Psychiatria Danubina, 2011; Vol. 23, No. 4, pp 396-397 *Brief view point article*

TEACHING HEALTH CARE PROFESSIONALS ABOUT SUICIDE SAFETY PLANNING

Leo Sher[1,2] & Vanessa LaBode[1]

[1]James J. Peters Veterans' Administration Medical Center, New York, USA
[2]Mount Sinai School of Medicine, New York, USA

received: 21.7.2011; revised: 23.8.2011; accepted: 25.10.2011

SUMMARY

The suicide safety plan is a plan of action created by the clinician and patient that essentially charts the course of what the patient should do if he/she begins to experience suicidal urges. It is important for clinicians to learn how to implement a safety plan so that they can offer this service to their patients and teach their colleagues and associates about suicide safety planning. The safety plan is a great tool employed to help patients with suicidal urges, but trainees-clinicians and clinician associates alike - should fully understand that it is not a form of treatment. However, since an effective treatment for suicidality does not exist, practitioners should definitely use suicide safety planning. Although more resources are now being provided to individuals with suicidal behavior, more research needs to be done to develop new, effective methods of treatment and prevention of suicidal behavior.

Key words: *suicide - training - public health*

* * * * *

INTRODUCTION

Suicide is a major healthcare problem in the United States and around the world (Sher 2004, Mann et al. 2005, Hawton et al. 2009). In the United States, more than 34,000 people commit suicide each year (CDC 2010). Globally, there are more than one million suicide deaths per year and this rate has increased by 60% in the last 45 years (World Health Organization 2011).

There is no effective treatment for suicidal behavior. More than 90% of individuals with suicidal behavior suffer from Axis I psychiatric disorders (Mann et al. 2005). Clinicians treat underlying psychiatric as well as neurological and medical conditions in an attempt to alleviate patients' suicidal ideations and urges (Sher 2004, Mann et al. 2005, Hawton et al. 2009). It is difficult to predict whether or not an individual will attempt to commit suicide (Murphy 1984, Sher 2004). Certain patterns exist in suicidality and there are known risk factors that may trigger suicidal behavior (Mann et al. 1999, Rihmer 2007). An individual's vulnerability to stress is frequently very important. Some patients attempt suicide once, others multiple times. When treating patients' psychiatric and medical conditions, clinicians should offer tools and resources to those patients at risk to maximize their chances of working against suicidal urges.

SAFETY PLANNING

A safety plan is a tool patients may utilize in the event that suicidal urges do resurface (Stanley & Brown, in press). This plan is made between the clinician and the patient, essentially outlining what the patient should/will do if a suicidal crisis is to arise in the future. The safety plan is implemented through six steps, which are (a) "Recognition of Warning Signs" where signs that immediately precede a crisis are outlined; (b) "Internal Coping Strategies" where patients are asked what they think they should/can do, personally, to thwart suicidal wishes; (c) "Socialization Strategies for Distraction and Support," which is a list of possible healthy activities that the patient can try to do to suppress suicidal urges; (d) "Social Contacts for Assistance in Resolving Suicidal Crises" is a list of social contacts, mainly composed of family and friends, that may provide support if the suicidal urges are too great to combat alone; (e) "Professional and Agency Contacts to Help Resolve Suicidal Crises" is a list of contact information of professionals trained to deal with suicidal crisis; and (f) "Means Restriction" is the section that addresses how to reduce the availability of means by which the patient would attempt to commit suicide.

The safety plan is a physical document that the patient can keep with him/her after leaving the clinician. As helpful as it is to make a safety plan, it is not a form of treatment for those with suicidal behavior. The safety plan is a method of care in an attempt to prevent suicide in patients with suicidal urges. The fact that suicidal behavior is frequently recurrent in nature implies that there is no treatment that eradicates or controls it. The safety plan is for suicide what an inhaler is for asthma. There is no telling when an asthmatic patient will have an attack, but if it were to occur, the inhaler would be employed essentially to prevent the patient from dying by opening up his/her airway. Likewise, the safety plan is utilized by a suicidal patient to prevent suicide in the event that suicidal urges reappear; the safety plan does not treat suicidality.

TEACHING CLINICIANS ABOUT SAFETY PLANNING

It is important to know how to create a safety plan effectively, both with regard to time efficiency and elicitation of content. Studies have shown that because of insufficient training, clinicians have a difficult time evaluating and treating suicidal patients (U.S. Department of Health and Human Services 2001, Sher, in press). Training should include lectures, seminars, observation, role play, and hands-on practice (i.e., implementing safety plans initially under supervision) (Fenwick et al. 2004). Through this dynamic teaching approach, clinicians will build confidence in their skills and ability. Learning how to create a safety plan assures that the most relevant and important information is discussed with the patient. Whether the actual safety plan document is useful is still up for debate, but the different components of the safety plan are absolutely important for discussion with patients. For this reason, it is very important that clinicians/trainees be taught well how to implement a safety plan. Having the safety plan allows for a structured discussion, making sure that the clinician addresses different points that are important to highlight for suicidal patients. In a way, the utilization of the safety plan bridges the gap between what is taught about suicide and what actually needs to be done in the clinical setting.

As great a tool as it may be, creating a safety plan is not practical to do for practicing physicians because it can take up to an hour to implement. One solution is to have this plan made between patients and physician associates, such as social workers.

CONCLUSION

The safety plan is a great tool employed to help patients with suicidal urges, but trainees-clinicians and clinician associates alike- should fully understand that it is not a form of treatment. However, since an effective treatment for suicidality does not exist, practitioners should definitely learn how to make a proper safety plan for patients as well as teach those not knowledgeable. Clinicians should make every effort to use all possible tools in an attempt to prevent suicidal behavior.

REFERENCES

1. *Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. (2010) Preventing Suicide. CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention. Retrieved July 19, 2011, from http://www.cdc.gov/Features/PreventingSuicide/*
2. *Fenwick, Vassilas C, Carter H, Haque M. Training health professionals in the recognition, assessment and management of suicide risk. Int J Psychiatry Clin Pract 2004; 8:117-21.*
3. *Hawton K, van Heeringen K. Suicide. Lancet 2009;373(9672):1372-81.*
4. *Mann J, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonngvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihmer Z, Schmidtke A, Shaffer D, Silverman M, Takahashi Y, Varnik A, Wasserman D, Yip P, Hendin H. Suicide Prevention Strategies. JAMA 2005;294(16): 2064-74.*
5. *Mann JJ, Waternaux C, Haas GL, Malone KM. Toward a clinical model of suicidal behavior in psychiatric patients. Am J Psychiatry 1999; 156:181-9.*
6. *Murphy GE. The prediction of suicide: why is it so difficult? Am J Psychother 1984; 38:341-9.*
7. *Rihmer Z. Suicide risk in mood disorders. Curr Opin Psychiatry 2007; 20:17-22.*
8. *Sher L. Preventing Suicide. QJM 2004; 97:677-680.*
9. *Sher L. Teaching medical professionals about suicide prevention: what's missing. QJM, in press.*
10. *Stanley B, Brown G. Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, in press.*
11. *U.S. Department of Health and Human Services. National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: Public Health Service; 2001.*
12. *World Health Organization. International Suicide Statistics. Suicide Prevention, Awareness, and Support. Retrieved July 18, 2011, from http://www.suicide.org/international-suicide-statistics.html*

Correspondence:
Leo Sher, M.D.
Department of Psychiatry, Mount Sinai School of Medicine
James J. Peters Veterans'Administration, Medical Center
130 West Kingsbridge Road, Bronx, New York 10468, USA
E-mail: Leo.Sher@mssm.edu; DrLeoSher@gmail.com