crisis that was associated with an increased risk for suicide; (2) to describe what was happening when the crisis started so that warning signs could be identified; (3) to identify specific thoughts, feelings and behaviors that occurred before and during the crisis; (4) to obtain enough information about the specific crisis so that it is clear that the risk for suicide escalated and then diminished over time.

SPIRS-VA

2. **Reviewed the Suicide Risk Curve**

0 **Not Present** – Clinician did not describe how suicidal thoughts come and go or did not describe how suicidal thoughts diminish over time.

1 **Inadequate** – Clinician briefly described how suicidal thoughts come and go or how suicidal crises diminish over time but did not use the patient's narrative to illustrate this point.

2 **Satisfactory** – The clinician used the patient's narrative to illustrate one or two of the following: (1) how suicidal thoughts come and go; (2) that the suicidal crisis often passes; (3) how the patient's suicidal crisis corresponds to the suicide risk curve.

3 **Excellent** – The clinician used the patient's narrative to illustrate all of the following: (1) how suicidal thoughts come and go; (2) that the suicidal crisis often passes; (3) how the patient's suicidal crisis corresponds to the suicide risk curve.

SPIRS-VA

3. **Provided a Rationale for Safety Plan**

0 **Not Present** -- Clinician did not provide a clear rationale that a Safety Plan is used for coping with suicidal feelings and to avert a suicidal crisis.

1 **Inadequate** – Clinician provided a brief rationale for the Safety Plan but did not explain in detail how the Safety Plan can be used to avert a suicidal crisis.

2 **Satisfactory** -- Clinician explained that the purpose of the Safety Plan involves either of the following: (1) helping patients to not act on suicidal feelings by giving suicidal thoughts time to diminish and become more manageable; (2) understanding that suicidal feelings do not last indefinitely and that having coping strategies and sources of support in place beforehand can help with managing a suicidal crisis and allow the crisis to pass without engaging in suicidal behavior.

3 **Excellent** -- Clinician explained that the purpose of the Safety Plan involves all of the following: (1) helping patients to not act on suicidal feelings by giving suicidal thoughts time to diminish and become more manageable; (2) understanding that suicidal feelings do not last indefinitely and that having coping strategies and sources of support in place beforehand can help with managing a suicidal crisis and allow the crisis to pass without engaging in suicidal behavior.

SPIRS-VA

4. **Described the Development of the Safety Plan as Collaborative Process**

0 **Not Present** – Clinician did not describe the development of a Safety Plan as a collaborative process or encourage the patient's active participation. Instead, the clinician instructed the patient what to include on the Safety Plan or asked the patient to complete the Safety Plan form with minimal input from the clinician.

1 **Inadequate** – Clinician only did <u>one</u> of the following when describing the collaborative process: (1) explained that the development of a Safety Plan is a collaborative process (uses a "team approach") between the clinician and the patient; (2) encouraged the patient's active participation by soliciting the individual's opinion or asking for feedback; (3) collaborated with the patient by brainstorming with the patient or offering choices.

2 **Satisfactory** – Clinician did <u>two</u> of the following when describing the collaborative process: (1) explained that the development of a Safety Plan is a collaborative process (uses a "team approach") between the clinician and the patient; (2) encouraged the patient's active participation by consistently soliciting the individual's opinion or asking for feedback; (3) collaborated with the patient by consistently brainstorming with the patient or offering choices.

3 **Excellent**– Clinician did <u>all</u> of the following when describing the collaborative process: (1) explained that the development of a Safety Plan is a collaborative process (uses a "team approach") between the clinician and the patient; (2) encouraged the patient's active participation by consistently soliciting the individual's opinion or asking for feedback; (3) collaborated with the patient by consistently brainstorming with the patient or offering choices.

SPIRS-VA

5. **Explained How to Follow Steps of the Safety Plan**

0 **Not Present** – Clinician did not explain to the patient how to progress through each step and utilize the Safety Plan.

1 **Inadequate** – Clinician explained how to progress through each step in a step-wise fashion and utilize the Safety Plan but the explanation was not detailed.

2 **Satisfactory** – Clinician provided most of the following detailed instructions: (1) how to progress through each step and that if one step is not helpful for reducing risk then proceed to the next step; (2) explained that if the suicidal crisis subsided after following a step, then the next step was not necessary; (3) explained that the patient was not locked into following each step in a specific order if the patient was in danger of acting on suicidal feelings, then steps can be skipped.

3 **Excellent** – Clinician provided all of the following detailed instructions: (1) how to progress through each step and that if one step is not helpful for reducing risk then proceed to the next step; (2) explained that if the suicidal crisis subsided after following a step, then the next step was not necessary; (3) explained that the patient was not locked into following each step in a specific order if the patient was in danger of acting on suicidal feelings, then steps can be skipped.

SPIRS-VA

6. **Discussed the Location, Sharing, Barriers and Likelihood of Use,**

0 **Not Present** – Clinician did not provide the patient with a completed Safety Plan and did not discuss any of the following: (1) the location for storing the Safety Plan; (2) the likelihood of using it and any barriers preventing its use; (3) sharing the Safety Plan with others who could provide help during a suicidal crisis.

1 **Inadequate** – Clinician provided the patient with a completed Safety Plan and/or discussed only one of the following: (1) the location for storing the Safety Plan; (2) the likelihood of using it and any barriers preventing its use; (3) sharing the Safety Plan with others who could provide help during a suicidal crisis.

2 **Satisfactory** – Clinician provided the patient with a completed Safety Plan and discussed two of the following uses: (1) the location for storing the Safety Plan; (2) the likelihood of using it and any barriers preventing its use; (3) sharing the Safety Plan with others who could provide help during a suicidal crisis.

3 **Excellent** – Clinician provided the patient with a completed Safety Plan and discussed all of the following uses: (1) the location for storing the Safety Plan; (2) the likelihood of using it and any barriers preventing its use; (3) sharing the Safety Plan with others who could provide help during a suicidal crisis.

SPIRS-VA

Part III. Constructing Each Step of the Safety Plan

1. **Warning Signs**

0 **Not Present** – Clinician did not assist the patient in identifying warning signs.

1 **Inadequate** – Clinician assisted the patient in identifying warning signs. However, the clinician did not help the patient to identify specific warning signs (i.e., the warning signs were vague); failed to describe the warnings signs as a cue to use the Safety Plan and did not ask for feedback whether the warning signs would be helpful.

2 **Satisfactory** – Clinician did most of the following: (1) identified specific and individualized warning signs; (2) explained how the warning signs serve as a cue to utilize the Safety Plan; (3) asked for feedback whether these warning signs would be helpful for reminding the patient to use the Safety Plan.

3 **Excellent** – Clinician did all of the following: (1) identified specific and individualized warning signs; (2) explained how the warning signs serve as a cue to utilize the Safety Plan; (3) asked for feedback whether these warning signs would be helpful for reminding the patient to use the Safety Plan.

SPIRS-VA

2. Internal Coping Strategies

0 **Not Present** – Clinician did not assist the patient in identifying internal coping strategies that the individual could independently utilize and that could provide a distraction from the crisis.

1 **Inadequate** – Clinician assisted the patient in identifying internal coping strategies that the individual could independently utilize and that could provide for a distraction from the crisis. However, the clinician (1) did not provide an adequate rationale, (2) did not identify specific or individualized distractors, or (3) did not ask for feedback or assess for barriers to using these strategies. Clinician listed coping strategies that involved other people or social settings.

2 **Satisfactory** – Clinician assisted the patient in identifying specific and individualized internal coping strategies that the individual could independently utilize and that could provide for a distraction from the crisis. Clinician did one of the following: (1) provided an adequate rationale that not thinking about suicide helps to lower risk by allowing time for suicidal thoughts to subside; (2) asked for feedback concerning the feasibility or usefulness or assess for barriers to using these strategies.

3 **Excellent** – Clinician assisted the patient in identifying specific and individualized internal coping strategies that the individual could independently utilize and that could provide for a distraction from the crisis. Clinician did all of the following: (1) provided an adequate rationale that not thinking about suicide helps to lower risk by allowing time for suicidal thoughts to subside; (2) asked for feedback concerning the feasibility or usefulness or assess for barriers to using these strategies.

SPIRS-VA

3. **Socialization and Social Support Strategies: Socializing With Others and Healthy Social Settings**

0 **Not Present** – Clinician failed to assist the patient in identifying people or healthy social settings that can provide support and distraction from the crisis.

1 **Inadequate** – Clinician assisted the patient in identifying people and/or social settings that can provide support and distraction from the crisis. However, the people or settings were not highly suitable or sufficiently distracting. Clinician (1) did not provide an adequate rationale that not thinking about suicide helps to lower risk by allowing time for suicidal thoughts to subside; (2) did not ask for feedback concerning the feasibility or usefulness or assess for barriers to using these strategies. Clinician listed individuals or social settings that were likely to increase the risk for suicide.

2 **Satisfactory** – Clinician assisted the patient in identifying either highly suitable people or healthy social settings that can provide a distraction from the crisis. Clinician did one or two of the following: (1) provided an adequate rationale that not thinking about suicide helps to lower risk by allowing time for suicidal thoughts to subside; (2) asked for feedback concerning the feasibility or usefulness or assessed for barriers to using these strategies; (3) described that people in this step are not to be used to share or discuss the crisis.

3 **Excellent** – Clinician assisted the patient in identifying either highly suitable people or healthy social settings that can provide a distraction from the crisis. Clinician did all of the following: (1) provided an adequate rationale that not thinking about suicide helps to lower risk by allowing time for suicidal thoughts to subside; (2) asked for feedback concerning the feasibility or usefulness or assessed for barriers to using these strategies; (3) described that people in this step are not to be used to share or discuss the crisis.

SPIRS-VA

4. **Contacting Family or Friends Who May Offer Help to Resolve a Crisis**

0 **Not Present** – Clinician failed to assist the patient in identifying suitable individuals, usually family members or friends with whom the patient could talk and seek help from during a crisis (unless there was no one the individual could identify).

1 **Inadequate** – Clinician assisted the patient in identifying family members or friends. However, these people were not suitable for seeking help from during a crisis. The clinician: (1) did not provide an adequate rationale for this step; (2) did not ask for feedback concerning feasibility or helpfulness; (3) did not discuss barriers to contacting these individuals; (4) did not include contact information for each person listed on the Safety Plan. Clinician listed professionals or agencies on this step.

2 **Satisfactory** – Clinician assisted the patient in identifying suitable family members or friends who the patient could contact for help during a crisis. The clinician did <u>most</u> of the following: (1) provided an adequate rationale for this step; (2) asked for feedback concerning feasibility or helpfulness; (3) discussed barriers to contacting these individuals; (4) included contact information for each person listed on the Safety Plan.

3 **Excellent** – Clinician assisted the patient in identifying suitable family members or friends who the patient could contact for help during a crisis. The clinician did <u>all</u> of the following: (1) provided an adequate rationale for this step; (2) asked for feedback concerning feasibility or helpfulness; (3) discussed barriers to contacting these individuals; (4) included contact information for each person listed on the Safety Plan.

SPIRS-VA

5. Contacting Professionals and Agencies

0 Not Present – Clinician failed to assist the patient in identifying professionals, agencies, or did not discuss other emergency services.

1 **Inadequate** – Clinician assisted the patient in identifying professionals, agencies, and other emergency services. The clinician: (1) did not provide an adequate rationale for this step; (2) did not ask for feedback concerning feasibility or helpfulness; (3) did not discuss barriers to contacting any professionals or agencies; (4) did not include contact information for each professional or agency listed on the Safety Plan.

2 **Satisfactory** – Clinician assisted the patient in identifying suitable professionals or agencies, and other emergency services. The clinician did most of the following: (1) provided an adequate rationale for this step; (2) asked for feedback concerning feasibility or helpfulness; (3) discussed barriers to contacting any professionals or agencies; (4) included contact information for each professional or agency listed on the Safety Plan.

3 **Excellent** – Clinician assisted the patient in identifying suitable professionals or agencies, and other emergency services. The clinician did all of the following: (1) provided an adequate rationale for this step; (2) asked for feedback concerning feasibility or helpfulness; (3) discussed barriers to contacting any professionals or agencies; (4) included contact information for each professional or agency listed on the Safety Plan.

SPIRS-VA

6. Making the Environment Safer

0 **Not Present** – Clinician did not identify access to lethal means in the individual's environment or develop a plan to limit access.

1 **Inadequate** – Clinician identified a general (but not specific) action plan(s) to limit access to lethal means in the patient's environment. The clinician: (1) did not develop an action plan for all of the methods for suicide that the patient had described (2) did not explain the rationale for restricting access to reduce the likelihood of acting on impulsive feelings; (3) did not ask for feedback about the feasibility of the action plan and assessed for any barriers.

2 **Satisfactory** – Clinician identified a specific action plan(s) to limit access to lethal means in the patient's environment especially for those methods for suicide that the patient had described. The clinician did <u>one</u> of the following: (1) explained the rationale for restricting access to reduce the likelihood of acting on impulsive feelings; (2) asked for feedback about the feasibility of the action plan and assessed for any barriers.

3 **Excellent** – Clinician identified a specific action plan(s) to limit access to lethal means in the patient's environment especially for those methods for suicide that the patient had described. The clinician did <u>all</u> of the following: (1) explained the rationale for restricting access to reduce the likelihood of acting on impulsive feelings; (2) asked for feedback about the feasibility of the action plan and assessed for any barriers.

SPIRS-VA

Directions for Scoring: Part I is not scored. Part II is scored by summing all of the items. Part III is scored by summing all of the items. Passing scores on both Parts II and III are required to be deemed competent in the Safety Planning Intervention.

Part II Total Score: ___ Maximum Possible Score: 18 Cut-off Score: 14 (78% correct)

Part III Total Score: ___ Maximum Possible Score: 18 Cut-off Score: 14 (78% correct)

Global Rating: Clinical judgment of Overall Quality of the Safety Planning Intervention (select one):

1	2	3	4
Not acceptable	Completes some elements	Completes most elements at a satisfactory level	Completes all elements at a satisfactory level

Is this clinician deemed competent to conduct (or continue to conduct) SPI for this project? ☐ Yes ☐ No