JASPR HEALTH

Jaspr Health Webinar

What Makes Suicide Crisis Coping Plans Effective?
Science and Expert Opinion

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Kelly Koerner: All right. Welcome, everyone. We'll get started here in a moment, at the top of the hour. Thank you all for joining. We're extremely excited to have together a group of people whose careers have been advancing all of us. Marcus, if we're ready, I'll kick us off.

Kelly Koerner: Great. Hello. I'm Kelly Koerner and I'm the host of the Jaspr Health Webinar series. We're joined by a group of panelists we're pleased to host. Stephen O'Connor and I have been in conversation around what the best way is to advance the field, especially how coping plans are related to the broader treatment of suicidality. We'll be discussing our panelists' expert opinions and three types of questions: discussing the broader contexts of suicidality, what is known about what is effective and what is needed, and finally, what we as practitioners and those involved in policies should take away from this and how we should proceed.

Thank you to those of you involved in treatment and policy for joining. Stephen, if you want to take it away.

Stephen O'Connor: Thank you. I'll just pull up my slides. There we go. Thank you very much to Jaspr Health for organizing this discussion today. We have the leading experts in the field of brief interventions specific to short-term risk reduction. I'll mention that everyone included is an NIH grantee at this time. We're excited for them to be able to share their work.

I'm the Chief of the Suicide Prevention Research Program in the NIMH Division of Services and Intervention Research.

We want to have a conceptual approach to intervention. I want to draw your attention to this three-dimensional Haddon matrix. Haddon wanted airbags to be a standard part of vehicles. He developed this model that focused on pre-event, before the crash, during the event, and post-crash, trying to reduce the damage someone would sustain. He considered the person, the vehicle, and other factors.

They considered other decision criteria like the effectiveness, the cost, the freedom that is potentially is lost to the person as a certain approach. Is there equity? Is there a certain level of stigmatization of receiving? Where are the preferences? And what is feasible to deliver as a system of care?

We have experimental therapeutics. It's not just understanding if interventions work, but why and how they work. You can see preventative or therapeutic interventions. In this case, they're meant to be delivered to an individual, family, or group. Those intervention approaches are comprised

of distinct elements that are supposed to engage the primary targets of an illness. In essence, the elements of the intervention engage these primary targets. We then see improvements in our clinical outcomes, like the presence of a disorder or the level of function a patient has. There are outcomes like suicidality, suicide attempts, or deaths.

We have to take into account conceptual factors that point to different populations in different points of time across the care continuum. We have to consider these factors. [Reading bullet points on screen.]

Must the intervention be linked to a cueing event like an emergency room visit? [Reads remaining bullet points.]

We want to match patient preferences, provide the appropriate dose, etc. [Reading bullet points on screen.]

Having that conceptual model allows you to use the experimental therapeutics paradigm to investigate how and why your intervention may work.

Now that I've stopped sharing my screen, I'd like to introduce our two speakers for today. Barbara Stanley is a professor of medical psychology in psychiatry at CUMC. She specializes in the treatment of individuals with suicidal behavior, self-injury, borderline personality disorder (BPD), and emotion regulation difficulties. Dr. Stanley's research includes suicide, suicidal behavior, nonsuicidal self-injury, BPD, depression, and Dialectical Behavior Therapy.

Our second presenter is Dr. Craig Bryan. He is the Stress, Trauma, and Resilience Professor of Psychiatry and Behavioral Health at The Ohio State University. He is an expert in cognitive behavioral treatments for individuals experiencing suicidal thoughts and posttraumatic stress disorder (PTSD). Dr. Bryan conducts research to help military veterans, first responders and other adults who are dealing with mental health issues.

Dr. Stanley?

Barbara Stanley: Thank you for inviting me to present today. It gave me a lot to think about. I am going to focus my presentation. I tried to address the questions that were sent to us. But I want to talk about mechanisms of action because I think it's important. It's something we haven't really addressed when we talk about brief interventions.

So, just to remind you, this is what the safety plan looks like. This is an emergency plan. Acute risk exacerbation is what we're talking about. The safety plan includes basically three things: warning signs, coping strategies, and resources to use during a scandal crisis. There are also means of restriction.

This relies heavily on distraction tactics. I'll talk about that as a mechanism of action.

This is a plane safety card. This helps us conceptualize why and how this works. If you've flown, you can probably talk about what is on this plane safety card by heart. So we all know that if we're traveling with a youngster and the cabin pressure goes down, we put the oxygen mask on ourselves first before we put it on the child traveling with us. This is really important for us to know. And we don't want to have to think about it or go reading something during an emergency because we're not great problem solvers during emergencies.

Oops, sorry. OK.

Question 1 was this. [Reading screen.]

Whenever I talk on safety planning, I always present this slide, which I call the suicide prevention wheel. I present this because I really want to emphasize that brief interventions is a spoke in this extensive wheel with many spokes for presenting suicide. This is important because, number 1, it emphasizes what else we need to do. A brief intervention doesn't mean we're home free in terms of treating suicidal individuals.

I also want to emphasize the kinds of questions we always get about safety planning: does it prevent suicide and suicide attempts? It's a fair question. But I don't think we should be evaluating these things in the context of a single intervention. It's asking a lot of one small thing, to prevent suicide. Does the *wheel* prevent suicide, or does some complex of these things prevent suicide? That seems a more reasonable way to think about these things.

Where does safety planning fit? I think about the acute risk for suicide, which is this brief period of time. You can look on the x-axis there. It's minutes or hours where there's this acute escalation of risk. This is where brief interventions, fast-acting medication, and emergency care helps.

Then, there's more elevated and chronic risk. This is weeks and months. We think about more disorder-specific treatment, or suicide specific psychotherapy, or medication. We think about PTSD, depression, stressors, etc.

The way I think about this is that an acute risk, in the absence of a chronic risk, does not lead to suicidal behavior. That's the working hypothesis I have. You have this chronic risk with an acute elevated risk that occurs. We need to think about these things when we think about risk for suicidal behavior.

[Reading question.]

I'm going to talk a bit about that now. This is a primary article. There are others. There's actually another article that should be coming out relatively soon that looks at the efficacy of this

intervention. We found in this comparison trial that it actually was effective. Remember, in this trial, we did SPI+, safety planning with follow-up phone calls. There was 45% less suicidal behavior. Interestingly, people were more likely to engage in outpatient care.

Maybe it's mediated through safety planning, which got people into outpatient care, which resulted in suicidal behavior going down. But in fact, it was the direct effect from safety planning. There wasn't mediation there.

I hope to go through this quickly. How does this intervention work? I'm going to just describe what the pieces are. When we formed this intervention, we based it on the literature. There wasn't a brief intervention we could look to at the time. So we pulled from the literature what were the kinds of effective interventions that could reduce suicidal behavior. We put them together in this one form.

I drew arrows to each of the places. The whole safety plan is an emergency plan. The first thing is problem solving skills diminish so we need an emergency plan.

Why does this help? Because you know what to do if you're in trouble, just like that plan safety card. There's something about that. Suicidal individuals will say that.

Warning signs are important. If you don't know when you're in trouble, if someone is way into the crisis before they know they're into a crisis and it's like the point of no return, that's why warning signs are helpful.

[Reading "distraction" on screen.] That's our safety plan. We have internal coping strategies and other people that provide distraction.

There's social support that decreases suicidality. We know that from the literature. And finally, means safety and means reduction decreases scandal behavior. I think we don't do enough to explain this to suicidal individuals. Like, why in the world are we doing means restriction?

Now, I want to focus on distracting individuals as a beautiful way of lessening the possibility of suicide. It's interesting how strands of your research sometimes come together. This is a completely separate grant from NIH I had, separate from safety planning. We're doing ecological momentary assessment where people rate a bunch of things over the course of a week, and we're trying to understand the trajectory of suicidality over the course of a week. We have people rank their suicidal ideation, their stressors, and their ways of coping. We have them rate them 6 times a day over the course of a week. People do different things. People try to do it over a month, or 4 times a day, and so forth.

As I said, this was totally independent of safety planning. I didn't actually think about this when we put together these coping strategies. We looked at what coping strategies led to a decrease in

suicidal ideation in the short term. I'm talking about this as a short-term intervention.

We found two factors. One was a more distraction oriented coping strategy. The other is a mindfulness-oriented strategy. These are not people who are trained in mindfulness, though. We found that all of the distraction strategies led to a decrease in suicidal ideation in the next epic. We could see that these strategies led to decreases. Perspective, calming, sitting with your feelings did not. That was interesting to me.

That took me back to the literature. We're also doing the social stress test. What this shows, which I find so interesting, is that distraction coping products cortisol recovery after an acute stressor better than other types of coping. They measured the decrease in salivary cortisol. What happens is you get a stressor, like people have to give a speech or do a test, and cortisol goes up. Then you can measure the peak coming down over time. People who use distraction as a coping mechanism have a better recovery. So there's something biological about this, too.

Another article, which is one of several, found that distraction leads to lower cortisol levels after acute stress.

This, then, took me back to work that a colleague of mine, John Kelip, is doing. I look at this as a cousin of distraction. He's finding that attempters versus ideators, chronic ideators and are age-controlled for not having made a suicide attempt, attempters have more control than just ideators. With the plans, we want to not necessarily prevent ideation, but prevent ideation from going to an attempt.

Kelly Koerner: Barbara, we're just about at time.

Barbara Stanley: I have two other slides.

Kelly Koerner: Sounds great.

Barbara Stanley: So, how should the state of the science inform practice? What are the clinician takeaways? Science is often limited. Clients having a problem with limited science need treatment, and we have to offer the "best available" science-based care. It's important to listen to our clients.

Finally, about policy, how should regulators approach this? I have a lot of sympathy for regulators here. They work with what they have and make the best recommendation in light of the science. They can't sit around and say, we're not going to get ahead of the science here. Maybe they can temper regulations or recommendations, but we need to do something.

I also want to stress here that there's also a question about why there's an emphasis on brief interventions versus larger scale. That feels a little pejorative to me. For some people, brief

interventions may be sufficient, and we can think about smart trial designs. But for some people, brief interventions may be all that's available. [Reading bullet points 2 and 3.]

[Reading 4th bullet point.] Clinicians may not have the more labor-intensive psychotherapies that we have to deliver.

Sorry I went a little over. I got very hyped up preparing this talk.

Kelly Koerner: That was fantastic, Barbara. Craig, please jump in.

Craig Bryan: That was a nice launching point for me and some of the ideas I wanted to talk about. Sometimes you get fortuitous synchrony of ideas but I think this will work really well.

Building upon this point that Barbara ended with, which is the difficult of clinicians learning interventions. People not being able to access the longer-term interventions is the main motivation for my work.

There are all these crisis survival skills and lots of acronyms and mnemonics for patients to remember in the moment to do. That was in the '80s. Later, we had the Brief cognitive behavioral therapy. I have here one of David Rudd's papers, "The Case of No-suicide contracts."

In that article, it really laid the foundation of the crisis response plan as it's often completed within our treatment protocols in our work.

Things got simpler and simpler for the reasons that Barbara noted. In a crisis, we need to get right to the point, bullet points here, so people know exactly what to do when people have trouble remembering what to do.

We've stuck with the index card format. A lot of patients like that you can put it in your back pocket, purse, bag. A lot of military personnel had pockets on their sleeves, and it was a very patient-centered way for them to remember to keep it on them at all times.

If we walked through the different sections of the crisis response plan, we would see those but I'm not planning on doing that today.

One of the aspects about the evolution of this intervention is that a lot of patients will not follow up with special teams and mental health services. I learned this years ago. They would either refuse to go or agree to go but never actually go. We know the number of therapy sessions attended in an outpatient setting, the modal number, is one.

So, we need to maximize the intervention in that one session, because we may not see that patient again. The work we're doing now is really influenced by the process model of emotional

regulation. If I went to DBT or BCBT, I would say the underlying notion is the notion of self-regulation. Recognizing how one feels and being able to inhibit I impulse to stop or change one's state, which reduces suicide risk.

This will differ where we are in proximity to the stressful event, and also in social context. What we do while we're by ourselves at home might be different than when we're at work or school. It's important to think about these different stages or processes of self-regulatory behaviors.

We have file models. The first is situation selection. That's avoiding or staying away from an event that might be stressful or upsetting. If I know my ex-spouse will be at an event that weekend, I may choose not to go.

Then further down the line, I'm in a situation modification. Maybe I'm somewhere and my ex shows up unexpectedly. I can go to a different room, outside, or perhaps I leave. I'm modifying the environment.

Then we get into more internal forms of self-regulation. Attentional deployment is where distraction fits in. There's also cognitive change, where we adjust our interpretations of what's happening. And finally, the last step in the process model is to modulate our response, where we change how we express our emotion. This is like when we try to bury emotions and things like that.

So, there's this notion of distraction of doing things that can take your mind off of what's bothering you and keep you occupied for a while.

A while ago, we started to ask, what happens if this patient doesn't come back? Is there something we can possibly do now during this 30 or 60 minutes that might have a longer-term impact?

We went to the literature. We found that different types of distractions are associated with different states. Passive-neutral distraction are things like playing Scrabble, watching TV, etc. It's doing something. We see that it has a moderate-to-small emotional impact on emotional stress.

We've found that active positive distraction has even larger effects. We see further down the line that reappraise has even larger effects. In the midst of a crisis, though, a person may not be able to actively alter their perspective, so that may not be the most effective way to manage acute stressors.

Bringing a pleasant memory into your mind is one way to do that. When you're stressed out, think about something that is pleasant or elicits a positive emotion. That has been effective.

This is what we call "the reasons for living" task. When we were following up with patients who

were going through cognitive behavioral therapy, we asked them what was helpful and what we should change. Overwhelmingly, there was this task that we'd spend 45 to 50 minutes where we'd talk about the reasons to live and what about life was positive or meaningful to them. They would keep an index card of their reasons for living, and they'd carry that around. We were surprised at how many of the patients would say, I still have my reasons for living card.

That was where we thought, maybe we should be doing this at the same time as crisis response plan. Not only are the patients saying it was powerful, but it lines up with this research about active positive distraction of thinking about something pleasant would have a positive effect.

We started doing that. During the forming of the crisis response plan, we would ask what the reasons for living are, or what stopped you from killing yourself. Patients might struggle in the moment to know, so we started to learn ways to help them remember.

Once they identified those things, we would ask the patients to tell us a story. Tell us a favorite memory of your family member. We asked them to talk about their pets. It became a more emotionally vivid memory than just something written down on the card. We would engage them in conversation about these things in their lives that gave them positive emotional states.

In that method, we found that this reasons-for-living task has an immediate impact on a person's suicidality state. Compared to the crisis response plan without "reasons for living," we see immediate increases in positive emotional states, most notably hope.

Interestingly, this was an unexpected finding. We found that blinded clinicians, the ones who were on-call to make hospitalization decisions, were less likely to hospitalize patients when they had done the reasons for living task. Something was happening that they were in essence not hospitalizing the patients who were talking about the reasons for living, at a much lower rate compared even to patients who were making crisis response plan but without the reasons for living.

Patients reported increases in optimism. We also found that patients who do the reasons for living task benefit more from meaning in life. The task doesn't lead to a stronger sense of purpose or meaning. We don't find a difference between those methods of interventions. But over time, it's like the patient can harness the protective strategies of that task and use it for themselves.

We also see faster and larger reductions of suicidal ideation when the patient uses their plan. The more they use it, the faster they get better. It's even better than the crisis response plan without this component.

When I reflect on the last question, the implications, this is almost a 50-year-old paper written about outcomes of research in psychotherapy. From this article, Paul has this classic question that's phrased and highlighted here. [Reading pink box on screen.]

There's actually a lot of complexity here, where I think sometimes when we look at the results of clinical trials, we say, we do this instead of this because on average, one thing might be better than the other. But there are individual differences where clinicians might deliver treatments in different ways, or patients might prefer one thing than another, or the setting might make one way more beneficial than another. It's important for us to have enough options for that patient that we're working with that something is likely to work. Whereas, if we become too reductionistic, we may not be too successful because of the heterogenous nature of suicide risk.

In my work, I do training and consulting with agencies around suicide prevention. I find that there tends to be a mistake in this field, where paperwork equals effective intervention. By that, I mean, there's a heavy emphasis on what is put into the medical record. Therapy notes and documentation is getting longer and longer. The questions asked are always, what's the form, what's the template? There's this creeping sense that as long as we have the form and the paperwork, then we've done our due diligence. But in reality, the interventions and what we do as clinicians are what makes a difference. I've become increasingly concerned that we're moving away from what matters the most, which is to help patients develop a plan to make a difference in their lives because it's more important to document things, even if that documentation doesn't reflect the quality of intervention.

I deliberately finished up with something that might stimulate some questions. I look forward to the discussion. Thanks for having me.

Kelly Koerner: Thank you. I'll pose a question to you and Barbara. Is there data on how much people use their crisis plans in a crisis? Further, are there things practitioners can do that promote that actual use of the plan? If either of you could just chime in, that would be great.

Craig Bryan: I can speak to that. We collected some data. I think we published it in *Depression and Anxiety* a few years ago. We were surprised. We did follow-up questions with patients like, do you remember your plan, do you have it, what's on your plan, what are you using, and things like that.

One of the fascinating results was that the patients' ability to remember what was on the plan mattered more than whether or not they used what was on the plan. It's not what we were expecting. We thought it would come down to, "I take it out of my pocket and I read it," but we found a much stronger correlation to "I know what's on it." Perhaps now it's more of a recall task, or they've harnessed the skill set. Even if they're not pulling it out of their pocket and reading it, they've benefited from the intervention.

Barbara Stanley: We did a similar publication. Everyone could remember they had a safety plan and a large percentage could say where their safety plan was at that moment. Not 100% had used their plan, but a lot of them did. We interviewed them anywhere from 6 months to a year

after, so it is a thing that's done.

I wanted to mention that at some point along the way, somebody added "reasons for living" at the bottom of our form, and it became our most widely-distributed form. We tell people, we should consider that option, because it wasn't in our trial. I don't have data on this, but I think this speaks to what works for whom. Anecdotally, there are some people who say it's the most helpful thing on the safety plan. There are others who say, I don't have any reasons for living. I can't think of any. So it's a bit of a risk to do this with people. Just know, sometimes, that's what will happen at the end. Have you had that happen, Craig?

Craig Bryan: Yeah. We've had that with pretty much all of the sections. People struggle to come up with distractions, people don't have social supports in their lives. It's another reason why David and I preserved the index card. If that happened, we didn't then have a blank section on their plan. It was just like, hey, let's put that on your treatment plan and we'll move on, so it wasn't a gaping hole. I think you're right. It's a what works for whom issue.

Barbara Stanley: We did the same thing. We didn't leave anything blank because we didn't want people to feel like a failure. There are a lot of similarities.

Kelly Koerner: There are similarities. I wonder if Stephen and Craig could talk on the similarities and facilitate the discussion between the panelists. Can we nail down some takeaways for people in the audience?

Dave Jobes: One thing that is boomingly clear is that no-harm contracts should not be done. Barbara helped to codify this, "how much do you want to kill yourself, and between now and next week, we'll hospitalize you," that's clearly not a thing. We know no-harm contracts don't work, so they shouldn't be used.

I was thinking about that when people are in crisis, we know there's limbic activation. Dr. O'Connor got me thinking years ago that good interventions train patients to become their own suicidologists. There's a who, what, when, where, why, and how moment. When you're upset and you're in flight or fight mode, you're not always fully online. Whether this is DBT, or CBT, or whatever, we're training the patient to recognize, oh, I'm getting in trouble, so what do I do? I do these items. I think of that as activating frontal-lobe functioning. That's a commonality that's super important.

The other piece I think about is around the idea of collaboration. Barbara, I'm struck by a thoughtful clinician really working through a safety plan when I watch your videos. It's really taking the time. It's thoughtful and personalized. It's so critical.

We also know that writing is better encoded, better retrieval, and we have better memory of things we write. That aspect shouldn't be underestimated.

I was also thinking about the order of the intervention. The lethal means reduction is the last part of the safety plan. Craig, where does the lethal means fit in on the crisis response plan? It's not a formal part of it, right?

Craig Bryan: Right. It's not a formal part of it. We typically do that after the crisis response plan. If you watch a session like us, we'll be like, OK great, you have a plan. Now, let's talk about your access to firearms, medications, whatever the method is. We engage them in lethal means discussion protocol. It shows it increases the likelihood of safe-storage behaviors. Once we develop the means of restriction, we develop a separate focused plan.

We split it up. I think you're hinting at this. We're finding that it can be a very challenging conversation to have. The work we've done with men and military personnel in particular would get anxious very fast. So, we'll do the self-regulation plan first, and we have your trust and buy-in. There was something about that psychological separation that worked really well for the patients I worked with.

Barbara Stanley: Craig and I had that discussion about this. It's important to have it at the end. If you show people they have means to help themselves through a crisis, they'd be more likely to engage in a helpful discussion about reduction of lethal means. When we look at clinicians' plans, lethal means restriction gets the short shrift, which is really a pity.

Dave Jobes: Stephen, did you have a comment?

Stephen O'Connor: I wanted to express my appreciation for the presenters really homing in on the most effective strategies. They're brief but mighty. And they can save lives. When working with an individual, it's always important to acknowledge that number 1, it's a privilege to work with them, and number 2, we can work on these things together but we need to give it time. If someone is not available for therapy, then therapy can't work. There's always a very transparent process that happens.

It's important to describe to a suicidal person the function of these risk reduction tools, and how it fits into the larger fabric of their care. Some of the things we've reflected on, if this is the beginning and end of treatment, we are asking people to do a lot and that can lead to demoralization. So this might be the introduction to the best suicide care they've experienced. We want to make a strong impression and we want to accurately convey what the scope of the intervention is and what the next steps are.

Dave Jobes: I think of a patient from years ago who would get into psychotic states. She would sit on her hands and just look at her safety plan, and that in and of itself was helpful for her.

This was a piece of our work that they could look at. That was in itself a distraction or soothing on

the way. I wish they'd do the things on the card, but that happens, too.

I'm grateful to Jaspr for putting this together. Thank you for the presenters. We have two leaders in the field. We know this pragmatic approach makes a difference in people's lives.

Kelly Koerner: I wish we had another hour to just talk amongst yourselves. The leading edge of your work and what happens next is excited. Maybe this is a to-be-continued. Those of you on here, you're own thinking on this and your own research is very inspiring. Thank you for joining.

Dave Jobes: Thanks, folks.

Kelly Koerner: Thanks, all. Bye.

[End of meeting.]