COLLABORATIVE SAFETY (RISK) PLANNING AND INTERVENTION

The competences in this section relate to the collaborative delivery of safety planning and intervention. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge

An ability to draw on knowledge of key mental health legislation relevant to safety planning
An ability to draw on knowledge that safety planning and management is a multidisciplinary process and the shared responsibility of the inpatient team
An ability to draw on knowledge that safety planning aims to increase the patient's safety, reduce risk, and work towards a safe discharge
An ability to draw on knowledge that safety planning should be undertaken collaboratively with the patient and their family and carers, and plans should be phrased in their own words and relate to their personal circumstances
An ability to draw on knowledge that a safety plan should seek to change the balance between risk and safety for the patient and include strategies to increase safety undertaken by the staff, patient and their family and carers
An ability to draw on knowledge that a safety plan should be based on the patient's strengths, and emphasise recovery
An ability to draw on knowledge that having identified a risk behaviour, a professional has a responsibility to act
An ability to identify behaviours that need immediate intervention to reduce risk of harm, for example, immediate plans to attempt suicide

Developing safety plans

An ability to develop a thorough safety plan which is based on:	
	knowledge of local and national policy
	a thorough and collaborative assessment and formulation of the patient's safety needs, taking into account their personal, social, and cultural context
	clinical judgement and prior experience of working with risk behaviours
	consideration of the resources available
	positive risk-taking i.e., balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether
	previous safety plans, if relevant, in order to not repeat something that already may be relevant and available

An ability to collaboratively develop a safety plan which:	
	involves all relevant parties, including the patient, their family and carers, their wider support network, the inpatient multi-disciplinary team, community services, and external services
	includes the management of ward-based triggers which may compromise the patient's safety and exacerbate risk behaviours, such as restricted leave from the ward
	includes a summary and formulation of all the identified threats to safety
	outlines actions/management strategies to be undertaken by staff, the patient, and, if applicable, their family and carers
	includes flexible strategies which utilise the least restrictive methods to manage the risk and increase safety
	can be applied to both the inpatient and home context (adaptation for each context may be required)

- An ability to ensure that the safety plan identifies indicators that the patient's safety may be compromised, such as:
  - the early signs that suggest the patient may be at risk of harm (such as, 'automatic' thoughts, images, thinking styles, moods, or behaviours)
  - the signs that suggest that the behaviour may be escalating
  - the signs that suggest the behaviour is at crisis point

- An ability to work with the patient to identify strategies they can use to increase their safety, for example:
  - identifying times they have managed to cope with similar difficulties in the past (drawing their attention to strategies they are familiar with)
  - identifying short-term targets that can be achieved (taking into consideration any presenting difficulties)
  - recording the short-term targets in a way that is accessible to the patient
  - generating (or choose from a list) activities that may help to reduce negative feelings and distract from harmful thinking (especially activities that will foster a sense of connection to others)
  - identifying strategies and activities that the patient agrees to engage in to try to manage their distress
  - the patient making decisions about when to access help from staff and how staff should respond
  - developing a list of emergency crisis numbers such as accessing a crisis line or emergency care
- An ability to draw up a written statement that specifies the safety plan and incorporates all relevant information

- An ability to ensure that the safety plan is:
  - appropriately documented in the clinical system i.e. in the patient's care plan
  - shared with the patient, their family and carers, and the wider inpatient team
  - reviewed regularly in light of new information or changes to the patient's safety
  - shared with all other services involved in supporting the patient such as community mental health services, psychiatric liaison, or police (as appropriate)
- An ability to collaboratively identify potential barriers to the implementation of the safety plan and strategies to overcome these
- An ability to regularly review the safety plan during the admission to ensure it reflects the patient's ongoing risk and needs

Intervening when patients are actively at risk of harming themselves

- An ability to draw on knowledge of relevant local and national policy which relates to managing self-harm and suicidal behaviour
- An ability to draw on knowledge that the priority of intervening when someone is demonstrating self-harming or suicidal behaviour is to help support them, through:
  - establishing rapport by listening and using empathetic communication such as:
    - showing a willingness to discuss the behaviour directly (and doing so) acknowledging and validating their pain/distress
    - taking the time to listen and showing understanding (for example, by offering summaries of what they have said)
    - holding off making any attempt to convince them to change their mind (as this may increase their resistance until sufficient rapport has been established)
  - only once rapport is established moving to advocate for not harming themselves, for example, by:

exploring other ways they could manage the situation and identify alternative coping strategies
gently challenging and potentially exploring the idea that others would be better off if they were dead (taking care not to imply that they should desist from suicide out of guilt about the reaction of others to their death)
advocating for delaying suicide because of its finality, considering possibilities for ongoing contact with services or family and carers, tailored to their needs and circumstances (as a way of instilling hope for the future)
An ability to advise on restricting and removing access to means to harm:
giving a clear rationale for the importance of limiting access to means
equipping them with other safer means of coping with distress
taking away the means (or agreeing for the means to be handed over to others)
An ability to ensure that any risk information is updated on the clinical system, and the person in charge and the supervisor/manager are informed of events that have occurred

An ability to ensure that any patient at risk of harming themselves has a comprehensive risk assessment, formulation and management plan in place which has been collaboratively developed with the patient and their family and carers
An ability to help the patient mobilise their family and carers by:
engaging them empathetically in discussions about the social support available to them and their use of it helping them
discuss (and ideally overcome) their apprehension about a lack of interest or willingness in those around them to step in to prevent them from acting on suicidal thoughts
helping them generate ideas about the types of requests they might make (for example, being able to check in regularly by phone call, text message or in person, making plans to engage in meaningful activities)
(with their permission) contacting their family and carers to advise on appropriate support and provide information about warning signs, and to check whether they need support
An ability to support the patient on the ward with managing suicidal behaviour by:
engaging them empathetically in discussions about social support available to them on the ward and devise a plan of who speak to
collaboratively generate ideas about how to utilise support available to them on the ward
considering the possibility of supportive medication to treat underlying diagnoses such as depression if not already used
updating the care plan with agreements and ensuring the team and risk assessment are updated

Intervening when an individual is actively at risk of harming others

An ability to draw on knowledge of relevant local and national policy which relates to managing violent and aggressive behaviour
An ability to draw on knowledge that the priority when the patient is demonstrating escalating violent or aggressive behaviour is to try and understand what is triggering them and utilised de-escalation strategies such as:
establishing rapport by listening and using empathetic communication such as:
showing a willingness to discuss the behaviour directly (and by doing so) directly acknowledging and validating their pain or distress
taking the time to listen to them carefully and showing understanding (for example, by offering summaries of what they have said)
talking to the patient in a calming and quiet tone, rather than a loud and argumentative tone, to avoid further provoking the situation

	removing the causes/triggers for the escalation of the behaviour and if possible and appropriate	
		if removing the trigger is not possible, calmly explaining why this cannot be done, for example, if they want to leave the ward but are unable to as they are on section
	giving the patient appropriate physical space and not crowding them	
	draw upon techniques and strategies that may calm the situation, for example, facilitating a phone call to a member in their family and carers, deep breathing or taking some time out	
an ability to ensure that any means used to reduce the risk do not inadvertently reinforce the behaviour and increase likelihood of future incidents		
An ability to ensure that any risk information is updated on the clinical system, and the person in charge and the supervisor/manager are informed of events that have occurred		

Intervening when an individual is actively at risk of harm others

An ability to ensure that any patient at risk of demonstrating violent or aggressive behaviour has a comprehensive risk assessment, formulation and management plan in place which has been collaboratively developed with the patient and their family and carers	
	if appropriate, an ability to develop a positive behaviour support plan to minimise the risk of behaviours escalating (or refer to an appropriately trained professional)
An ability to support the patient on the ward with managing violence and aggression by:	
	engaging them empathetically in discussions about social support available to them on the ward and devise a plan of who speak to
	collaboratively generate ideas about how to utilise support available to them on the ward
	updating the care plan with agreements and ensuring the team and risk assessment are updated

Implementing restrictive practices

Where attempts to de-escalate have exhausted all available options but the patient's behaviour continues to escalate and is becoming a risk to themselves or others, an ability to institute appropriate restrictive interventions (in line with local and national policy), such as:	
	physical restraint
	mechanical restraint
	rapid tranquilisation
	seclusion
An ability to deliver restrictive interventions, which are:	
	the least restrictive option available
	clearly explained to the patient, for example, explaining what is happening and why, and offering reassurance
	implemented in a respectful manner
	accompanied by an opportunity to debrief and discuss what happened
An ability to offer patients emotional support if they are feeling distressed by the restrictive intervention	
An ability to review restrictive interventions regularly and reduce them as early as the risk allows	
An ability to ensure that any risk information is updated on the clinical system and the person in charge and your supervisor/manager are informed of events that have occurred	