Chapter 9
Safety Planning and Lethal Means Counseling with Youth

Maureen F. Monahan and Barbara Stanley

There is a growing body of research to suggest that most suicidal crises (i.e., the period of time in which someone seriously contemplates killing themselves) are relatively brief. Close to 50% of youth aged 11–15 who died by suicide had no evidence of pre-planning (Holland et al., 2017), and 24% of those aged 13–34 made a near lethal attempt after 5 min of deliberation (Simon et al., 2001). Given that many youth contemplate suicide for a short period of time, targeted interventions during these periods may avert suicide attempts. In particular, having limited access to lethal means and effective methods of distracting from suicidal thoughts and urges play a key role in youth suicide prevention.

One way to thwart suicidal behaviors and allow suicidal crises to dissipate is through the use of a safety plan (SP; Stanley & Brown, 2012; Stanley et al., 2018). SPs are individualized lists of factors that indicate heightened risk of suicide (i.e., warning signs) and ways to prevent the person from engaging in suicidal behaviors. These plans are tailored to individuals at risk and highlight their preferred internal coping strategies, external distractors (i.e., persons and social settings), and contact information for supportive family members, friends, and mental health professionals that can assist during a crisis. Arguably, the most critical component of an SP is lethal means counseling (LMC), the final step in the Stanley-Brown Safety Planning Intervention (Stanley & Brown, 2012), which has been adopted in many healthcare and community settings. LMC involves working directly with individuals at risk for suicide to limit access to lethal methods (e.g., locking pills in a cabinet) until the risk of suicide has diminished substantially. LMC may be especially important for youth living in homes where firearms are present. Studies have documented that youth who live in homes with firearms have up to a fivefold increased risk of

M. F. Monahan (✉) · B. Stanley
New York State Psychiatric Institute, New York, NY, USA

Department of Psychiatry, Columbia University Irving Medical Center, New York, NY, USA
e-mail: Maureen.Monahan@nyspi.columbia.edu; Barbara.Stanley@nyspi.columbia.edu

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suicide, even if they are not the owner of the firearm (for a review see Barber & Miller, 2014). This risk can diminish by 30–50% when firearm access is limited (e.g., temporary removal of firearms from the home, utilizing gun locks), and research suggests limiting access to other lethal means can help further decrease the overall risk of suicide (Barber & Miller, 2014). Thus, LMC in addition to safety planning can have a profound impact on preventing youth suicide.

Safety Planning/Lethal Means Counseling with Youth

An important distinction between youth- and adult-focused suicide-specific treatments (D'Anci et al., 2019) is the emphasis on family involvement, particularly through providing psychoeducation and enhancing family communication and connection. Promising youth treatments that incorporate families include As Safe as Possible (ASAP; Kennard et al., 2018), Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP; Stanley et al., 2009), the Treatment of Adolescent Suicide Attempters (TASA; Brent et al., 2009), the SAFETY Program (Asarnow et al., 2017), and a specialized emergency room (ER) care intervention (Rotheram-Borus et al., 2000). Family support is a critical component of many successful youth interventions and is also used in the current stand-alone SP interventions for this age group.

Previous work suggests that lethal means interventions that emphasize psychoeducation for parents can significantly increase the likelihood of limiting their child's access to household lethal means (Barber & Miller, 2014). More recent studies have documented positive relationships between SP interventions that involve families and increased outpatient treatment adherence (Asarnow et al., 2011), SP use and means safety behaviors (Hill et al., 2020), and self-efficacy in implementing coping strategies to refrain from suicidal behavior (Czyz et al., 2019). As such, family involvement is likely an important component of youth SP/LMC. Clinical considerations for incorporating families in treatment, as well as other recommendations for engaging in SP/LMC with youth, are discussed below.

Important Considerations for SP/LMC with Youth Clients

Developing an SP with youth clients should always involve a caregiver, either during the development of the plan or after the plan has been created. In either case, caregivers should be provided with copies of their child's SP. This collaboration can increase caregiver self-efficacy in helping youth manage crises and identifying when immediate, emergency care is needed. With caregiver involvement playing a significant role in maintaining safety over time, it is equally as important that youth consent/assent is obtained, and youth are made aware their SP will be shared with

their caregivers. Safety planning is built on a foundation of trust between the client and mental health provider. Failing to disclose parent involvement and limitations of confidentiality generally could be perceived as a betrayal of trust with negative implications for treatment adherence and outcomes.

The next set of recommendations relate to the school environment. Similar to working with caregivers, providers should strongly consider communicating with the youth's school regarding their SP and make note of any special accommodations that may be warranted (e.g., unrestricted access to guidance counselors, permission to step out of classroom to use coping skills when highly distressed). Providers should obtain youth consent/assent, make youth clients aware of what will be discussed with the school, and carefully follow each school's unique consenting procedures. Another important consideration is that youth may have different internal coping strategies at school versus at home or outside of school, based on availability of resources and the degree to which each skill can be used covertly (Hill et al., 2020; e.g., deep breathing versus singing aloud versus taking a cold shower). Providers and youth clients may want to develop separate SPs for home and school or create distinct categories for each setting in one comprehensive SP.

It is also important to be aware of how youth's developmental stage may differentially impact the safety planning process. Most youth do not initiate therapy on their own (Stiffman et al., 2004) and may feel a lack of autonomy related to being in treatment in the first place. Without initial buy-in, youth may be less likely to fully engage in therapy, which could negatively impact their likelihood of developing a meaningful SP or disclosing thoughts of suicide. Developmental considerations are especially relevant with respect to counseling on lethal means. SPs should be developed as collaboratively as possible so that the youth feel empowered to have an active role in creating a safe environment rather than restricted. If approached in a prescriptive or rigid manner, clients can interpret a discussion on limiting their access to lethal means as a violation of their rights or a form of punishment. Mental health providers may decide to devote extra time toward reframing this process as a way for the individual to help keep themselves safe, as opposed to a way to restrict their independence.

Fostering the youth's autonomy in this process should be carefully balanced with the overarching goal of keeping them safe. This balance may be more salient when generating lists of internal coping strategies and external supports (Hill et al., 2020). When compared to adults, youth may have less life experience and often a smaller repertoire of coping skills. Thus, providers may have to offer a range of suggestions and teach adaptive coping strategies that will be effective in a time of crisis. In addition, providers should keep in mind the changing peer relationships and perceptions of closeness inherent in adolescence (Marsh et al., 2006). Only adult contacts should be listed as people the youth can turn to for help in a crisis. Trusted peers may only be listed as people who can help *distract* them from suicidal thoughts.

Finally, given the facility youth have with electronic media and its ubiquity, providers should consider utilizing mHealth (mobile health) applications, such as the Stanley-Brown Safety Plan© app (Two Penguins Studios LLC, 2013) or the MY3

app (Mental Health Association of New York City Inc, 2013), in addition to paper copies of the SP. An added benefit of mobile applications is that they are more readily accessible through the youth's phone, as opposed to a paper version which may be more inconvenient or susceptible to being misplaced. It is important to note that these recommendations for youth SP are largely based on clinical judgment and experience as opposed to specific empirical findings. There is a pressing need for research to address the gaps in youth SP.

Future Directions for Research and Policy

Some gaps are methodological and others technological. There is a striking need for studies with rigorous designs (e.g., longitudinal, randomized controlled trials) to assess the effect of youth SP/LMC on key outcomes (e.g., suicidal ideation, attempts, suicides). Along these same lines, future work should investigate the active elements of SP on treatment outcomes to generate a clearer picture of which steps are critical for preventing youth suicide. The field would also benefit from greater development and testing of mHealth or web-based SP interventions for youth. Areas for further study include mobile app push notifications that prompt users to practice coping strategies and reinforcement after successful SP app use to increase the likelihood of using SP strategies in the future. Studying how mobile technologies can increase SP/LMC use is especially relevant in light of the world's growing reliance on technology.

While continued research in these areas is important, SP/LMC practices must also be adopted in real-world settings to effect meaningful change. We are highlighting a call to action to allocate more funding, training, and resources for large-scale implementation and dissemination of SP/LMC across youth educational institutions. Training more school counselors in these brief and effective interventions could have a major impact on youth suicide. Unfortunately, youth at risk often do not get referred for specialized care as suicide risk is complex and sometimes difficult to recognize. Therefore, this initiative would be most effective if, in addition to training school counselors in SP/LMC, training in suicide risk screening was broadly disseminated to school staff and community members (e.g., teachers, administrators, coaches, mentors, etc.). These parallel initiatives could facilitate more referrals to school counselors trained in SP/LMC in the hopes of reducing youth suicide.

Lastly, attention should be paid to care transitions. Youth are at a significantly heightened risk of suicide when transitioning between levels of care (e.g., inpatient unit to outpatient treatment; Fontanella et al., 2020). While SPs can aid in reducing risk during this time, more research and policy work should focus on how healthcare and education systems can work together to make care transitions as safe and seamless as possible.

Conclusion

Research has identified how limiting access to lethal means greatly reduces suicide among adults, yet there is much to learn about SP/LMC with youth clients. Based on what is known regarding current best practices, providers should center SP adaptations around family involvement and strongly consider working with youths' schools to maximize SP efficacy. Providers must also pay careful attention to issues of consent and confidentiality, ensuring that youth are aware of what information will be shared and with whom. Further, providers may decide to devote extra time toward generating buy-in and maintaining a collaborative stance throughout the SP/LMC process. Policy work should focus on care transitions, implementation of SP/LMC in schools, broad dissemination of suicide risk screening in communities, and technological advancement of SP/LMC.

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