Staff Perspectives of Safety Planning as a Suicide Prevention Intervention for People of Refugee and Asylum-Seeker Background

A Qualitative Investigation

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Abstract. *Background:* Safety planning involves the co-development of a personalized list of coping strategies to prevent a suicide crisis. *Aims:* We explored the perspectives of workers regarding safety planning as a suicide prevention strategy for people of refugee background and those seeking asylum in Australia. *Method:* Participants attended suicide prevention training, specific to refugees and asylum seekers, at which safety planning was a key component. Semistructured, posttraining interviews (n = 12) were analyzed thematically. *Results:* Four key themes were identified: safety planning as a co-created, personalized activity for the client; therapeutic benefits of developing a safety plan; barriers to engaging in safety planning; strategies to enhance safety planning engagement. *Limitations:* First-hand refugee and asylum-seeker experiences were not included. *Conclusion:* As a relatively low-cost, flexible intervention, safety planning may be valuable and effective for these groups.

Keywords: safety planning, suicide prevention, refugees, asylum seekers

In 2018, nearly 30 million refugees and asylum seekers were forcibly displaced worldwide (United Nations High Commissioner for Refugees, 2019). These individuals are at increased risk of suicide, including ideation, behavior, and fatalities (Cohen, 2008; Goosen et al., 2011; Hagaman et al., 2016; van Oostrum et al., 2011; Vijayakumar & Jotheeswaran, 2010). In Australia, there were over 800 reported incidents of self-harm in immigration detention between 2012 and 2013 (Australian Human Rights Commission, 2013), and nearly 30 confirmed/suspected suicide deaths by refugees and asylum seekers who had arrived by boat between 2014 and 2019 (Border Crossing Observatory, 2019). Numerous pre- and postmigration factors contribute to these elevated suicide experiences: a deep, pervasive feeling of "lethal hopelessness" (Procter et al., 2018), often associated with prolonged uncertainty regarding visa status (Nickerson et al., 2019); ongoing trauma associated with exposure to war and conflict; discrimination; isolation and relationship loss; separation from, and ongoing concern for, family (Ao et al., 2012; Hagaman et al., 2016; Vijayakumar & Jotheeswaran, 2010; World Health Organization [WHO], 2014).

Targeted suicide prevention approaches for vulnerable groups are needed (Department of Health, 2017; WHO, 2014), and specific, tailored interventions for high-risk groups are a critical new development in suicidology (O'Connor & Portzky, 2018). However, despite the concerning prevalence of suicidality among refugees and asylum seekers, particularly those experiencing ongoing uncertainty, there is a paucity of research exploring evidence-based suicide prevention strategies for these groups.

The Safety Planning Intervention

Safety planning is gaining momentum as a valuable indicated suicide prevention intervention. Through the co-creation of a personalized list of coping strategies for a person to support themselves during the onset or

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worsening of suicide-related distress, safety plans typically comprise six components: (1) recognizing individual warning signs for an impending suicidal crisis; (2) identifying and employing internal coping strategies; (3) using social supports to distract from suicidal thoughts; (4) contacting trusted family/friends to help address the crisis; (5) contacting specific mental health services; and (6) reducing use of lethal means (Stanley & Brown, 2012).

Practically, there are many benefits to safety planning. It is a brief intervention (approximately 20–45 min), coproduced between the client and multidisciplinary staff in diverse care settings (Stanley & Brown, 2012), and can be an adjunct to other interventions (e.g., telephone follow-up; Stanley et al., 2015). Further, safety plans are "living documents," and the coproduction process means that they can be personalized with strategies that are meaningful to the person's life context, and can be revised to address the fluctuating states of suicidality (Kleiman & Nock, 2018).

Safety planning is associated with reduced suicidal behavior and hospitalizations, and improved treatment attendance (Gamarra et al., 2015; Green et al., 2018; Stanley et al., 2018, 2015; Zonana et al., 2018). It is perceived as acceptable and feasible to consumers (Kayman et al., 2015; Stanley et al., 2016) and clinicians (Chesin et al., 2017). While promising, this research has largely been conducted with veterans, in the United States.

Safety Planning for Refugees and Asylum Seekers

A feasibility study by Vijayakumar et al. (2017) appears to be the only published research examining the use of safety planning by refugees and/or asylum seekers, finding significantly fewer suicide attempts among Sri Lankan refugees in South Indian intervention camps versus those in control camps after the intervention (15-month follow-up) compared with baseline.

Given the dearth of evidence-based suicide prevention strategies for refugees and asylum seekers, one starting point is to understand worker perspectives of engaging in safety planning with these clients. Notwithstanding the importance of understanding direct client impacts, as suicide interventions are likely to be worker-initiated, worker perspectives are valuable for understanding the barriers and enablers to engaging in interventions in the first place, and for uncovering the support needs of workers to engage in this practice.

Aim

This study explored the experiences and perspectives of safety planning from workers who support refugee and asylum seeker clients.

Method

The University of South Australia Ethics Committee approved this study. It draws on data from a larger, mixed-methods project investigating the impact of an Australia-wide, 2-day suicide prevention education program for staff/volunteers (n = 430) supporting refugees and asylum seekers. Safety planning was a key component, including theoretical rationale and practical steps, a role play, and implementation considerations. The first phase of the research was a repeated measures survey of participants' attitudes, competence, and confidence, immediately pre- and posttraining, and at 6-month follow-up, which has been reported elsewhere (Procter et al., 2021). This study describes methodology and data from the second, qualitative study phase, which sought a more in-depth understanding of participants' posttraining experiences.

Study Design

This is a qualitative interview study, reported according to the Consolidated Criteria for Reporting Qualitative Research guidelines (Tong et al., 2007).

Participants and Recruitment

Participants were workers from various Australian nongovernment organizations providing case management, support, or counselling to refugees and asylum seekers who had varied prior training and experience of working with this population group (see Results). Purposive sampling for the interviews was used to recruit attendees of the suicide prevention education program (the original population group), who completed pre/post and follow-up surveys and opted in to the interview. Potential participants were contacted 6 months after training, by telephone and/or email.

Data Collection/Procedure

With participants located around Australia, individual interviews were conducted by telephone (May–September 2018), from the location of the participants' choice. The interviews were conducted by MP, who was minimally involved in the program development/delivery. MP is a postdoctoral research fellow, and a clinical psychologist, with experience conducting qualitative research and working with refugee and asylum seeker clients.

We developed a semistructured protocol to guide and provide consistency across interviews. The protocol

included information about the interview process (e.g., reminding participants about informed consent), demographic items, as well as various questions and prompts related to the research questions, including: "Have you had opportunity to apply the knowledge and skills gained in the training?"; "Have you engaged in safety planning with clients since the training? Can you give me examples?"

To preserve anonymity, participants selected a pseudonym. All interviews were audio-recorded and lasted approximately 1 h each.

Data Analysis

Interviews were transcribed by a paid, independent transcriber, who signed a confidentiality agreement. As the interviews were transcribed verbatim, they were not returned to participants, but were checked for accuracy prior to analysis.

Data analysis followed a reflexive thematic analysis approach (Braun & Clarke, 2006; Braun et al., 2019), initially conducted by MF, with input from the project team. MF is an early-career suicide prevention academic, involved in developing and delivering the education program.

Six phases of data analysis were undertaken recursively: MF immersed herself in the data through repeatedly reading hard copy and electronic transcripts, taking notes to generate initial understandings within and across the data; NVivo 12 Plus (QSR International Pty Ltd, 2020), an electronic software program for collecting and analyzing qualitative data, was used to inductively organize data into preliminary codes, with meaning initially identified at the semantic level, followed by codes being reorganized at the latent level; early themes were developed by collapsing codes into preliminary themes for discussion (MF and NP – a professorial-level suicide prevention researcher); preliminary themes were revised and reorganized as required; finally, themes were further refined through the write-up process (with input from the author team). Findings were not returned to participants for checking.

Results

Of the 75 follow-up survey participants, 20 provided contact details for interview, and 15 participated. This paper is based on 12 interviews where participants had used and/or expressed an opinion of safety planning. During the interview, participants could discuss their use of the safety planning tool, with their clients, at any time in the previous 6 months since the training occurred.

Participants were primarily female (n = 8; average age = 41 years, range = 27–64 years), including four case workers/managers, four counsellors, two team leaders, a social worker, and a community services coordinator. Participants had an average of 8 years' (range = 3–20 years) experience working with refugees and asylum seekers, and over 4 years' (range = 1.5–10 years) experience in their current roles.

Four key themes related to participants' experiences with and perceptions of safety planning were generated.

Theme 1: Safety Planning as a Cocreated, Personalized Activity for the Client

Participants reflected on the collaborative and personalized nature of safety planning.

A Collaborative Process

Participants commonly described the collaborative nature of safety planning, recognizing that it is not something that is done, or given, to the person ("It's not a risk assessment" [Kuia]), but rather something that the worker and client cocreate and codevelop:

> The safety plan is for the client but not for us, so it's really important that its actually done, you know, really with, pretty much the clients; us facilitating it, but pretty much really the client doing their own safety plan, because it's for them. (Betty)

This collaborative process allows the individual to "be in control" (Kuia) and acknowledges the client as the expert in their life:

> . . .utilizing clients' skills and knowledge to come up with the safety plan and then mutually deciding with them what will be the best way to follow up. (Catherine)

Nonetheless, the worker needs to be active in the process:

> . . .we have responsibilities to assist where they can find social supports or professional supports, and ask the questions that work out further understanding of what reasons they have to live. We're responsible and accountable to fleshing out those conversations... (Peter)

An Ongoing Conversation, for All

Participants reflected that a safety plan is an ongoing, living document, revised and revisited as part of ongoing client–worker interactions. Participants guided this

process by checking in on, and encouraging, use of the safety plan:

> . . .reminding them every time as well about their safety plan, so that. . .there is more of the chance of them to remember it when they are in distress. (Tom)

Participants recognized that safety planning is not just for clients in acute suicide distress:

> [Safety planning is] something that we ought to do with the majority of clients I work with rather than just with those that are expressing [suicidality] or we feel that they are at risk of suicide... (Janice)

Theme 2: Therapeutic Benefits of Having a Safety Plan

Participants reflected on their perceived benefits of safety planning for the client, particularly its value as a therapeutic tool to address suicidality.

Increasing Client Awareness of Triggers and Coping Strategies

The main benefit was that cocreating a safety plan can help to highlight the person's unique distress triggers, as well to externalize their unique coping strategies and supports:

> . . .like really clearly identifying that going to the beach is something that makes [the client] happy. He might have already known that, but it might not have sort of been identified that he did know that. (Fiona)

Normalizing the Client Experience

Similarly, safety planning can be a catalyst for normalizing and acknowledging the client's experience, supporting them to externalize, and develop a sense of agency to respond to, their suicide-related distress:

> . . .it's helping the person I am working with to be more assertive, understanding of why and how, you know, the triggers that make him to feel more low, then he's aware of those moments, so we are normalizing not just the moment where he's feeling very low but also the whole process. . .I think that he feels more safe to have the discussion where before. . .he was feeling very embarrassed. (Janice)

Reminders Can Help to Keep People Safe

The importance of strategies to help keep people safe – particularly using visual reminders (e.g., family photographs – is a key benefit of safety planning. These reminders can interrupt the trajectory of suicidal thoughts:

> . . .the result can be very big and with some clients it helps them when they get very emotional, they want to just see something that changes their mind and think about a different picture. (John)

Reminders may also include written notes:

> . . .something that [the client] found useful was writing notes that he would stick around his bedroom. . .Kind of reminding him of things, alternatives. . . (Betty)

Theme 3: The Barriers to Engaging in Safety Planning

Participants reflected on several barriers to implementation and use, some familiar across settings, and others specific to the refugee and asylum seeker context.

Client Readiness

A common message related to client readiness. Participants highlighted that it can be challenging when "a client doesn't really want to engage in safety planning" (Betty). They may decline to participate – "When I first introduced the word "safety plan" to the client, because there was a suicide idea, they said "no". . .they didn't want to do it" (Peter) – and there may be little shifting in this view: "they just won't budge an inch" (Kuia). This may be attributed to cognitive constriction as a feature of the suicidal mind, with clients being very focused on their suicide outcome and unable to see alternatives. In other instances, clients will have more immediate, practical concerns (e.g., securing housing or transport) that take priority.

Specific to this client group, fear of disclosing suicidality and the perceived impact on their visa status is a critical barrier to trust and can hinder engagement:

> . . .[clients] know that we would convey some information about them back to immigration and they don't know what information. . .because it is a little bit, sort of vague, as to how much immigration can take of our information.
> And so they would sometimes worry. . . "how is this going to affect my visa?" . . . "maybe I will not tell her that [I'm suicidal] because maybe then they'll think I'm a risk to society and then they won't want me here. . .?" (Fiona)

Language and Literacy

Speaking a language other than English is a barrier, particularly given the typical written format of safety

planning. Similarly, literacy and mental health literacy can be obstacles:

> . . .we assume that all clients will be able to engage with the content that we are discussing and come up with safety plans in their own words but it's not always the case. . . there needs to be mental health literacy first before we even ask about suicide. (Catherine)

Organizational Conditions

Organizational-level factors can impact safety planning implementation. The "hub" style service provision model, whereby clients lack a regular caseworker, can hinder the continuity of the relationship and trust in the worker:

> . . .a client might not necessarily have a one-on-one case worker. . .they may be seen by any available case worker. . .so it's difficult to maintain a relationship or to build up a rapport to have such a difficult and really vulnerable conversation. (Sally)

Practical Challenges

Participants articulated practical difficulties associated with cocreating safety plans. Identifying information to include in the safety plan can be challenging for these clients, particularly given the absence of obvious protective factors (e.g., employment or family), or difficulty accessing mainstream support services:

> . . .unfortunately, what we find is a lot of the services that [you] might be able to rely on normally, like the, you know, the call-back services and things like that, if our clients don't have a fair level of English, sometimes those services can be difficult for them to navigate. (Betty)

Another barrier, linked to client readiness, is that while some clients are receptive to safety planning conversations, they may be fearful about writing it down:

> Some others don't prefer to write, some they just prefer to hold those thoughts in their minds, maybe they don't want to write them down because somebody will see them. . .some other clients will say 'no way, we can't write it down because that makes it more real'. (Catherine)

Theme 4: Strategies to Enhance Engagement in Safety Planning

Participants highlighted various strategies for maximizing the use and impact of safety planning.

Being Flexible and Creative

Participants stressed needing to be creative, moving beyond a written safety plan template in English language, to alternatives more accessible to these clients:

> . . .to make those safety plans culturally, linguistically and I think literacy, considering the literacy levels of the client, making them appropriate for the client. (Catherine)

This could include the use of photographs, images, or drawings. Janice explained a colleague's strategy of using an image of a hand:

> The [client] that she was working with put in each of the fingers hope and what matters and how it shows strong meaning culturally. . .

Employing Therapeutic Strategies

A number of therapeutic strategies may assist to gently ease in to safety planning conversations. Peter shared an experience after a client initially declined to cocreate a safety planning:

> . . .after he said "no," I then said to him, "would you be able to tell me what reasons you have to live?" And he answered it. . .And then I started to chat about the supports he had.

Trust and rapport were also seen as important enablers, as well as the ability to establish a "human connection" (Rose).

Addressing Language Barriers

Participants described the role of interpreters to address language barriers:

> . . .an interpreter needs to be available to ensure that communication is clear and meaningful. (John)

Enlisting the support of a trusted family member might also be helpful.

Support for Workers

Workers must be supported to engage in safety planning. Participants saw a need for, and value in, opportunities to debrief with their peers. This can open opportunities to share experiences of strategies to enhance safety planning, such as "showing alternative ways to do safety plans" (John).

Discussion

To our knowledge, this is the first study exploring workers' experiences and perspectives of safety planning as a suicide prevention strategy for refugees and asylum seekers. Four key themes related to participants' (primarily case workers and counsellors) experiences with and perceptions of safety planning were generated. Participants reflected on the unique nature of safety planning (Theme 1: Safety planning as a cocreated, personalized activity *for* the client) in a way that aligns with the intervention's intended purpose. Cocreation of safety planning was commonly described as a collaborative activity involving equal contribution from the worker and the client with both acknowledging that the client is the expert in their own life. Similarly, participants identified strengths of this intervention (Theme 2: The therapeutic benefits of developing a safety plan) consistent with the general benefits and intentions of what a safety plan can, and has been found to, produce in other studies. However, they also identified challenges (Theme 3: The barriers to engaging in safety planning); while some of these may be experienced across various practice settings (e.g., a person not being "ready" for a safety plan), other barriers are unique to this client group (e.g., language, immediate living/practical concerns, fear of disclosure impacting visa status). Participants highlighted numerous strategies and worker skills to address these barriers and maximize the use and impact of safety planning (Theme 4: Strategies to enhance engagement in safety planning).

These findings support the value of safety planning indicating that the universal rationale underpinning this intervention may be translatable to diverse populations. This may be attributed to its flexible and personalized nature. This complements the known benefits of safety planning from quantitative research with veterans in the United States (Gamarra et al., 2015; Green et al., 2018; Stanley et al., 2018, 2015; Zonana et al., 2018), and Sri Lankan refugees (Vijayakumar et al., 2017). Despite our focus on worker perspectives, the findings align with a qualitative study of veterans' experiences with safety planning, in which clients found the collaborative aspect of the process to be beneficial (Kayman et al., 2015).

This research reveals some notable barriers and practical considerations for cocreating safety plans with refugees and asylum seekers. Client readiness was a key barrier, particularly regarding their experience of immediate concerns, the high acuity of their distress, and fears about how disclosing suicidality might impact their visa status. This latter concern highlights the importance of explicit processes for sharing these disclosures with authorities, to dispel client concerns where possible but also ensure they are fully aware of the process. Staff may need education around communicating this to clients. Anecdotally, these barriers were also frequently discussed during the training program.

Given issues of client readiness, the timing of when to introduce and cocreate a safety plan requires consideration, along with how to support workers to confidently engage in it. Similarly, alternatives to hard-copy safety planning may be preferred, such as a smartphone application (Melvin et al., 2019), or visual safety plans that do not require literacy. These areas must be better understood to ensure the accessibility, uptake, and benefits of safety planning can be maximized.

Future Directions

These findings indicate the potential of safety planning for refugees and asylum seekers, particularly given that it is a relatively low-cost intervention, and can be coproduced by diverse workers. However, as an exploratory study, future research should focus specifically on safety planning through mixed-methods evaluations of safety planning from client, family/carer, and worker perspectives. This information could facilitate safety planning interventions that are culturally appropriate and acceptable, and that address the barriers that participants raised.

Limitations

This study adds to the small evidence base regarding suicide prevention strategies for refugees and asylum seekers. However, a key limitation is that this is a study of worker perspectives, rather than the direct experiences of refugees and asylum seekers. Another limitation is the amount of exposure participants had to safety planning – while all had opinions of safety planning, some had limited opportunities to engage in it since the training (e.g., due to the nature of their workload). Perceptions may differ among those with more safety planning experience; this may have been realized with a larger sample size (for an explanation of limitations to the study's sample size, see Procter et al., 2021).

Conclusion

This study indicates that safety planning is perceived by workers as a valuable suicide prevention intervention for people of refugee and asylum-seeker background. As a flexible and personalized approach, safety planning can provide practitioners with a clear path forward for working with clients, which may be particularly empowering in this difficult space. Further research is warranted to understand how best to maximize this approach.

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Miriam Posselt, BPsychHons, MClinPsych, PhD, is a clinical psychologist and has considerable experience in conducting research. Her area of interest is improving mental health service provision for populations who have experienced trauma. She has worked in private practice, community mental health, youth mental health, and in immigration detention environments in Christmas Island and Nauru.

Heather McIntyre, BA, BAHons, GradDipAS, PhD candidate, is a research assistant and has 20 years' experience working in the academic sector. Her areas of expertise include conducting systematic reviews. Heather's interests include researching evidence-based suicide prevention strategies for at-risk groups in the community. Heather is currently the inaugural recipient of the MIND Australia PhD scholarship.

Mark Loughhead, BSWHons, PhD, is the inaugural lecturer of lived experience in mental health within the University of South Australia. His work aims to promote the values of consumer experience, recovery, peer-led approaches, and person-centered care. His background includes 20 years' experience in community health where he has demonstrated experience and leadership in professional education, community development, and consumer advocacy.

Mary-Anne Kenny, LLBHons, LLM, is associate professor in the College of Arts, Social Science, Business and Law, Murdoch University. She teaches and researches in the area of refugee and immigration law. She has a particular interest in the intersection of refugee law and issues related to mental health.

Vicki Mau is the National Manager of Migration Programs at Australian Red Cross. Her teams support migrants in vulnerable situations both directly and through sector partnerships, community engagement, and government advocacy. She is co-chair of the Red Cross and Red Crescent Asia-Pacific Migration Network.

Nicholas Procter, BA(Soc), PsycNurs, RN, MBA, PhD, has worked for over 30 years in higher education teaching and research and is Australia's national representative to the International Association for Suicide Prevention. He is also member of the Expert Advisory Group to the Prime Minister's National Suicide Prevention Adviser, National Suicide Prevention Taskforce.