Health and Social Care in Northern Ireland

TOWARDS ZERO SUICIDE
Improving Suicide Prevention Care

IIMHL/IIDL 2022 Leadership Exchange

DELIVERING A SUICIDE PREVENTION FOCUS ACROSS N.IRELAND'S MENTAL HEALTH SERVICES

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the CHURCHILL fellowship

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Presentation Objectives

- Present the N.Ireland Towards Zero Suicide Patient Safety Programme
- Highlight key approaches to Suicide Prevention being applied
- Share the process of translating evidence into local practice

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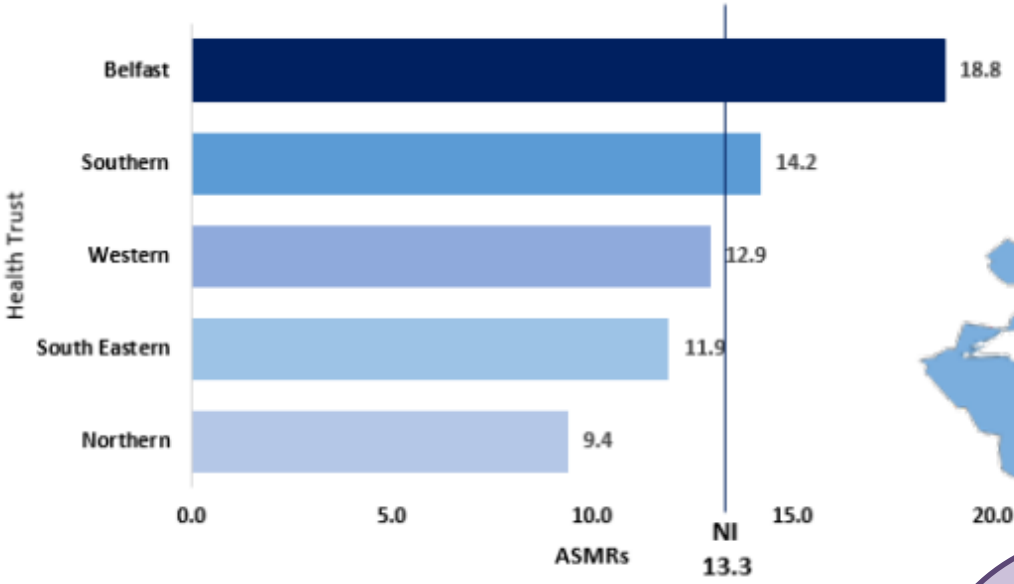
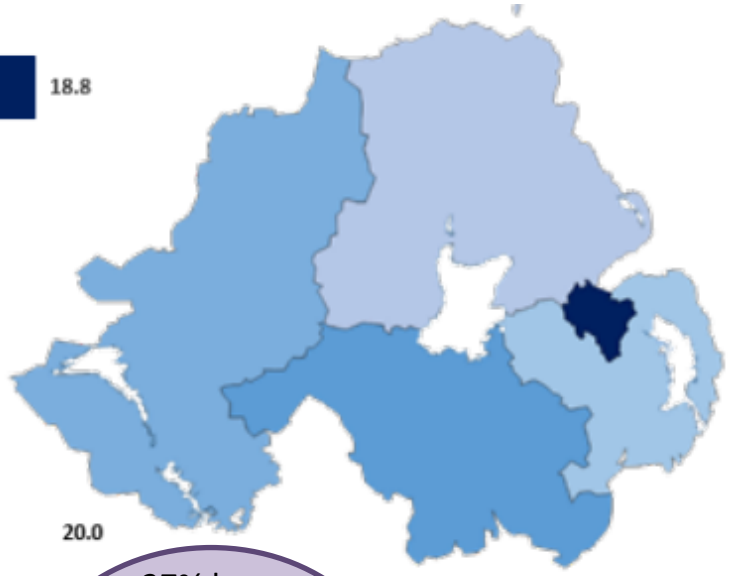
Age-standardised Suicide rate by N.Ireland Health Trust Area 2020





27% have been in contact with Adult Mental Health Services

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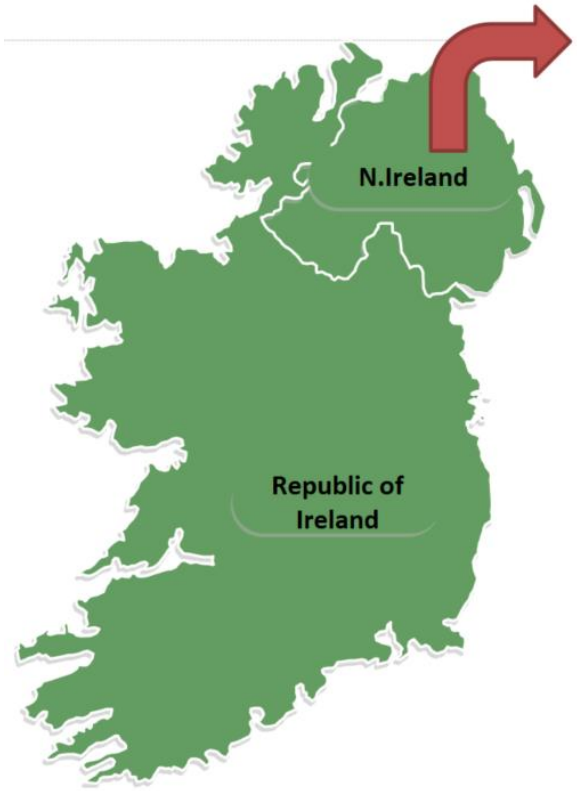
Collaborating to improve outcomes in Suicide Prevention



- 5 Integrated Health & Social Care Trusts
- Healthcare in Prisons
- Lived Experience & Advocacy
- Department of Health
- Public Health Agency
- Professional Colleges
- Community & Voluntary Services
- Ulster University

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What is Towards Zero Suicide?

An integrated system-wide strategy for suicide prevention in patients known to mental health services


Research Trends

Suicide in Northern Ireland

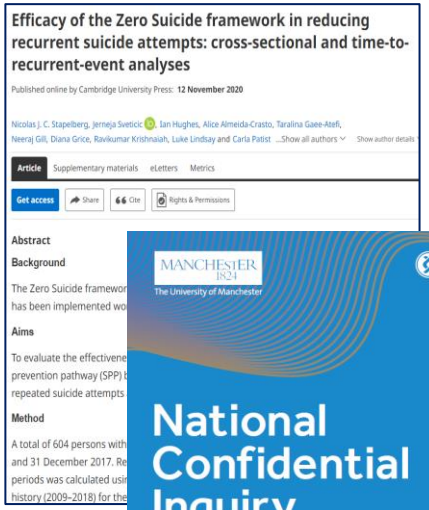
An Analysis of Gender Differences in Demographic, Psychological, and Contextual Factors

Siobhan O'Neill[1], Colette Corry[2], Danielle McFeeters[1], Sam Murphy[1], and Brendan Bunting[1]

[1]Psychology Research Institute, Ulster University, Londonderry, UK
[2]National Suicide Research Foundation, University College Cork, Ireland

Abstract. *Background:* The circumstances surrounding death by suicide can give us insight into the factors affecting suicide risk in particular regions. *Aims:* This study examined gender and circumstances surrounding death by suicide in Northern Ireland from 2005 to 2011. *Method:* The study analyzed 1,671 suicides (77% male and 23% female cases) using information contained from the coroner's files on suicides and undetermined deaths. *Results:* Hanging was the most common method and more than one third of the deceased had prior suicide attempts. There was evidence of alcohol use in 41% of the cases. Only, 61% of cases had recorded adverse events; most had multiple and complex combinations of experiences. Relationship and interpersonal difficulties were the most common category of adverse event (40.3%). However, illness and bereave-

- Informed by national and international research
- Shaped by Lived Experience
- Driven by service information
- QI approach - testing small & scaling out across NI


Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses

Published online by Cambridge University Press: 12 November 2020

Nicolas J. C. Stapelberg, Jerneja Sveticic, Ian Hughes, Alice Almeida-Crasto, Taralina Gaee-Atefi, Neeraj Gill, Diana Grice, Ravikumar Krishnaiah, Luke Lindsay and Carla Patist ...Show all authors Show author details

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Abstract

Background

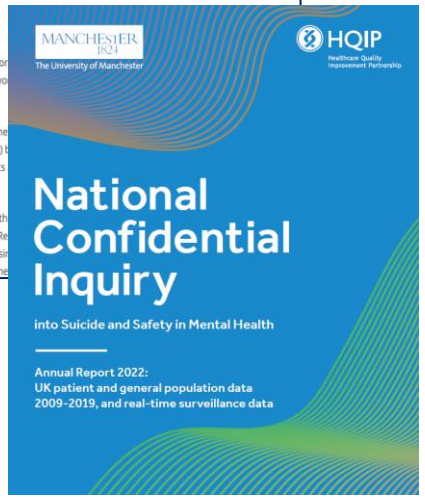
The Zero Suicide framework has been implemented wo

Aims

To evaluate the effectiveness prevention pathway (SPP) repeated suicide attempts

Method

A total of 604 persons with and 31 December 2017. Re periods was calculated usi history (2009–2018) for the



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From	To
Seeing suicide as a choice and inevitable in mental health care	A Whole Systems Approach can lead to prevention of suicides.
A focus on diagnosis - Suicide as a symptom of mental illness	Suicidal Behaviours must be responded to and treated in their own right – treating suicidality directly
Risk Assessment to predict risk of suicidal behaviour. Containment	Risk Assessments - *not used to predict behaviour but to treat and shape interventions.* Collaborative safety, treatment, recovery.
Stand alone training and tools	Training integrated into overall systems and culture change
Individualized clinician judgment and actions	Standardized screening, assessment and interventions. Handovers
A culture of Blame	Systems that seeks to learn and to support staff.

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Towards Zero Suicide A Whole System Approach

Towards Zero Suicide - Strategic Approach to Improving Suicide Prevention in Mental Health Care

Stream 1 Strategic Leadership for System Change.	• Protect Life 2 Strategy • Review of Crisis MH Services • TZS Suicide Collaborative Board and Operational Team • Involvement of People with Lived Experience & Carers • Involvement of C & V Sector • Trust Local Implementation Groups
Stream 2 Whole System Change	• Organisational Self-Assessment. • Works Streams to safer services • Suicide Prevention Care Pathway
Stream 3 Training – creating a competent, confident, and caring workforce in suicide prevention	• System wide level 1 Training • Level 2 training SPCP • Level 3 training – Suicide Specific Interventions
Stream 4 A Just Culture – Staff Support Systems.	• Regional Review of SAIs • Mersey Care Approach • Staff Support Systems
Stream 5 Evidence and Learning	• Research Paper UU • SPCP Model • Gold Coast & Mersey Care NHS Trust • SAI Learning– Through the Lense of TZS • QI Methods • Data Sharing Agreements

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Training and Competencies

Q. “What is your fear about asking someone if they're thinking of suicide?“

A. "That they'll say yes."

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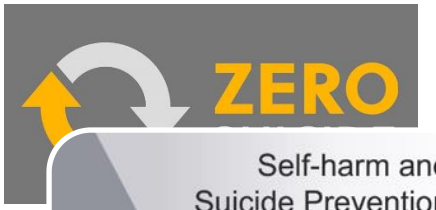
Scoping Exercise



Who

What

Organisational self study

Training

Competence

Confidence

Training

Availability

Cost

Time

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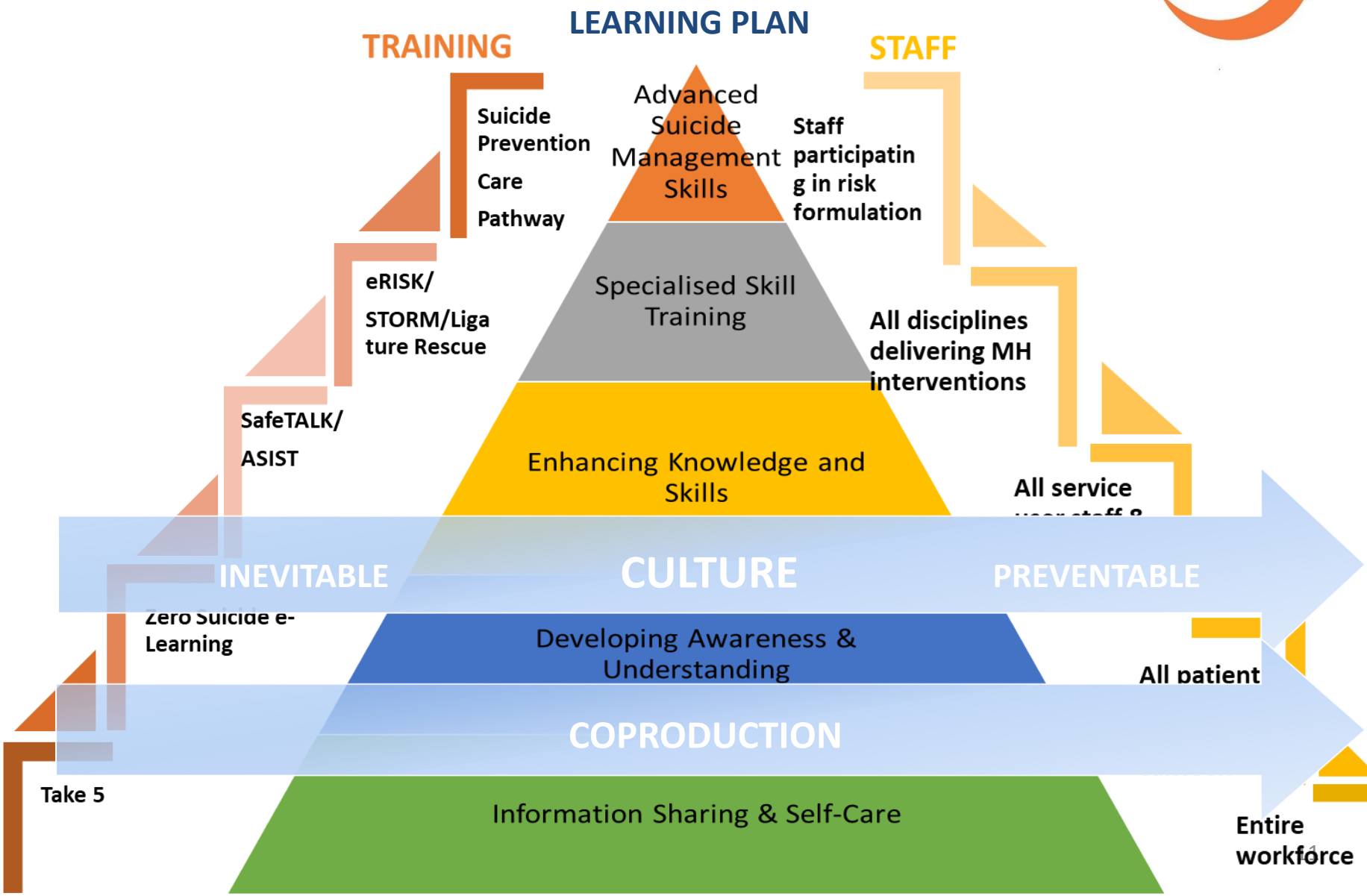

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CO-PRODUCTION

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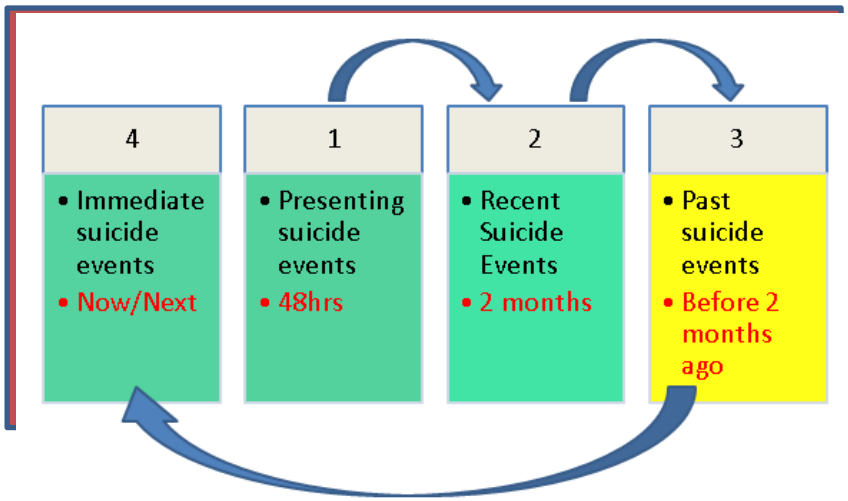
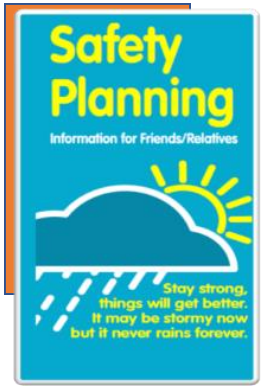
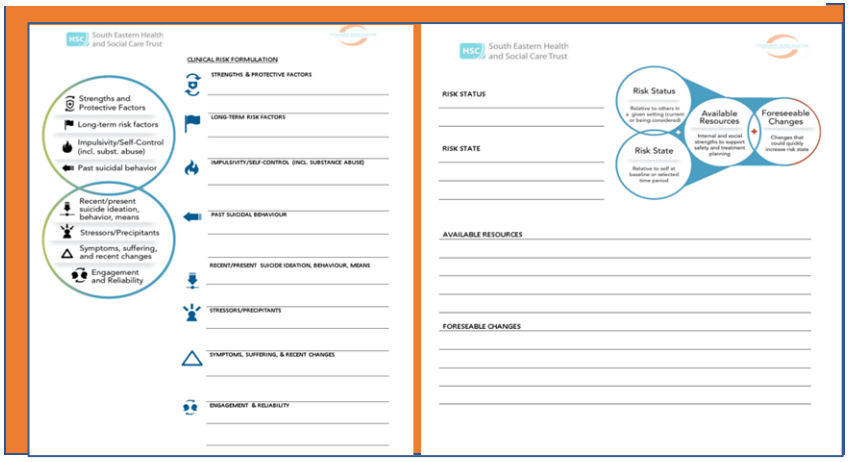
Advanced Suicide Management Practice







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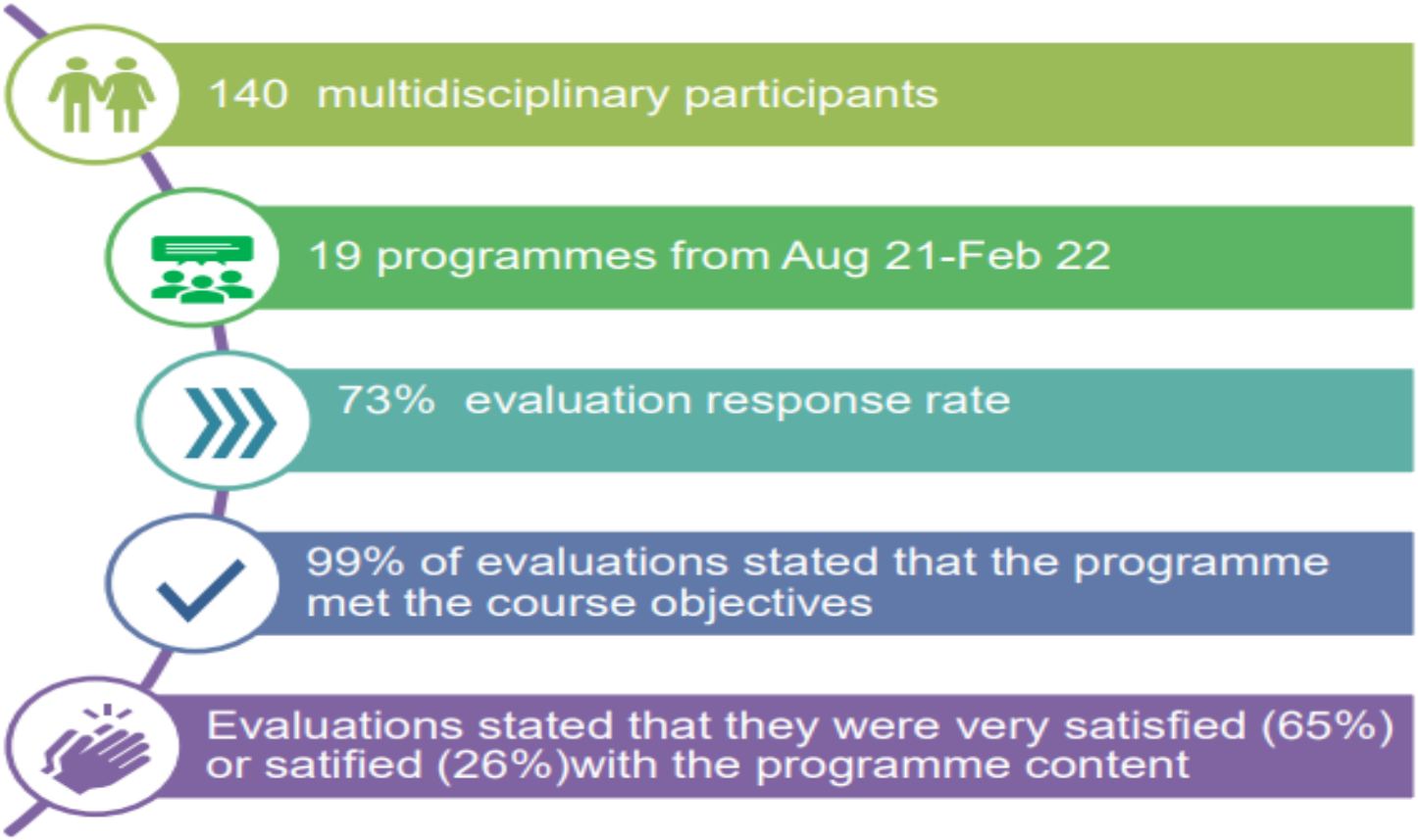
CEC Evaluation

4 Programme Outcomes



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Feedback on training

Where you satisfied with the delivery of the programme?

"Excellent presented with key service user involvement".

"Trainers were excellent and took the group on a journey through the training material and connected it to practice".

"Peer support worker was excellent, great delivery from both colleagues giving different perspectives".

What did you find most beneficial about the programme and why?

"Having lived experience in the room".

"Safe confidential forum which allowed open reflection".

"Having time to discuss important issues around service user's safety".

Would you recommend this programme?

"Sharing discussions with others in the group, hearing from the peer worker, and stats for NI". "Every Mental Health Nurse should attend this programme"

"Facilitators provided many examples of practice experience which promoted discussion, it was helpful to have a patient representative".

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Collaborative Safety Planning

Safety Planning Intervention - Rationale

- Suicide risk fluctuates over time (SPI pre-empts this fluctuation). Interventions that help an individual get through times of crisis can be effective in reducing suicidal behaviors.
- Problem solving capacity diminishes during crises (Using "over-practicing" and a specific template can enhance coping)
- Up to a 40% greater reduction in suicidal behaviours compared to the comparison group who received treatment as usual (Brown, 2015).
- Can significantly increase likelihood that patients will attend follow up following an ED presentation for a suicide related reason, than those who do not receive SPI (Stanley et al., 2015).

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Meta- analysis in 2021 published in the British Journal of psychiatry (Impact factor of 7.2):

- *Safety planning type interventions for suicide prevention were associated with reductions in suicidal behaviour, but no effect was identified on suicidal ideation.*
- *Risk of **suicidal behaviour** was reduced by 43% (Number Needed to Treat= 16) for patients who were utilising Safety Planning Type Interventions. No significant impact on suicidal ideation.*
- Annual report 2022: UK patient and general population data 2009-2019 highlights … *"Working more closely with families could improve suicide prevention"*
- Exploration of a shorter Safety Plan model (Barbara Stanley and Gregory Brown potential to reduce suicide attempts, lower suicidal ideation, and increase treatment engagement with patients presenting to unscheduled care.

Plan Do Study Act

PDSA 1

- MH Liaison
- Crisis
- CMHT
- Unscheduled Care
- Self-Harm Service
- Home Treatment
- Prisons – Mental Health

PDSA 2

- Acute Inpatient Wards
- Crisis Cafés
- GP Federation MH Teams

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Safety Planning QI project – Prototype bundle

Information leaflet developed for Supporters on Safety planning and their role in supporting loved ones.

Pocket sized Z plans and information leaflets

Development of a worksheet, which contains guidance to aide completing the plans for staff and patients

Staff training

Evaluation tools + safety protocol

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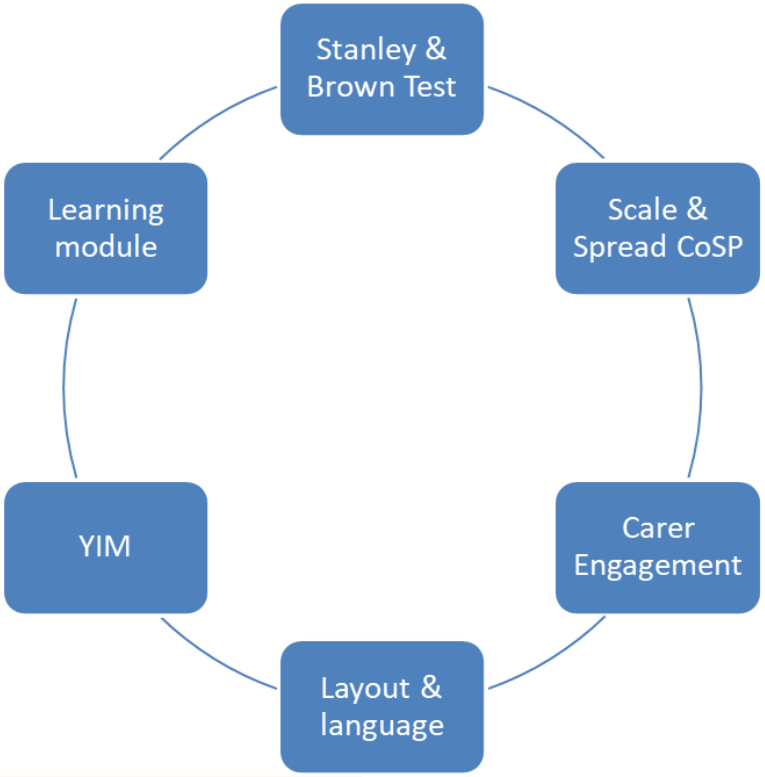

- ✓ 990 patients completed CoSP by Aug 21
- ✓ 289 staff trained to deliver Safety Plan Brief Intervention.

"I still have my safety plan; I have it pinned on the wall. I don't care who sees it, I know that it helps me. Seeing it reminds me of the fact I want to get better" - Person in Prison Care

PDSA 1

Average times to complete the SB Safety Plan in MHLS was 18 – 20 minutes, and in Crisis was 36mins – within limits for these services

Average time to complete the follow-up calls in MHLS was 15 – 20 mins and in Crisis was 36 mins - This average is within limits for these services

Service users and clinicians both rated this model highly in terms of meaningfulness with average responses between 7.5/8 out of 10 for Service Users and 8/9 out of 10 from clinicians.

Limited data available around completing 72hr follow up suggests reasons for not conducting follow-up are consent for follow-up refused; couldn't make contact at follow up; patient declined follow-up at point of call or patient moved into another service.

Stanley & Brown Safety Plan is viewed to be an acceptable and meaningful model for use with Mental Health Liaison and Crisis-type presentations

The limited amount of 72-hour follow-up conducted does not give a clear picture of a preferred model to achieve effective follow-up.

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Challenges

- Change – culture
- Staff concerns regarding time to complete – pressurised services
- Training for staff
- IT issues
- Data collection and evidencing improvement
- 72 hour follow-up

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Spread and Scale Plan

- Finalise 72hr follow up model for each Trust
- Spread practitioner Training across all Adult Mental Health Services
- Complete adaptations for Prisons settings
- Adapt ICT systems
- Monitor SPI quality
- Celebrate achievements

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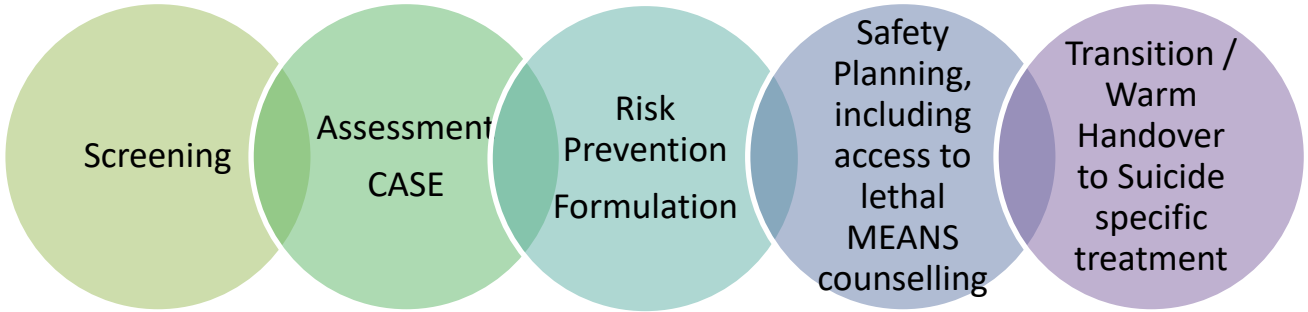
Suicide Prevention Care Pathway



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Suicide Prevention Care Pathway (SPCP)

- Based on best available evidence
- Trans-diagnostic
- Anticipated updated NICE guidance
- Draws on expertise and experience of others (ZS Institute, Gold Coast Mental Health Service, Mersey Care NHS Foundation Trust)
- Co-production
- Training programme for staff
- Utilises a Quality Improvement approach
- Consistent approach across the 5 Trusts & IS providers in N Ireland

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SPCP- Key Components

- Screening and engagement
- Assessment using the Chronological Assessment of Suicide Events (CASE) approach (*Shea SR, 1998)*
- Risk formulation using the Prevention Oriented Risk Formulation approach (*Pisani AR, 2016)*
- Brief interventions- safety planning *(Stanley B & Brown GK, 2008)* and lethal means counselling
- Rapid referral with warm handover and structured transition to appropriate services

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Process

- Test sites across a wide range of acute mental health services in the 5 Trusts (ED liaison, assessment centre, crisis, home treatment, CAMHS teams)
- Ensure its acceptance by busy clinicians and by management
  1. Preparatory meetings to raise awareness, explain the rationale and the concept behind the SPCP
  2. Cross –sector Local Project Teams
  3. Self Assessment - Process mapping
  4. Co-design Lived Experience
  5. Training for staff
  6. Quality Improvement approach with small-scale testing

- Challenges:
  1. Staff time
  2. IT & Data gathering
  3. Information sharing
  4. Duplication of documentation and integration with currently used systems

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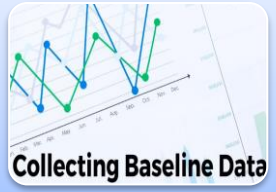
Preparation

Collaboration with Lived Experience



Baseline Data

Stakeholders and Process Mapping Pathways

Process Mapping – Self Assessment DE

Suicide Prevention Care Pathway - Mapping Existing Processes Template

Towards Zero Suicide Element	Description of TZS best practice	What we do now	What are the gaps/deficiencies in what we do now?
	systems and care planning or case management.		
Formulation *Decisions on the level and nature of service and support are informed by the formulation of a person's suicide risk.*	A suicide risk formulation tool is utilised alongside clinical judgement with people at risk of suicide.		
	Services use an appropriate suicide risk formulation approach eg Pisani		
	There is a systematic approach to decisions about treatment modality (eg Inpatient, Home Treatment, Crisis Care, Outpatient Care, SHIP (C&V)) based on the findings in the formulation		
	Staff are trained in the administration, purpose and interpretation of comprehensive suicide risk formulation assessments, alongside clinical judgement.		

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Partnerships

Lifeline
0808 808 8000
www.lifelinehelpline.info

inspire mental health
wellbeing and recovery

cause
families, partners, friends caring for mental health

CAMHS
Child & Adolescent Mental Health Services

Federation of Family Practices
Newry & District

The WELL-Bean Cafe

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Challenges – how we responded

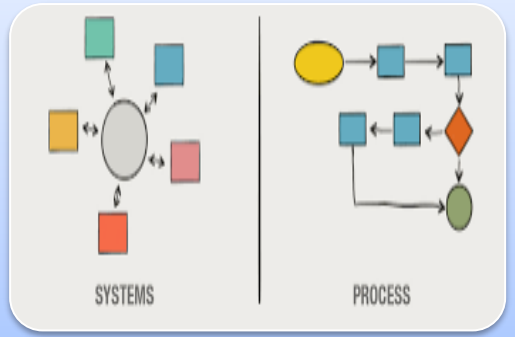
Work force Development

Fatigue

Leadership

Hearts and Minds

Training



Systems and Process

Regional Mental Health Service

ICT

Duplication

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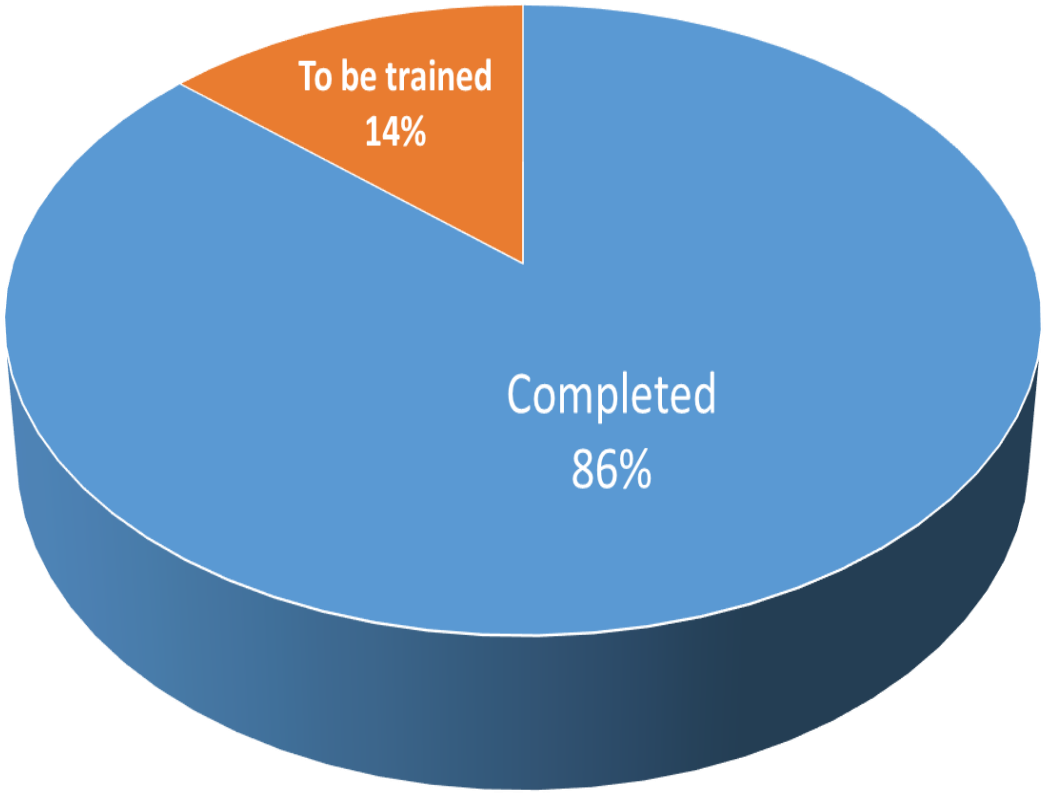
- Benefits

- 86% Staff trained in delivery of Suicide Prevention Care Plan



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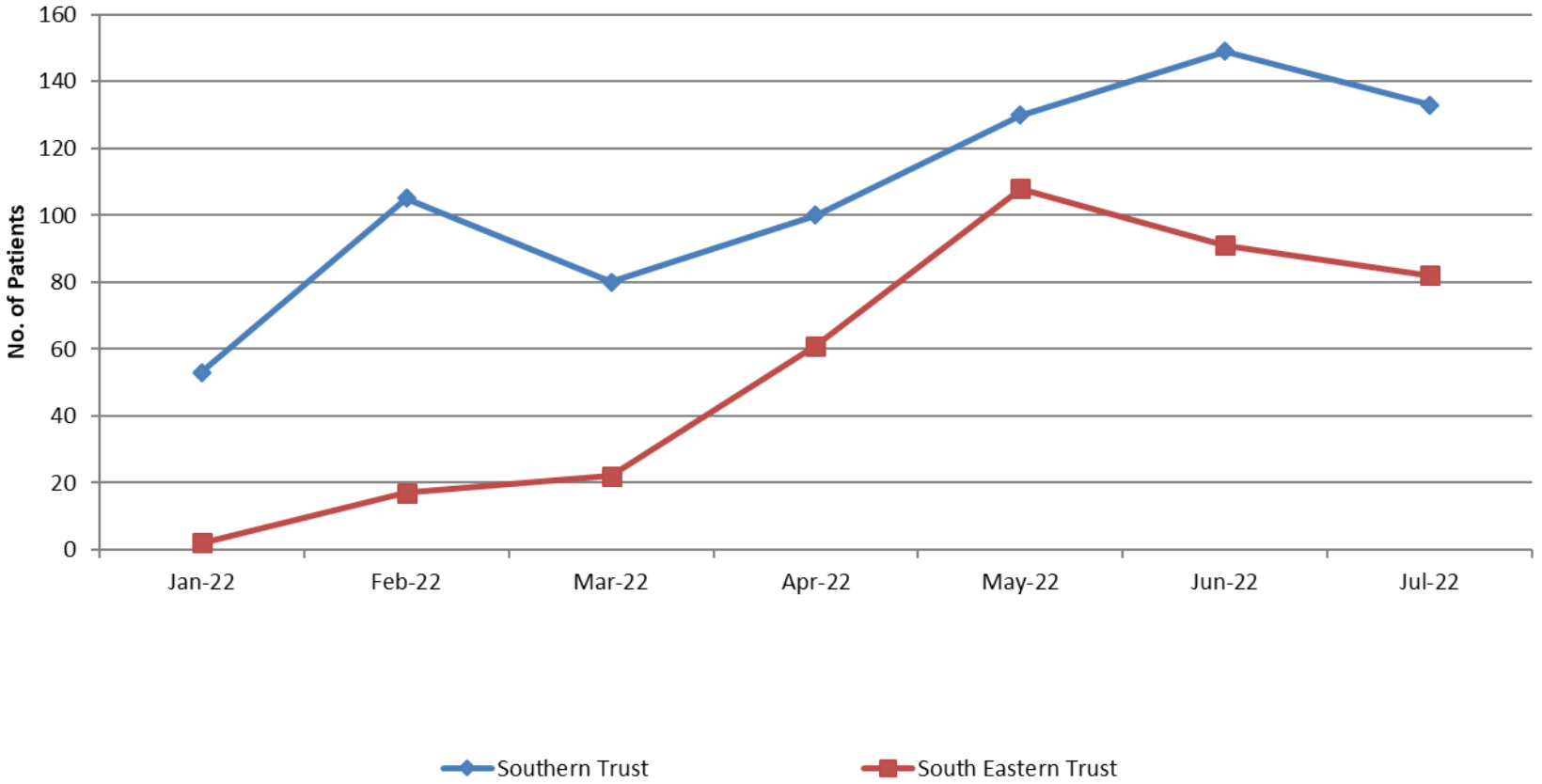
Number of Patients accessing the SPCP



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Next Steps

- SPCP Tests BHSCT September & WHSCT November
- Embedding of SPCP in Regional YiM Care Plan
- Consolidation of SPCP in current test sites
- CAMHS roll-out
- Spread and Scale - across all acute mental health services
- Training capacity
- Co-produced service user and carer information
- SHARE guidelines and training
- Prison Services – safety planning and generic training
- Just Culture

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DELIVERING A SUICIDE SPECIFIC FOCUS ACROSS N.IRELAND'S MENTAL HEALTH SERVICES

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