Implementing Psychiatric Safety Planning in the

Adult Emergency Setting to Decrease Re-Presentation

by

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Abstract

Problem & Purpose

In the previous year, of those who complete suicide, 31.1% were seen in the emergency department (Schaffer et al., 2016). This statistic presents an important opportunity for intervention within healthcare. The purpose of this quality improvement project was to improve discharge planning by implementing the Stanley Brown Safety Plan (SBSP) in the Psychiatric Emergency Service (PES) for patients who report suicidality before discharged.

Methods

This project implemented the SBSP within the adult PES of a large urban academic hospital. The process change was to measure the number of patients who have documentation related to the SBSP in their chart upon chart audit. The data collection process utilized a "student- developed" chart audit model based on an electronic medical record report that is composed of date, CSN of patient, staff member, and whether the SBSP or refusal of participation was documented. The structure measures were education of the staff and feedback provided to the staff based on weekly audits.

Results

Education of staff pre-implementation and individualized feedback provided had 100% compliance throughout the project. Patients who had documentation of SBSP or refusal to participate in their project in their chart was successful; demonstrated by weekly improvement throughout the project and project high of 82% in the last week. The compliance ranged from 29% to 82% with a median of 41.5, a mean of 53.8 and a standard deviation of 15.8. Re-presentation rates increased from 18% in the first month data was recorded to 34% in the last month of recorded data with a median of 29.6, a mean of 28.6 and a standard deviation of 4.7.

Conclusion

Clinical staff's knowledge on safety planning improved after education training. The documentation score suggests that the standardized safety planning protocol was easy to use and implement as the standard of care. Findings highlighted the confounding variables that effected the safety planning protocol's ability to prevent re-presentation. Standardizing the safety planning protocol and educating the clinical staff on safety planning not only improved the documentation but is essential to improving discharge planning for the suicidal patient.

Introduction

Suicide is the 10th leading cause of death in America. Of those who complete suicide, 31.1% were seen in the emergency department within the previous year (Schaffer et al., 2016). This statistic presents an important opportunity for intervention within healthcare.

At a large academic hospital in an urban setting, a Psychiatric Emergency Service (PES) saw 4,932 patients in FY18/19. Approximately 70% of the patients did not meet the criteria for an inpatient admission and are therefore discharged. Suicidal ideation was a primary complaint of those seen. Discharge planning was often sparse, resulting in frequent re-presentation.

When looking at evidence-based care for suicidal patients, a key element is to mitigate the risk of suicide before discharge. A review of the literature supports five risk reduction strategies as ideal including: means restriction, teaching brief problem-solving and coping skills, enhancing social support, identifying emergency contacts, and motivational enhancement for further treatment (Stanley & Brown, 2012). The Stanley Brown Safety Plan (SBSP) is a tool that is patient directed, with support from the healthcare provider, incorporating all the strategies.

The SBSP has been found to be valid and effective at preventing suicide in the emergency department when combined with a crisis assessment and a follow up care plan (Stanley & Brown, 2018). As this is an intervention tool, not a measurement, reliability is not discussed in the literature. This tool is noted to be a "best practice" on the American Foundation for Suicide Prevention Best Practices Registry (Stanley et al., 2016).

The purpose of this project was to improve discharge planning by implementing the Stanley Brown Safety Plan (SBSP) in the Psychiatric Emergency Service (PES) for patients who report suicidality during the stay but are discharged.

Theoretical Framework

This project was supported by Lewin's Change Theory, which is a three-step process that views change as a dynamic balance of forces working in opposing directions (Kritsonis, 2005). Driving forces facilitate change as they push people in the direction that is necessary (Kritsonis, 2005). In this project, the driving forces were: a staff's desire to improve the care for suicidal patients that are discharged, a need for a process to engage patients in treatment, and patients presenting in crisis. Restraining forces inhibit change as they pull people in opposite directions of the change (Kritsonis, 2005). The restraining forces before the project include the SBSP not being in the clinical documentation, and patient's frequent re-presentation.

In order to facilitate the unfreezing stage, this project leveraged the driving factors by identifying passionate staff to champion the change, designing education to create a process that facilitated engagement in implementing the SBSP and utilizing a process for implementation of the SBSP. By using these actions to increase driving forces, the restraining forces became unbalanced, thus allowing transition into the second stage. The change stage occurred during the implementation of the SBSP in the PES.   This required engaging all of the staff in the process and support from all levels to achieve new balance through discussions at leadership meetings, and auditing with individualized feedback for the staff participating in the project. Once equilibrium is established, the final stage began. Post-implementation it was necessary for the PES to sustain the change through ongoing monitoring of the continued use to "refreeze" the new change. This occurred through ongoing auditing and discussion at leadership meetings as to on-going progress and outcomes of the project. See Appendix 2 for a visual aid of the theory applied to this project.

Literature Review

A literature review was conducted, resulting in eight articles supporting safety planning in the emergency setting. See Appendix 8 for Literature Review. Of the articles analyzed, all supported the intervention of implementing the SBSP in the PES for suicidal patients. Below are the prevalent themes in the literature, including a description of the safety planning interventions used, its' effectiveness suicide prevention, an overview of the impact of safety planning on treatment engagement and staff, and patient satisfaction with the process.

All of the studies implemented psychiatric safety planning as an engagement tool between the provider and the patient, describing this interaction as a therapeutic intervention in the emergency setting. The literature indicated that crisis response planning impacts clinical decision making as providers are engaging the patient in outpatient management of symptoms with higher levels of quality (Bryan et al., 2018; Gamarra, Luciano, Gradus, & Stirman, 2015). For patients completing the tool with a provider, their odds of attending at least one outpatient mental health visit doubled (Stanley et al., 2018). Further results indicated a generalized increase in rates of outpatient behavioral health treatment attendance post- intervention with rates increasing from 63.5% to 77.1% over six-months (Brown et al., 2015). Safety planning and the follow-up phone call combined were noted to be the most effective at preventing psychiatric admission. However safety planning with a follow up phone-call was seen as statistically the same as the safety planning intervention by itself in another study (Bryan et al., 2017; Stanley et al., 2018).

The literature indicated that both staff and patients are satisfied with safety planning as an intervention. In a study of staff currently utilizing the SBSP, 98% reported satisfaction, 94%

found the intervention to be helpful, and 85% found the intervention to increase connections to

services (Chesin et al., 2017). Patients reported a 97% satisfaction with the intervention, while

99% reported at least one helpful component. At the time of the interview, 61% of the patients

reported using the SBSP to reduce suicide risk currently (Brown et al., 2016). The follow- up

phone call was also found to be positive, with 96% of patients reporting satisfaction with the call

of the 98% who remembered the phone call. The combined intervention was considered useful

by 93% of participants (Brown et al., 2016).

It is important to note that four of the articles utilized the SBSP as the safety planning

tool (Chesin et al, 2017; Stanley et al., 2017; Stanley et al., 2016; Stanley et al., 2015). While

several of the studies executed the tool independently, others paired the tool with at least one

structured follow-up phone call (Bryan et al., 2017; Bryan et al., 2018; Chesin et al., 2017;

Stanley et al., 2018; Stanley et al., 2016). Studies differed in whether this increased effectiveness

of the safety planning (Bryan et al, 2018; Bryan et al., 2017; Stanley et al., 2018). The remaining

four articles did not specify the tool that was used, instead describing suicide mitigation

techniques aligning with the contents of the SBSP. (Bryan et al., 2017; Bryan et al., 2018;

Gamarra, J., Luciano, M., Gradus, J., & Stirman, S; McCabe, R., Garside, R., Backhouse, A.,

Xanthopoulou, P, 2018).

A systematic review shows that while there is a small evidence base, the intervention of

early engagement, and therapeutic interaction based on psychological theories in the emergency

department setting, appear to be effective at preventing suicide (McCabe, Carside, Backhouse, &

Xanthopoulou, 2018). Safety planning was associated with a significantly faster decline in

suicidal ideation with the SBSP specifically being found to decrease the behavior by 50% over

six months (Bryan et al., 2017; Stanley et al., 2018). The literature indicates this intervention is

effective for adult patients who were suicidal within the emergency setting and did not meet

criteria for inpatient hospitalization. This is notable as this highlights the need for the patient's

symptomology to be at a manageable point in order to engage in the intervention.

Safety Planning is an intervention that improves quality of care, staff satisfaction, and

long-term patient outcomes; however, this literature review indicated further large-scale research

is necessary.

Methods

This DNP project, implemented the SBSP as a quality improvement project within the

adult PES of a large urban academic hospital. See Appendix 3 for the permission to use the

adapted tool in this project. Inclusion criteria for patients included patient charts that have

complaints of suicidality that were seen by PES staff and clinical staff members that work in the

PES. Exclusion criteria included patients that do not have a suicidal complaint and patients that

were not seen by the PES staff with a suicidal complaint, non-clinical staff that work in the PES

and clinical staff that do not work in the PES.

This project impacted both structures and processes in the PES. See Appendix 5 for the

procedure to be implemented. The educational structure of the clinical staff of the PES was

altered as staff receive training on the implementation process. Staff received education on the

purpose, process, and expectation of the project as well as feedback on their documentation

throughout the project. These processes supported implementation by creating a baseline

knowledge of expectation but also utilized ongoing feedback as a way to support the

sustainability of the use of the SBSP post-project.

The process change from this project was to measure the number of patients who have documentation related to the SBSP in their chart upon chart audit. An online education module was created that nursing staff will be required to complete prior to the start date. Participants had the opportunity to ask questions during in person discussions and completed a post-test. For the provider staff, there was a "train the trainer" approach utilizing targeted education with the permanent social worker, psychiatric nurse practitioner, and attending psychiatrist who worked with the rotating residents. A Fast-Facts was created for staff to utilize during the initial roll-out process. See Appendix 6 for overview of a planned in-service education and training on use of the tool. Audits and direct feedback were utilized through email as a method to improve and reinforce performance throughout the process.

The data collection process utilized a student developed chart audit model based on an electronic medical record report composed of date, CSN of patient, staff member, and whether the SBSP or refusal of participation was documented. All patient and staff collected information was coded and stored in a separate word document on a password protected virtual desktop. See Appendix 4 for auditing tools. A project description was submitted and approved to the University of Maryland Baltimore and Johns Hopkins Hospital Institutional Review Board (IRB) for a Non-Human Subjects Research (NHSR) determination.

The structure measures of the project were the education of the staff and feedback provided to the staff based on weekly audits. The results of the audits will be used to determine if the education designed for the project was effectively impacting the staff and their practice.   The process measure was the documentation in the patient's charts that is completed correctly. This result determined if the alterations in the workflow were effectively supporting the completion of the SBSP. The outcome measure was the number of patients who re-presented to the PES within 30 days of initial presentation.

This result determined the project's effectiveness at preventing patients from re-presenting to the PES. Refer to Appendix 8 for Process Map.

These results were analyzed in several ways. Run charts were utilized weekly to analyze progress on the success of feedback, and the ongoing percentage of appropriate documentation of the SBSP. Descriptive statistics of mean, median, and standard deviation were used for the documentation and re-presentation rates throughout course of the project.

Results

As a result of this project, there were several successful changes in practice. The structure measures, education of staff pre-implementation and individualized feedback provided had 100% compliance throughout the project. Pre-implementation included 23 individualized online and in-person education, 3 provider "train the trainer" sessions, and 14 residents receiving online education. The process measure of patients who had documentation of the SBSP or refusal to participate in their chart was also a success as progress was demonstrated as improving weekly with a project high of 82% in the last week of recorded data. The compliance ranged from 29% to 82% with a median of 41.5, a mean of 53.8 and a standard deviation of 15.8. See Appendix 7 for more information on results.

Several facilitators were vital to the success of these measures. Staff engagement was critical as this project had strong support from the PES leadership as well as staff engagement throughout as the staff believed this change would improve the care and outcome of the patients. The communication model was also crucial as this project was modeled around clear and frequent communication during both education and implementation which motivated the staff throughout the implementation period. The intervention design demonstrated the effectiveness of the project utilizing simplicity to accommodate the fast-paced environment of the PES.

Despite positive results, there were several barriers identified during this project as well. The electronic medical record (EMR) was a challenge throughout the project. The EMR did not contain the SBSP. This would be completed on paper and then scanned into the chart. There was an initial delay in the provider's note being altered to include a template discussing the safety planning. Unfortunately this was not complete until the third week of implementation. The EMR reporting mechanism was not working, causing a delay in feedback to the staff. Another barrier was the 24/7 staffing model used in the PES, in combination with rotating resident coverage which made education challenging as it required frequent follow-up for compliance during project. Lastly, new suicide screening requirements that were rolled out by The Joint Commission putting, additional workload burden on staff during implementation.

The outcome measure for this project was re-presentation rates of patients 30 days post interventions. Re-presentation rates increased from 18% the first month data was recorded to 34% in the last month of recorded data. These rates had a median of 29.6, a mean of 28.6 and a standard deviation of 4.7.

Discussion

The process of safety planning prior to discharge for patients who report suicidal ideation while in the psychiatric emergency setting is an effective discharge tool which increases outpatient engagement and prevents suicide post-discharge.

This safety planning protocol, utilizing the SBSP, led to proper execution of the safety plan prior to discharge for patients who presented with suicidal ideation to an emergency setting. The education design was supported by a compliance rate of 84% upon review of 1,206 charts through the duration of the project.   The QI data trend of increased compliance throughout the

twelve week period suggested continued trajectory toward goal of 100% with an extended

timeline. Throughout the project, compliance rates were impacted by the rotation of the staff and

the acuity of the service. The re-presentation rates suggest competing variables throughout the

project. Confounding variables impacted re-presentation rate including: quality of SBSP

completed, diversity of population and secondary gain of patients including housing insecurities

and active substance use. While not measured during the project, staff spontaneously reported

improved satisfaction at patient interactions while using the SBSP in discharge planning.

   The project aligned with the literature's discussion of compliance with the tool as well as

staff satisfaction. The findings are in contrast with the literature as the re-presentation rates

increased. Findings of re-presentation rates highlighted that there were confounding variables

that effected the safety planning protocol's ability to reduce re-presentation rates. so the re-

presentation rates may be an indicator of success of the program, not a negative. Although the

setting was an adult PES which was similar, the studies in the literature were all performed with

the military or VA health system, which had a homogenous population that had direct access to

outpatient mental health resources that the setting of the project did not. The VA systems had

additional resources for outpatient care and follow-up services that were not available and are

compounding variables to consider in designing the next steps of the project.

   A strength of this project was the education model used through implementation. By

creating individualized feedback, the staff had increased buy-in to the process, and sustained

engagement lead to creating the SBSP as the standard of care within the PES. The feedback

process led to sustainability of its use which aligns with recommended best practice by the

American Foundation for Suicide Prevention Best Practices Registry.   This project's education

and feedback model will be essential to the next steps of the project. Findings are not generalized to other settings.

During the project, funding was approved for a suicide assessor to complete regulatory screenings as well as the SBSP for patients with suicidal complaints. This will continue the use of the tool within this setting and allow for follow-up phone calls to be initiated in the PES post-discharge and SBSP completion. As Bryan et al., (2018) and Stanley et al., (2018) suggests, having a singular person dedicated to the engagement and initiation of the SBSP tool and the introduction of follow-up phone calls will greatly contribute to the efficacy of the tool. Having one staff member dedicated to the completion of the SBSP, the quality of completion will improve as someone is dedicated to ensuring the tool is completely filled out and allows for re-engagement if a person initially refuses to participate.

Conclusion

The SBSP was successfully implemented into the PES as the standard clinical care for patients who reported suicidality that will be discharged. Clinical staff's knowledge on safety planning improved after education training. The documentation score suggests that the standardized safety planning protocol was easy to use and implement as the standard of care. The SBSP is integrated within the workflow of the PES leading to improved care for patients with suicidal ideation before discharge.

The documentation score suggests that the standardized safety planning protocol was easy to use and implement as the standard of care. The audits and subsequent feedback were instrumental in improving compliance throughout this project. While weekly personalized feedback is labor intensive and not necessarily feasible, it is recommended to design a

manageable monitoring system to prevent backslide in progress, analyze continued efforts and provide staff feedback on processes.

Standardizing the safety planning protocol and educating the clinical staff on safety planning not only improved the documentation but is essential to improving discharge planning for the suicidal patient. This project was the first phase in the long-term process aiming to decrease re-presentation to the PES with this population through safety planning. This phase was effective in integrating the use of the tool, but not in decreasing re-presentation. Findings highlighted the confounding variables that effected the safety planning protocol's ability to prevent re-presentation. Further projects include reviewing which patients are completing the tool and which ones are refusing to complete the tool. Comparisons can then be made between those charts with the re-presenting population to look for trends and design interventions supporting the use of the tool.

Follow up phone calls are recommended in the literature for patients once discharged before first outpatient appointment. Bryan et al., (2018) and Stanley et al., (2018) recommends the SBSP in conjunction with follow-up phone calls for this population. It is recommended in the future to implement these calls as the standard of care within the PES.

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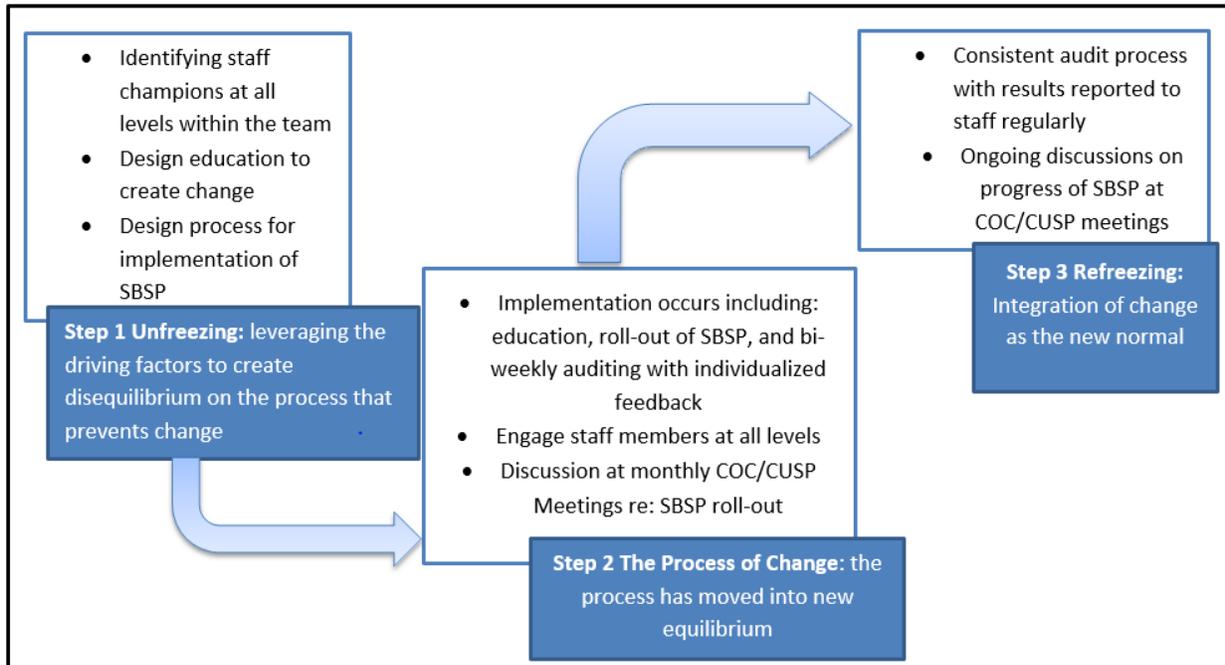
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Appendix 1: Stanley Brown Safety Plan

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

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. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

Appendix 2: Lewin's Theory of Change Applied to the Implementation of the SBSP in the PES

- Identifying staff champions at all levels within the team
- Design education to create change
- Design process for implementation of SBSP

Step 1 Unfreezing: leveraging the driving factors to create disequilibrium on the process that prevents change

- Implementation occurs including: education, roll-out of SBSP, and bi-weekly auditing with individualized feedback
- Engage staff members at all levels
- Discussion at monthly COC/CUSP Meetings re: SBSP roll-out

Step 2 The Process of Change: the process has moved into new equilibrium

- Consistent audit process with results reported to staff regularly
- Ongoing discussions on progress of SBSP at COC/CUSP meetings

Step 3 Refreezing: Integration of change as the new normal

Appendix 3: Permission to Use SBSP

From: Stanley, Barbara (NYSPI) [mailto:Barbara.Stanley@nyspi.columbia.edu]
Sent: Monday, March 11, 2019 10:35 AM
To: Joyce Parks <jparks@jhmi.edu>
Cc: Noriega, Yvonne (NYSPI) <Yvonne.Noriega@nyspi.columbia.edu>
Subject: Re: Seeking permission to use the Safety Planning Intervention in the Johns Hopkins Department of Psychiatry

Hi Joyce, I'm really sorry you haven't heard back from us. My assistant responds weekly to email requests for SPI permission. You have permission to use the SPI. Please just register at www.suicidesafetyplan.com. Please let us know if you have staff training needs or train the trainer needs. Sincerely, Barbara Stanley, Ph.D>

suicidesafetyplan

www.suicidesafetyplan.com

Welcome to our website. This site contains information about the Safety Planning Intervention that was developed by Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D.

Appendix 4: Evaluation Tools

Tool for Completion of SBSP in Chart

Date	Coded CSN	Completion/Refusal of Tool Documented (Y/N)	Coded RN at time of Discharge	Return w/in 30 Days (Y/N)

Audit Tool for Completing of Education Prior to Implementation

Staff Member	Education Completed	Staff Member	Education Completed

Audit of Feedback Given to Staff Throughout Project

Date	Person Given Feedback	CSN	

Appendix 5: Policies, Procedures, Protocols

Procedure for completion of the SBSP in the PES

1. The Psychiatric Provider will complete an assessment of the suicidal patient determining that an inpatient psychiatric admission is not warranted

2. The Psychiatric Provider and/or Psychiatric Social Worker will introduce the SBSP as safety planning measure to help design a discharge plan to meet the patient's needs outlining the steps of the plan for the patient.

   a. If patient refuses to participate in SBSP, the Provider/Social Worker will document this in their note.

3. The patient will spend time working on the SBSP, utilizing Providers, Social Work, and RN as needed.

4. Once the SBSP is complete, the RN will review and provide supportive feedback.

5. The RN will then make a copy of the tool for the patient to keep, and then give the tool to the PDC to have scanned into the patient's chart.

6. Upon discharge the RN will reinforce the SBSP created by the patient

7. If patient re-presents to the PES, the provider will print completed SBSP and use as a therapeutic tool during assessment.

Appendix 6: Trainings/Education of Patients or Staff

Learning Objectives	Content Outline	Method of Instruction	Time Spent	Method of Evaluation
To educate all RNs on the Implementation of the Stanley Brown Safety Plan in the PES	1. Overview of SBSP 2. Project Details 3. Roles within the Project 4. Auditing Plan	Online PowerPoint module with in person follow up	30 minutes	Post-test
To educate champion providers and social workers on the Implementation of the Stanley Brown Safety Plan in the PES	1. Overview of SBSP 2. Project Details 3. Roles within the Project 4. Auditing Plan	Online PowerPoint module with in person follow up	30 minutes	Post-Test

Outline of Education Content

1. Overview of SBSP

   a. Origins of the tool

      i. Use of the tool began at the VA as a discharge planning tool with patients

      ii. Benefits come through the interaction between the patient and the

          healthcare providers to create plan together

   b. Benefits of the tool

      i. Decrease suicide post-discharge from emergency setting

      ii. Increase outpatient engagement

      iii. Decrease re-presentation to emergency setting

   c. Description of the tool

      i. Warning sign

      ii. Internal coping strategies

      iii. People and social settings that provide distraction

      iv. People who I can ask for help

      v. Professionals or agencies I can contract during a crisis

      vi. Making the environment safe

   vii. Instillation of hope

 2. Project Details

   a. Purpose: This project will implement the SBSP in the PES for all patients who reports current or recent suicidality, or passive death wish but do not meet criteria for the inpatient psychiatric admission

   b. Plan:

    i. Date: Kick-Off on Sept 2nd 2019 at 7am

   c. Expectations: To have a completed SBSP documented in the chart or a refusal by the patient to participate prior to discharge for all suicidal patients

 3. Roles within the Project:

   a. Provider/SW:

    i. Introduce the SBSP to the patient engage patient in working on the tool

    ii. If patient refuses, document within your note the patient's refusal

   b. RN

    i. Engage patient in the completion of the tool

     1. Once complete, make copy for patient, and give SBSP to PDC to have scanned into the chart

     2. Document in a quick note if patient refused to participate in completion of the tool
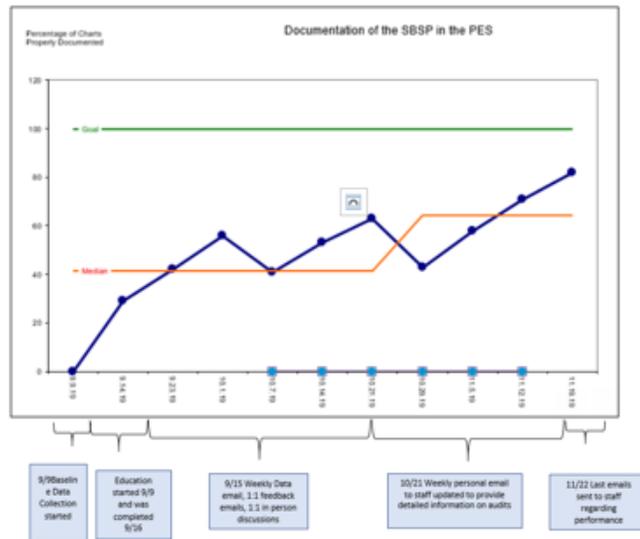
 4. Auditing Plan

   a. Staff must complete brief education module with follow up in person quiz prior to Sept 1st.

   b. All charts will be audited and staff will receive feedback based on performance
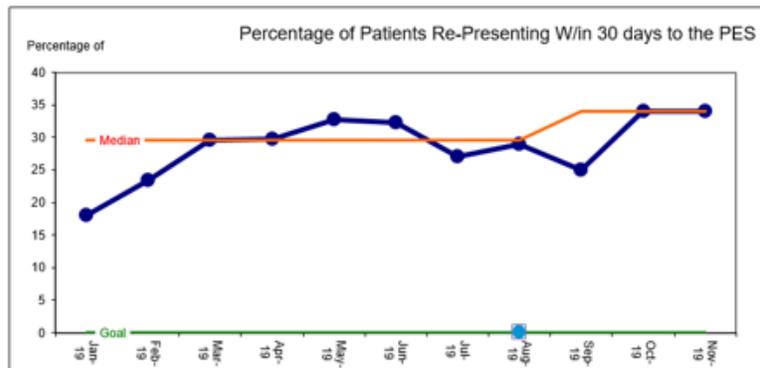
Appendix 7: Results

Documentation of the SBSP in the PES

- Achievement of 82% at highest compliance
- Median: 41.5
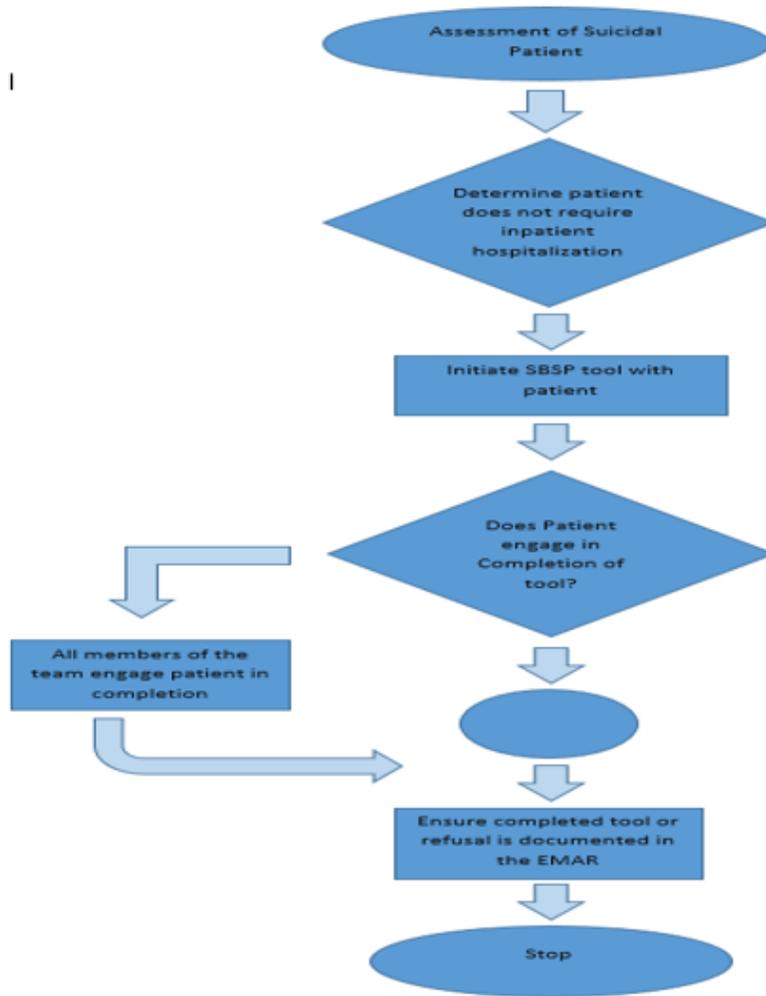- Mean: 53.8
- Range:29-82
- Standard Deviation: 15.8

Percentage of All Patients Re-Presenting Within 30 days to the PES

- Median: 29.6
- Mean: 28.6
- Range- 18% (Jan 19)- 34% (Nov 19)
- Standard Deviation: 4.7

Appendix 8: Process Map

Appendix 8: Evidence Review Table

Author(s), year	Study objective/intervention/ exposures compared	Design	Sample (*n*)	Outcomes studies (how measured)	Results	Level and Quality Rating
Bryan, C., Mintz, J., Clemans, T., Leeson, B., Burch, T., Williams, S., Maney, E., & Rudd, M. (2017)	To evaluate the effectiveness of crisis response planning for the prevention of suicide attempts	Randomized clinical trial of patient presenting with an emergency health appointment	*N*= 97 Active duty soldiers with active suicidal ideation or a lifetime history of suicide attempts who voluntarily presented for an emergency behavioral health evaluation	Participants were randomly assigned to receive a contract for safety, standard crisis response plan, or an enhanced crisis response plan in which the following variables were measured using the SASII: 1.Efficacy on time to first suicide attempt using survival curve analysis 2. Efficacy on severity of suicide ideation and follow-up mental health care utilization using longitudinal mixed effects models	Three people receiving crisis response plan, and 5 people receiving contract attempted suicide ($x2(1) =4.85$, $p=.028$ CI=.06-.96. Crisis response planning was associated with significantly faster decline in suicidal ideation ($F (3,195) =18.64$, $p<.001$. There was no statistical different between enhanced and standard crisis response plan conditions	IIA
Bryan, C, Mintz, J., Clemans, T., Burch, T., Leeson, B., Williams, S., & Rudd, D. (2018)	To examine the immediate effect of crisis interventions on the emotional state of acutely suicidal soldiers and clinician decision making.	A secondary data analysis of a randomized clinical trial.	*n*= 97 Participants presented to emergency department or behavioral health clinic	Scales used include: the Scale for Suicide Ideation, Beck Hopelessness Scale, PTSD Checklist-Military Version, The Suicide Attempt Self-injury Interview and Suicide Risk Score Psychiatric Admission	No association between group for suicide risk scores ($F=.3$, df=2 and 89, $p=.769$) Enhanced crisis response plan was statistically significant for preventing psychiatric admission ($x^2=4.0$, N=97, df=1, $p=.045$)	II B

				Between-groups mean differences examined using mixed-effects models		

Chesin, M., Stanley, B., Haigh, E., Chaudhury, S., Pontoski, K., Knox, K., & Brown, G. (2017)	To summarize staff perceptions of the acceptability and utility of the safety planning and structured post-discharge follow-up (SPI/SFU) contact intervention	A purposive sampling qualitative evaluative study.	$N= 50$ Staff members who were using or knew of the safety planning/structured follow up intervention	Semi-structured interview about the SPI/SFU were conducted. These interviews were then coded with descriptive statistics and rating scale items with (noted good interrater reliability) of the following variables: 1.Acceptability (not noted) 2.Perceive helpfulness (kappa-.93) 3.Implementation (kappa-.91) 4.Recommendations for improvement (kappa-.94)	1. 98% of staff reported satisfaction with intervention 2.94% found intervention helpful 85% found intervention to increase connections to services 3. 65 % reports initially concerns about the addition of SPI/SFU to the ED workflow but after implementation found the intervention integral to suicide prevention services 4. Recommendations for improvement include: expanding hours of staff completing intervention, extending follow-up and expanding population Eligible for services.	VI B
Gamarra,J., Luciano, M., Gradus, J., & Stirman, S. (2015)	T examine the implementation fidelity and variability of safety plan use in a regional VA hospital and to explore associations between safety plan fidelity and clinical outcomes	A pilot study that was a retrospective chart review using a standardized abstraction tool Of note, only the first(or index) safety plan was evaluated	$N=180$ Composed of participants who were identified as high risk for suicide within the last 12 months	Using descriptive statistics with inter-rater reliability (rater-agreement, interclass correlations, percent agreement, and logistic regression analysis) 1. The safety plan was measured by assessing completeness and quality of each step which was then added together for a tool score for each.	Rate agreement for fidelity variables were high. The safety plans were found to be mostly complete (ICC=.944, M=11.2, SD= 2.43). The plans were of moderate quality (ICC=.948, M= 15.5, SD= 3.28), with some variability. Provider Follow Up 45.6% of chart found no provider follow-up Association with Subsequent Outcomes 17% of pts made a subsequent suicide attempt	IV A

				2. Information on the collaborative process between pt. and provider and mention of safety plan follow up at subsequent visits were also measured in terms of three predictors; subsequent suicide attempt, subsequent psychiatric hospitalization, and attending 4 or more outpatient visits.	Positive association was found between total quality and subsequent hospitalization indicating less likely to be hospitalized (*OR*= .88, 95% CI= .80-.97) Total completeness was not associated with any subsequent pt. outcomes. Variability implementation fidelity and infrequent follow-up suggest a need for additional training and support regarding the use of the safety plan.	
McCabe, R., Garside, R., Backhouse, A., & Xanthopoulou, P. (2018)	To conduct a systematic review utilizing PRISMA guidelines, of the effectiveness of brief psychological interventions in addressing suicidal thoughts and behavior in healthcare settings	PRISMA guidelines were followed using a predefined search strategy, and two independent reviewers using quality appraisal and a narrative synthesis were conducted.	*N*=4 controlled studies	Studies were analyzed using a modified Cochrane Risk of Bias Tool for Randomized Controlled Trials to assess the extent of the body of literature related to brief psychological interventions for suicidal presentations.	Analysis of articles on subject found evidence base small however interventions appear to be effective at reducing suicide and suicide attempts in the ED setting	IB
Stanley, B., Brown, G., Brenner, L., Galfalvy, H., Currier, G., Knox, K., Chaudhury, S., Bush, A., & Green, K. (2018)	To determine whether the safety planning intervention administered in the EDs with follow-up contact (SPI +) for suicidal patient was associated with reduced suicidal behavior and improved outpatient treatment engagement 6 months post-discharge	Cohort comparison design with 6-month follow-up (5 intervention, and 4 control sites)	*N*= 1640 Participants were 18 or older, presented to ED with suicide-related complaint, however inpatient hospitalization was not clinically indicated.	The following variables were measured after being extracted from medical records for 6 months following ED discharge was a comparison of those receiving SPI plus at least two telephone and those receiving usual care follow-up: 1.Suicidal behavior following ED discharge	SPI+ phone call participants were less likely to engage in suicidal behavior (n=36/1186; 3.03%) than those receiving usual care (n=24/454; 5.29%) SPI+ phone call participants have 45 % fewer suicidal behaviors halving odds of suicidal behavior over 6 months (odds ratio, .56; 95% Ci, .33-.95, *P*=.03). SPI+ phone call participants had double the odds of attending at least 1 outpatient mental health visit (odds ratio, 2.06; 95%CI, 1.57-2.71; *P*<.001).	IV A

				2.Behavioral health outpatient services engagement following ED discharge		
Stanley, B., Chaudnury, S., Chesin, M., Pontoski, K., Bush, A., Knox, K., & Brown, G. (2016)	To assess the acceptability and perceived usefulness by the patient of using the safety plan intervention with structured follow up (SPI/SFU).	Semi-structured interviews with open ended question about acceptability, usefulness, and helpfulness of both the SPI and SFU.	*N*=100 A convenience sampling composed of participants contacted at random from a list of people who presented to the ED for a suicide-related concern but did not require psychiatric hospitalization and received the combined the (SPI/SFU) intervention at 2 sites.	Interviews were conducted with open ended questions and 2 5-point Likert rating scales to quantify each of the interventions SPI and SFU: 1.Acceptability 2.Usefulness 3.Helpfulness Themes were summarized with descriptive analysis that demonstrated good interrater reliability.	SPI 97% reported satisfaction 99% reported at least one helpful component 61% reports using SPI to reduce suicide risk SFU 96% reported satisfaction 98% remember the follow up phone call 93% found the combined interventions useful Themes from interviews describe overall combination intervention to be acceptable and helpful however for those who identified as unsatisfied stated the intervention did not target their primary issue, felt the SPI and/or the SFU were too long.	IVA
Stanley, B., Brown, G., Currier, G., Lyons, C., Chesin, M., & Knox, K. (2015)	To evaluate the effect of a 2-part behavioral intervention on effectiveness of intervention for increasing outpatient treatment attendance and decreasing ED visits and inpatient utilization	A comparison study	*N*= 96 A convenience sample composed of patients who prevented to5 VA EDs with 2 or more suicide-related visits in a 6 month period who were clinically determined not to require admission for inpatient care	Using x2 analysis and paired *t* testing to compare the prevalence and incidence of outpatient and acute service use among subsample members in the 3 months after both ED visits for those who did not receive SPI/SPU and those that did	Increased rates of outpatient behavioral health treatment attendance from 63.5 % to 77.1% (*P*- .02). Trend toward lower incidence of suicide-related hospitalizations post SPI/SFU of a statistically insignificant inverse relationship however it is noted that this may be significant with a larger sample size.	III B