Striving for Zero Suicide

Update

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Natasha Berthollier
Geoff Dennis
Sue Mclaughlin

Zero Suicide
Striving for zero suicide.

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Background

- The ‘zero suicide’ programme was developed by the Henry Ford Hospital System in Detroit. Their perfect depression care pathway, with zero suicide as the key outcome measure resulted in a dramatic reduction in suicide over a ten year period, eventually reaching zero.
- Mersey Care were the first Trust to adopt the ambition in the UK in 2015 – data analysis is underway.

What is the BHFT Zero Suicide Ambition?

- ✓ Challenge old ideas about the inevitability of suicide
- ✓ Embed a learning culture (training, reflective practice, learning from suicide)
- ✓ Support for service users, families and staff

"Even if you believe we are never going to eradicate suicide, we must strive towards that"

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Day One

Knowledge

Awareness & Risk update

Integrating models to practice

Challenging cases

Involving Family/Carers

Day Two

Practicing Skills

Telephone assessment

Face-to-face assessment

Peer & Self-appraisal

Day Three

Application

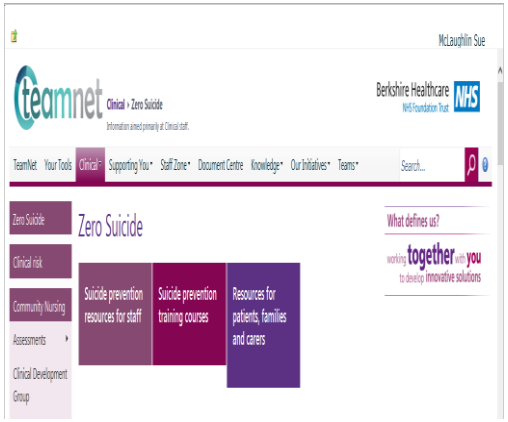
Learning from incidents

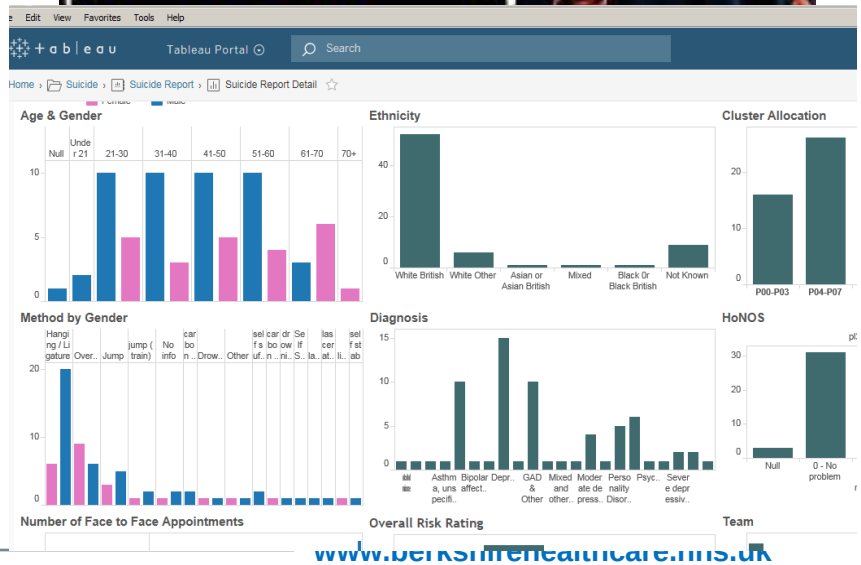
Risk management & audit

Global Perspectives

Reflective Peer Review

Self-assessment





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Practice Example

Patient involvement in patient safety

Mental Health ASSiST
Alternative to Admission Psychological Stabilisation Team

- Providing psychotherapeutic alternatives to repeated hospital admissions
- Offering an innovative service to high risk- to- self non-psychotic patients who are normally frequently hospitalised for own safety
- A Trauma-informed approach: we are dealing with people with problems, not patients with illnesses/disorders (90% of EUPD experienced trauma)
- Dual diagnosis: often one of the exclusion criteria, and yet a common coping strategy (2/3rds of ASSiST patients)

- A ‘missing link’ between In-patients and Community psychological services
- Embedding evidence- based approaches proven to make a difference in the treatment of individuals with emotional intensity and trauma disorders (such as DBT, STEPPS, MBT, EMDR, CBT, MBCT, MI)
- Guided by the evidence of what are the most significant factors contributing to the highest of the risk presentations

ASSiST Care Plan

- Based on The Interpersonal Theory of Suicide (Joiner, 2015)
- Three main factors contributing to high risk of suicide:

    1. Thwarted sense of belongingness
    2. Acquired Capability for completing suicide
    3. Perceived Burdensomeness.

ASSiST interventions use :

1. Social connectedness (EMBRACE group programme, peer mentoring, co-production, volunteering)
2. Psycho-educational modalities (evidence-based for this client group: DBT, CBT, MBT, STEPPS, MBCT, MI interventions)
3. Building on strength, asset-based and future-focused psychological sustainability /a recovery focus.

A comprehensive research strategy for Every new development

- Adopted a multi-method stance towards research and evaluation of the service
- The collection of both qualitative and quantitative data, guided by both scientific and humanistic persuasion, ensuring we actually give patients their voice
- E.g. just this year, three research projects have been presented at the Annual conference of The British and Irish Group for the Study of Personality Disorder
- May 2017 Bristol Patient Safety and Innovation conference
- Thames Valley Suicide Prevention and Intervention Conference in September 2017

Dissemination of ASSiST model

- As a result of ASSiST's objectively evidenced outstanding outcomes, the service is regularly visited by professionals
- There are currently four Mental Health trusts that have approached their local commissioners for funding of a development of an ASSiST model of service, having observed it as an innovative cost-saving and unusually patient-focused engaging treatment methodology, with proven positive outcomes.

Outcomes

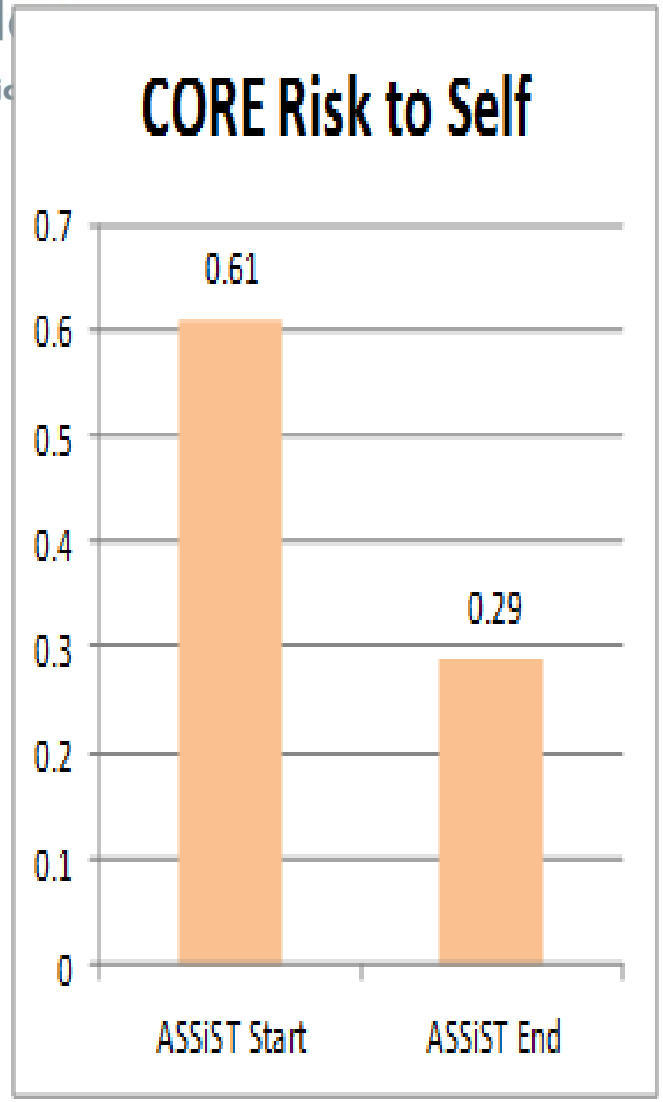
- The data used relate to the cohort of patients for 12 month pre-ASSiST start date of interventions and 12 month since ASSiST start date (First 103 patients)
- The data gathered for ASSiST have been extracted from RiO by the BHFT Data Analyst
- Quantitative measures (questionnaires)
- Qualitative feedback carers/patients/services

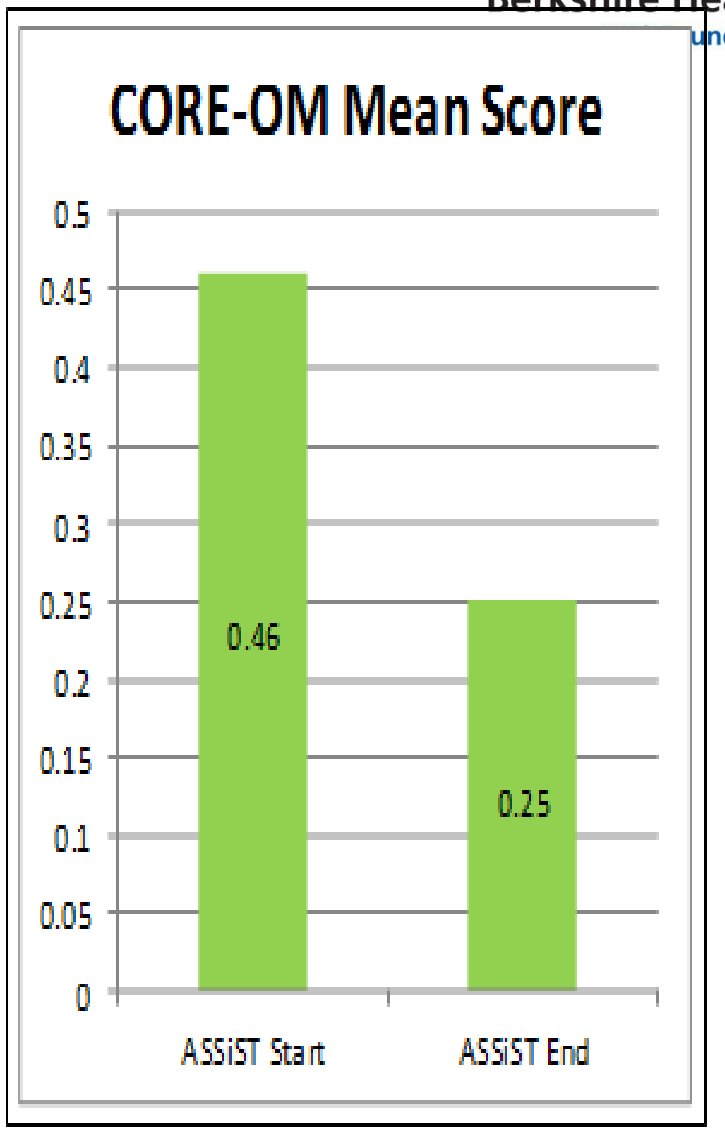
ASSiST Outcome Data

	12 months Pre-ASSiST	12 months Since Start Date of ASSiST
Number of admission episodes	173	15
Bed Days	4786	312
Cost of Bed days	£1,550,664.00	£101,088.00
CRHTT	4248	1199
A&E	203	37

CORE: Outcome Measure

- CORE (Evans, C et al (2000). CORE-OM: Clinical Outcomes in Routine Evaluation, Journal of Mental Health) measures on the following domains: Anxiety, Depression, Somatic symptoms, Trauma, Subjective Wellbeing, Close Relationship Functioning, Risk to Self/Others and General Wellbeing
- Significant improvements in all measured psychological domains and in particular reduced risk to self and others. The data also suggests vast improvements to the individual's wellbeing, interpersonal relationships and trauma, psychological and physical symptoms.

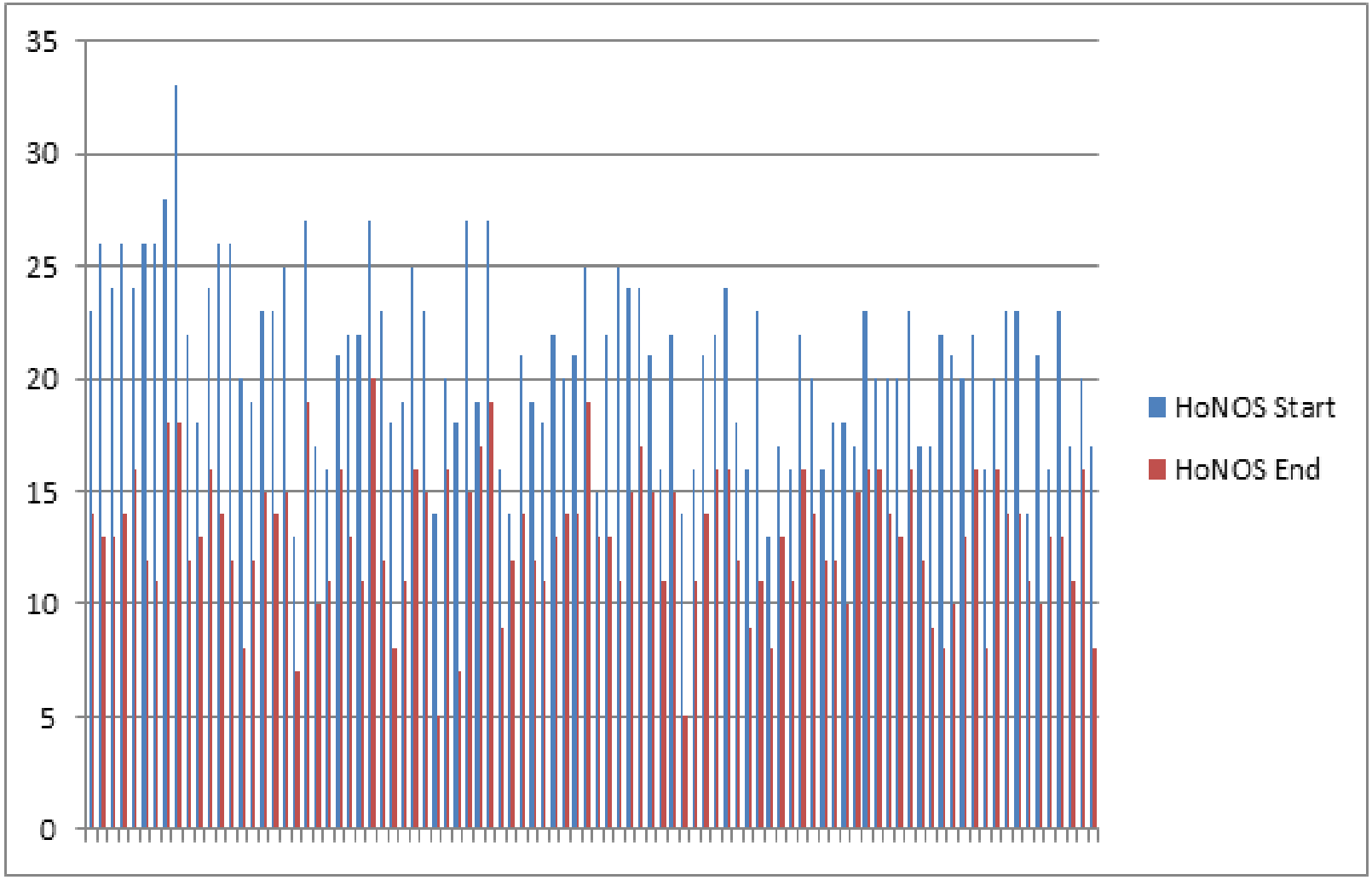

CORE Risk to Self
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.61
0.29
ASSiST Start
ASSiST End


CORE-OM Mean Score
0.5
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
0.46
0.25
ASSiST Start
ASSiST End

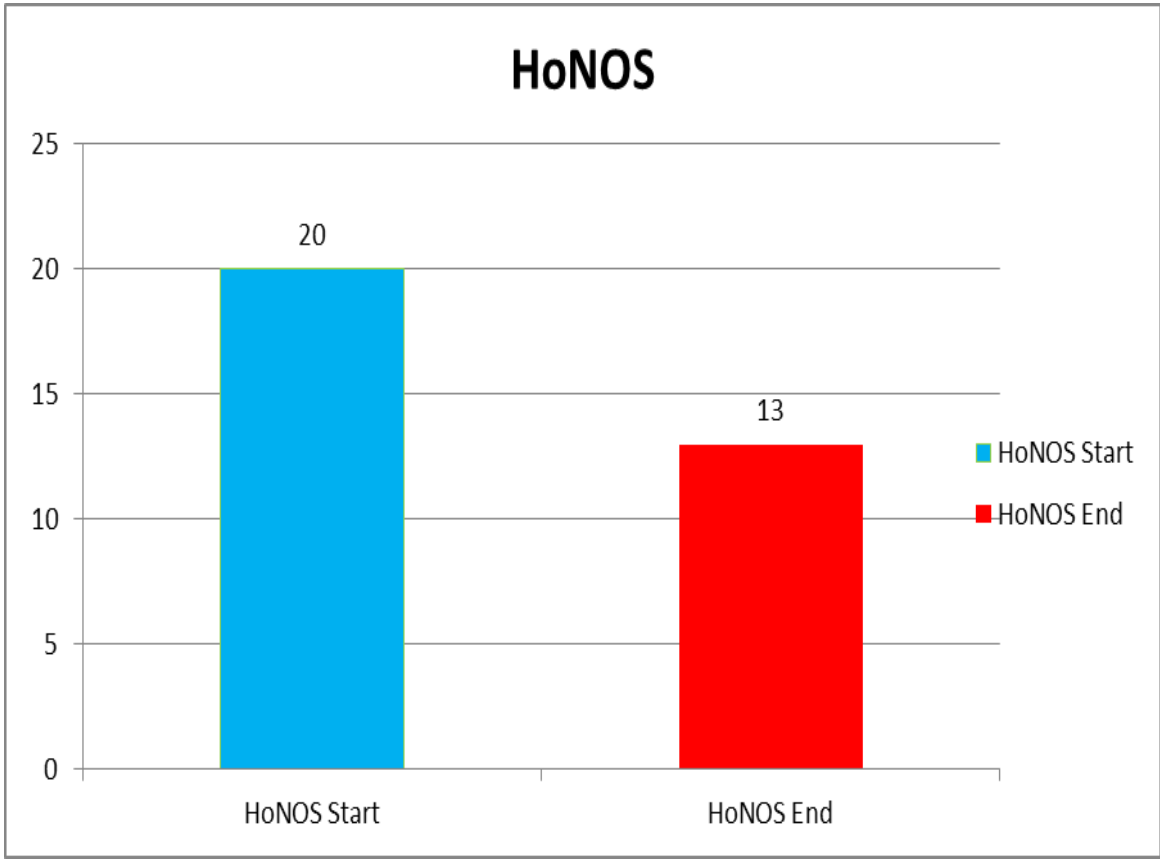
CORE-Om

	Mean Core Score: Pre ASSiST Intervention	Mean CORE Score: Post ASSiST Intervention
Core total	0.46	0.25
Depression	0.56	0.22
trauma	0.46	0.29
General functioning	0.63	0.29
Relationship functioning	0.46	0.31
Risk to self	0.61	0.28
Risk to others	0.13	0.08
Anxiety	0.56	0.29

Health of The Nation Outcome Scale (HoNOS) compared scores for 103 patients pre and post ASSiST



Mean scores for HoNOS start /finish of treatment



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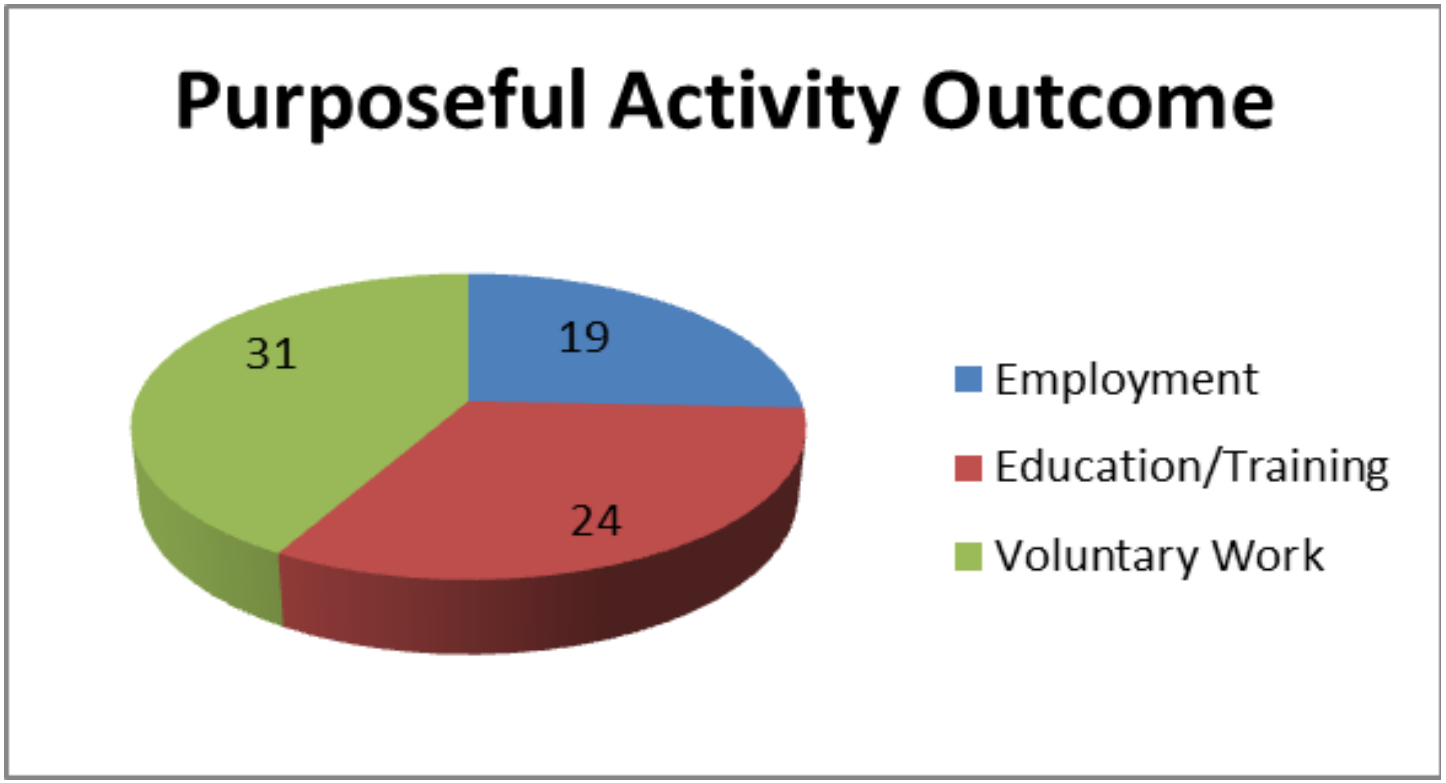
Out of first 103 ASSiST patients, we have supported 74 to return to employment, training and education



CQC

- During the recent CQC inspection, ASSiST's EMBRACE group was observed
- Patients and carers were individually interviewed
- In the CQC report on the BHFT performance ASSiST was quoted four times as an example of good practice. As per below, inspectors commented on the inherent value of patient's voice in the ASSiST service:

Are services effective?

By effective, we mean that people's care outcomes, promotes a good quality of li evidence.

- We observed an 'embrace' group in progress and saw the compassionate attitude of staff while patients themselves highlighted to us the level of empathy and commitment they felt from staff. We saw that staff provided an individually tailored response to patients and were flexible in their approach. People spoke about the skills they had acquired and the value of peer support. Patients described having their lives transformed and consistently described that the group had engendered hope, helped them overcome suicidal urges and helped keep them out of hospital. All of the patients we spoke to echoed their own belief that this has been of vital importance for them. One patient told us they had the opportunity to chair the Embrace group and take minutes. A carer also present said they had opportunity to come into sessions and told us that they believed it to be essential.

Co-production: the development of EMBRACE

- With the implementation of ASSiST and the success of the service, it became evident that a transition phase was required and we developed and implemented EMBRACE
- EMBRACE is a community meeting which allows all participants to continue with their recovery in a group process and engage **in a wider network of health & social care activities**
- This has led to senior participants training as peer mentors who are now co-facilitating psycho-educational groups in **Slough's Recovery College**
- Peer mentorship is a route to more training and employment opportunities for all participants

Co-Production/Co-Creation

- ‘Embedding Co-production in Mental Health’ (A framework for strategic leads, commissioners and managers, The National Development Team for Inclusion, 2016)
  - Fully embedded in and comprehensive, all levels
  - Patient and carer involvement in service development, management and delivery activities, evaluating services
  - Actively supporting service user power
  - Improved service-user engagement and a culture of working equally with people who use our services

Principles

- Shared Ownership:

Co-Production

- Integrated Pathway
- Long-term planning
- Relational Practice
- Formulation Based
- Positive Risk management
- Service User, Carer involvement
- Remaining Human
- Clarity of outcomes
- Staff /System Training and attitudes
- Strength-based approach Recovery focus
- Peer Mentors
- **Slough 'An Enabling Town'**

Slough Mental Health Services

Service Philosophy

Co-produced during 'The Circle Works'

20th April 2017.