Guide to Safety Planning for Community Professionals

Contents

1. Brief Psychological Intervention 1
2. Indications 2
3. Implementation with the Young Person 2
4. Implementation with Parents/Caregivers 3
5. Support Contacts 4
6. References 4
Appendix 6

1. Brief Psychological Intervention



Suicide safety planning is a highly effective, strengths-based (Jacups & Kozlowski, 2021) brief psychological intervention for reducing risk and harmful behaviours (Moscardini et al., 2020). Client interactions that incorporate safety planning may offer an alternative to emergency department referrals for young people who are not at imminent risk (**if risk is imminent, please call your local crisis team – numbers supplied over page**) and can help develop strategies to cope, access support, restrict access to lethal means and increase parental/caregiver support and supervision (O'Neill et al., 2021). Most of the time managing safety at home is the best option and other resources (e.g. respite or inpatient care) can sometimes increase risk in the long-term so this needs to be carefully considered by specialist mental health services.

Safety plans can vary in content from crisis response plans to collaborative assessment and management of suicidality. The Safety Planning Intervention (SPI) tool developed by Stanley & Brown (2012) has its roots in Cognitive Behavioural Therapy for Suicide Prevention (CBT-SP) and has been recommended as best practice by the American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention. It is probably the most well-known safety tool (O'Connor, 2022). The SPI combines evidence-based suicide reduction strategies such as coping skills and problem solving, means reduction, increasing support and identifying emergency contact details of people and family who can help during a suicide crisis (Brodsky et al., 2018).

Stanley & Brown (2012) recommend using a safety plan when working face to face with a client expressing either suicidal ideation or thoughts to deliberately self-harm, initially designed for emergency departments and acute settings but with equal effectiveness in other client-facing settings, such as outpatient clinics and schools. Studies show that clients who were part of a collaborative safety plan combined with follow up phone contact and/or supportive text message (Radin et al., 2023) when presenting acutely, were half as likely to experience suicidal behavior and twice as likely to engage with mental health treatment compared to those without a safety plan (Stanley et al., 2018).

Safety planning is a collaborative, holistic and comprehensive process that involves analysis and decision-making appropriate to the young person, requiring an understanding of the client's individual, situational and social factors and how these relate to their risk (Abbott-Smith et al., 2023).

Guide to Safety Planning for Community Professionals

2. Indications

Suicidal risk fluctuates as the human body is unable to sustain intense distress for prolonged periods of time (O'Connor, 2022). If clients are given tools and skills that can help them during acute periods of distress to reduce suicidal urges, then risk is also likely to decrease. Research shows that talking about suicidal risk and safety planning with young people does not increase risk, and may even decrease distress in youth experiencing suicidal ideation (Pettit et al., 2018). Raising concern and engaging in open dialogue about risk can help increase rapport and encourage disclosure with our young people (Pettit et al., 2018).

3. Implementation with the Young Person

A **collaborative** approach is important when completing a safety plan with a young person, especially if they are difficult to engage with or feel ambivalent about their risk and treatment (Pettit et al., 2018). Aiming to build hope and reasons for living, the safety plan can be used across settings i.e. school, home, work (O'Neill et al., 2021). Make sure that your safety plan is developmentally appropriate, culturally and ethnically aware and gender specific to better engage the client and meet their needs (Abbott-Smith et al., 2023). The young person must think about each section of the safety plan and come up with effective, individualized coping strategies in their own words with support from parents/caregivers and the clinician (Pettit et al., 2018). Discuss the recent crisis and the events that triggered this so the young person can identify early warning signs and apply these to the safety plan (Pettit et al., 2018).



Safety planning process:

1. Help identify the early warning signs which lead up to the suicidal crisis. Be specific. Ascertain if an increase in emotion always leads to suicidal thoughts.
2. Young people may need prompting or examples of warning signs, coping strategies and ways to distract, but make sure they list signs and strategies that they will **use, if not, do not list**
3. List internal coping strategies that serve as distraction i.e. watching a show, listening to a particular song, sport. Explore technology-based strategies i.e. Manawa, Distract, Calm Harm.
4. List safe adults that can help the young person distract themselves from self-harm thoughts – focus on positive, helpful relationships
5. Discuss and list people who can help in a suicidal crisis (trusted adults only) include the school setting i.e. trusted teachers, counsellors, school nurses (make sure these adults are aware of their role in keeping the young person safe)
6. Write a list of professional resources the young person can contact for help i.e. local crisis team, Lifeline and the hours they can be reached
7. List ways to make their environment safe and limit access to lethal means - removing access to medications (locked box or car boot), sharps, belts. Consider psychoeducation on the disinhibiting effects of alcohol and drugs.
8. Important reasons to live or protective factors for the young person i.e. family, friends, goals

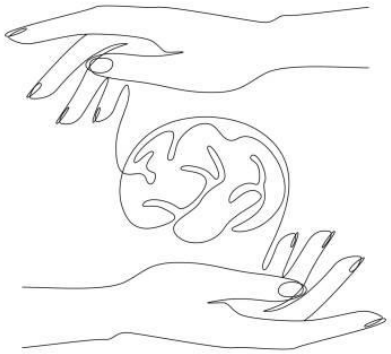
9. Inform the young person's parent/caregiver the same day as the suicidal/self-harm disclosure – parents/caregivers need to be able to keep their children safe when they leave school, GP practice or clinic

(Pettit et al., 2018; O'Neill et al., 2021; Jacups & Kozlowski, 2021; Abbott-Smith et al., 2023;

Explain to the young person that they can skip steps if necessary, going straight to trusted adults or the crisis team if their risk is imminent (Stanley & Brown, 2012).
Copies of the safety plan need to be given to the young person, their parents/caregivers and a copy kept on record. Consider the option of taking a picture of the safety plan that can be read digitally not physically, increasing access when the young person is distressed and does not want to read a paper copy of the safety plan in front of peers (O'Neill et al., 2021).
Remember that the safety plan is a 'live document' and may need to be reviewed and updated on a regular basis.
It is important to tell the young person before contacting their parent/caregivers to disclose risk, providing education as to why their parents/caregivers need to be informed (O'Neill et al., 2021). The young person may want the opportunity to be a part of this conversation, or may decide to opt out – offer the option.
Young people may need support in disclosing their risk with parents/caregivers which can include scripting the interaction prior to the meeting, helping to express their thoughts and feelings (O'Neill et al., 2021).

4. Implementation with Parents/Caregivers

Research has shown that parents/caregivers play a key role in reducing suicidal risk in adolescents and should be involved in the construction and utilization of the safety plan without minimising the autonomy of the young person (O'Connor, 2022). **In cases where parents/caregivers may <u>increase</u> the risk of the young person and there are care and protection concerns, <u>Oranga Tamariki must be informed</u>**. When safety plans are formulated collaboratively with parents/caregivers, this adds strength and support to the plan (Abbott-Smith et al., 2023). Furthermore, parents/caregivers need to be informed of their child's suicide risk and should be included in the safety planning process to ensure safe environments across settings (O'Neill et al., 2021).



Parents/caregivers have a protective role, can provide collateral and context regarding their child's current distress and can monitor and provide support outside of the school environment while taking steps to improve safety (O'Neill et al., 2021; Abbott-Smith et al., 2023) i.e. removing access to sharps and medications by purchasing a locked box. Means reduction (or restriction) is reported to be an intervention measure with the strongest empirical support as many clients tend to use the method most readily available to them (Yip et al., 2012). When a lethal planned method is unavailable, suicide attempts face a sudden obstacle and the attempt may be delayed past suicidal ideation and into re-regulation (Yip et al., 2012).
Collaboration with parents/caregivers enhances trust between schools and healthcare providers and improves communication regarding the risk profile of the young person and appropriate follow up treatment (O'Neill et al., 2021).
Tips for approaching parents/caregivers to discuss safety planning:

Guide to Safety Planning for Community Professionals

1. Introduce yourself in a safe and private place to talk
2. Explain the reason for the meeting, be direct, open and honest
3. Listen and validate their emotions and concerns and the help-seeking behaviours of their child
4. Psychoeducation regarding the benefits of safety planning, implementation and warning signs and triggers
5. Means safety i.e. keeping sharps and medications in a locked box or car boot
6. Encourage sharing and use of the safety plan – being aware of high-risk periods for their young person
7. Discuss supervision/monitoring as appropriate – it is a general rule that parents/caregivers should know where their child is at all times during an acute risk crisis
8. Develop parents/caregivers own network of support i.e. supply crisis team numbers
9. Informed consent must be obtained from parents/caregivers and the young person before referring to secondary services
10. Encourage parents/caregivers to keep communicating with their child i.e. talking in the car, regular texting to check in
11. Provide parents/caregivers with a copy of the CASA Guidelines for Providing a Safe Home (link next page)

(O'Neill et al., 2021; Abbott-Smith et al., 2023)

5. Support Contacts

Youthline 0800 376 633 or free text 234
Free text or call 1737 (24 hours)
Lifeline 0800 543 354
Marinoto Duty 0800 489 555 (during work hours)
Emergency services 111
West Auckland Crisis Team 0800 133 131 (after hours)
Rodney Crisis Team 0800 432 523 (after hours)
North Shore Crisis Team 0800 647 000 (after hours)
Central Crisis Team 0800 800 717 (after hours)
https://www.casa.org.nz/resources/public/13-guidelines-for-providing-a-safe-home/file

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Guide to Safety Planning for Community Professionals

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Guide to Safety Planning for Community Professionals

Appendix

MY SAFETY PLAN



WAYS I CAN KEEP MYSELF AND MY SPACE SAFE

SKILLS I CAN USE WHEN DISTRESSED

SAFE SPACES I CAN GO

PEOPLE I CAN ASK FOR HELP

DESIGNED BY ASHLEIGH (SOCIAL WORKER, MARINOTO WEST)

Guide to Safety Planning for Community Professionals

