RISK ASSESSMENT and SAFETY PLANNING

Sarah Lack and Helen Kennerley November 2024

As healthcare workers we are responsible for safeguarding our patients, their families and their carers from harm. This responsibility extends to a duty to protect the general public from harm if we judge that our patient is a likely risk to others. Therefore, there may be times when we are required to breach confidentiality when it comes to such safety concerns and this must be explained to all patients at the outset of therapy, in a respectful, non-threatening manner. When explaining these limits to confidentiality, you might state something like this:

> *Although everything you tell me during therapy is confidential between you, me and my supervisor, there are limits to this confidentiality. I am obliged to act if I believe you or anyone else is at risk of harm. After all, your safety and the safety of those around you is a priority. Therefore, if I am really concerned that you are at risk of serious harm to yourself, to someone else, from someone else, or if a child or a vulnerable adult is at risk of harm I will need to alert other professionals. I will always discuss this with you first, if possible. How does that sound to you?*

This guide focuses on the assessment of risk to self and risk to family or carers. Risk assessment and monitoring is an integral part of all psychological therapy, but recent NICE guidance has recommended that we do not use risk assessment tools and scales to predict future suicide or repetition of self-harm (2022). Instead, we are advised to include risk assessment and safety planning within our overall assessment and formulations, so risk can be managed dynamically and flexibly. This makes good sense and fits with the ethos of good CBT.

Managing suicidal feelings

Whilst we will always be patient-centred in our approach to risk assessment, there are some known factors associated with increased suicide that it is prudent to include in our assessments and formulations:

A history of self-harm and/or suicidality as risk can remain elevated several years after a suicide attempt and those who initially engage in non-lethal self-harm do have increased likelihood of attempting suicide later. A history of violent suicide attempts (e.g. hanging or shooting) carries greater risk for reattempting.
Being male, particularly between the ages of 45-54 and over 90 years old, (although we should still take suicide risk seriously in women e.g. the risk of suicide increases for women during pregnancy and until the first year after birth.)
The presence of suicidal prospective imagery or suicidal 'flashforwards'. The more detailed the imagery or the more the imagery is associated with relief and positive feeling, the higher the risk

Adverse life experiences, such as developmental trauma, unemployment, financial pressures, debt, abuse, entrapment (e.g. the peri and post-natal period increases risk of suicide in women.)
Poor social network, lack of a confidant, or relationships stresses
Minority stress – being in a minoritised and disadvantaged group (LGBTQ+, BAME, neurodiverse) can mean exposure to hostility, social exclusion or continuous disadvantage which are harmful to mental health
Mental health problems such as depression, anxiety, PTSD, major loss, severe mental health problems. In particular *hopelessness* is a factor in predicting suicidality.
Disability and/or physical illness, especially if associated with long term pain, functional impairment, poor sleeping, poor eating. This is particularly relevant in the older population.
Impulsivity - such as is associated with some psychiatric, neurodiverse and personality-related conditions, or with drug or alcohol misuse
Working in an occupation which increases access to means of dying by suicide (doctors, vets, farmers) or having relatively easy access to the means of suicide, such as a those who can take medication prescribed to a family member or close friend
Suicide in the family or personal network or in the media (high profile role models) – 'contagion' effect
Addictive behaviours that impact on relational, social, occupational and financial stress (e.g. gambling, pornography, binge-eating etc)

Although all these factors can be routinely enquired about during our CBT assessments and formulations, it is also important to:

- Note any compounding effect of multiple risk factors in one individual
- Monitor suicidality throughout treatment and especially in the aftermath of critical events or new risk factors.

It might be understandable why someone feels hopeless or entrapped if they experience a number of the identified risk factors, and it might be tempting to stop the formulation at this point. However, practitioners need to recognise that beliefs reflect a perception not a fact. Therefore, a good risk formulation will go beyond a negative automatic thought or underlying assumption to establish its accuracy. It will identify predisposing, precipitating, perpetuating and protective factors, and consider how these interact to create risk. It will identify the causes underlying the distress, the triggers to and function of suicidal feelings.

The following are the important themes to ask about in all risk assessments:

- The presence of hopelessness or entrapment, which in cognitive terms is the belief that a situation is bleak and will remain so for the foreseeable future.
  What are their beliefs about the future and to what extent do their circumstances and/or symptoms impact these?
  What are their assumptions about their ability to cope?
  What are the indications that there is hope and that they can cope?

- The presence of suicidal ideas, how often these happen, and how long they last for.
  What is the quality of these thoughts how detailed are they?
  Are "permission-giving" thoughts present?
  What is the quality of the thoughts – are they images, and if so, how detailed?
  What is the quality of the thoughts – are they psychotic?
  What is the predicted outcome in terms of a suicide attempt?
  What is the meaning of a successful suicide: escape, guilt, relief, reunion with loved ones?
  How strong is the urge right now?
  What has happened since these thoughts began?
  What has stopped the person from acting on these so far?

- Previous history of suicidal behaviour.
  How many attempts has the person made and at what frequency?
  What was the means of killing themself?
  Was their most recent attempt carefully planned or impulsive?
  Was 'rescue' anticipated or likely?
  Did the person believe they would die?

- Expressions of intent (direct and indirect).
  How did they communicate their needs and intentions?
  To what effect?

- Suicide plans, along with access to means, and the potential lethality of means.
  How long has the person had plans?
  How often does the person think about them?
  Have they written suicide letters / e-mails?
  Has the person made a special effort to find information about methods of suicide or knowledge about means?

- Recent discharge from psychiatric or inpatient facility.

- Behaviours which reduce inhibitions or increase impulsivity, such as using drugs and alcohol.

- Recent interpersonal crisis; major loss; chronic stress or stressful events.

- More recent focus on online influences, which can signal withdrawal or the researching of methods.

- Suicide plans, along with access to means, and the potential lethality of means.
  What help do they think is available / accessible?
  What gets in the way of them seeking help?

- The safety of others in the patient's system especially those who may be under the care of the patient (children or vulnerable adults)
  Have the person's thoughts ever included harming others?
  Is there risk of murder-suicide?

Are the children safe? Are others in the person's system safe?

- Coping potential and protective factors
  Does the person have capacity for a therapeutic relationship?
  How have they managed previous life events and stressors? What problem-solving strategies are they open to?
  Are there social or community supports? Can the person access them and engage with them?
  Can they bring to mind reasons for living?

Biases

It is also important to be alert to your own potential biases about suicidality or biases held by other professionals in the multi-disciplinary team or wider agency system, as these could lead to blind spots and missed opportunities to instigate crisis support or safeguarding. Here is a table of recognised societal myths about suicide, each presented beside a more realistic perspective.

Myths about suicide	**The reality**
Those who talk about suicide are not at risk	All expressions about suicide must be taken seriously
Only depressed or mentally unwell people are suicidal	Many are unknown to services and a person without mental health problems can be suicidal.
Suicide comes without warning	There are usually verbal and behavioural signs
Asking about suicide puts the idea in their head	It will not, but it can be a relief for people to talk
Suicidal people want to die	Most want to escape intolerable distress
If someone is suicidal, they remain this way	Many recover – formulation driven interventions help them see a way forward.
Suicidality is inherited	Family history increases risk, but it is treatable
Suicidal behaviour is attention seeking	Take all attempts seriously: often attention seeking is with good reason
Suicide is caused by a single factor	There are usually a number of 'perfect storm' factors
Suicide cannot be prevented	It can be interrupted, but needs clinical sensitivity
Suicide is about social class	It affects all social classes, but poverty is a risk factor
Improved emotional state means reduced risk	Seeming calmer may mean suicide decision is made
Suicidal ideation is rare	It is very common indeed
Low lethality attempts mean lower risk	Not necessarily: understand intent and impulsivity

Safety planning

Adopting a compassionate and collaborative stance when co-designing safety plans with your patients is a crucial part of any therapy agreement and of course, this is the stance you adopt anyway as a CBT psychotherapist. Use of Socratic Dialogue will help you personalise a patient's safety plan, but you will need to be more direct in your questioning and more didactic in your instruction than is usually the case in CBT. The safety plan is an action plan, a 'go to' list of prompts and actions for the patient if or when they notice

thoughts of not wanting to be here, urges to self-harm or thoughts of suicide. If your patient currently self-harms as a way of managing their strong emotions the safety plan is often the last resort because as part of your therapy, or therapy they may be receiving from someone else in the care team, they will be learning how to reduce self-harm and develop alternative strategies for regulating their emotions. Remember, those who self-harm without lethal intent carry an elevated risk of committing suicide.

The safety plan is a written or typed document that the patient has in their possession, designed to:
- delay and disrupt the urge to self-harm or act on suicidal thoughts
- distract the patient from suicidal rumination and thought biases
- identify and modify hopeless thoughts
- remind the patient of, and refocus them on their main reasons for living and reasons to feel hopeful
- provide an accessible list of people and numbers to call (both their social network and statutory services)
- can include a 'crisis kit / self-soothing kit' and plans to reduce access to means of self-harm and suicide.

When introducing safety planning you might state something like this:

> *Let's work together on a plan to help you keep safe. It's up to you if you use it. But it is a way of interrupting distressing times, and helping you find a route to help. Then if you feel you need extra help, you can use your plan as a reminder of things that can be useful to try, people to contact who you know in your personal life, and also professional support or helplines. Let's write things down together and then let's think about where your plan needs to live, so you can access it easily when needed, and also who in your care network needs to know about it.*

Example safety plan template

PERSONAL SAFETY PLAN
1. Warning signs that I need to use my safety plan:
2. Coping strategies that have helped before (things I can do on my own to take care of myself):
3. When the urge to act on hopeless and suicidal thoughts is strong, delay acting on them for 30 minutes. In this 30 minutes I will … *(list of what to do starting with the easiest):*
4. People, places or things that are important to me:
5. People I can contact in my personal network:
6. Services I can contact: (9-5 pm) 7. Services I can contact out of hours:

As therapy progresses, it is important to review and update the safety plan, and when it is put to use, it is crucial that the experience is reviewed or de-briefed. Relapse management is an essential skill for anyone who has had suicidal feelings, and the de-brief presents an opportunity to revise and develop relapse management skills. This means formulating why the suicidal urge was understandable, reviewing what the person has learnt from coping in this situation and using this to refine future coping plans.

Keeping others safe

Safeguarding children and vulnerable adults

During therapy your patient may share information with you which leads you to feel concerned about the current safety of someone in their care or someone they know. Agencies and services should work together to ensure children, vulnerable adults and other members of the public are safeguarded and their welfare is promoted. This includes ensuring relevant clinical information is shared effectively to facilitate accurate and timely decision making, and that a culture of learning and reflection is promoted. In the event that you need to instigate other agencies to follow up safeguarding concerns, it is important to work alongside the patient as much as possible. Be open and honest about your concerns unless you believe this increases the risk.

Another cause for concern may be an inadvertent consequence of your therapy on the patient's attitudes or behaviours. For example, whilst supporting a patient to learn assertiveness skills, always consider the impact this might have on their system. Will being assertive change domestic dynamics and put them or their children at risk of harm? Could learning how to prioritise their own needs lead to the neglect of others, especially if the patient cares for children or vulnerable adults?

Referrals to children's social care

If you believe a referral to children's social care is required, you must follow the procedures required by your employer and/or professional body. Do make sure that you are aware of these. Depending on the urgency of the case, and before contacting children's social care, you need to:

- Be clear about why you think the concerns have reached the threshold and what the risk factors are.
- Discuss the concern with colleagues / your supervisor for their perspectives and additional information.
- Use any toolkits provided by your workplace to assist you in your judgement – this may include contacting your local safeguarding team for advice and guidance.
- Look at the records regarding the family, to check for any prior concerns or attempts made by your organisation to address them.
- Discuss your concerns with your patient, unless you believe that to do so would endanger the child or children, or someone else - for example, if your concern relates to domestic abuse in the home.

Safeguarding adults at risk

Those who were previously referred to as 'vulnerable adults' in safeguarding terms are now commonly referred to as Adults at risk, Adults with care and support need, or Adults in need.

If you are concerned about an adult at risk (who may be your patient or may be someone else in your patient's system) speak to the designated person in your organisation who handles safeguarding queries. If you are an independent practitioner, then seek professional supervision and guidance. Even if your concerns are not proven, it is important that you raise your concern.

Keeping yourself safe

Therapists can be at risk of harm from patients. This can be direct (from physical or verbal attack or harassment) or indirect (from stress or vicarious trauma). It is crucial that therapists work in settings that maximise staff security, take regular supervision that can include staff review, and have access to necessary support so that their well-being is protected.

Further resources

https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self

Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Domestic-Abuse-and-Suicide.pdf (refuge.org.uk)

NHS England » Safeguarding children, young people and adults at risk in the NHS

Assessment of Suicide Risk in Mental Health Practice - Shifting from Prediction to Therapeutic Assessment, Formulation and Risk Management. Keith Hawton & Karen Lascelles: https://youtu.be/XNSF0QFdcSY?si=aP2eu2_GSEQYkWye