BEYOND THE NCI:
HOW CRISIS TEAMS ARE WORKING TO SAVE LIVES

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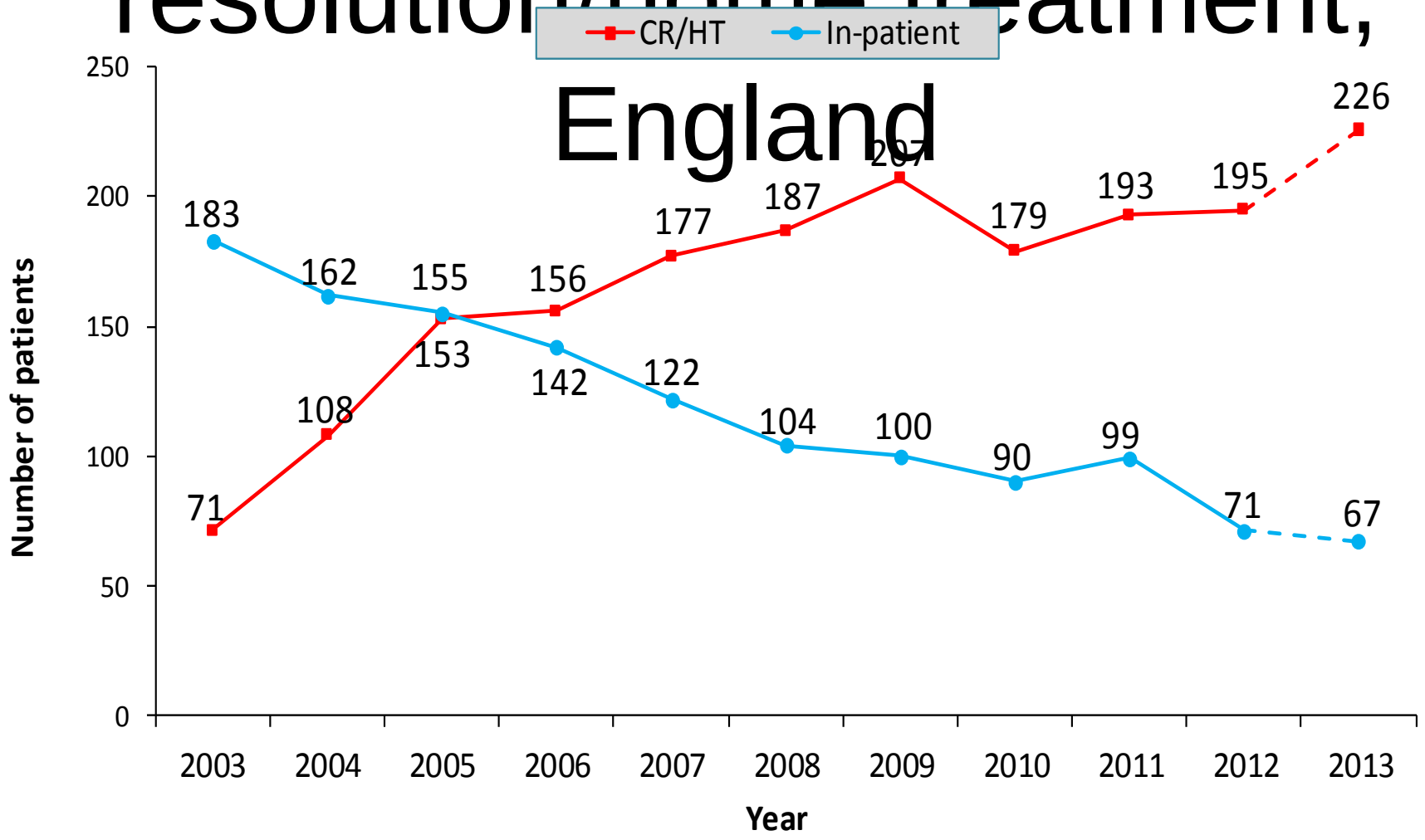
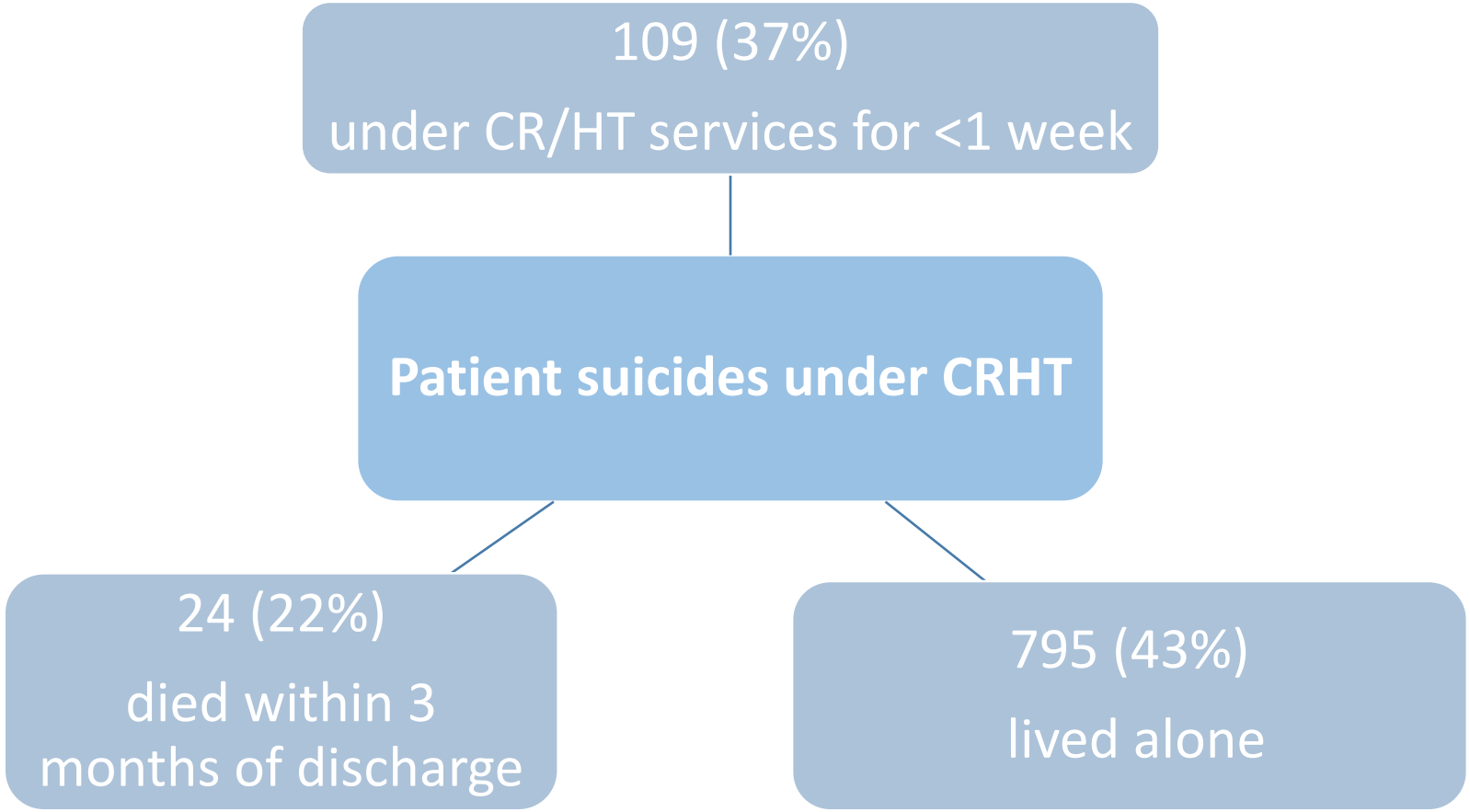
Suicide under crisis resolution/home treatment, England



Characteristics of patients who died under crisis resolution/home treatment services



NCI – Risk Assessment

- The overall quality of risk assessments was considered unsatisfactory in 36% (*n* = 15) of the patient suicides and 41% (*n* = 16) of the patient homicides.

- Risk formulations and management plans were the domains most likely to be judged unsatisfactory in both suicides and homicides.

Risk Assessment – "Informed *Defensible* Decisions"

- A sound knowledge base to underpin practice.
- A Risk Assessment Template.
- Risk – Minimisation

Managing non-compliance, high risk periods, an ongoing never ending process not an event.

- A strategic conversation – evidence based interventions.
- Formulation.
- Mental State Examination.
- Documentation.
- Supervision.
- Communication – ***Same Day***!!!! ???

Management of Risk

- Management should acknowledge the dynamic nature of suicidal behaviours and take into account contingencies and strengths within the individual and their environment.
- Risk management can have positive features rather than the emphasis being on the avoidance of liability and attempts by professionals to remove all risks.
- The emphasis of clinicians practices should shift away from attempts to control risk and move towards risk minimisation. (Ryan 1996).
- A certain amount of risk taking has the potential to extend the strengths and opportunities for people using mental health services. (Braye 1995)

Food for thought:

"There is no honest way of explaining what its like (*being suicidal and highly perturbed*) …..only those who know what it is like to have your world fall apart ***can*** know. Its easy to pick over the bones after its all happened."

Steve L, 2015.

Interventions/Training

- Assessing/formulating risk as an ***ongoing*** process not a stand alone event
- Over reliance of scoring systems/risk tools – not an individualised approach.
- Extending training away from basic risk and protective factors to a more narrative psychological description
- Recognition of and managing *PERTURBATION **
- Carer support/involving family in safety plans
- Models Erickson; Shneidman & Joiner; Fiske SFBT Approach
- (Deep rapport, genuineness; mirroring; pacing, realistic goals; degree of future orientation; strengths based dialogue; signs of safety; reasons for living; injecting hope; reframing; externalising and reconnecting to others)

Key Messages

- Completed suicide is multi-dimensional and cannot be explained by risk and protective factors alone.
- Crisis teams work hard alongside families and service users and have a strong safety agenda – could this be better?
- HBT remains a viable option if risks are suitably managed (capacity for daily contact; working with carers; use of crisis houses?)
- Training (how to engage people, assessing risk, understanding the psychological pathway of risks, providing interventions ?using survivors/recovery colleges to train staff)
- Survivor stories like Steve's and the success of providing help by crisis teams needs more exposure and recognition