The evidence for personalised risk management and safety planning for adults experiencing suicidality.

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Introduction

1. Background
2. Paula's story
3. The personalised safety planning study
4. Next steps
5. Questions

My Journey into research

ARC support

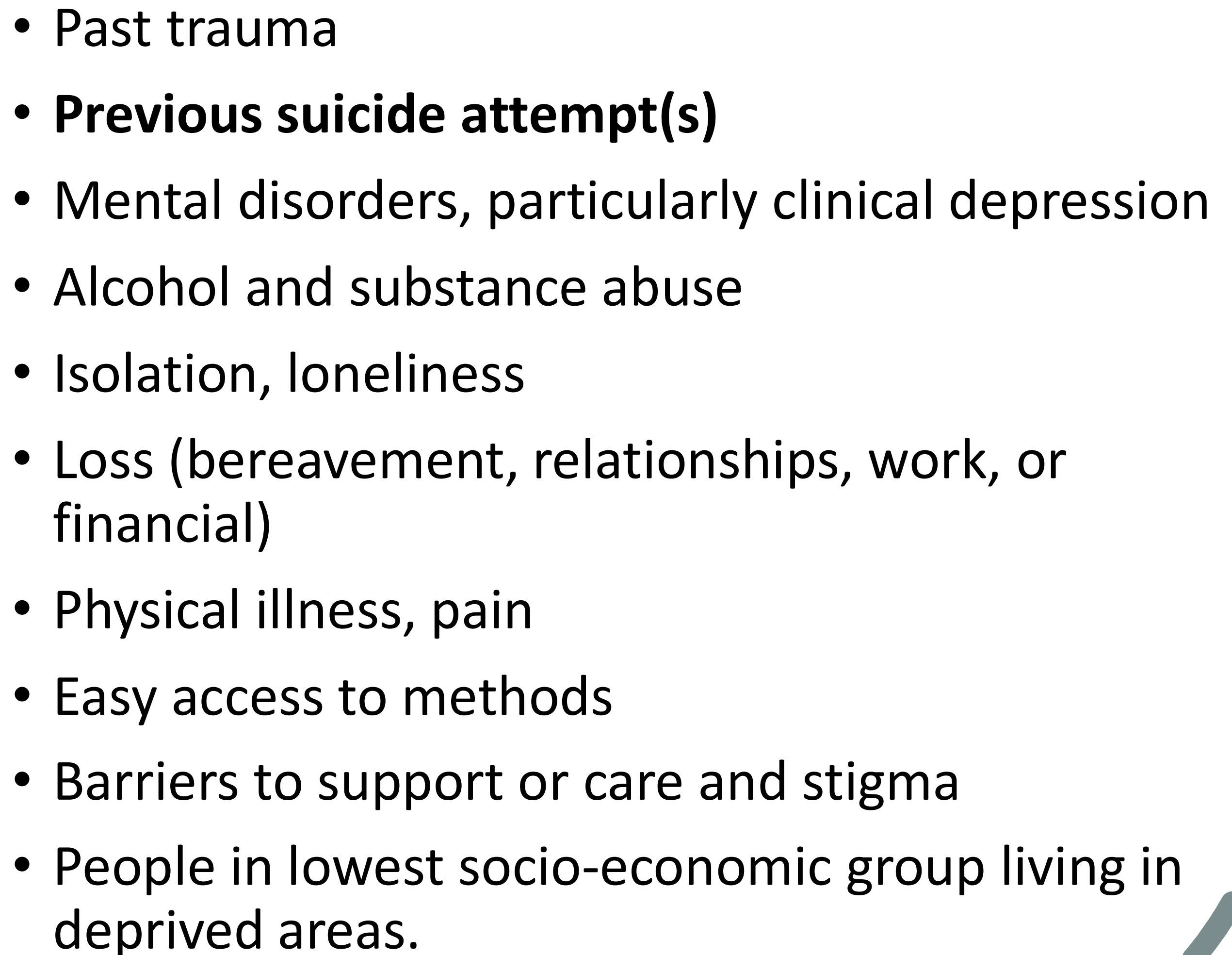
- Focus on **applied research**.
- Encouraged **co-production** approach.
- Links with **academic expertise**.
- Advice **and encouragement**.
- Training and support.
- Helped me feel **I can do it.**

Suicide prevention is a priority

- NHS **Long term plan.**
- **Suicide prevention strategy** for England 2023-28.
- Priority for **NE/NC ICB.**

Why is it a priority?

Complex - multiple risk factors



- Past trauma
- **Previous suicide attempt(s)**
- Mental disorders, particularly clinical depression
- Alcohol and substance abuse
- Isolation, loneliness
- Loss (bereavement, relationships, work, or financial)
- Physical illness, pain
- Easy access to methods
- Barriers to support or care and stigma
- People in lowest socio-economic group living in deprived areas.

Ben

“Please just do something”

April 2018, Kate – Ben’s mum

Co-production of an evidence-based framework and related guidance for practitioners on personalised risk management and safety planning for adults experiencing suicidality

Teesside University

UNIVERSITY of Cumbria

Northumbria University NEWCASTLE

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Dedicated to Jaymie

Lead investigator – Katherine McGleenan

Co-leads – Prof Darren Flynn & Jill Barker

Peer researchers – Paula, Tara , Rebecca and Vick
Research associates – Dr Isobel Gordon & Hollie Smith

Academics/senior clinicians - 3 regional universities

NE/NC SP Network - multiagency partners

Safeguarding advice - NCISH & Glasgow University Suicidal Behaviour Research Laboratory

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Paula – Jaymie's mum

- Paula's Story (vimeo.com)

Safety planning description.

A brief intervention to help prevent suicide.

Template to helps:

- *Encourage people to **safely navigate suicidal feelings and urges & to help build hope.***
- ***Identify strategies** to resist suicidal thoughts*
- *Develop **ways to cope** with **emotional distress**.*

Background & rationale for the study

1. **Priority identified by people with lived experience.**
2. **Need to move from risk prediction.**

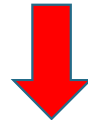
- **Risk prediction tools - little predictive value.**
- **Safety planning - a research priority.**
- **Personalisation a priority.**

Study Aims

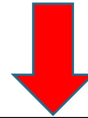
- **Co-produce** a 'draft' **personalised safety planning framework** for practitioners.
- **In partnership** with **experts by experience**.
- Focus on **– individuals needs and preferences**, the **process** *& the **practitioner role*** - rather than the tool its self.
- Focus on - **prevention, mitigation, early intervention.**

Rapid Scoping Review

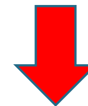
Qualitative Interviews



Co-produced first draft framework



Interactive Group Workshops



Co-produced draft safety planning framework

Qualitative interviews

- Explore peoples lived experience of suicidality and safety planning.
- Semi structured interviews.
- Views, priorities and preferences on the content of related guidance for practitioners.

Inclusive criteria used;

- 18 years or over
- Current or past suicidality
- Currently receiving support

11 participants interviews

Demographics:

- 8 females, 3 males
- Aged between 24 and 62
- 10 White British, 1 Asian/Asian British (Indian)
- Range of socioeconomic backgrounds.

Diverse lived experiences:

- Borderline personality disorder
- Post natal depression
- Psychosis
- PTSD
- Depression
- Anxiety
- ADHD
- Autism
- Past/recent trauma
- Self-harm
- Substance addiction

Findings from interviews: 6 themes

Personalisation

- Co-Production
- Family and friends
- Making it truly personal

Guidance on the process

- Purpose
- Format
- Implementation

Co-production

- “it would definitely have been better if they'd have **sat down with me** and I'd have been able to write it out with them, rather than them **impose their own thing on me**.”

Family and friends

- *“if you're gonna have a trusted other involved in safety planning it can’t be just at the end,* ***“Here, here’s the bit of paper.”***

Making it *truly* personal

- *"they give you* ***a generic plan*** *which doesn't pertain to you, it often* ***contains parts which are not relevant to you*** *which is churned out basically to meet a CQC criteria but* ***doesn't actually have any meaning to the individual****."*

Purpose

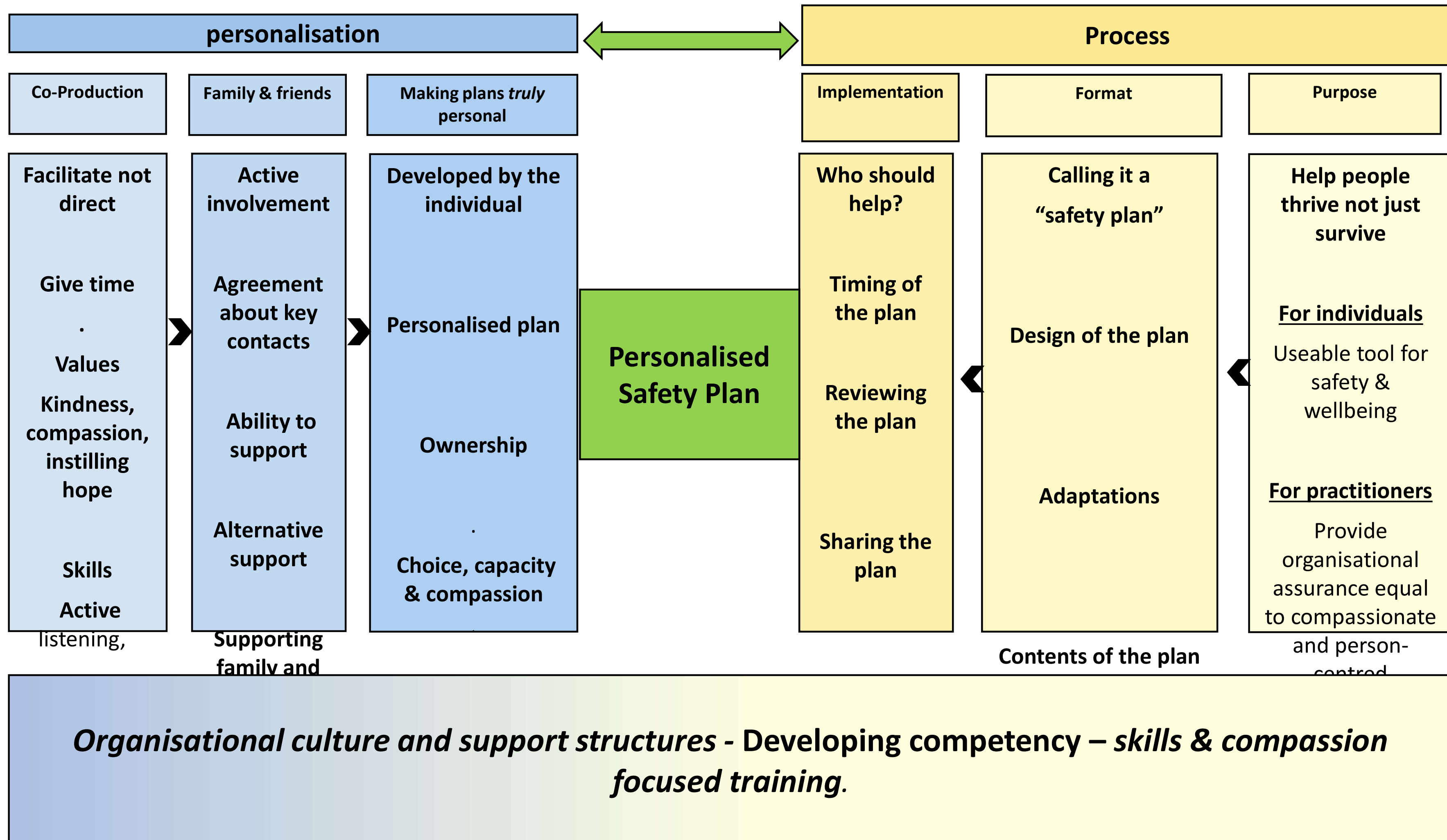
- *“always that* ***tension between the need for professionals to document*** *and to sort of cover themselves.”*
- *“It felt like* ***from their point of view they had a safety plan, but I didn’t*** *necessarily* ***have anything that made me feel any safer.”***

Format of a safety plan

- *"For me, **writing it down never works, because I have a bad habit of using the bin** quite a lot."*
- *"I'm a bit of an obsessive planner and because **I feel like nothing happens unless I write it down** you know I'm a real list maker,"*

Implementation

- ***“A trusting relationship** was really important”.*
- *“Skills and confidence to be able to **listen to what I said**.”*
- ***“The groundwork has to be started** when someone is in a more level place”*
- *“it should be **simple and practical.”***
- *“ Initially it felt quite supportive. **But then nothing happened**…..”*



personalisation
Process
Co-Production
Family & friends
Making plans truly personal
Implementation
Format
Purpose
Facilitate not direct
Give time
Values
Kindness, compassion, instilling hope
Skills
Active listening,
Active involvement
Agreement about key contacts
Ability to support
Alternative support
Supporting family and
Developed by the individual
Personalised plan
Ownership
Choice, capacity & compassion
Personalised Safety Plan
Who should help?
Timing of the plan
Reviewing the plan
Sharing the plan
Calling it a "safety plan"
Design of the plan
Adaptations
Contents of the plan
Help people thrive not just survive
For individuals
Useable tool for safety & wellbeing
For practitioners
Provide organisational assurance equal to compassionate and person-
Organisational culture and support structures - Developing competency – skills & compassion focused training.

2 multiagency workshops

Total 21 participants - NE/NC

Attendees included; Psychiatrists, 3rd sector mental health charity staff, GP, carer, autism clinical lead, inclusion lead, police, social worker, lived experience director, mental health nurses, crisis service manager and psychiatric liaison practitioners.

Benefits of the Framework.

Support a **holistic** approach rather than **one size fits all.**

Proactive - rather than a reactive one-off intervention in response to crisis.

Supports a trauma informed approach.

Balance between **individual** and **organisational assurance**.

Aligns well with current practice.

Easy to follow.

Barriers to implementation.

Gaps in support following crisis.

Lack of consistent approach across the system

More of a time challenge? Practitioners reported following a template/tick box process is easier when under time pressure.

If not careful, this may become another tick box exercise.

Enablers to support implementation.

A system wide workforce of **skilled practitioners.**

A system wide **consistent approach**

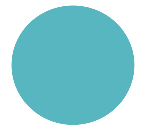
Multiagency **sharing**.

Requires **the right organisation culture – compassion focus**.

A clear **implementation plan**.

Next Steps.....

“it’s taken me, what, thirteen attempts to realize that I didn’t want to die.” participant 8



Zero Suicide Alliance
Because ONE life lost is ONE too many
SAVE A LIFE...
TAKE THE TRAINING
zerosuicidealliance.com

Questions