

# Chapter 8

## After Screening: A Developmentally Informed Approach to Safety Planning and Stabilization



Lucas Zullo, Tamar Kodish, and Joan Asarnow

This chapter focuses on clinical interventions after a youth has been evaluated as showing signs of suicide risk. We build on evidence-based approaches for identifying youth at risk for suicide (see Mournet et al., Chap. 7, this volume) and focus on Safe Alternatives for Teens and Youths-Acute (SAFETY-A, also known as the Family Intervention for Suicide Prevention, FISP), a brief therapeutic assessment and intervention that emphasizes stability, safety, and linkage. This approach has potential for preventing unnecessary and costly hospitalizations, which have variable effectiveness compared to intensive community-based outpatient services (Giles et al., 2021; Hutcherson et al., 2021; Coyle et al., 2018; Hughes et al., 2017). Such brief interventions aim to elicit behaviors and protective factors that mitigate the risk of suicidal behavior and allow for transition to outpatient care for youth who might otherwise require extended hospitalization or acute behavioral healthcare to maintain safety.

### State of the Evidence: What Have We Learned?

Currently, there are several interventions that have shown promise for reducing suicide attempts and suicide attempt risk in randomized controlled trials (RCTs) with youth. Three interventions have shown efficacy for reducing suicide attempts in single RCTs relative to comparison conditions: Integrated Cognitive Behavior Therapy for Suicidality and Substance Abuse (Esposito-Smythers et al., 2011); the 12-week SAFETY treatment, a DBT-informed cognitive behavioral and family

---

L. Zullo (✉) · T. Kodish · J. Asarnow  
Department of Psychiatry and Biobehavioral Sciences, University of California,  
Los Angeles, CA, USA  
e-mail: [LZullo@mednet.ucla.edu](mailto:LZullo@mednet.ucla.edu); [tamarkodish@ucla.edu](mailto:tamarkodish@ucla.edu); [jasarnow@mednet.ucla.edu](mailto:jasarnow@mednet.ucla.edu)

treatment (Asarnow et al., 2017); and Dialectical Behavior Therapy (DBT, McCauley et al., 2018). DBT has also been classified as a “well-established” intervention for self-harm, inclusive of both suicidal and non-suicidal self-injurious behavior, based on evidence from three independent RCTs (Mehlum et al., 2019; McCauley et al., 2018; Santamarina-Perez et al., 2020). Five “probably efficacious” interventions for self-injurious thoughts and behaviors have also been identified. These include cognitive behavioral therapy with individual and family components, interpersonal therapy for adolescents, psychodynamic therapy with individual and family components, integrated family therapy, and parent training (for review, see Glenn et al., 2019). Additional promising suicide-specific interventions include attachment-based family therapy (Diamond et al., 2010), as well as Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) (Stanley et al., 2009) and the Collaborative Assessment and Management of Suicidality (CAMS) (Jobes et al., 2019), both of which have been tested primarily in adults. Because successful replication of benefits for reducing self-harm in youth was identified only for DBT, and there have been failures to replicate benefits, continued research to replicate and extend these findings is needed. Research is also needed to test interventions among youth from diverse backgrounds (e.g., racial and ethnic minority youth, LGBTQ+ youth, urban vs. rural, youth in foster care) to determine the degree to which treatment benefits extend to heterogeneous groups of youth presenting with suicide and self-harm risk.

Despite emerging data pointing to effective treatments for suicidality and self-harm, the majority of youth at risk for suicide do not receive care, and racial/ethnic minority youth are less likely to receive evidence-based treatments (EBTs) relative to nonminority youth (Wu et al., 2010; Asarnow & Miranda, 2014). Racial and ethnic minority youth may be particularly likely to benefit from EBTs (Ngo et al., 2009; Adrian et al., 2019), underscoring the value that integrating evidence-based suicide prevention into community care may have in reducing racial disparities in mental health. To accomplish this goal, barriers such as systematic racism and structural inequity within our healthcare systems must be addressed through policy initiatives. In addition, interventions designed to enhance continuity of care for suicidal youth should be implemented in routine care settings, and strategies that support sustainability of these programs are needed.

## **SAFETY-A**

In this section, we illustrate one promising suicide-specific care model used with adolescents with initial evidence of effectiveness. SAFETY-A is a therapeutic assessment approach which aims to achieve three primary aims: (1) provide crisis intervention for youth presenting with suicidal episodes; (2) enhance youth safety; and (3) improve linkage to follow-up care and continuity of care. Results of a two-site RCT indicate that SAFETY-A is effective in improving rates of linkage to follow-up treatment after an emergency department (ED) visit for suicidal ideation or

behavior (Asarnow et al., 2011). This is an important outcome and treatment goal, as rates of follow-up treatment are low in this population and receiving follow-up care is a necessary condition for receiving effective treatment. Of note, improving continuity of care is listed as Objective 8.4 of our National Strategy for Suicide Prevention (United States Department of Health and Human Services, 2012).

Figure 8.1 illustrates how SAFETY-A fits into a care process model for treating youth presenting with elevated risk for suicide. Following initial identification of suicide or self-harm risk, and medical clearance, SAFETY-A provides additional evaluation and brief therapeutic intervention. Initially developed for use in the ED and based on an earlier specialized ED intervention (Rotheram-Borus et al., 1996), SAFETY-A can be completed in 20–90 minutes depending on available time, allowing for adjustments based on youth and parent/caregiver response and practical considerations (Asarnow et al., 2009, 2020).

This strengths-based, developmentally nuanced approach includes five key youth tasks and three parent/caregiver (hereafter referred to as parents) tasks. These “tasks” aim to assess whether the clinician can elicit behaviors that are incompatible with suicidal thoughts and self-harm. Youth tasks include (1) identifying three strengths in the youth and family/environment; (2) understanding the youth’s emotional reactions using an “emotional thermometer”; (3) participating in safety planning in which the youth identifies skills/strategies that can be used instead of self-harm; (4) identifying a minimum of three people the youth can go to for support in staying safe (emphasizing responsible adults); and (5) making a commitment to using the safety plan instead of resorting to self-harm behavior. The clinician also provides some counseling on means restriction and the potential disinhibiting effects of substance use.

By leading with a focus on strengths, a clinician disrupts the emphasis on problem behavior and provides an opportunity for the youth to focus on content that is associated with feelings of self-worth, hopeful thoughts, and reasons for living.

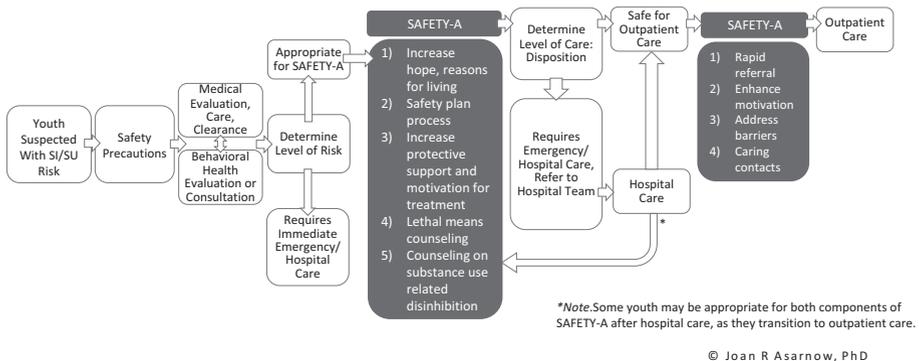


Fig. 8.1 SAFETY-A care process model

Changing the tone of crisis care in this way allows the clinician to build rapport with the youth, shift the focus to thoughts and behaviors that are incompatible with suicide/suicide attempts, and gather key information that can be used in safety planning. Conversely, if a youth is unable to identify strengths in themselves or the environment, this may be an indicator that additional evaluation and intensive support is needed prior to discharge to home or a lower level of care.

Parent tasks feature the following elements: (1) identifying three strengths in the youth and family/environment; (2) committing to and developing a plan for restricting access to dangerous self-harm methods (e.g., firearms) and increasing supportive monitoring and protective supervision; and (3) enhancing caregiver ability to support youth in using the safety plan instead of self-harm. When a parent is unavailable, parent involvement is contraindicated (e.g., abuse), and/or there are other key caregivers; this work can also include or substitute significant others in the youth's life. Safety planning should attend to the youth's current social environment (e.g., outreach to noncustodial parent and adults with whom the youth may reside).

Several promising findings have emerged using this model. After an average of 2 months, youth receiving SAFETY-A were significantly more likely to attend outpatient treatment; receive psychotherapy; and had more psychotherapy visits. However, analyses (adjusting for selection biases in receipt of treatment) did not result in benefits of linkage to community treatment as usual (Asarnow et al., 2011). While this trial did not indicate SAFETY-A led to improved clinical outcomes, the assessment approximately 2 months after hospital discharge may have been too late to detect clinical response. This is suggested by results from the earlier/first-generation ED intervention which indicated decreased suicidal ideation at an immediate post-discharge evaluation (Rotheram-Borus et al., 1996). In addition, open trial data of response to SAFETY-A in an outpatient crisis clinic indicated that after delivery of SAFETY-A, youth and parents reported significant improvements in their confidence that they could keep themselves or their children safe (Zullo et al., 2020). Significant reductions were also seen from pre- to post-intervention in youths' urges to self-harm, intent to end their lives by suicide, and level of misery/unhappiness.

Importantly, both an earlier trial with the early/first-generation version of SAFETY-A and a later trial that incorporated the emergency/SAFETY-A intervention as the first session of a more extended yet still brief follow-up treatment found reduced suicidality relative to comparison conditions (Rotheram-Borus et al., 2000; Asarnow et al., 2017). These studies support the benefits of the SAFETY-A approach for reducing suicide attempt risk when combined with a suicide-focused evidence-informed intervention. Specifically, the data support SAFETY-A is an effective first step during the transition to evidence-based programs such as DBT or longer-term treatments such as SAFETY or Integrated CBT. Moreover, SAFETY-A has some key overlap with longer-term treatments and sets the groundwork for an initial follow-up session by establishing safety through the creation of a developmentally informed safety plan. SAFETY-A complements these evidence-based modalities by targeting the critical component of safety before follow-up care is administered. Typical recommended courses of action following SAFETY-A are supporting the

rapid linkage to evidence-based care and protective action from caregivers as needed during this transition period.

## Conclusions and Policy Implications

It is critical that healthcare settings offer evidence-based suicide-specific interventions to youth at risk for suicide. In addition to outpatient treatment modalities such as DBT, CBT-SP, CAMS, and other interpersonal, dynamic, and cognitive behavioral treatments with support, brief targeted emergency department intervention can have a positive impact. SAFETY-A fills a critical gap in the clinical pathway for treating suicidal youth (Fig. 8.1). After a youth screens positive for elevated suicide risk, a brief therapeutic intervention to further assess risk and enhance safety for youth who can be safely discharged home is an important next step. Use of SAFETY-A to further assess risk and offer a brief intervention allows for improved access to evidence-based suicide prevention care, with the potential for especially large benefits for racial and ethnic minority youth who often lack access to such care (Asarnow & Miranda, 2014).

Suicide-specific care models have the potential to drive improved intervention outcomes among vulnerable youth. We highlighted how one such evidence-based approach, SAFETY-A, contributes to enhanced evaluation, safety planning, and linkage after a positive screen for suicide risk. SAFETY-A represents a critical next step as screening without effective therapeutic intervention may contribute to poor outcomes (e.g., elevated readmission and suicide rates) and increase burden on the healthcare system and families. Early results suggest integrated mental health and medical care can help reduce the financial burden of mental health problems emerging after a suicide loss (Perrin et al., 2019). Now that strong evidence-based approaches to screening have been developed (Mournet et al., Chap. 7, this volume), research and quality improvement efforts should consider how to best augment screening by increasing the availability of effective therapeutic assessments and follow-up care.

One such initiative to increase access to evidence-based care for youth suicide prevention is through the UCLA-Duke Center for Trauma-Informed Suicide, Self-Harm & Substance Abuse Treatment & Prevention ASAP Center (SAMHSA U79SM08004). Given the strong association between suicide/self-harm risk and trauma exposure, the ASAP Center advances the dissemination and implementation of evidence-based interventions for youth mental health by offering resources and trainings on trauma-informed care, SAFETY-A, and the 12-week SAFETY program and integrating effective strategies for evaluating and reducing suicide and self-harm risk in primary care, emergency, school, and other key service settings (Goldston & Asarnow, 2021). More information on the ASAP Center resources and programs can be found at <https://asapnctsn.org/>.

SAFETY-A and other promising suicide-specific intervention approaches have the potential to increase the chances that youth at risk for suicide receive care that

meets their individual needs for safety, stability, family support, and ongoing therapeutic care. Ultimately, this type of work is highly complementary of existing suicide prevention efforts. It is our hope that clinicians and policy makers will use this information to enhance suicide care in their communities and prevent premature deaths and suffering among our youth.

**Funding Details** Dr. Asarnow has received grant, research, or other support from the National Institute of Mental Health, the American Foundation for Suicide Prevention, the Substance Abuse and Mental Health Services Administration, the American Psychological Association (APA), the Society of Clinical Child and Adolescent Psychology (Division 53 of the APA), the American Psychological Foundation, and the Association for Child and Adolescent Mental Health. She has served as a consultant on quality improvement for depression and suicide/self-harm prevention and serves on the Scientific Council of the American Foundation for Suicide Prevention and the Scientific Advisory Board of the Klingenstein Third Generation Foundation. Work on this chapter was supported partly by National Institutes of Health under Award Number R01MH112147-04S1. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

## References

- Adrian, M., McCauley, E., Berk, M. S., Asarnow, J. R., Korslund, K., Avina, C., Gallop, R., & Linehan, M. M. (2019). Predictors and moderators of recurring self-harm in adolescents participating in a comparative treatment trial of psychological interventions. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *60*(10), 1123–1132. <https://doi.org/10.1111/jcpp.13099>
- Asarnow, J. R., & Miranda, J. (2014). Improving care for depression and suicide risk in adolescents: Innovative strategies for bringing treatments to community settings. *Annual Review of Clinical Psychology*, *10*, 275–303. <https://doi.org/10.1146/annurev-clinpsy-032813-153742>
- Asarnow, J. R., Berk, M. S., & Baraff, L. J. (2009). Family intervention for suicide prevention: A specialized emergency department intervention for suicidal youths. *Professional Psychology: Research and Practice*, *40*(2), 118. <https://doi.org/10.1037/a0012599>
- Asarnow, J. R., Baraff, L. J., Berk, M., Grob, C. S., Devich-Navarro, M., Suddath, R., Piacentini, J. C., Rotheram-Borus, M. J., Cohen, D., & Tang, L. (2011). An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. *Psychiatric Services (Washington, DC)*, *62*(11), 1303–1309. [https://doi.org/10.1176/ps.62.11.pss6211\\_1303](https://doi.org/10.1176/ps.62.11.pss6211_1303)
- Asarnow, J. R., Hughes, J. L., Babeva, K. N., & Sugar, C. A. (2017). Cognitive-behavioral family treatment for suicide attempt prevention: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(6), 506–514. <https://doi.org/10.1016/j.jaac.2017.03.015>
- Asarnow, J. R., Goldston, D. B., Tunno, A. M., Inscoc, A. B., & Pynoos, R. (2020). Suicide, self-harm, & traumatic stress exposure: A trauma-informed approach to the evaluation and management of suicide risk. *Evidence-Based Practice in Child & Adolescent Mental Health*. <https://doi.org/10.1080/23794925.2020.1796547>
- Coyle, T. N., Shaver, J. A., & Linehan, M. M. (2018). On the potential for iatrogenic effects of psychiatric crisis services: The example of dialectical behavior therapy for adult women with borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *86*(2), 116. <https://doi.org/10.1037/ccp0000275>

- Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 122–131. <https://doi.org/10.1016/j.jaac.2009.11.002>
- Esposito-Smythers, C., Spirito, A., Kahler, C. W., Hunt, J., & Monti, P. (2011). Treatment of co-occurring substance abuse and suicidality among adolescents: A randomized trial. *Journal of Consulting and Clinical Psychology*, 79(6), 728. <https://doi.org/10.1037/a0026074>
- Giles, L., Shepard, L., Asarnow, J., & Keeshin, B. R. (2021). Implementation of a trauma-informed suicide prevention intervention for youth presenting to the emergency department in crisis. *Evidence-Based Practice in Child and Adolescent Mental Health*, 6(3), 343–353. <https://doi.org/10.1080/23794925.2021.1961643>
- Glenn, C. R., Esposito, E. C., Porter, A. C., & Robinson, D. J. (2019). Evidence base update of psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child & Adolescent Psychology*, 48(3), 357–392. <https://doi.org/10.1080/15374416.2019.1591281>
- Goldston, D. B., & Asarnow, J. R. (2021). Quality improvement for acute trauma-informed suicide prevention care: introduction to special issue. *Evidence-Based Practice in Child and Adolescent Mental Health*, 6, 303–306. <https://doi.org/10.1080/23794925.2021.1961645>
- Hughes, J. L., Anderson, N. L., Wiblin, J. L., & Asarnow, J. R. (2017). Predictors and outcomes of psychiatric hospitalization in youth presenting to the emergency department with suicidality. *Suicide and Life-threatening Behavior*, 47(2), 193–204. <https://doi.org/10.1111/sltb.12271>
- Hutcherson, K., Kennard, B. D., Michaels, M., & Miles, J. (2021). Adapting the safety-acute intervention to improve quality of care for suicidal youth in emergency rooms and medical floors. *Evidence-Based Practice in Child and Adolescent Mental Health*, 6(3), 369–378. <https://doi.org/10.1080/23794925.2021.1975516>
- Jobes, D. A., Vergara, G. A., Lanzillo, E. C., & Ridge-Anderson, A. (2019). The potential use of CAMS for suicidal youth: Building on epidemiology and clinical interventions. *Children's Health Care*, 48(4), 444–468. <https://doi.org/10.1080/02739615.2019.1630279>
- McCauley, E., Berk, M. S., Asarnow, J. R., Adrian, M., Cohen, J., Korslund, K., Avina, C., Hughes, J., Hamed, M., Gallop, R., & Linehan, M. M. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 75(8), 777–785. <https://doi.org/10.1001/jamapsychiatry.2018.1109>
- Mehlum, L., Ramleth, R. K., Tørmoen, A. J., Haga, E., Diep, L. M., Stanley, B. H., Miller, A. L., Larsson, B., Sund, A. M., & Grøholt, B. (2019). Long term effectiveness of dialectical behavior therapy versus enhanced usual care for adolescents with self-harming and suicidal behavior. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 60(10), 1112–1122. <https://doi.org/10.1111/jcpp.13077>
- Ngo, V. K., Asarnow, J. R., Lange, J., Jaycox, L. H., Rea, M. M., Landon, C., Tang, L., & Miranda, J. (2009). Outcomes for youths from racial-ethnic minority groups in a quality improvement intervention for depression treatment. *Psychiatric Services (Washington, DC)*, 60(10), 1357–1364. <https://doi.org/10.1176/ps.2009.60.10.1357>
- Perrin, J. M., Asarnow, J. R., Stancin, T., Melek, S. P., & Fritz, G. K. (2019). Mental health conditions and health care payments for children with chronic medical conditions. *Academic Pediatrics*, 19(1), 44–50. <https://doi.org/10.1016/j.acap.2018.10.001>
- Rotheram-Borus, M. J., Piacentini, J., Van Rossem, R., Graae, F., Cantwell, C., Castro-Blanco, D., Miller, S., & Feldman, J. (1996). Enhancing treatment adherence with a specialized emergency room program for adolescent suicide attempters. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(5), 654–663. <https://doi.org/10.1097/00004583-199605000-00021>
- Rotheram-Borus, M. J., Piacentini, J., Cantwell, C., Belin, T. R., & Song, J. (2000). The 18-month impact of an emergency room intervention for adolescent female suicide attempters. *Journal of Consulting and Clinical Psychology*, 68(6), 1081. <https://doi.org/10.1037/0022-006X.68.6.1081>
- Santamarina-Perez, P., Mendez, I., Singh, M. K., Berk, M., Picado, M., Font, E., Moreno, E., Martínez, E., Morer, A., Borràs, R., Cosi, A., & Romero, S. (2020). Adapted dialectical behav-

- ior therapy for adolescents with a high risk of suicide in a community clinic: A pragmatic randomized controlled trial. *Suicide & Life-Threatening Behavior*, 50(3), 652–667. <https://doi.org/10.1111/sltb.12612>
- Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B. D., Wagner, A., Cwik, M. F., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): Treatment model, feasibility, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48(10), 1005–1013. <https://doi.org/10.1097/CHI.0b013e3181b5dbfe>
- United States Department of Health and Human Services. (2012). *2012 National Strategy for suicide prevention: Goals and objectives for action*. United States Department of Health and Human Services.
- Wu, P., Katic, B. J., Liu, X., Fan, B., & Fuller, C. J. (2010). Mental health service use among suicidal adolescents: Findings from a US national community survey. *Psychiatric Services*, 61(1), 17–24. <https://doi.org/10.1176/ps.2010.61.1.17>
- Zullo, L., Meza, J. I., Rolon-Arroyo, B., Vargas, S., Venables, C., Miranda, J., & Asarnow, J. R. (2020). Enhancing safety: Acute and short-term treatment strategies for youths presenting with suicidality and self-harm. *The Behavior Therapist*, 43(8), 300–304.

**Open Access** This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.

