## 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

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| 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: |
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| 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: |
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| 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:

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| 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 |

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| 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**

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| 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 |

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| 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**

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| 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**

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| 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 |

## COLLABORATIVE PROBLEM SOLVING

This section outlines competences for collaborative problem solving. These competences are for professionals who have had appropriate training in collaborative problem solving.

### Knowledge

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| An ability to draw on knowledge that patients experiencing acute mental health crisis usually have a multitude of problems or stressors contributing to their distress (for example, homelessness or financial difficulties), and that: | |
| | they may not have the resources to overcome these problems |
| | they may struggle with how to manage or solve these problems |
| | their problems may not have a clear solution |
| An ability to draw on knowledge that the problems that the patient is facing may not be solvable by them alone and that: | |
| | staff may have to intervene with problems, such as, homelessness or difficulties accessing benefits |
| | the problems may be long standing and not immediately solvable and therefore should be incorporated into their discharge and community care or recovery plan |
| An ability to draw on knowledge that high levels of distress can hinder problem-solving and perpetuate the crisis therefore problem-solving can be an important crisis intervention in its own right | |
| An ability to draw on knowledge that problem-solving is not about locating the problem in the individual as there are most often wider interpersonal, social, cultural, and political causes to the problems they face | |

### An ability to deliver problem-solving strategies

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| An ability to deliver problem-solving in a normalising, validating, and compassionate manner bearing in mind that: | |
| | patients may have a large number of presenting problems and may feel understandably overwhelmed and distressed about them |
| | some problems may not be solvable and therefore know when problem-solving strategies may not be suitable or invalidating |
| An ability to include the patient's family and carers in the delivery of problem-solving interventions | |
| An ability to identify the key problems which have contributed to and are perpetuating the current crisis, and prioritise the ones which are most urgent to address | |
| An ability to explain the rationale for problem-solving (i.e., a focus on helping to manage stressors effectively in order to help manage the crisis) | |
| If relevant, an ability to help the patient identify any cognitive "biases" or thinking styles that contribute to difficulties in problem-solving (for example, believing they have no control over their problems) | |
| An ability to help the patient undertake problem-solving in an effective manner by: | |
| | asking them to describe their problems in a concrete and specific way |
| | brainstorm initial ideas and generate possible solutions |
| | choose their preferred solution |
| | examine the consequences and weigh up the pros and cons |
| | supporting them to test out these possible solutions |
| | review and revise the solutions if necessary to see if they can be improved |
| An ability to help patients develop alternative (backup) plans which they can put in place if their first plan does not work | |

## MOTIVATIONAL STRATEGIES

This section describes strategies that can be employed when there are opportunities to discuss motivation to make changes in behaviour. These strategies promote hope for change and can help manage the crisis and move the patient towards a safe discharge. These strategies may be particularly helpful for patients whom substances misuse is a significant issue. These competences are for professionals who have had appropriate training in delivering motivational strategies.

### Practitioner stance

- An ability to maintain an empathic, non-confrontational, collaborative, and non-judgmental stance
- An ability to convey genuine acceptance of the patient's position and avoid the use of persuasion
  - an ability to 'roll with the resistance' and so avoid direct confrontation
- An ability to work from a position that respects the patient's autonomy and respects their responsibility for change

### Knowledge

- An ability to draw on knowledge of the psychology of behaviour change and motivation including that:
  - motivation is shaped by an individual's perception of their ability to carry out a behaviour and the opportunity for them to do so
  - motivation to engage in a particular behaviour will typically fluctuate in response to competing internal (psychological) and external demands
  - ambivalence about behaviour change is not a pathological trait but rather a common precursor to making a change
  - psychological reactance (defending a status quo) is a typical response to confrontation aimed at forcing behaviour change
  - practitioner empathy is a good predictor of successful behaviour change

### Identifying discrepancies

- An ability to draw out the patient's ideas, feeling and wants, and their intrinsic motivation for change
- An ability to help the patient discuss any distinction (and discrepancy) between their current situation and:
  - the extent to which this matches living according to their values
  - their goals for the future
- An ability to help the patient explore and resolve their ambivalence in favour of change
- An ability to encourage exploration of ambivalence by using open questions to help the patient identify the pros of change and barriers to achieving this change
- An ability to enhance the patient's perception of the importance of change and their confidence and readiness to make this change, by discussing ambivalence and highlighting reasons for change

### Style of interaction

- An ability to use affirmative statements which acknowledge the patient's efforts and strengths
- An ability to use open-ended questions to encourage reflection on behaviour change
- An ability for the practitioner to avoid the use of 'traps', such as:
  - question-answer traps (for example, repeatedly asking questions that elicit mono-syllabic responses)

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| | premature focus traps (focusing on a problem area without fully exploring other areas of concern to the patient and identifying their priorities) |
| | taking-side traps (arguing against the patient's view of the problem) |
| | blaming traps (seeking to blame others or the patient for the current situation |
| | expert traps (overruling the patient's perspective by asserting professional authority) |
| An ability to consistently maintain a reflective listening style by: | |
| | forming hypotheses about the meaning of the patient's statements |
| | testing hypotheses by making reflective statements |
| | paying particular attention to statements indicating a desire or ability to change and reflecting these back to the patient in summary statements |
| An ability to elicit 'change talk' in a collaborative manner by: | |
| | recognising and reflecting on different levels of motivation when the patient talks about their desire to change, their ability to change, and their reasons for change |
| | recognising and strengthening language that indicates a commitment to making a positive behaviour change |

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| An ability to offer summaries so as to demonstrate an understanding of the patient's difficulties and structure the intervention |
| An ability to reframe discussion positively with a focus on behaviour change |
| An ability to help the patient consider new perspectives, ensuring that this is done in a non-confrontational manner |
| An ability to only offer specific information and advice when this is solicited |
| An ability to help the patient discuss the benefits and barriers to changing problem behaviour |
| An ability to develop, in collaboration with the patient, plans for behaviour change |
| An ability to summarise any decisions agreed upon regarding behaviour change |

**Monitoring**

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| An ability to identify the patient's readiness for change, through open-ended discussion |
| An ability to provide positive and constructive feedback on behaviour change |
| An ability to help the patient make use of self-monitoring tools to reflect on progress |

## MANAGING EMOTIONS AND REDUCING DISTRESS

This section focuses on a practitioner's ability to support a patient to manage and reduce their emotional distress. These competences are for those with a core profession and/or those with sufficient and appropriate training.

### Knowledge

- An ability to draw in knowledge that the experience and expression of feelings may be influenced by how the inpatient ward itself is functioning (for example, whether there is a positive therapeutic environment/milieu or high levels of disturbance)
- An ability to draw on knowledge that patient's emotional distress is often the result of their social and interpersonal context (for example, financial problems, trauma, relationship breakdown) and can be worsened by the restrictive inpatient environment
- An ability to draw on knowledge that patients in acute mental health crisis are often experiencing high levels of emotional distress which they are struggling to regulate or manage
- An ability to draw on knowledge that strategies that help patients regulate or manage their emotional distress can reduce risk, such as the frequency of self-harming behaviours, and increase their safety
- An ability to draw on knowledge that emotion regulation and managing distress should only be considered:
  - within the context of the patient's formulation and goals
  - alongside interventions and treatments which are addressing the patient's wider context, for example, presenting mental health issues and relevant social problems

### An ability to help manage the patient's emotional distress

- An ability to enquire about the social and interpersonal difficulties that are causing the emotional distress, and the patient's resources to manage these
- An ability to observe and enquire about emotional issues that are impacting on the patient, such as:
  - depression
  - shame
  - anxiety and worry
  - affect that is linked to current or past psychotic experiences (for example, post-psychotic depression, anxiety, worry, shame)
  - anger (for example, with others or services)
- An ability to identify the ways in which the patient currently manages their emotional distress and identify what is helpful and unhelpful
- An ability to support the patient apply coping strategies to manage their emotional distress in situations which are emotionally charged (i.e. to support them to practice strategies in vivo) and ensure that any strategies suggested are not experienced as invalidating
- An ability to work with the patient to notice and to manage their distress by drawing on a repertoire of cognitive behavioural and dialectical behavioural techniques and coping strategies relevant to the presenting problems

- An ability to teach patients strategies that will help them manage their emotional distress, such as:
  - tension and release
  - release only
  - cue-controlled relaxation
  - differential relaxation of different parts of the body while engaged in various activities and while moving
  - rapid relaxation

- An ability to help the patient make use of ‘grounding’ strategies to help manage their emotions, such as:
  - grounding cards (for example, messages and strategies for safety)
  - being present by describing surrounds and location
  - rubbing arms and legs
  - listening to surrounding sounds
  - observing the body
  - breathing strategies (such as breathing retraining)

- An ability to help the patient learn a range of mindfulness exercises in order to assist with mood regulation, for example:
  - mindful walking, mindful eating, or engaging in an activity in a focussed manner that enables the patient to concentrate more on the immediate present rather than on elements of their past or future
  - consciously taking an observer role in relation to thoughts, feeling and emotions in the present
  - consciously focussing on gently inhaling and exhaling whilst allowing thoughts and emotions to happen without taking steps to control or explore them

- An ability to help the patient employ strategies to reduce emotional distress such as:
  - distraction techniques (for example, reading a book, listening to music, going to a ward group)
  - self-soothing by engaging the senses (for example, taking a walk outdoors, eating favourite foods, take a bath or shower)
  - safe place or compassionate imagery (bringing to mind a safe and calming image and engaging senses)

- An ability to help the patient identify strategies to support implementation of these strategies such as, regular practice, having written materials, or using apps and scripts

- An ability to help the patient increase their capacity to regulate emotions, for example by:
  - identifying the relationship between periods of distressing emotions and difficulties in interpersonal relationships
  - using chain analysis to help understand the development of the emotional distress

- An ability to help the patient increase their capacity to control impulsive behaviour by:
  - offering psychoeducation on the management of impulse control problems:
    - drawing attention to the consequences of focusing on emotions (leading to action without reflection and lack of premeditation and planning)
    - identifying the importance of decreasing the attention paid to thoughts and emotions
  - working with the patient to identify examples of impulse-control problems they have experienced
  - considering the development of impulse control problems stage by stage, and working with the patient to identify alternative problem-solving strategies that could be implemented at each point in the sequence

## SELF-MANAGEMENT STRATEGIES

This section describes self-management strategies that can be employed to help patients manage their difficulties. These strategies promote hope for change and can help manage the crisis and move the patient towards a safe discharge. These competences are for healthcare professionals who have had appropriate training in delivering self-management strategies.

### Knowledge

An ability to draw on knowledge that coping strategy enhancement, psychoeducation, and relapse prevention are forms of self-management, which help patients to manage their difficulties by equipping them with strategies to successfully live with the physical, social, and emotional impact of their mental health difficulties

An ability to draw on knowledge that coping strategy enhancement should:

- build upon the existing strengths that the patient, and their family and carers already have
- target core psychological issues underpinning the crisis
- be idiosyncratic and adapted to the patient's presenting needs
- help teach the patient new strategies (for example, distraction techniques, relaxation, mindfulness, and activity scheduling)

An ability to draw on knowledge that psychoeducation should:

- adopt a biopsychosocial model to understanding and managing the crisis, including a focus on the patient's social and cultural context
- target core psychological issues underpinning the crisis
- deliver specific information about the crisis and its management using a range of 'user-friendly' formats
- teach, and allow practice of, effective crisis management skills

An ability to draw on knowledge that the primary objective of psychoeducation is to:

- normalise the overwhelming nature of patient's current or past experiences
- increase compassionate understanding of the factors that have contributed to the crisis, including the individual, interpersonal, social, cultural, and political
- increase awareness of the causes of crisis in an attempt to prevent future ones
- help the client detect the early warning signs of crisis
- encourage engagement in treatment (medication and psychosocial therapies)
- avoid or decrease substance use and misuse

An ability to draw on knowledge that a relapse prevention plan draws together the key elements of psychoeducation and coping strategy enhancement such as:

- the identification of the early warning signs of crisis/relapse indicators
- the mapping of the early warning signs in order
- the identification of coping strategies to manage these

an ability to do this in a compassionate and normalising way

### An ability to deliver self-management strategies to those in crisis

An ability to collaboratively deliver coping strategy enhancement, psychoeducation, and relapse prevention which is based on a comprehensive assessment and formulation of the patient's needs and priorities

An ability to increase the patient's awareness of mental health crises by conveying comprehensive information and adopting an open and collaborative approach that encourages dialogue in order:

- to establish what patients already know

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| to help patients discuss and debate the stance they take |
| empower them to make changes, where possible |
| An ability to convey basic information about mental health crises, including the identification of: |
| the potential causes and triggers of the crisis (including individual, interpersonal, social, and cultural triggers) |
| symptoms and experiences (including thoughts, feelings, behaviours, interpersonal difficulties) which are part of the crisis |
| An ability to discuss issues relating to engagement with mental health services and treatment, such as: |
| patterns of engagement in treatment and care |
| impacts of non-engagement |
| factors that may influence engagement such as stigma, previous negative experiences of mental health services, and medication side-effects |
| An ability to help patients to identify: |
| the key indicators of relapse and the order in which they present |
| a trusted person or people who could help support them to manage future crises |
| their own strengths and resources |
| personal coping strategies |

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| An ability to help patients develop a structured self-management or relapse prevention plan to manage their crises, which includes: |
| the identification of the early warning signs of crisis and relapse indicators |
| the mapping of the early warning signs in order |
| the identification of coping strategies to manage these |
| An ability to deliver a self-management or relapse prevention plan in a collaborative and empowering manner to ensure patients feel confident to implement the strategies independently |
| An ability to deliver a self-management or relapse prevention plan which is recovery focused and enables patients to manage their mental health difficulties and prevent future crises |
| An ability to help the patient utilise medication management strategies to prevent future mental health crises by: |
| listening to them and validating their concerns |
| considering the relative merits of medication/adherence |
| considering the impacts of medication, including any side effects |
| considering their relationship to medication (including any ambivalence about taking medication) |
| troubleshooting any medication issues |
| helping the patient consider how best to discuss medication-related issues with their clinical team |
| helping patients whose preference is for a “no medication” option to consider how this might be negotiated and managed with relevant parties (for example, including a safety plan that details how indicators of relapse would be responded to) |
| An ability to help the patient draft an advanced statement/decision outlining how they would like to be treated during future hospitalisations, including treatments they would like to refuse |