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Clinician Experience and Attitudes Toward Safety Planning with Adolescents at Risk for Suicide

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This study examined clinician experiences and attitudes toward safety planning in a large urban pediatric psychiatry department serving primarily Latino youth. A total of 46 clinicians completed a survey assessing their experience with and attitudes toward safety planning with adolescents at-risk for suicide. The majority of clinicians were female (78%), non-Latino White (54%), and aged 30–39 (52%). Clinicians' attitudes were largely positive ($M = 3.69$ $SD = 0.47$, $Range = 2.42–4.42$). However, many clinicians ($n = 24$) were not convinced that safety planning reduces the imminent risk of suicidal behavior in patients. This study provides more depth to our understanding of the way in which safety planning is perceived by clinicians.

Keywords adolescent, Latino, safety planning, suicide

In the United States, suicide accounts for one in every ten adolescent deaths and is the third leading cause of death among 15- to 24-year-olds (Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, 2014; Husky et al., 2012). There is an urgent need to provide adolescents at-risk for suicide with best practices in mental health treatment, since many drop out of treatment prematurely (Husky et al., 2012; Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002). In national surveys, Latino adolescents are more likely than White and African-American adolescents

to report feeling sad or hopeless, seriously considering suicide, and making a suicide attempt (Kann et al., 2014; Zayas, Hausmann-Stabile, & Kuhlberg, 2011). In addition, Latino adolescents have been found to be less likely than White adolescents to receive quality care and to be more likely to drop out of treatment prematurely (Hough et al., 2002). Given their poor compliance with treatment, it is imperative that mental health providers intervene quickly when suicidal thoughts and behaviors become evident.

Research has found that the majority of recurrent suicidal events occur within

4 weeks of treatment intake, underscoring the importance of treatment engagement. Brent and colleagues suggest that interventions for at-risk adolescents be “front-loaded” to offer early, immediate, and effective treatment techniques (Brent et al., 2009). One such recommended treatment intervention is safety planning. Currently, safety planning is being adopted by many mental health agencies as a recommended or even a required intervention for any patient facing suicidal crises (Zuckerbrot, Cheung, Jensen, Stein, & Laraque, 2007), although the literature on the use of safety plans and clinical utility of safety planning interventions is sparse. The only study of safety planning as a standalone intervention was carried out in a veteran population (Knox et al., 2011). While not a randomized control trial (RCT), the intervention being tested, known as SAFE VET, was shown to increase engagement in treatment and prevent further suicidal behavior.

Safety planning was included as part of the intervention delivered in the Treatment for Adolescent Suicide Attempts (TASA) study; however, it was not used as a standalone intervention but rather was part of a new manualized psychotherapy intervention for suicidal adolescents (Stanley et al., 2009). Despite the limited research, many clinicians working with adolescents at-risk for suicide are currently required to safety plan with these patients. To our knowledge, no current studies explore the impact of a standalone safety planning intervention on suicidal ideation and/or behavior, engagement in treatment, and/or psychiatric symptoms in adolescents. Understanding clinicians’ experience with and attitude toward safety planning can provide insight into the intervention’s clinical utility as well as information that might help guide future

effectiveness and implementation research efforts for at-risk adolescents.

Little is known regarding clinician attitudes toward safety planning and whether clinicians perceive safety planning as a useful tool in preventing suicide in adolescents. Clinicians’ attitudes toward a particular intervention can influence whether or not they use the intervention in their clinical practice (Aarons, 2004; Perkins et al., 2007). For instance, in a study of 214 therapists across 15 states, Nelson and Steele (2007) found that attitudes toward treatment research was a significant predictor of evidence-based practice use after controlling for theoretical orientation and clinical setting. As another example, Becker-Haimes et al. (2017) found that clinicians’ openness to innovation in general was associated with increased use of exposure, an evidence-based intervention for anxiety disorders, in community mental health settings. Given the influence of clinician attitudes on intervention adoption, understanding the attitudes clinicians hold in relation to safety planning might be an important first step toward implementing safety planning in mental health settings serving at-risk adolescents.

One recent study interviewed clinicians about their views of SAFE VET (Chesin et al., 2017). Most clinicians endorsed that safety planning resulted in both increased veteran safety and increased comfort in discharging veterans reporting some suicidal risk. Given these promising results among clinicians working with an adult at-risk population, the current study sought to extend our understanding of clinician perspectives on safety planning to another at-risk population, namely, urban Latino adolescents. As noted above, there is a need to develop and advance innovative treatments for ethnic minority

adolescents at-risk for suicide (Goldston et al., 2008). Obtaining greater understanding of the perspectives of clinicians who treat at-risk minority adolescents can help to advance our knowledge of how to best intervene with this population.

The current study aims to examine clinician experiences and attitudes toward safety planning in a large urban pediatric psychiatry department serving primarily Latino adolescents. We aim to answer the following research questions:

1. How comfortable are clinicians with conducting safety plans with at-risk adolescents?
2. How often do clinicians conduct safety plans with at-risk adolescents?
3. Do clinicians have negative or positive attitudes toward safety planning?

Based on previous literature (e.g., Chesin et al., 2017), it is hypothesized that clinicians will have positive attitudes toward safety planning. Additionally, provider characteristics such as gender, higher educational attainment, and discipline have been found to be associated with clinicians' attitudes regarding practice innovation (Aarons et al., 2012). Therefore, it is also hypothesized that clinicians' attitudes will be positively associated with their level of comfort with safety planning, as well as with the number of years since they completed professional training, their role in clinic, and receipt of formal or informal training.

METHOD

Study Setting

The study was conducted in an outpatient child and adolescent psychiatry

clinic in the children's hospital of a large university medical center which serves youth ages 4 through 21 and is located in a low-income, predominantly Latino neighborhood in New York City. The clinic trains predoctoral psychology interns, child psychiatry residents who have completed a residency in general psychiatry, and social work interns each year, and provides mental health services for approximately 500 children (up to age 10) and nearly 800 adolescents (ages 11 and older). In 2014, over 693 patients presented with a principal diagnosis of anxiety and/or depressive disorders.

Participants

Participants were 46 mental health clinicians working in the outpatient child and adolescent psychiatry clinic. Participants included psychologists ($n = 17$), psychiatrists ($n = 7$), social workers ($n = 6$), psychology trainees ($n = 5$), child psychiatry residents, ($n = 9$), and a psychiatric nurse practitioner. The majority of clinicians were female ($n = 36$), non-Latino White ($n = 25$), and between the ages of 30 and 39 ($n = 24$). Fifty-nine percent of clinicians ($n = 27$) reported having completed their clinical training in the last five years.

Measures

Data were collected via an online survey instrument. The instrument comprised two parts: Demographic questions, which were used to describe the sample (see above) and questions about clinicians' experience with and attitudes toward safety planning (Clinician Attitudes Toward Safety Planning; CATSP). The demographic questionnaire elicited information

on clinician age, gender, race/ethnicity, position, and prior treatment experience. The CATSP is a 25-item measure developed by the study investigators (see Appendix A). Six items assessed whether the clinician received training on how to complete a safety plan (e.g., “Do you feel you have sufficient training in how to complete a safety plan?”), as well as their level of comfort with safety planning (e.g., “How comfortable are you with the principles and techniques of safety planning?”). Seven items examined the clinician’s experience conducting safety plans with patients at-risk for suicide (e.g., “How often do you use safety planning in your clinical work with patients at-risk for suicide?”). Items on the training and experience subscales were rated via a mix of “Yes” or “No” responses, as well as fill ins and 5-point Likert scales. Twelve items assessed the clinician’s attitudes toward safety planning (e.g., “Safety planning with patients at-risk for suicide is a useful clinical practice”). Each item was rated using a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). For the analyses, negatively worded items were reversed scored (e.g., “Safety plans do not lower a patient’s imminent risk for suicidal behavior”). Items were summed to create a subscale score, with higher values indicating more positive attitudes toward safety planning. Cronbach’s alpha for the subscale comprised of the 12 attitude items was .83.

Data Analysis

The three main research questions for the study were analyzed using descriptive statistics examining demographic variables and items from the three survey sections. Pearson product-moment correlations were computed to examine associations among

clinician attitudes, years since completed professional training which was used a proxy for clinician level of expertise, role in clinic, receipt of formal or informal training, and level of comfort with safety planning. The statistics reported for each variable and test are based on participants who responded to the given item on the survey. Missing data for a given item ranged from 0.0% to 6.5%. As such, the total number of participants used in computing percentages varies.

Procedure

In September 2014, all clinicians working in the clinic were invited to complete the on-line, computerized survey described above. Clinicians were informed about the study during staff meetings, received a recruitment flyer in their mailboxes, and were instructed to contact the study investigators if interested in participating. Of 75 eligible clinicians, 46 (61.3%) consented to participate in the study. After a clinician provided consent, he/she received an e-mail containing a link to the online survey. Clinicians received a \$15 gift card for their participation. The Institutional Review Board of Columbia University Medical Center approved this study.

RESULTS

Clinicians’ Comfort with Safety Planning

Of the 46 participating clinicians, 80% ($n = 37$) reported that they had sufficient training in how to complete a safety plan, and 89% ($n = 41$) reported being at least somewhat comfortable with the principles and techniques of safety planning. Fifty-six percent ($n = 26$) reported having

had received some formal training on how to complete a safety plan either during graduate school or while on fellowship. Those clinicians who did not report having had formal training reported that they had received informal training ($n = 18$; 39%) either through supervision or staff meetings (see Table 1).

Clinicians' Experience with Safety Planning

A small minority—nine clinicians (20%)—reported sometimes completing a safety plan with patients at-risk for suicide. The rest reported higher usage of safety plans with at-risk patients: 50% ($n = 23$) reported often completing a safety plan, and 30% ($n = 14$) reported always completing a safety plan. Seventy-six percent ($n = 35$) of clinicians reported having treated a patient at-risk for suicide in the past four months. Of these, 51% ($n = 18$) reported “often” using a safety plan with these patients and 40% ($n = 14$) reported “always” using a safety plan with these patients (see Table 1).

Clinicians' Attitudes Toward Safety Planning

The frequency of clinician responses to each of the 12 items on the attitudes subscale is presented in Table 2. Clinician attitudes toward safety planning were largely positive. The mean scale score for the attitude subscale was 3.69 ($SD = 0.47$) out of a possible 5, with scores ranging from 2.42 to 4.42. Eighty-three percent ($n = 38$) of clinicians viewed safety planning as a useful clinical practice, 73.9% ($n = 34$) agreed that safety planning can improve treatment outcomes, and 87% ($n = 39$) considered safety planning more effective than a “no-suicide” contract.

Forty-three percent ($n = 20$) of clinicians also agreed that creating a safety plan is easy and 67.4% ($n = 31$) agreed that a 45–50 minute therapy session is enough time to create a safety plan with a patient. Additionally, 56.5% ($n = 26$) did not endorse the belief that their patients dislike safety planning and 42.2% ($n = 19$) did not endorse the belief that their adolescent patients were unmotivated to use their safety plans. Despite these positive attitudes, 46% ($n = 21$) of clinicians neither agreed nor disagreed that safety planning lowers a patient’s imminent risk of suicidal behavior. Correlational analyses revealed that clinician attitudes toward safety planning were not significantly associated with years since completed professional training, role in the clinic, receipt of formal or informal training, or feelings of having received sufficient training. However, level of comfort with safety planning was significantly and positively associated with clinicians’ attitudes (see Table 3).

DISCUSSION

This study aimed to increase understanding of clinician perspectives on the use of safety planning in their clinical work with primarily Latino adolescents at-risk for suicide. Almost all participating clinicians viewed safety planning as a useful tool in the clinical care of at-risk adolescents. In particular, most clinicians agreed that completing a safety plan with a patient can improve treatment outcomes and is more effective than a “no suicide” contract. Overall, clinicians believed that safety planning is neither difficult nor time consuming despite working in a busy urban outpatient hospital clinic. These results suggest that safety planning is well-tolerated by clinicians in a busy pediatric clinic

TABLE 1. Frequency of Clinician Responses To Items on the Comfort and Experience Subscales of the Clinician Attitudes Toward Safety Planning Survey

Item	Values	<i>n</i>	(%)
Have you received some formal training on how to complete a safety plan?	Yes	26	56.5
	No	18	39.1
If no, have you received informal training?	Yes	18	90
	No	2	10
Do you feel you have sufficient training in how to complete a safety plan?	Yes	37	82.2
	No	8	17.8
How comfortable are you with the principles and techniques of safety planning?	Not at all	0	0
	Not very	3	6.5
	Neutral	2	4.3
	Somewhat	21	45.7
	Very	20	43.5
In the last 4 months, have you treated a patient at-risk for suicide?	Yes	35	76.1
	No	11	23.9
How often have you used safety planning with these patients?	Never	0	0
	Rarely	2	5.7
	Sometimes	1	2.9
	Often	18	51.4
	Always	14	40
Overall, how would you describe your experience with safety planning?	Very Positive	2	4.7
	Positive	21	48.8
	Neutral	17	39.5
	Negative	3	7.0
	Very Negative	0	0
How often do you use safety planning in your clinical work with patients at-risk for suicide?	Never	0	0
	Rarely	0	0
	Sometimes	9	19.6
	Often	23	50
	Always	14	30.4
How often are the resources (e.g., computer, printer, office space) needed to implement a safety plan available to you at CHONY?	Never	0	0
	Rarely	0	0
	Sometimes	7	15.2
	Often	13	28.3
	Always	23	50.0

serving a predominantly low-income, Latino community.

There is an urgent need to provide Latino adolescents at-risk for suicide with best practices in mental health treatment,

as they are often less likely than White adolescents to receive quality care that is timely. Additionally, there is a paucity of research supporting the use of EBTs and practice innovations with ethnic minority

TABLE 2. Frequency of Clinician Responses To Items on the Attitudes Subscale of the Clinician Attitudes Toward Safety Planning Survey

Item	1		2		3		4		5		Total n (%)
	Strongly disagree n (%)	Disagree n (%)	Disagree n (%)	Neither agree/ Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly agree n (%)				
1. Safety planning, if used appropriately, will improve the average treatment outcomes of patients at-risk for suicide.	0 (0)	1 (2.2)	11 (23.9)	25 (54.3)	9 (19.6)	46 (100)					
2. Creating a safety plan with a patient is more effective than a no-suicide contract.	0 (0)	1 (2.2)	5 (11.1)	24 (53.3)	15 (33.3)	45 (100)					
3. It is easy to create a safety plan with a patient at-risk for suicide.	1 (2.2)	7 (15.2)	18 (39.1)	19 (41.3)	1 (2.2)	46 (100)					
4. In general, patients at-risk for suicide dislike safety planning. ^a	1 (2.2)	25 (54.3)	17 (37.0)	3 (6.5)	0 (0)	46 (100)					
5. Safety planning with patients at-risk for suicide is a useful clinical practice.	0 (0)	0 (0)	8 (17.4)	27 (58.7)	11 (23.9)	46 (100)					
6. A regular 45–50 minute therapy session is not enough time to create a safety plan with a patient at-risk for suicide. ^a	4 (8.7)	27 (58.7)	7 (15.2)	6 (13.0)	2 (4.3)	46 (100)					
7. Safety plans do not lower a patient's imminent risk for suicidal behavior. ^a	2 (4.4)	19 (42.2)	21 (46.7)	3 (6.7)	0 (0)	45 (100)					
8. There are too many steps involved in safety planning. ^a	3 (6.5)	29 (63.0)	9 (19.6)	4 (8.7)	1 (2.2)	46 (100)					
9. A clinician-generated list of coping strategies is more helpful than a safety plan for patients at-risk for suicide. ^a	3 (6.7)	27 (60.0)	11 (24.4)	3 (6.7)	1 (2.2)	45 (100)					
10. Patients at-risk for suicide are often unmotivated to use their safety plans. ^a	1 (2.2)	18 (40.0)	19 (42.2)	7 (15.6)	0 (0)	45 (100)					
11. Safety planning with patients at-risk for suicide places an increased burden on clinicians. ^a	7 (15.2)	26 (56.5)	7 (15.2)	5 (10.9)	1 (2.2)	46 (100)					
12. Safety planning with patients at-risk for suicide is a big waste of time. ^a	17 (37.0)	22 (47.8)	7 (15.2)	0 (0)	0 (0)	46 (100)					

Note. ^aItem reverse coded.

TABLE 3. Bivariate Correlations Comparing Clinician Demographic Variables and Means Clinician Attitudes Toward Safety Planning Score

	1	2	3	4	5	6	7
1. Years since completed training	–						
2. Role in the clinic	–.220	–					
3. Receipt of formal training	.041	.114	–				
4. Receipt of informal training	.280	–.126	.111	–			
5. Felt received sufficient training	–.084	.034	.146	–.180	–		
6. Level of comfort	.053	–.190	–.245	.017	–.436**	–	
7. Mean CATSP Score	–.174	–.068	.085	.066	–.208	.345*	–

Note. * $p < .05$ ** $p < .01$; CATSP: Clinician attitudes toward safety planning.

children and families (Goldston et al., 2008; Lau, 2006). Although the safety planning intervention used by clinicians in this study was not specifically adapted for Latinos, clinicians reported that their patients liked safety planning and were motivated to use safety planning as part their treatment. These results suggest that safety planning might be a useful intervention for Latino adolescents, as it provides a framework that is flexible enough to address triggers and coping strategies hypothesized to be most relevant to Latinos, such as parent-child conflict arising from discrepancies in acculturation (trigger) and support from extended family (coping strategy). Future research should evaluate the content of safety plans and how safety plan content relates to at-risk adolescent outcomes, particularly among minority adolescents.

Other findings of interest were that the majority of clinicians in this study were not convinced that safety planning actually reduces the imminent risk of suicidal behavior in patients. Given the overall positive view of safety planning, it is somewhat notable that clinicians are still unsure whether the tool has any impact on decreasing suicidal behaviors. These results are consistent with those of Chesin et al.

(2017) who found that while emergency department staff felt positive about the use of safety planning with an at-risk veteran population, many did not believe that safety planning would decrease imminent risk of suicide. There are currently major gaps in our knowledge about risk factors that predict imminent risk of suicide (Glenn & Nock, 2014) and protective strategies. It is possible that safety planning increases clinicians' comfort with at-risk patients by allowing them to more thoroughly discuss coping strategies with these individuals. However, given the limited knowledge available to clinicians about which imminent risk factors they should be attending to, this increased comfort might not translate to increased confidence that at-risk patients will use their safety plan during a crisis.

In contrast to previous research (e.g., Aarons et al., 2012), clinicians' attitudes toward safety planning were not associated with clinician characteristics, such as years since completed professional training, role in the clinic, receipt of formal or informal training, or feeling of having received sufficient training. However, as clinicians' level of comfort with safety planning increased so did their positive attitudes toward safety planning. This finding mirrors previous

research indicating that clinicians' level of comfort with an intervention is associated with positive attitudes toward that intervention (e.g., Glebova, Foster, Cunningham, Brennan, & Whitmore, 2012). Future research should aim to improve clinicians' level of comfort with safety planning in order to ensure effective implementation of the intervention.

There are several limitations to this study, the most significant being that this study relied solely on self-report. Although clinicians can provide useful information about their attitudes, this is only the first step in evaluating the effectiveness of safety planning. Studies linking safety planning to actual patient and clinician-rated outcomes are needed. It is possible that clinicians in an academic medical center where safety planning has been part of the research program and staff training may be more likely to endorse positive perceptions of safety planning. This could result in higher levels of perceived impact than might be found in a more general population of clinicians. Yet even in this sample of clinicians trained in the use of safety planning, almost a third reported that safety planning does not affect patient outcomes. Another potential limitation is that the participants were a sample of convenience drawn from one particular outpatient pediatric setting in an academic hospital in New York City. Therefore, this sample is not representative of clinician attitudes as a whole and may limit the generalizability of the findings. Our small sample size also limited our power to detect significant results when examining clinician characteristics associated with clinician attitudes.

Future research should examine whether clinicians' attitudes toward safety planning influences their behavior, including frequency and quality of safety planning. Future research should also compare

safety planning to another intervention for suicide prevention (e.g., unstructured coaching) in order to tease apart whether clinicians' attitudes are specific to safety planning or whether they extend to other interventions with at-risk adolescents. Finally, future research should examine whether safety planning in this population may in fact improve clinical care and patient treatment outcomes.

CONCLUSIONS

Providing brief suicide prevention interventions in at-risk outpatient populations has been identified as a national priority (Office of the Surgeon General (U.S.) and National Action Alliance for Suicide Prevention (U.S.), 2012). We found that clinicians had overall positive perspectives and expectations for the utility of safety planning with minority adolescents at-risk for suicide. Although it remains unclear if safety planning in this population significantly improves patient outcomes, our results suggest that clinicians' attitudes should be assessed as part of any study evaluating safety planning effectiveness.

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APPENDIX A

CLINICIAN ATTITUDES TOWARD SAFETY PLANNING

Experience with Safety Planning

Instructions: Please complete the following questions based on your experience with safety planning at CHONY.

1. Have you received some formal training on how to complete a safety plan?
2. If yes, when? _____
3. If no, have you received informal training?
4. If yes, what was that training? _____
5. Do you feel you have sufficient training in how to complete a safety plan?
6. How comfortable are you with the principles and techniques of safety planning?
7. In the last 4 months, have you treated a patient at-risk for suicide?
8. How often have you used safety planning with these patients?
9. How many of your patients at-risk for suicide have caused you to complete a safety plan with them in the last 4 months.

Please fill in the number. _____

10. How many total safety plans for patients at-risk for suicide have you completed in the last 4 months?

Please fill in the number. _____

11. Overall, how would you describe your experience with safety planning?
12. How often do you use safety planning in your clinical work with patients at-risk for suicide?
13. How often are the resources (e.g., computer, printer, office space) needed to implement a safety plan available to you at CHONY?

Attitudes Toward Safety Planning

Instructions: Please indicate how much you agree with the following statements.

14. Safety planning, if used appropriately, will improve the average treatment outcomes of patients at-risk for suicide.
15. Creating a safety plan with a patient is more effective than a no-suicide contract.
16. It is easy to create a safety plan with a patient at-risk for suicide.
17. In general, patients at-risk for suicide dislike safety planning.
18. Safety planning with patients at-risk for suicide is a useful clinical practice.
19. A regular 45–50 minute therapy session is not enough time to create a safety plan with a patient at-risk for suicide.
20. Safety plans do not lower a patient's imminent risk for suicidal behavior.
21. There are too many steps involved in safety planning.
22. A clinician-generated list of coping strategies is more helpful than a safety plan for patients at-risk for suicide.
23. Patients at-risk for suicide are often unmotivated to use their safety plans.
24. Safety planning with patients at-risk for suicide places an increased burden on clinicians.
25. Safety planning with patients at-risk for suicide is a big waste of time.

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