



HSE National Office for Suicide Prevention  
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# Safety Planning Group Intervention (SPGI) delivered with people experiencing Suicidality in an Adult Acute Mental Health Unit

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Connecting for Life

## PROJECT TITLE

Safety Planning Group Intervention (SPGI) delivered with people experiencing Suicidality in an Adult Acute Mental Health Unit.

## KEY MESSAGES

- This is the first safety planning group intervention within an inpatient unit in Ireland or UK.
- A safety plan is a brief but clinical type of suicide intervention that outlines six main components aimed to assist with identifying an impending suicidal crisis and lowering the risk of suicidal behaviour during the acute stage.
- A safety plan consists of the following steps: (1) Recognizing warning signs, identifying: (2) internal coping strategies (3) social supports and settings for distraction (4) family and friends who can help (5) professional emergency contacts; and (6) ways to make the environment safer by reducing access to lethal means.
- Disciplines of psychiatry, occupational therapy, psychology, and nursing facilitated this intervention, delivered over a nine-month period from September 2021 – May 2022.
- This intervention was an extra source of support for patients and provided an opportunity to learn and engage with safety planning skills and psychoeducation within a collaborative group environment and receive peer support.
- Safety planning skills included grounding strategies, crisis management, risk, and identifying community networks using a sociogram (session one), feelings wheel, early warning signs, stress symptoms, and a scale of intensity (session two). Session three culminated in the creation of a paper-based safety plan.
- It was aimed to assist participants in developing (1) emotion regulation strategies to alleviate psychological distress and hopelessness, (2) engage in skills that are both self-directed and support-seeking, and (3) assistance in reducing access to means.
- The intervention skills, incorporated into a treatment plan, may be particularly beneficial for crisis presentations at Emergency Departments. This would mean clinicians meeting patients in crisis at A&E would have a clear next step. Patients will also be reassured that they will be receiving a timely and appropriate intervention.

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## AFFILIATIONS

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## CONTEXT AND BACKGROUND

Safety planning interventions (SPIs) for patients at risk of suicide are used in clinical practice and employ the use of a safety plan, which is stepwise in nature, derived from cognitive therapies for suicide prevention, and is a research-informed intervention (Melvin et al., 2019).

Coping and problem-solving skills can diminish during suicidal crises (Stanley & Brown, 2012), so predetermining a list of coping strategies and sources of support (Stanley et al., 2009) can help to avert thoughts and urges.

SPIs are low-burden, customisable (Stanley & Brown, 2012), straightforward, and efficient (Melvin et al., 2019). SPIs are also adaptable: they can be digital or paper-based, delivered online or face-to-face, self-administered or facilitated by a clinician, a combined or stand-alone intervention (Ferguson et al., 2021), and can support individuals who do not or cannot, readily engage with mental health services (Melvin et al., 2019). Overall, SPIs are a valuable intervention and appear to be feasible (Ferguson et al., 2021), supported, and accepted by clinicians and suicidal patients (Melvin et al., 2019).

SPIs are usually created by a patient in collaboration with a clinician. Recently, a more collaborative approach to safety planning has been adopted internationally, with research focusing on the effectiveness of group safety planning. Research suggests the effectiveness of this group approach in decreasing suicidality, depression, and hopelessness (Goodman, 2021), though pilot studies have focused on specific cohorts such as veterans (Johnson et al., 2014; Goodman et al., 2020, 2021), or older adults (Marin et al., 2019); thus, these studies have limited generalizability. More research is needed on whether these interventions are effective within a group setting within an unspecific cohort, particularly for those experiencing chronic suicidality.

Gaining more insight into the benefit of group interventions is important as group treatments can maximise cost-effectiveness (Goodman et al., 2020; Melvin et al., 2019) and staff resources, as well as help to diminish social isolation and increase social supports (Goodman et al., 2020).

As well as suicidality, it was important for this intervention to examine feelings of thwarted belongingness, perceived burdensomeness, and hopelessness based on Joiner's (2005) Interpersonal Psychological Theory of Suicide. Thwarted belongingness (TB) is defined as perceived disconnectedness and a lack of reciprocal, positive relationships. Perceived burdensomeness (PB) is the feeling of being a burden or liability (Joiner et al., 2012) and the belief that one's death would be more beneficial to others than one's life (Van Orden et al., 2010). When these constructs occur together, this creates a sense of hopelessness. Hopelessness plays a pivotal role in Joiner's (2005) theory (Van Orden et al., 2010), as when experienced along with TB and PB, may lead to the desire to actively end one's life (Joiner et al., 2012).

For suicide to occur, an individual must also feel that they have capability. Acquired capability can occur when individuals become habituated to pain and fear (Joiner et al., 2009). As ideation-to-action theories of suicide such as the IPTS are recommended for treatment of suicidality (Klonsky et al., 2017), it is also important to understand the effectiveness of SPIs when considering this theory.

## AIM/OBJECTIVE(S)

### Aims of the Intervention:

1. To facilitate the co-development of a Safety Planning Group Intervention (SPGI) that assists mental health patients who have experienced recent suicidality, understand their personal warning signs of suicidal crisis.
2. To reduce levels of thwarted belongingness, perceived burdensomeness, hopelessness, and suicidality following the implementation of the SPI.
3. To assist identified mental health patients find reasons for living by the co-development of coping strategies during future suicidal crisis situations.

### Objectives of the Research:

1. Assess the impact of a group delivered SPGI to identified mental health patients who have experienced recent suicidality by measuring whether the participants' levels of suicidality reduce following the intervention.
2. To examine whether participants' levels of perceived interpersonal needs and hopelessness reduce and levels of coping increase following the group SPI.

It is hypothesised that those with chronic suicidality (defined as two or more self-reported suicide attempts) will have less improvement in TB, PB, and hopelessness relative to those with acute suicidality (defined as less than two self-reported suicide attempts).

Therefore, our research question was “Is a three-week SPI effective in reducing hopelessness, thwarted belongingness (TB), and perceived burdensomeness (PB) in individuals experiencing acute suicidality relative to those with chronic suicidality?”

## METHODOLOGY

This quasi-experimental study took place in the outpatient department of the Adult Acute Mental Health Unit (AAMHU) of University Hospital Galway (UHG) and utilised a pre-test/post-test design involving opportunistic participant recruitment for patients for whom an SPGI was clinically indicated.

To fulfil eligibility criteria, participants were aged 18-65, admitted voluntarily if inpatient, experiencing suicidality, and able to give informed consent and engage in group psychoeducation. Patients with an active psychotic or dementia-related illness, or who were admitted involuntarily if inpatient, were excluded from the study.

Suicidality is defined as engaging in suicide attempts and self-injurious behaviours, such as self-harm, with and without the intent to end one's life (Silverman et al., 2007). For the purpose of data analysis, participants were divided into those experiencing acute (less than two attempts) or chronic (two or more suicide attempts) suicidality.

All participants completed a battery of seven psychometric measures pre- and post-intervention which aimed to assess suicidality, as well as TB, PB, and hopelessness, constructs associated with Joiner's (2005) theory.

The **Columbia Suicide Severity Rating Scale (CSSR-S)** is the gold standard to assess suicidality (Posner et al., 2008). The item "Most severe ideation" of the CSSR-S was used (Posner et al., 2008). Participants were asked to consider how they felt on a scale of 1-5 (1= wish to be dead, 2 = non-specific active suicidal thoughts, 3 = active SI with any methods without intent to act, 4 = active SI with some intent to act, without a specific plan, and 5 = active SI with specific plan and intent).

The 20-item **Beck Hopelessness Scale** (Beck et al., 1974) assessed hopelessness through True/False items such as "I look forward to the future with hope and enthusiasm." Scores can range from 0 to 20, with higher scores indicating greater hopelessness (0-3=none or minimal, 4-8=mild, 9-14=moderate, 15+ =severe).

The **15-item Interpersonal Needs Questionnaire** (Van Orden et al., 2012) consists of statements to assess perceived burdensomeness (items 1-6, e.g. "These days, the people in my life would be better if I were gone" and thwarted belongingness (items 7-15, e.g. "These days, I feel like I belong"). Items are rated on a 7-point Likert-type scale from 1 "Not at all true for me" to 7 "Very true for me." Higher scores indicate greater PB or TB (Wang et al., 2021).

Participants attended a three-week psychoeducational group, based on the 20-week Skills for Safer Living programme (SfSL; Bergmans & Links, 2002). SfSL aims to reduce the frequency, intensity, and duration of suicidal crises (Bergmans & Eynan, 2014).

Facilitators also completed STORM 4 2 Day Skills Training for Suicide Prevention and Self-Harm Mitigation. Butchart (2020) found that educating staff on safety planning improved their knowledge and confidence and overall benefitted the patient in producing a comprehensive safety plan. It was aimed for participants to create a tailored safety plan that was meaningful for them; an important goal as research suggests safety plans can be poor quality, impersonal, or incomplete (Green et al., 2018).

In addition to accessing treatment as usual, safety checks to assess for active suicidality, based on the **Scale for Suicide Ideation** (Beck et al., 1974), were conducted after each session and the patient's multi-disciplinary team was notified of their current level of suicidality. This meant that patients were

assessed for suicidality five times throughout the intervention, and participant safety was a priority and was highly monitored.

The sample consisted of 70 participants who self-identified as: 18 male (25.7%), 51 female (72.8%), and 1 non-binary person. Ages ranged from 18-61. See **Table 1** for further demographic information and **Table 2** for a breakdown of suicidality and attempts prior to the intervention. Information was obtained through the use of a demographic questionnaire.

**Table 1: Demographic information**

	Acute (n=29)	Chronic (n=41)	p
<b>Age</b> (mean, SD in years)	27.3 (9.5)	30.9 (10.9)	0.150
	<b>N (%)*</b>	<b>N (%)*</b>	
<b>Gender</b>			
Female	21 (72%)	29 (71%)	1.000
Identified as Female	-	1 (2%)	
Male	8 (28%)	10 (24%)	
Non-binary	-	1 (2%)	
<b>Ethnicity</b>			
Any other white background	4 (14%)	7 (17%)	0.361
Black or African American	-	2 (5%)	
Other	5 (17%)	2 (5%)	
Traveller	-	1 (2%)	
White Irish	20 (69%)	29 (71%)	
<b>Relationship Status</b>			
Divorced/separated	2 (7%)	4 (10%)	0.002
Long term relationship	13 (45%)	5 (12%)	
Married	2 (7%)	0 (0%)	
Single	12 (41%)	32 (78%)	
<b>Smoker</b>			
No	16 (55%)	18 (45%)	0.450
Yes	13 (45%)	22 (55%)	
<b>Alcohol Misuse</b>			
No	20 (69%)	22 (55%)	0.319
Yes	9 (31%)	18 (45%)	
<b>Cannabinoids Misuse</b>			
No	22 (76%)	23 (57%)	0.132
Yes	7 (24%)	17 (42%)	

\*Percentages rounded to the nearest decimal place.



**Table 2: Summary of suicidal ideation, attempts, and diagnosis**

	Overall (n=70)	Chronic (n=41)	Acute (n=29)
<b>Suicidal ideation pre-intervention</b> (with or without suicide attempt)	<b>N (%)*</b>	<b>N (%)*</b>	<b>N (%)*</b>
Extended over years prior to intervention	61 (87%)	40 (66%)	21 (34%)
Experienced first episode prior to intervention	9 (13%)	1 (11%)	8 (89%)
<b>Suicidality pre-intervention</b>			
Passive (no attempts, intent, or desire in last 3 months)	6 (9%)	1 (17%)	5 (83%)
Active (no attempts in last 3 months, intent/desire)	41 (59%)	22 (54%)	19 (46%)
Made a suicide attempt within last 3 months	23 (33%)	18 (78%)	5 (22%)
<b>Suicide attempts pre-intervention</b>			
None	13 (19%)	-	13 (100%)
1	16 (23%)	-	16 (100%)
2 or more	41 (59%)	41 (100%)	0 (0%)
<b>Admissions</b>			
None	38 (54%)	17 (45%)	21 (55%)
1	12 (17%)	5 (42%)	7 (58%)
2	6 (9%)	5 (83%)	1 (17%)
2+	13 (19%)	13 (100%)	-
<b>Mental Health Act 2001 Status</b>			
Not Applicable	6 (9%)	6 (100%)	-
All admissions voluntary	38 (54%)	17 (45%)	21 (55%)
All admissions involuntary	-	-	-
Both (voluntary/involuntary) admissions	25 (36%)	17 (68%)	8 (32%)
<b>Primary diagnosis</b>			
Emotionally Unstable Personality Disorder	48 (68%)	29 (60%)	19 (40%)
Mood Disorder	17 (24%)	8 (47%)	9 (53%)
Anxiety	5 (7%)	4 (80%)	1 (20%)
<b>Secondary Diagnosis</b>			
No	42 (60%)	23 (55%)	19 (45%)
Yes	28 (40%)	18 (64%)	10 (36%)
<b>More than two diagnosis</b>			
No	11 (52%)	7 (64%)	4 (36%)
Yes	59 (84%)	34 (58%)	25 (42%)

\*Percentages rounded to the nearest decimal place.



Four linear regression models were conducted to analyse change between scores of suicidality, hopelessness, TB, and PB pre and post-intervention. Participants were divided into acutely suicidal (n=29) or chronically suicidal (n=41). See **Table 3** and **Table 4**.

**Table 3: Pre- and post-intervention score along with improvement of different outcomes across acute and chronic suicidal group after removing outliers**

	Acute			Chronic				
	<i>n</i>	Pre Mean (SD)	Post Mean (SD)	Improvement Mean (SD)	<i>n</i>	Pre Mean (SD)	Post Mean (SD)	Improvement Mean (SD)
<b>CSSRS</b>	29	3.55 (1.4)	2.21 (1.2)	1.34 (1.95)	41	3.71 (1.08)	3.17 (1.34)	0.5 (1.3)
<b>BHI</b>	27	13.19 (3.5)	10.3 (5.85)	3.6 (3.9)	40	16.1 (4.08)	12.9 (5.17)	3.2 (4.5)
<b>INQPB</b>	29	24.2 (9.22)	19.8 (10.5)	4.38 (7.08)	38	27.6 (7.07)	24.5 (8.32)	3.1 (7.29)
<b>INQTB</b>	29	39.3 (11.8)	35.5 (11.1)	3.76 (8.7)	37	42.7 (9.8)	39.7 (9.59)	3.03 (8.51)

*Note: CSSRS = Columbia Suicide Severity Rating Scale. BHI = Beck's Hopelessness Inventory. INQPB = Interpersonal Needs Questionnaires Perceived Burdensomeness. INQTB = Interpersonal Needs Questionnaires Thwarted Belongingness*



**Table 4: Regression analysis of different outcome**

Independent variables	Improved CSSRS Estimate (CI)	Improved BHI Estimate (CI)	Improved PB Estimate (CI)	Improved TB Estimate (CI)
<b>Intercept</b>	-3.70 [-5.27, -2.12]*	0.54 [-5.62, 6.71]	-8.72 [-17.8, 0.35]	-10.7 [-21.3, -0.02]*
<b>Suicidality level</b>				
Chronic	Ref.	Ref.	Ref.	Ref.
Acute	1.00 [0.34, 1.65]*	0.99 [-1.49, 3.48]	2.69 [-1.07, 6.45]	1.12 [-2.94, 5.19]
Pre-Score	0.86 [0.60, 1.12]*	0.10 [-0.20, 0.40]	0.25 [0.02, 0.48]*	0.32 [0.14, 0.50]*
<b>Age</b>	0.04 [0.01, 0.07]*	0.08 [-0.04, 0.20]	0.23 [0.05, 0.41]*	0.10 [-0.09, 0.29]
<b>Gender</b>				
Female	Ref.	Ref.	Ref.	Ref.
Identified as female	-0.90 [-3.45, 1.65]	-1.48 [-10.5, 7.59]	-6.43 [-20.6, 7.75]	2.54 [-12.7, 17.8]
Male	-0.41 [-1.12, 0.31]	0.05 [-2.55, 2.65]	-0.61 [-4.89, 3.67]	0.98 [-3.31, 5.28]
Non-binary	-0.78 [-3.35, 1.79]	-3.33 [-12.5, 5.85]	-6.32 [-20.6, 7.97]	-11.1 [-26.5, 4.30]
<b>Ethnicity</b>				
Any other white background	Ref.	Ref.	Ref.	Ref.
Black or African American	-0.25 [-2.21, 1.70]	0.23 [-6.71, 7.16]	0.26 [-10.9, 11.4]	-16.4 [-28.4, -4.51]*
Other	0.01 [-1.24, 1.25]	-1.62 [-6.24, 3.00]	-0.06 [-7.15, 7.02]	-0.82 [-8.36, 6.72]
Traveller	-1.65 [-4.27, 0.98]	-1.65 [-11.0, 7.67]	0.71 [-14.3, 15.7]	-
White Irish	0.11 [-0.78, 1.01]	-1.67 [-4.81, 1.48]	-2.59 [-7.76, 2.58]	-3.02 [-8.46, 2.42]

Note: CSSRS = Columbia Suicide Severity Rating Scale. BHI = Beck's Hopelessness Inventory. PB = Perceived Burdensomeness TB = Thwarted Belongingness. CI = 95% confidence interval. \* means statistically significant at level 0.05.

## RESULTS / FINDINGS

As can be observed, scores of suicidality decreased for those experiencing acute suicidality. Difference in scores of TB, PB, or hopelessness between the acute and chronic groups was not significant. This suggests that a three-week group-based safety planning intervention may be appropriate for individuals with acute presentations of suicidality. Individuals with chronic presentations would benefit from a longer and more intensive intervention. Suitable interventions may include the 20-week Skills for Safer Living programme or the 24-week Eden Programme.

Informal feedback was obtained by the Research Assistant when meeting participants for post-measure psychometric assessments. Participants liked the group environment, related to what other group members shared, and found it comforting to know that they were not alone. The intervention was well structured, and enough time was given to each skill. Information was helpful, practical, and well-explained. Handouts were helpful to take notes and personalise the material according to their own experiences and were also able to reflect on the material at home. This helped them to put the skills into practice. The sensory items provided, such as stress balls and fidget toys, and refreshments were a good grounding and distraction technique, and an effort was made to make them feel welcome.

Some quotes from participants include: ***“I didn’t realise a group could change my life so much,” “I feel like a different person,”*** and ***“I think it was amazing. Everyone should do it.”***

Overall, participants felt that the intervention was a good support. They named that they felt ***“inspired,” “optimistic,” “hopeful,”*** and ***“positive”*** after taking part. They felt that they had made progress and were more confident and knowledgeable about keeping safe. Participants felt that the intervention should be rolled out across different areas and services to give others the opportunity to attend. Some participants shared that they had not had thoughts of suicide after attending the intervention.

To our knowledge, the pilot intervention was the first safety planning group intervention within an inpatient unit in Ireland. As the group consisted of three sessions and was open to a new group each month, wait times were minimal. The intervention was facilitated by multiple disciplines with years of combined experience in crisis intervention and psychoeducation, who completed further training before facilitation. Due to the positive feedback, large referral numbers, and interest and support from clinicians that have been upheld since the intervention ended, it is believed that the intervention is needed, and reached only a small sample of patients, relevant to need. Attendance at other psychoeducational groups, if available, may only be helpful to a certain point, when considering a suicidal population.



## RECOMMENDATIONS

- It is recommended that safety planning interventions are rolled out to community teams, clinicians, and other CHO inpatient areas.
- For CfL priority groups, attending a psychoeducational and collaborative recovery-focused group can be beneficial. Engagement in the intervention can lead to an increased awareness of warning signs of suicidality and coping skills. This may lead to a reduction in suicidality and suicidal behaviour, which may culminate in less crisis admissions and safer hospital discharges.
- A manual distributed to other CHO areas would be helpful to inform them of how to best facilitate this intervention. This is suggested to consist of the intervention material and handouts, suggested pauses and recommended pauses, and discussion points to touch on. It may also be helpful to seek input from any participants who took part in the group intervention. Their experience and insight would be invaluable and any feedback may also be incorporated to ensure the intervention can be replicated to ensure the most benefit to those experiencing suicidality.
- When considering future research, it would be helpful to divide suicidality into three categories: (1) Have never made a non-fatal attempt, (2) Have made less than two, and (3) Have made two or more. For the purpose of this research, participants with 0 suicide attempts were placed in the acutely suicidal category along with those who had experienced up to two non-fatal attempts. A larger sample size would support this further breakdown and may facilitate a more balanced sample in terms of gender and diagnosis. The present sample was predominately young females with a diagnosis of EUPD. A larger sample would allow findings to be more generalizable and allow further insight into the efficacy of a group SPI for individuals who have not acted on their suicidality.
- Considering EUPD was the predominate diagnosis (n=48; 68.6%), it may also be helpful to analyse the data of this sample only, to obtain a greater insight into why this population experiences high levels of suicidality and how helpful this population found the intervention to be.
- The longitudinal impact of participation in a group SPI could also be examined. Although there was at least a month between pre-and-post assessments within this study, a longer period is desirable to examine the long-term effectiveness of a group SPI.
- It is also important to note the absence of a control condition. Further research could examine the effect of the intervention versus treatment as usual. However, the ethical considerations of depriving a population who have been identified as suicidal of a safety planning intervention must be considered. It may be more ethical to examine the effectiveness of traditional one-to-one safety planning with a clinician compared to the effectiveness of a group safety planning intervention.

## LINKS / SUPPLEMENTARY MATERIALS

Link to study protocol:

<https://cmhaww.ca/programs-services/skills-for-safer-living/>

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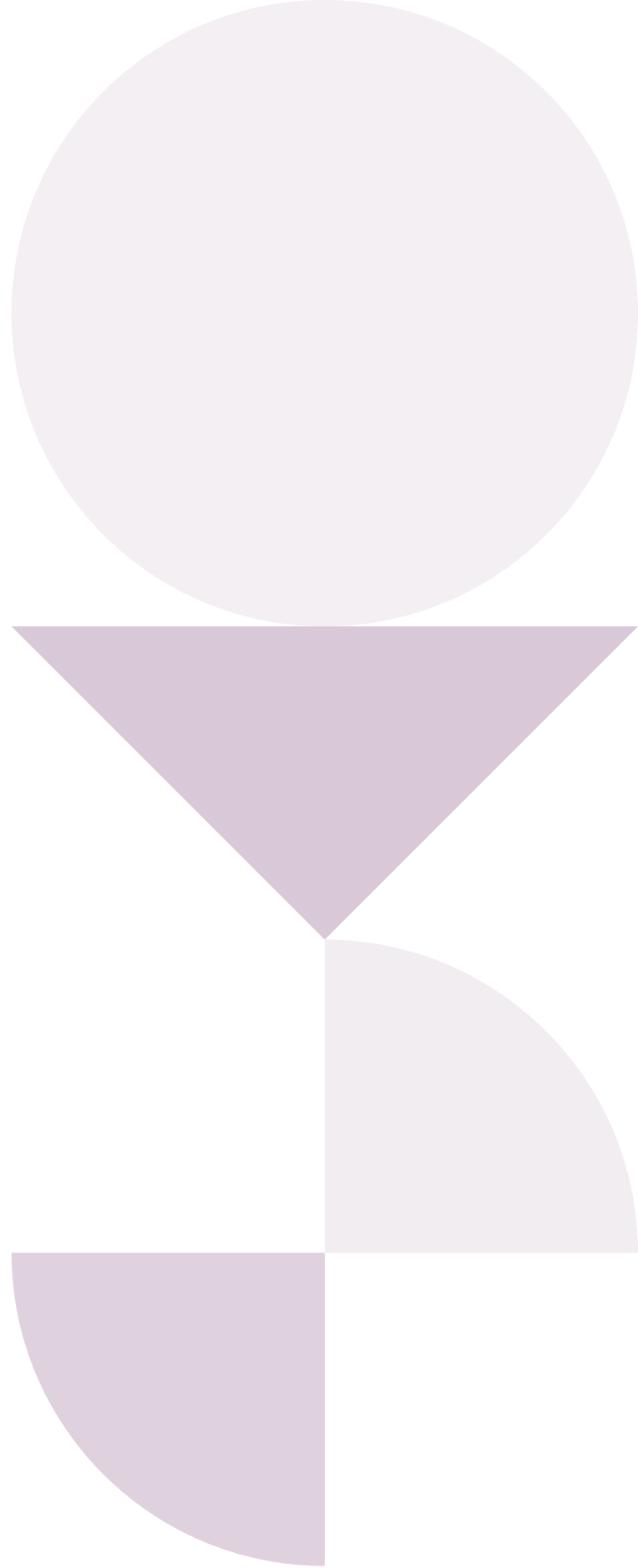
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