

## A Safety and Coping Planning Intervention for Suicidal Adolescents in Acute Psychiatric Care

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*Transitioning from an acute psychiatric care setting to a less restrictive environment after a suicidal event is arguably the most critical period of suicide risk for adolescents, making comprehensive safety and coping plans for this population ever more critical. In this paper we provide theoretical and empirical rationale for the need for developmental adaptations to current safety planning procedures for suicidal adolescents, as well as the standardization of pediatric safety plans for broader use across settings that provide acute psychiatric care to adolescents. We describe how we developed the Adolescent Safety and Coping Plan (ASCP) using qualitative in-depth interviews with 20 adolescents and their parents, explain the specific components of the ASCP, and give a case example of the ASCP being used with a young adolescent and her parents. Finally, we conclude with a discussion of the barriers and facilitators of the use of the ASCP in settings that provide acute psychiatric care, as well as the need for future research to test the ASCP with diverse adolescent and family populations and settings.*

SUICIDE is an increasingly serious public health problem in the United States (U.S.) and the current rate is higher than it has been in decades. From 1999 through 2017, the age-adjusted suicide rate increased by 33% from 10.5 to 14.0 per 100,000, and in 2016, suicide became the second leading cause of death among 15- to 24-year-olds (Hedegaard, Curtin, & Warner, 2018). The age adjusted rate in this age group increased by 10% among boys (20.5 to 22.7) and 7.4% among girls (5.4 to 5.8) from 2016 to 2017 (Hedegaard et al., 2018). Additionally, nationally representative data from 2017 showed that 7.4% of U.S. high school students attempted suicide one or more times in the previous 12 months, and 2.4% reported that their suicide attempt resulted in an injury that required treatment by a doctor or nurse (Kann et al., 2018).

The number of adolescents presenting to an emergency department (ED) for suicide ideation or a suicide attempt doubled from 2007 to 2015, suggesting the critical need for post-ED risk reduction initiatives (Burstein, Agostino, &

Greenfield, 2019). Many suicidal adolescents who are seen in an ED are then psychiatrically hospitalized for a brief period of time for safety and containment. This transition from an acute psychiatric care setting (e.g., ED or inpatient psychiatric unit) to a less restrictive environment after a suicidal event is arguably the most critical period of suicide risk for adolescents (Hunt et al., 2009; Knesper, 2011; Spirito & Esposito-Smythers, 2006), especially in the 3 months after discharge (Chung et al., 2017). Despite elevated risk of repeated suicide attempts and death by suicide after discharge from settings that provide acute psychiatric care (Groholt, Ekeberg, & Haldorsen, 2006; Knesper, 2011), few interventions have been designed specifically for use during this high-risk period (Knesper, 2011).

An emerging body of research has bolstered the evidence base for safety planning with individuals in a suicidal crisis. The Safety Planning Intervention (SPI; Stanley & Brown, 2012) is one such intervention designed for use with adults, which now has an adapted version for veterans (Knox et al., 2011; Stanley & Brown, 2012). The SPI is created collaboratively by the patient and clinician and typically consists of written strategies and sources of support that the patient can use when they are experiencing a suicidal crisis and includes six core steps: (1) recognize warning signs of crisis, (2) utilize coping strategies, (3) contact social supports, (4) enlist family

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members/adult figures to help, (5) contact mental health providers, and (6) remove lethal means (Stanley & Brown, 2012). Because suicidal thoughts fluctuate considerably among adolescents recently discharged from acute psychiatric care (Czyz, Horwitz, Arango, & King, 2018) and because the crisis that precedes a suicide attempt is normally short-lived, a brief intervention, such as the SPI, that targets the ability to cope with such crises may be especially useful in reducing the likelihood of future suicidal events (Stanley & Brown, 2012).

Adolescent suicidal behaviors are distinct from those of adults, suggesting the two age groups have different needs with respect to safety planning. Adolescent suicidal behaviors tend to be more impulsive and less lethal than those of adults (Parellada et al., 2008), suggesting a critical emphasis on means safety as well as specific coping skills for in-the-moment crises. Adolescents also appear to be at greater risk for suicide due to media and social media exposure than adults (Shain, 2016), suggesting that it be addressed within the context of safety planning procedures. In addition, the inclusion of trusted adults is only considered as one component of safety planning with adults (Stanley & Brown, 2012), but the involvement of parents (and/or guardians) is paramount with adolescents (Pettit, Buitron, & Green, 2018). In order for means safety to be comprehensively addressed, and for adolescents to feel fully supported, trusted adults must be an active part of the safety planning process.

Discharge from acute psychiatric care settings is an ideal time and place to implement such a safety planning intervention for adolescents, as their parents (and/or guardians) are present and can be collaboratively incorporated into the intervention as a source of support and accountability in future suicidal crises (Stanley et al., 2018). Although safety planning has been used routinely with adolescents in clinical settings and research protocols (e.g., Wolff et al., 2018), safety and coping plans have not been standardized for use as independent interventions with high-risk adolescents. For instance, Wolff et al. (2018) included a safety plan module in their intervention study, which consisted of the following components: a list of dangerous items to remove from their surroundings (e.g., alcohol, knives, razors, medications) to reduce access to means, warning signs and vulnerabilities that indicated they may become unsafe, coping strategies, and people that could help them manage negative feelings.

To our knowledge, no studies have used qualitative research methods with adolescents who have attempted suicide and their parents to inform developmental adaptations to current safety planning procedures. Because safety planning was initially developed to address the needs of the general population of adults, it does not focus on adolescents' unique risks and the critical role of parents in establishing and maintaining the safety of

suicidal adolescents. However, to prevent subsequent suicidal events among adolescents, it is important that safety planning interventions are developmentally appropriate and incorporate parents so that they can understand their role in keeping their suicidal adolescent safe upon discharge. Given the essential role of parents in the effectiveness of interventions with suicidal adolescents (Asarnow et al., 2015; Diamond et al., 2013; Hughes & Asarnow, 2013; Wells & Heilbron, 2012), it is critical that safety planning interventions with suicidal adolescents are family-focused. The aim of this study was to conduct qualitative interviews with suicidal adolescents and their parents to inform the development of a safety and coping plan that can be used after discharge from an acute psychiatric care setting.

## Adolescent Safety and Coping Plan

### Developmental Design

The need to incorporate adolescent and parent feedback into the suicidal adolescent's safety plan in a feasible and acceptable way is essential, as it facilitates improved communication and safety planning for the family as a unit, especially at the critical time of discharge from EDs and inpatient psychiatric units. To inform the development of the Adolescent Safety and Coping Plan (ASCP), we conducted qualitative in-depth interviews with 20 adolescents who were psychiatrically hospitalized following a suicide attempt, and their 20 parents (or guardians) separately, in a study approved by our hospital's Institutional Review Board. We conducted 45-minute semistructured, in-depth interviews with adolescents and parents separately to obtain their feedback on current standardized safety planning procedures for adults (i.e., SPI) and how they could be improved to best meet the needs of suicidal adolescents and their parents. We used purposive sampling to recruit 20 adolescent participants from the inpatient psychiatric unit of a general pediatric hospital in the northeast United States. To be eligible for the study, adolescent participants had to be between the ages of 13 to 17, and psychiatrically hospitalized following a suicide attempt. We obtained parental consent and adolescent assent prior to participation.

### Sample

All 20 adolescents ( $M = 14.4$  years of age) were interviewed within 2 weeks of a suicide attempt. Adolescent participants identified their gender as female ( $n = 15$ ), male ( $n = 3$ ), or transgender ( $n = 2$ ), and sexual orientation as heterosexual (70%), bisexual (20%), homosexual (5%), and declined to state (5%). The racial composition of the sample (participants could make multiple selections) was White (60%), Asian (20%), Black/African American

(15%), American Indian/Alaska Native (5%), Native Hawaiian or Pacific Islander (5%), and other (15%), and 15% of participants reported their ethnicity as Hispanic/Latino. Parent (or guardian) participants ( $M = 46.5$  years of age) identified their gender as female ( $n = 13$ ), male ( $n = 1$ ), or transgender FTM ( $n = 1$ ) and sexual orientation as heterosexual (100%). The racial composition of the parents/guardians (participants could make multiple selections) was White (73%), Asian (7%), Black/African American (13%), American Indian/Alaska Native (7%), and other (7%); no parent participants reported their ethnicity as Hispanic/Latino.

## Methods

All interviews were conducted with the adolescents and parents separately in a private room on the inpatient psychiatric unit, and were conducted by either the principal investigator (KO), a licensed social worker with a PhD, or co-investigator (JA), a licensed social worker and doctoral student. For consistency across interviews, we requested that only one parent participate. In cases where two or more parents were interested in participating, we had the family (including the adolescent) decide on one parent to be the participant. Each participant received a \$20 gift card for completion of the interview. All of the interviews were audio-recorded. To prepare for analysis, the interviews were transcribed and cleaned for confirmation of content and de-identification. Transcripts were double-coded, and data were analyzed with NVivo 11 software. To gather information to inform the development of the ASCP, we had the participants thoroughly review the components of the Safety Planning Intervention (SPI; Stanley & Brown, 2012) together with the interviewer. Specifically, we focused our analyses on data that were generated by the question: "Here is a written safety plan which involves a written series of steps to take during a suicidal crisis. [Handed SPI to participant]. What do you think of it?" To gain greater insight about their impressions of the safety plan, we further probed participants with the following questions as appropriate: "What is the most helpful thing about it? Least helpful thing? Thing it needed to have but didn't? How would you write one? What would it need to have in it to keep you safe? Who would you ask for information and support?" We coded data from all of these passages as "overall impression of SPI," and separated responses into "positive aspects of SPI" and "negative aspects of SPI." The principal investigator wrote memos for each of these categories (i.e., positive, and negative) as well as notes on suggested components of the ASCP based on adolescent and parent feedback. All co-investigators read the memos, agreed on the interpretation, and discussed the ideas for ASCP components prior to development.

## Results

Findings from the qualitative interviews are summarized in Table 1. Overall, analyses demonstrated the need for the ASCP to have developmentally appropriate language, layout, and content. For instance, adolescents suggested that we rename "warning signs" to "stressors or triggers" and change "internal coping strategies" to "ways to help myself." Adolescents and parents also wanted to make warning signs directly connected to skills adolescents can use. In addition, adolescents wanted greater emphasis placed on positivity and reasons for living in the safety plan. With respect to layout, adolescents wanted more open space under each category so they could write more if needed. Adolescents also wanted to incorporate Crisis Text Line into the list of emergency resources, as texting is their preferred method of communication. Parents wanted to see more direct parental involvement, and many adolescents and parents felt that two separate but related safety and coping plans tailored specifically to the adolescent and parent may be a more effective way to address the fact that parents and adolescents need different things in a safety planning intervention.

It is important to note that during the interviews, adolescents and parents spontaneously endorsed the helpfulness of the safety scale that the clinicians used with them on the inpatient psychiatric unit (see next paragraph for description), and when they made suggestions about the safety and coping plan, they mentioned that incorporating some of the elements of the safety scale would be helpful. They felt that the safety scale should be put into the ASCP to directly connect feelings to actions using developmentally appropriate language to ensure that they share the same mode of communication. For example, adolescents and parents noted it would be beneficial to include the number scale, coping skills, and, for parents, the list of professionals to contact for help. Parents also indicated a need to make a guide or manual for clinicians that explains how to use the ASCP with the adolescent and parent, and suggested that the ASCP should not only be used in a crisis, but also as daily means of communication and preventative care.

### *Incorporation of the Safety Scale*

Because adolescents and parents endorsed the helpfulness of the "safety scale," a tool used clinically on the inpatient psychiatric unit, it is important to describe its components in detail to understand how they were incorporated into the ASCP. On admission to the unit, each adolescent receives a safety and coping scale. Safety, as used in the scale, is defined by the adolescent's reason for admission (e.g., dangerousness to self, dangerousness to others, and/or inability to function in the community). The range of the standard scale is one through six, where one

Table 1  
Summary of Responses by Adolescents (n=20) and Parents (n=20)

	Adolescents	Parents
Positive aspects of SPI	<ul style="list-style-type: none"> <li>&gt; Reasons for living (n=15)</li> <li>&gt; Having name and numbers of people to ask for help (n=10)</li> <li>&gt; Coping strategies (n=4)</li> <li>&gt; Warning signs (n=4)</li> <li>&gt; People and setting that provide distraction (n=5)</li> <li>&gt; Go over with a therapist (n=2)</li> <li>&gt; Everything in one place (n=1)</li> <li>&gt; Keep environment safe (n=1)</li> </ul>	<ul style="list-style-type: none"> <li>&gt; People to ask for help (n=5)</li> <li>&gt; Professionals to call (n=2), 911 (n=1), crisis line (n=2)</li> <li>&gt; Coping strategies (n=3)</li> <li>&gt; Everything in one place (n=3)</li> <li>&gt; Reasons for living (n=3)</li> <li>&gt; Warning signs (n=3)</li> <li>&gt; Keep environment safe (n=2)</li> </ul>
Negative aspects of SPI	<ul style="list-style-type: none"> <li>&gt; Don't like warning signs (n=2), hard to know what warning signs are (n=1), warning signs should be connected to coping skills/what to do (n=2)</li> <li>&gt; Hard to talk to adult when feeling like this (n=2), just a piece of paper, can't really do anything in the moment (n=3)</li> <li>&gt; Take out "professionals/clinicians" (n=3), want to talk to someone they know vs. a professional or a hotline (n=1)</li> <li>&gt; Space needs to reflect importance, need space to write more if needed (n=4)</li> <li>&gt; Need list of "coping skills" (n=2), conflict between what parents and adolescents think are good coping skills (n=1)</li> <li>&gt; Expand on reasons for living and put at top (n=2)</li> <li>&gt; Make emergency numbers more prominent (n=2)</li> <li>&gt; Needs to be done close to discharge (n=2)</li> <li>&gt; Needs to be easily accessible (n=2)</li> <li>&gt; Reasons for living can't necessarily help in an immediate crisis (n=2)</li> <li>&gt; Should be a separate plan for parents (n=2)</li> <li>&gt; Combine people and professionals sections (n=1)</li> <li>&gt; Distractions not helpful (n=1)</li> <li>&gt; Does not feel personalized (n=1)</li> <li>&gt; Environmental safety can mean different things for adolescents (n=1)</li> <li>&gt; Language needs to be simplified (n=1)</li> <li>&gt; Needs a way to deescalate a crisis quickly (n=1)</li> <li>&gt; Needs list of triggers, stressors (n=1)</li> <li>&gt; Should be something not just for a crisis but to use regularly/preventatively (n=1)</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Should feel professional yet personalized in order to be engaging to adolescents (n=4)</li> <li>&gt; Contacting professionals probably not helpful for the adolescent (n=3), professionals not always available after hours (n=2)</li> <li>&gt; Concerns about it being easily accessible (n=3)</li> <li>&gt; Expand on reasons for living and put at top (n=3)</li> <li>&gt; Combine people and professionals sections (n=2)</li> <li>&gt; May not be helpful in an immediate crisis (n=2)</li> <li>&gt; Should include safety scale (n=2)</li> <li>&gt; Warning signs section not helpful because they are not always there (n=1), warning signs should be connected to coping skills/what to do (n=1)</li> <li>&gt; Expand and emphasize making environment safe (n=1)</li> <li>&gt; Instead of phone numbers put text and other options adolescents more likely to use (n=1)</li> <li>&gt; Need to ensure adolescents are contacting adults in crisis rather than peers (n=1)</li> <li>&gt; Needs a connection to parents (n=1)</li> <li>&gt; Should include information about parent supervision of adolescents (n=1)</li> <li>&gt; Should include "who would miss me if I was gone" (n=1)</li> <li>&gt; Should be done together in a session with adolescent and parent (n=1)</li> <li>&gt; Space needs to reflect importance, need space to write more if needed (n=1)</li> </ul>

(1) corresponds with the highest level of safety and six (6) corresponds with an adolescent's lowest level of safety and often includes behaviors that prompted admission to the unit. The scale is generated by the adolescent, and they are encouraged to include significant supporting details at each level on their scale. Based on core concepts from cognitive behavioral therapy (CBT), the scale is structured to encourage adolescents to identify and examine their thoughts, feelings, and behaviors. At each level (1 through 6), adolescents are prompted to report on three separate facets of their experience: "How I feel," "How I act," and "What I need." "How I feel" is intended to elicit responses regarding the adolescent's internal experience—including but not limited to physical sensations and/or negative thoughts. "How I act" is intended to allow adolescents and their parents/caregivers to discuss and document the outward physical signs that correspond to an adolescent's internal emotions. "What I need" allows space for adolescents to begin the process of identifying appropriate and effective coping skills for each level of their scale. Other versions of the scale are used for children/preadolescents; these versions include similar content, but are represented either by a three-level "stoplight" scale or a two-level "thumbs up/thumbs down" scale.

Although the scale is designed to allow for adolescents to identify specific coping skills to use at each level of safety, adolescents are also asked to create a full list of all the coping skills they have identified. In this context, a "coping skill" refers to anything that an adolescent can do (physically or mentally) to reduce their level of distress during periods of acute worsening of symptoms. Importantly, coping skills allow adolescents to move from a level of unsafe thoughts or actions to a level of increased safety. By building and practicing these skills throughout the course of their admission, adolescents learn to regulate their emotions and gain control over their unsafe thoughts and behaviors. The scale also includes a section for each adolescent to mark what is triggering to them (i.e., situations or events that move an adolescent from a one [1] on their scale to a level of decreased safety). Additionally, there is a section for the adolescent to identify names and numbers of supports (i.e., family members, therapists, psychiatrists, and school counselors). This section also includes a list of emergency hotlines (i.e., National Suicide Prevention Hotline: 1-800-273-TALK [8255], Samaritans 24-hour Helpline: 617-247-0220, and Parent Hotline: 800-840-6537).

The adolescent receives a blank copy of the scale and an explanation of its use at admission, and typically first reviews the scale independently and the following day reviews it with their individual clinician on the unit. The scale is improved and developed throughout admission. Ideally, the adolescent completes a draft of this scale prior to the first family meeting, which typically occurs the second day

of admission. If possible, the adolescent shares this scale with the family in the first family meeting, and the family clarifies or adds information if the adolescent is responsive and agrees with the feedback. The scale is structured to promote self-monitoring skills while also allowing family and others to assist in identifying coping skills and triggers. A primary goal of the scale is to provide a practical way that clinicians, parents, and adolescents can communicate about the adolescent's feelings of safety and their needs. Prior to discharge, adolescents and their families practice using the scale as a communication tool. The safety scale is intended to be an evolving document, which is altered throughout admission as the adolescent gains exposure to additional coping skills and insight into triggers. At discharge, the content of the scale is adapted so that the adolescent and family can share it with community supports (i.e., outpatient therapist, psychiatrist, and school).

#### *Components of the Adolescent Safety and Coping Plan*

The details of how the clinician can develop the ASCP along with the adolescent and parent(s) are described in the manual in [Appendix A](#), and a template is provided in [Appendix B](#). The ASCP begins with the clinician explaining to the adolescent and parent(s) that in this session they will work together to create a plan to keep the adolescent safe, encourage healthy coping, and increase parent-child communication upon return home from the hospital. The clinician explains that there are three parts of the session: (1) clinician meeting with the adolescent alone and developing the adolescent's plan to keep them safe in a crisis, (2) clinician meeting with the parent(s) alone and developing the parent(s) plan to keep the adolescent safe in a crisis, and (3) clinician meeting with the adolescent and parent(s) together to review the two safety plans (and safety scale) and discuss a plan for when and how they will use them together, as well as potential barriers to and facilitators of using the safety plans. For further detail on how to conduct safety planning with adolescents in general, including potential problems that may arise and how to manage them, clinicians can consult [Pettit et al. \(2018\)](#), which outlines the process of using the SPI ([Stanley & Brown, 2012](#)) with an adolescent and parent(s) and illustrates its use with a case example. The safety planning process outlined by [Pettit et al. \(2018\)](#) is similar to the ASCP in terms of their focus on coping skills, emergency contacts, and means safety, but differs in that the entire process is conducted together with adolescent and parent(s), adolescents and parents work off of the same safety plan, and there is no development of a safety scale to use for communication and graduated coping skills based on their level of distress.

#### *Potential Challenges and Solutions*

Although the ASCP may be most promising with families in which the parent is willing to acknowledge and engage

with their adolescent's mental health concerns and in cases where the parent-adolescent relationship and communication are strong, the ASCP can still be successful when this may not be true. By meeting with the adolescent alone first, the clinician builds rapport by prioritizing their needs and giving them the chance to brainstorm any potential challenges they may face when meeting together with the parent(s). When meeting alone with the parent(s), the clinician can provide critical means safety information, which may trigger distress in the adolescent (e.g., if the means of a prior traumatic suicide attempt were discussed in detail), discord in the parent-adolescent relationship (e.g., if the discussion of the restriction of lethal means in the home would cause the adolescent to feel overcontrolled and stripped of autonomy), or be contraindicated to do together with the adolescent (e.g., telling the parent the lethality of Acetaminophen vs. Ibuprofen and recommending keeping a small amount of Ibuprofen in the medicine cabinet in case of method substitution as a harm reduction approach).

Another potential problem relates to the logistics of the ASCP and whether or not it would be difficult to incorporate the safety scale if it was not previously completed earlier in the hospitalization. Although this would certainly extend the length of the session, the ASCP is developed as a stand-alone intervention which could be replicated in multiple settings which may or may not have a similar safety scale built into its standard care. The ASCP manual (see [Appendix A](#)) guides the clinician on how and when to complete the safety scale in cases where it has not yet been completed. As such, the ASCP can be viewed as a transitional intervention that helps the adolescent move to a lower level of care (e.g., from inpatient to partial, emergency room to outpatient) with significant supports embedded within a systematic process. The ASCP does not represent the end of acute treatment, but rather, a transition to the next level of care. In fact, the document is intended to be shared with ongoing treatment providers and any other professionals involved in future mental health care of the adolescent.

### Case Example

#### Clinical Presentation

Morgan (name changed for confidentiality) is a 14-year-old White female with a history of ADHD, depression, anxiety, and Type 1 Diabetes Mellitus, admitted to the inpatient psychiatric unit after a suicide attempt via an intentional administration of approximately 20 extra units of insulin. Prior to admission, Morgan reported that she had experienced intense suicidal ideation for a week leading up to her attempt, including intentionally administered extra insulin to harm herself 2 days prior to her attempt. Morgan reported that the day of her suicide attempt she was feeling down despite it being her

mother's birthday, a time she felt she should have been happy. Morgan reported she wanted to be alone and went upstairs to her room. Morgan reported that as she was going up the stairs her grandmother told her to "suck it up." Morgan reported that after hearing this, she went to her room and gave herself the 20 extra units of insulin and did not tell anyone at the time.

Morgan reported that her parents remotely monitor her blood glucose level via her insulin pump, and shortly after her suicide attempt her father noticed that her blood sugar was low and called her to figure out why. Morgan reported that her father then realized she had administered extra insulin and brought her to the hospital. Morgan stated that there was no clear trigger for her attempt. She said that "the world around me felt slow and seemed colorless . . . like no one cared about me anymore." She reported that she felt "alone and scary" and she did not think she could live like that, nor did she know what to do about it. Although she had struggled with suicide ideation in the past, and had made other suicide plans before such as jumping out of a window, Morgan denied any prior history of suicide attempt. Morgan also stated that she had a history of cutting, particularly with needles from her insulin syringes.

Morgan was able to identify some triggers for worsening depressive and anxiety symptoms, including her best friend recently changing schools, worsening grades (i.e., C's and D's compared to honor roll the year prior), the recent presidential election, and increased arguments with her parents surrounding school work and her inability to focus. Morgan identified that although none of these events were acute, the culmination of them felt overwhelming. Morgan reported symptoms consistent with depression including low mood, difficulty sleeping, feeling like the world was moving in slow motion, increased isolation, and suicidal ideation. She also described panic attacks where she felt like the world was collapsing around her, feeling alone, and having difficulty breathing. Although Morgan reported feeling extremely happy every few months, she denied other symptoms consistent with mania. She also reported that when stressed she could hear voices saying negative things to her or hear her name being shouted. She denied further symptoms of psychosis such as disorganization, paranoia, and visual hallucinations. Morgan denied having coping skills and the only thing she could identify that would make her feel better was her cat.

Morgan lives with her mother, father, and 16-year-old brother, as well as a dog and 2 cats. She reported she gets along well with her mother and father, but has some conflict with her older brother. Per Morgan, both of her parents suffered from mental health issues when they were younger. Morgan is in middle school and has an Individualized Educational Plan for ADHD and Diabetes

Mellitus Type I, but felt it has not been helpful. Although Morgan denied a history of trauma, she reported some past bullying at school. She identified currently having some friends but no close friends. Morgan also denied a history of drug or alcohol use.

### **Adolescent Safety and Coping Plan**

We began the safety and coping planning process by explaining the goals of the ASCP to Morgan and her parents. We explained that we were all working together to keep Morgan safe, to increase her ability to communicate with her family, and to help her access some of her coping skills when she is distressed. Next, we explained the outline of the ASCP and explained that the three phases of the intervention included meeting alone with Morgan to create her individual safety plan, meeting alone with her parents to create the parent safety plan, and then meeting all together to review the safety and coping plan and how they will use it together as a family. Together with Morgan and her parents, we noted that discussing and addressing any foreseeable barriers to using the plans will be an important part of using it successfully at home. For an example of how the components of the ASCP translate to the template found in [Appendix B](#), we have included Morgan's completed ASCP document in [Appendix C](#).

#### *Adolescent Alone*

Morgan was engaged and cooperative in her individual session. She did need some prompting from her clinician to think about the different aspects of the ASCP, but was able to demonstrate moderate insight into her stressors and triggers. Morgan was able to describe her reasons for living and listed her animals, including a new puppy and two cats. Morgan was also able to talk about her love of the singer Adele and her Instagram account (dedicated to Adele) as another reason for living. With some prompting Morgan was also able to describe her love of Kung Fu and teaching young kids Kung Fu as another reason for living. All of these reasons were then written on the ASCP.

We then transitioned into talking about Morgan's stressors and triggers. Morgan was able to demonstrate moderate insight and discussed recently watching the TV show "13 Reasons Why" as a recent trigger. Morgan was able to expand on this and reported that thinking about others' self-harm and suicide attempts is a big trigger for her own suicidality. We probed Morgan further about other possible stressors and triggers in the past and she was able to talk about her diabetes diagnosis and all the care and management that it requires. She reported that most adolescents do not have to deal with a chronic medical problem and having diabetes makes her feel even more different from her peers. From this conversation we added diabetes and feeling different to her list of triggers on the ASCP.

Next we discussed with Morgan some concrete ways she can help herself when she is distressed. Morgan was easily able to list hugging her cats and listening to Adele as things that almost always make her feel better. We pushed Morgan to think about other ways she can help herself when she is stressed, particularly thinking about what she can use and access anywhere. We noted that she may not always have access to Adele and her cats. Morgan then reported that running and practicing Kung Fu helps her to calm and clear her mind. In addition, she stated that drawing and talking to friends are also helpful. She reported that her friends are usually pretty reachable and supportive of her. Morgan was unable to describe cognitive strategies that would be beneficial for her at this point in her treatment. We talked about continuing to work on developing coping skills and updating her safety and coping plan as she continues to engage in outpatient treatment.

We then asked Morgan who she can reach out to for help in a crisis. Morgan was easily able to identify her parents as well as her psychiatrist. Morgan discussed that she often visits with her school nurse regarding her diabetic care and felt comfortable reaching out to the school nurse as well. We shared with Morgan numbers that she can call and/or text including the Samaritans 24-hour Helpline, National Suicide Prevention Hotline, and Crisis Text Line. Last, we reviewed her safety scale (where 1 is safe and 6 is the most unsafe). We reviewed Morgan's different levels of distress and asked her to complete this part thinking about how she feels, how she acts, and what she needs during each of those different feeling states. At a 1 on her safety scale, Morgan was able to write that she feels "awesome," acts happy and needs her cat. At a 6 on her scale she reported she feels "suicidal, depressed, and worthless." She reported that at a 6 she either acts slow and quiet or is screaming. The "what I need" at a 6 on the safety scale says "Take me to the hospital. This is an emergency!" Morgan was able to think through each number on the scale and describe how she may be feeling and what she may need. During the creation of the safety scale it can be helpful for adolescents to think back to times when they felt like a certain number on the scale and what they did in that moment that either helped or hurt them. This section, as in all sections of the ASCP, should feel like a fluid back-and-forth conversation between the adolescent and clinician rather than a "fill in the blank" worksheet.

#### *Potential Challenges and Solutions*

For adolescents who are resistant to hospitalization and safety planning, the clinician may need to conduct some individualized work prior to doing the ASCP (i.e., rapport building, psychoeducation, and motivational interviewing) in order to prepare the adolescent to appropriately and effectively engage in the process. For adolescents who are cognitively able to understand the safety scale but refuse to engage, the clinician can explain that the expectations for

discharge are to actively participate in the creation of the ASCP so that they can help to establish a plan to keep themselves safe when they are home. Although some adolescents may continue to resist, clinicians can improve the chances of them buying into the process by giving them an option of where to start first or by tailoring the ASCP to the adolescent in a way that helps to increase their engagement (e.g., find specific interests to relate to and incorporate in the plan first, like a favorite singer or pet).

#### *Parents Alone*

After the session with Morgan, we met with Morgan's parents. Morgan's parents were motivated to keep Morgan safe and to increase their knowledge and ability to help Morgan cope with her suicidal thoughts. We provided a brief synopsis of the work we did with Morgan alone, and then shared Morgan's safety plan. Morgan's stressors and triggers were then added to the parents' safety plan and we discussed if any of the information was new or shocking to the parents. The parents reported that they were aware of most of Morgan's stressors and triggers; however, they seemed saddened by how different she feels from her peers because of her diabetes. We validated the parents' feelings and discussed this as an area to continue to explore with Morgan in therapy moving forward.

Next, we discussed ways they can keep the home safe. We informed the parents that research suggests that reducing access to lethal means is the most effective way of preventing suicide (Barber & Miller, 2014). Together with the parents we acknowledged that this was something that has been reviewed with the family during family sessions on the unit and the parents expressed understanding of means safety and its importance. The parents agreed with locking up all medications (over the counter and prescriptions, including Morgan's insulin), sharps (knives, scissors, syringes, etc.), and toxic chemicals, and providing constant supervision of Morgan. We informed the parents that supervision of Morgan after hospitalization is of utmost importance in keeping her safe. With regard to her diabetic needs, we discussed that parents would take control over Morgan's diabetic care, including her insulin administration, and that she would no longer be on the insulin pump. The parents reported that they are purchasing a lock box for the refrigerator for Morgan's diabetic supplies. We continued to discuss with parents the importance of locking up any alcohol in the home and informed them of the strong association between alcohol use and suicide. We reviewed the lethality of weapons and firearms with Morgan's parents and discussed locking up firearms and any weapons in the home. The parents denied having firearms or weapons in the home, and reported they would do their best to make sure that Morgan is not exposed to weapons, firearms, or other dangerous items.

Last, we discussed with the parents who they can turn to for support when Morgan is in crisis. The parents were able to identify Morgan's grandparents as well as Morgan's psychiatrist as people they could reach out to in a crisis. We provided the parents with the Samaritans 24-hour Helpline, National Suicide Prevention Hotline, and Parent Hotline, and discussed returning to the emergency room for an evaluation if they were concerned about Morgan's safety in any capacity. The parents expressed understanding and agreement with these recommendations, which we also wrote on the parents' section of the ASCP.

#### *Potential Challenges and Solutions*

Parents who are resistant to hospitalization are typically more willing to engage in safety planning, while parents who are afraid to leave their adolescent without 24/7 supervision will need more assistance in building their confidence throughout the process. One way clinicians can help to enhance parental self-efficacy is by asking them to reflect back on times when they were able to help their adolescent through a difficult time, and discuss with them what they did to enable this to happen. In addition to a lack of confidence, some parents hold problematic beliefs about the root of their adolescents' suicidal behaviors. For example, some parents view their adolescents' suicidal statements, suicide attempts, and/or self-harm behaviors as "attention seeking." In these cases, parents typically respond well to validation and psychoeducation, and are able to join with the clinician particularly when the importance of safety is highlighted. During the component of the ASCP with the parent alone it is critical to align with the parent, hear and validate their concerns, and move towards a common goal of safety for their adolescent.

#### *Adolescent and Parents Together*

Finally, we reviewed the ASCP that Morgan and her parents created all together. Morgan and her parents first reviewed her reasons for living as well as some of Morgan's stressors. The parents appropriately discussed with Morgan their plan to address some of Morgan's stressors, including decreasing Morgan's access to social media that contains content around self-harm and suicide. Morgan's parents validated and acknowledged all of her stressors, and discussed getting behind in school work as another major stressor. This allowed Morgan's parents to introduce the idea of an executive functioning coach to help her after discharge. Morgan and her parents also reviewed means safety and the parents reiterated that Morgan would no longer have her insulin pump; rather, they would be in charge of administering Morgan's insulin.

Next, Morgan and her parents thoroughly reviewed Morgan's safety scale and different feeling states and what actions would be helpful to utilize when Morgan moves into the unsafe zone. Morgan and her parents discussed

checking in regularly, and they were able to identify times of the day that will be helpful for these check-ins using Morgan's safety scale as a method of communication. Morgan and her parents agreed with using her safety scale when she returns home. Morgan was able to share some of her coping skills with her parents, including her pets and Kung Fu. Morgan's parents discussed engaging in some physical activity with Morgan such as running when Morgan feels stressed. Morgan was able to share with her parents what she will do when feeling distressed including letting her parents know, letting her psychiatrist know, or letting her school nurse know when she is at school.

The parents shared with Morgan that they would also be in contact with her psychiatrist as well as use their own parents (Morgan's grandparents) as support. Morgan and her family were able to discuss some barriers to using the ASCP. They identified Morgan's mood, particularly around low or high blood sugars that may affect her willingness to participate. The family talked about Morgan writing or texting how she is doing instead of having to orally discuss how she is doing or where she is on her safety scale. Morgan and her parents were in agreement with the backup plan to the potential barriers as well as reaching out to the identified supports when needed. Last, Morgan's parents took a picture of the completed ASCP and shared it via text with Morgan. We all discussed the importance of practicing using her safety plan on passes (i.e., brief trips off of the unit) to begin to incorporate it into the family's typical routine prior to discharge. Morgan and her parents were in agreement with all of the safety and coping planning outlined in this intervention.

#### *Potential Challenges and Solutions*

It is not uncommon for the ASCP component with the adolescent and parents together to have some degree of tension. In fact, this tension can serve as an important time in treatment for adolescents and parents to learn and practice healthy communication, with the clinician as the model. When threats or other verbal assaults happen during the session, the clinician should remind the family that respectful language and "I" statements should be used, and again emphasize that the shared goal is the adolescent's safety and well-being. As such, this safety planning session can also be used as a model for future family communication. If tension continues to exist or the family is not engaging in the process, the clinician should stress the importance of having a safety plan prior to discharge, and do more psychoeducation on how and why having one can help. Even families who do not want to engage in treatment in general will usually acknowledge the importance of having a safety plan, and will understand that not having one is a barrier to discharge. At times during this component of the ASCP, clinicians may need to reengage the family using motivational interviewing techniques to

help them understand the importance of safety planning in the discharge process.

### **Discussion**

Suicide is on the rise for adolescents, and the immediate post-hospitalization period is the most critical period of risk, with about one third of suicides happening within 3 months of discharge following a psychiatric hospitalization (Olsson et al., 2016). Despite the great need for interventions and treatment tools that can be used by adolescents and their families during this high-risk period, there is very little research to date on specific interventions designed for post-acute psychiatric care for this population. In this study we developed the Adolescent Safety and Coping Plan (ASCP) to fill the gap of existing standardized safety planning procedures for adolescents. The ASCP was designed specifically to account for the unique developmental needs of adolescents, including the critical incorporation of parents into the safety planning process.

Our qualitative study findings indicated that adolescents preferred the use of simpler, more positive language, with a focus on actions they can take to help themselves during the crisis. This is particularly important because literature suggests that suicidal crises can be short-lived (Stanley & Brown, 2012), and therefore a brief intervention that involves quick self-directed access to coping skills may be enough to resolve the imminent threat. This focus on positivity is also important to note, and is in line with recent research suggesting the importance of targeting positive affect in interventions with suicidal adolescents (Yen et al., 2019).

Adolescent participants also specifically requested the addition of crisis text lines in the list of supports. This is not surprising given that texting is a preferred method of communication among adolescents and one that is increasingly utilized to assess their functioning in real time (Garcia et al., 2014). Texting has already shown promising results as a means of communication in times of crisis, and numerous national and international suicide prevention organizations have incorporated its use (Luxton, June, & Kinn, 2011).

The request to include a separate parent component to the ASCP was also a notable finding. Parents expressed the need to know warning signs and coping skills, but also to have a clear list of supporting professionals. Having a separate plan for parents empowers them to take a more active role and intervene whenever necessary. It also alleviates some of the pressure from the adolescents, who no longer need to consider themselves the main holders of the safety plan. Parents taking an active role in developing the individualized ASCP highlights for adolescents their support and commitment to their safety. This is vital given that adolescents' perception of parental support can act as an independent predictor of suicide attempts (Miller, Esposito-Smythers, & Leichtweis, 2015).

Perhaps one of the most important findings of this study is the spontaneous yet nearly unanimous request by both adolescents and parents to have the ASCP include the safety scale they developed during their treatment on the inpatient unit. This demonstrates how essential qualitative research with key stakeholders (i.e., adolescents and parents) is to intervention development (Hjelmeland & Knizek, 2010). As Owens et al. (2011) found in their participatory approach to developing a text-messaging intervention to reduce repetition of self-harm, conducting research with individuals with lived experience requires investigators to be open, flexible, and ready to abandon or radically revise initial intervention designs. Without having asked adolescents and parents what they thought the ASCP should include, it would look like and function as a completely different document. But in order to create interventions that work, we need to rely on those who will use them to guide their development.

The adolescents and parents in this study felt the safety scale used on the unit was helpful to their inpatient treatment and could be easily translated into safety planning. The scale utilizes CBT principles and prompts adolescents to link their thoughts and feelings (“how I feel”) to their actions (“how I act”) and then couple them with specific, graded coping skills depending on their level of distress (“what I need”). By doing so, adolescents are taught to identify and monitor their feelings and how they might lead to suicidal thoughts. They gradually become better at assessing their internal state and “catching themselves” at a lower level, before things feel out of control. Incorporating specific components that assess feeling states in the ASCP is crucial because research suggests that transient increases in depressed and anxious states, even in the absence of clinically significant symptoms, can predict future suicide attempts (Berona et al., 2017).

The safety scale also becomes a means of structured, daily communication—similar to texting—where with the report of a number adolescents can quickly relay their internal state to their parents and professionals, without having to find the right words to describe their feelings. This concrete way of communicating can be particularly helpful in moments of high distress, when adolescents are more prone to regress and lose their ability to utilize more abstract thinking and their ability to communicate their feelings. The daily use of the scale can also give parents a sense of whether their adolescents are perseverating on suicidal thoughts, and offer the chance for early intervention by incorporating coping skills, helping the adolescents gain more cognitive flexibility, and decrease their overall distress, all of which can have a protective effect (Berona et al., 2017).

One of the greatest advantages of the ASCP is its ease of implementation. The individual and parent sessions can easily be incorporated into an inpatient psychiatric treatment plan or discharge planning from an ED. If used

during inpatient psychiatric care, adolescents can work on their ASCP during individual therapy and share their progress with their parents during family therapy sessions. In addition, the plan is designed in a way that does not require specialized training for clinicians. Its simplicity, however, can lead to questioning and disbelief on behalf of the adolescents and parents, whose buy-in is imperative for its success. Another challenge can be parents’ and adolescents’ commitment to continued use beyond the hospital, as well as outpatient clinicians’ willingness to incorporate it into their treatment plan.

The ASCP has certain challenges that are important to consider in its implementation. First, adolescents in acute psychiatric care are often resistant to treatment, making rapport building and motivational interviewing skills a critical preliminary step. The tension that often exists between the adolescent and parent is another factor, and one that may hinder the effectiveness of the ASCP if not addressed. The first two individual components of the ASCP allow the clinician to work with the adolescent and parent separately to air out their concerns without the other present, which allows for the validation needed to lay the groundwork for the final component where both parties sit together to discuss the plan. Modeling healthy communication skills is an important job of the clinician and must be integrated throughout the safety planning process. Another barrier is the length of time it takes to complete the ASCP, which varies, but tends to be longer and more comprehensive than other safety planning interventions because of the three components and the generation of the safety scale. We hope that clinicians and organizations will find that investing the extra time and effort into the ASCP will help to bolster adolescent skills and parent self-efficacy such that it pays off in decreased future suicidal events and hospital revisits.

Despite these challenges and barriers, the ASCP is a promising new safety planning intervention for adolescents and parents that has the flexibility to use in a variety of settings with adolescents who have varying levels of acuity. Future randomized controlled trials are needed to assess the effectiveness of the ASCP on suicide-related outcomes in the post-hospitalization period, including methods to determine if there are differential findings based on underlying psychopathology or demographic characteristics. The ASCP should also be examined with respect to its usefulness as a transitional intervention that helps the adolescent move to a lower level of care, and enables the parents to support the adolescent in this transition. As such, future studies are necessary to determine the applicability of the ASCP in other settings that provide acute psychiatric care, such as EDs or acute residential treatment centers.

This study is the first of our knowledge to use qualitative in-depth interviews with suicidal adolescents in inpatient psychiatric treatment and their parents to

develop a safety and coping plan for adolescents being discharged from acute psychiatric care settings. Given the need for such interventions designed for this high-risk period for suicidal adolescents, this study makes an important contribution to the field by offering an

innovative and flexible approach that is easy to replicate. By letting the voices of suicidal adolescents and their parents guide the development of the ASCP, we can have confidence in our first steps towards creating a safety and coping planning intervention for adolescents that works.

## Appendix A

### ADOLESCENT SAFETY AND COPING PLAN (ASCP)

*Begin by explaining that in this session the adolescent and parent(s) will work together with the clinician to create a plan to keep the adolescent safe, encourage healthy coping, and increase parent-child communication upon return home from the hospital. Explain that there are three parts of the session: 1) therapist meeting with the adolescent alone and developing the adolescents plan to keep them safe in a crisis, 2) therapist meeting with the parent(s) alone and developing the parent(s) plan to keep the adolescent safe in a crisis, and 3) therapist meeting with the adolescent and parent(s) together to review the two safety plans (and safety scale) and discuss a plan for when and how to they will use them together, as well as barriers and facilitators that might get in the way of using the safety plans.*

#### Adolescent Alone

*Therapist should begin by explaining that the purpose of safety planning is to work together to develop a specific set of concrete strategies they could use to help keep themselves safe, especially when they get home from the hospital. The basic steps of the safety plan include: 1) reasons for living, 2) stressors and triggers, 3) ways you can help yourself, 4) people who can help you, 5) safety scale.*

*Ask the adolescent about the following items (clinician should inquire with adolescent who they would prefer to be the writer, once the writer has been designated, the writer should place the adolescents name on the top of the safety plan):*

1. My Reasons for Living
  - a. Explain that some people find it helpful to focus on reasons for living when distressed.
  - b. What are your most important reasons for living? What else?
  - c. What gives you a feeling of meaning or purpose in life? What else?
2. My Stressors and Triggers
  - a. Explain that it can be helpful to know what your stressors or triggers are to feeling distressed or suicidal so that you can use strategies to avoid or cope with them.
  - b. What things in their life are currently giving you stress? What else?
  - c. What triggers you to feel unsafe or like you want to die? What else?
3. Ways I Can Help Myself
  - a. Explain that this section lists concrete ways you can help yourself when you are starting to feel distressed or suicidal.
  - b. How can you help yourself when you are starting to feel stressed, sad, or unsafe? Ask about cognitive and/or behavioral coping strategies. What else?
4. People Who Can Help Me
  - a. Explain that this section lists specific people who can help you when you are starting to feel distressed or suicidal.
  - b. Who can help you when you are starting to feel stressed, sad, or unsafe? Ask about family, friends, professionals. Inform adolescent about the Suicide Prevention Lifeline and 24/7 Crisis Text Line service. What else?
5. Safety Scale
  - a. First inform adolescent they will complete this independently (using their current safety plan if applicable) while the therapist is meeting with parent(s).
  - b. Explain that the purpose of the safety scale is to use numbers 1-6 (1=safe/happy; 6=unsafe/distressed) to help you learn to identify your emotions at any given time, and identify your level and severity of distress and link it with unsafe thoughts and behaviors and also with specific coping skills you can use at each level.
  - b. Starting with the lowest number, start filling in the safety scale with the adolescent, asking them "How do you feel?...How do you act?...What do you need?" for each number, 1-6. During this process, ask them to reflect on what "Stressors and Triggers" from above may cause them to go up in numbers, and what "Ways I Can Help Myself" or "People Who Can Help Me" or "Reasons for Living" could be used at different times to maintain or decrease the number.

*Inform the adolescent that you will now meet with the parent(s) alone briefly to go over what you have written in order to create a safety plan specifically for the parent(s). Tell the adolescent that after meeting with the parent(s) you will all meet together to go over the two safety plans and discuss a plan for when and how to use them together, as well as barriers and facilitators that might get in the way of using the safety plans. Therapist will then repopulate the parent(s) safety plan with "Stressors and Triggers" from the adolescents safety plan.*

**Parent(s) Alone**

*First, review the parent(s) template and make sure that you have pre-populated the “Stressors and Triggers” from the adolescent template into the parent template.*

*Begin by explaining that in this session the therapist and parent(s) will review the adolescent’s safety plan and discuss any questions or concerns, and encourage parent(s) to add content from their own observations and experiences. Then the therapist and parent(s) will create the parent(s) safety plan.*

*Therapist should begin by explaining that the purpose of a safety planning is to provide them with a specific set of concrete strategies they could use to help keep the adolescent safe, especially after coming home from the hospital. The basic steps of the parent safety plan include: 1) means restriction strategies, and 2) people who can help you keep your adolescent safe in a crisis.*

*Ask the parent(s) about the following items (clinician should inquire with parent who they would prefer to be the writer, once the writer has been designated, the writer should place the parent(s) name on the top of the safety plan):*

**1. How I Can Keep the Home Safe**

- a. Introduce section by explaining what means restriction is: keeping potential lethal ways of killing oneself unavailable. Tell parent that some research shows that means restriction is the most effective method of suicide prevention that exists.
- b. Ask the parent: do you have firearms in the home? If yes, strongly suggest they find another place outside of the home to store firearms. If this is not possible, instruct the parents to safely store firearms (<http://www.projectchildsafe.org/safety/safe-storage>).
- c. Do you have alcohol in the home? Inform parents about alcohol use as a risk factor for suicide. If they do have alcohol in the home, strongly suggest they find another place outside of the home to store alcohol.
- d. What medications do you have in the home? Inform them about the lethality of certain medications (e.g., Tylenol, other non-SSRI prescription medications), and instruct them to lock up lethal medications in a lockbox. [If parent(s) do not have a lockbox, inform them they can get one for free at the BCH Injury Prevention Dept. or ED Case Management Dept.].
- e. Strongly suggest that parent(s) remove easily accessible sharp objects from the home which could cause tissue damage.
- f. Do you have toxic household chemicals in the home? Inform them about the lethality of chemicals. Strongly suggest they find another place outside of the home to store chemicals or encourage the use of a lock box
- g. Discuss the importance of 24 hour supervision, especially once the adolescent is home from the hospital.
- h. Do you have other weapons in the home? Inform them about the lethality of weapons. Strongly suggest they find another place outside of the home to store weapons and/or encourage the use of a lock box.
- i. At end, hand parent the suicide safe brochure for future reference.

**2. People Who Can Help Me**

- a. Explain that this section lists specific people who can help you when you are concerned that your adolescent may be suicidal.
- b. Who could you contact for help if you were worried about your child’s safety? Ask about family, friends, professionals.
- c. Provide additional information about crisis services to contact.

**Adolescent and Parent(s) Together**

*Begin, by explaining that the third part of the session involves the therapist meeting with the adolescent and parent(s) together to review the two safety plans (including the safety scale that the adolescent is currently completing) and discuss a plan for when and how to they will use them together, as well as barriers and facilitators that might get in the way of using the safety plans. Review the two safety plans with the adolescent and parent by having the adolescent present their safety plan and then have the parent(s) present their plan. Give permission to adolescent and parent(s) to discuss any questions or concerns and provide clarification. Next, ask the adolescent and parent together about the final item (with the clinician inquiring who would be the writer):*

**1. Safety Scale**

- a. First, explain the safety scale to the parent so they understand what the adolescent has just been completing (See Adolescent Alone section, #5).
- b. Review the Safety Scale with adolescent and parent together.
- c. Discuss how the safety scale be incorporated into their everyday communication to help the adolescent feel calm, happy, and safe.

*Explain the next section of the parent safety plan as identifying concrete steps that each of them (adolescent and parent) can take when the adolescent is in a suicidal crisis.*

**2. What Can Adolescent Do**

- a. What can the adolescent do when starting to feel stressed, unhappy, or unsafe?

**3. What Can I (Parent) Do**

- b. What can the parent do to help the adolescent when they are starting to feel stressed, unhappy, or unsafe?

*Instruct the parent(s) to take a picture of each safety plan and save images to their phone(s) and then text/email the safety plans to their adolescent. Then, discuss a plan for when and how the adolescent and parent will practice using their safety plans together prior to discharge so that they will feel ready to use the ASCP when they return home. Ask about what could help them use the plan, and what might get in the way of them using the plan.*

Appendix B



..... 's Safety Plan

<b>My Reasons for Living</b>	<b>My Stressors and Triggers</b>
<b>Ways I Can Help Myself</b>	<b>People Who Can Help Me</b> (Crisis Text Line: Text 741-741 Any Time)



..... 's Safety Plan

..... 's <b>Stressors and Triggers</b>	<b>How I Can Keep the Home Safe</b>
<b>What ..... Can Do</b>  <b>What I Can Do</b>	<b>People Who Can Help Me</b>

**← SAFE SAFETY SCALE UNSAFE →**

1	2	3	4	5	6
How I feel:					
How I act:					
What I need:					

## Appendix C



## Morgan's Safety Plan

## My Reasons for Living

new puppy  
my cats  
Adele  
Instagram account dedicated to Adele  
Kung Fu  
teaching kids Kung Fu

## My Stressors and Triggers

13 Reasons Why  
others' self-harm and suicide attempts  
diabetes  
feeling different

## Ways I Can Help Myself

hugging my cats  
listening to Adele  
running  
Kung Fu  
drawing  
talking to friends

## People Who Can Help Me

(Crisis Text Line: Text 741-741 Any Time)

parents  
psychiatrist  
school nurse  
Samaritans 617-247-0220  
Lifeline 800-273-8255



## Morgan's Safety Plan

## Morgan's

## Stressors and Triggers

13 Reasons Why  
others' self-harm and suicide attempts  
diabetes  
feeling different

## How I Can Keep the Home Safe

lock up medications, insulin, sharps,  
chemicals, alcohol  
supervise insulin administration  
continue to keep firearms out of home

## What Morgan Can Do

hugging my cats, listening to Adele, running,  
Kung Fu, drawing, talking to friends

## What I Can Do

take control over Morgan's diabetic care,  
purchase lock box for refrigerator

## People Who Can Help Me

Morgan's grandparents  
Morgan's psychiatrist  
Samaritans 617-247-0220  
Lifeline 800-273-8255  
Parent Hotline 800-840-6537



## References

- Asarnow, J. R., Berk, M., Hughes, J. L., & Anderson, N. L. (2015). The SAFETY program: A treatment-development trial of a cognitive-behavioral family treatment for adolescent suicide attempters. *Journal of Clinical Child & Adolescent Psychology, 44*(1), 194–203.
- Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: a research agenda. *American Journal of Preventive Medicine, 47*(3), S264–S272.
- Berona, J., Horwitz, A. G., Czyz, E. K., & King, C. A. (2017). Psychopathology profiles of acutely suicidal adolescents: Associations with post-discharge suicide attempts and rehospitalization. *Journal of Affective Disorders, 209*, 97–104.
- Burstein, B., Agostino, H., & Greenfield, B. (2019). Suicidal attempts and ideation among children and adolescents in US emergency departments, 2007-2015. *JAMA Pediatrics, 2019*.
- Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. *JAMA Psychiatry, 74*(7), 694–702.
- Czyz, E. K., Horwitz, A. G., Arango, A., & King, C. A. (2018). Short-term change and prediction of suicidal ideation among adolescents: a daily diary study following psychiatric hospitalization. *Journal of Child Psychology and Psychiatry, 59*(1), 1–10.
- Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2013). *Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings.*
- Garcia, C., Hardeman, R. R., Kwon, G., Lando-King, E., Zhang, L., Genis, T., & Kinder, E. (2014). Teenagers and texting: Use of a youth ecological momentary assessment system in trajectory health research with latina adolescents. *JMIR mHealth and uHealth, 2*(1), e3.
- Groholt, B., Ekeberg, Ø., & Haldorsen, T. (2006). Adolescent suicide attempters: What predicts future suicidal acts? *Suicide and Life-Threatening Behavior, 36*(6), 638–650.
- Hedegaard, H., Curtin, S. C., & Warner, M. (2018). Suicide mortality in the United States, 1999-2017. *NCHS Data Brief, 330*, 1–8.
- Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior, 40*(1), 74–80.
- Hughes, J. L., & Asarnow, J. R. (2013). Enhanced mental health interventions in the emergency department: suicide and suicide attempt prevention. *Clinical Pediatric Emergency Medicine, 14*(1), 28–34.
- Hunt, I. M., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw, J., & Appleby, L. (2009). Suicide in recently discharged psychiatric patients: a case-control study. *Psychological Medicine, 39*(3), 443–449.
- Kann, L., McManus, T., Harris, W. A., Shanklin, S. L., Flint, K. H., Queen, B., & Lim, C. (2018). Youth risk behavior surveillance—United States, 2017. *MMWR Surveillance Summaries, 67*(8), 1.
- Knesper, D. J. (2011). *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from an emergency department or an inpatient psychiatry unit.* : Suicide Prevention Resource Center.
- Knox, K. L., Stanley, B., Currier, G. W., Brenner, L., Ghahramanlou-Holloway, M., & Brown, G. (2011). An emergency department-based brief intervention for veterans at risk for suicide (SAFE VET). *American Journal of Public Health, 102*(S1), S33–S37.

- Luxton, D. D., June, J. D., & Kinn, J. T. (2011). Technology-based suicide prevention: current applications and future directions. *Telematics and e-Health, 17*(1), 50–54.
- Miller, A. B., Esposito-Smythers, C., & Leichtweis, R. N. (2015). Role of social support in adolescent suicidal ideation and suicide attempts. *Journal of Adolescent Health, 56*(3), 286–292.
- Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S. M., Gerhard, T., & Blanco, C. (2016). Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry, 73*(11), 1119–1126.
- Owens, C., Farrand, P., Darvill, R., Emmens, T., Hewis, E., & Aitken, P. (2011). Involving service users in intervention design: a participatory approach to developing a text-messaging intervention to reduce repetition of self-harm. *Health Expectations, 14*(3), 285–295.
- Parellada, M., Saiz, P., Moreno, D., Vidal, J., Llorente, C., Álvarez, M., & Bobes, J. (2008). Is attempted suicide different in adolescent and adults? *Psychiatry Research, 157*(1-3), 131–137.
- Pettit, J. W., Buitron, V., & Green, K. L. (2018). Assessment and Management of Suicide Risk In Children and Adolescents. *Cognitive and Behavioral Practice, 25*(4), 460–472.
- Shain, B. (2016). Suicide and suicide attempts in adolescents. *Pediatrics, 138*(1)e20161420.
- Spirito, A., & Esposito-Smythers, C. (2006). Attempted and completed suicide in adolescence. *Annual Review of Clinical Psychology, 2*, 237–266.
- Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264.
- Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry, 75*(9), 894–900.
- Wells, K. C., & Heilbron, N. (2012). Family-based cognitive-behavioral treatments for suicidal adolescents and their integration with individual treatment. *Cognitive and Behavioral Practice, 19*(2), 301–314.
- Wolff, J. C., Frazier, E. A., Weatherall, S. L., Thompson, A. D., Liu, R. T., & Hunt, J. I. (2018). Piloting of COPES: An Empirically Informed Psychosocial Intervention on an Adolescent Psychiatric Inpatient Unit. *Journal of Child and Adolescent Psychopharmacology, 28*(6), 409–414.
- Yen, S., Ranney, M. L., Tezanos, K. M., Chuong, A., Kahler, C. W., Solomon, J. B., & Spirito, A. (2019). Skills to enhance positivity in suicidal adolescents: results from an open development trial. *Behavior Modification, 43*(2), 202–221.

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