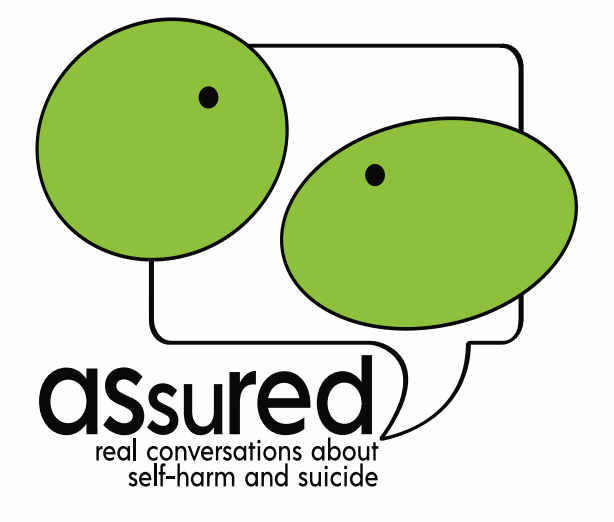
ASsuRED

Practitioner Manual



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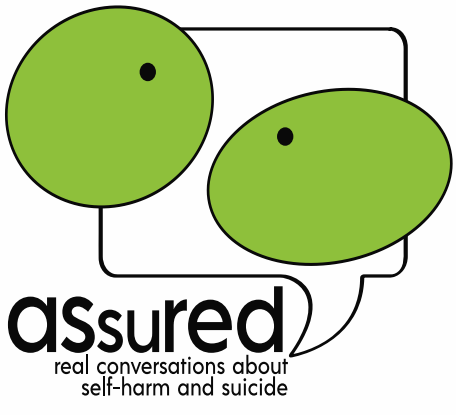


INTERVENTION OVERVIEW

Aim: To improve patients' experience of feeling supported in the ED and to reduce attendance to the ED for self-harm or suicidal thoughts/behaviour

#1 ED meeting

Narrative interview precedes risk assessment
Helping the patient understand cycle of self-harm, suicide mode and warning signs
My Safety Plan in the person's words, shared with professionals with consent

#2 Rapid follow-up care by the same practitioner

Phone call within 72 hours to check in
Three follow-up meetings at 1 week, 4 weeks and 8 weeks

- 4-step solution-focused approach
- Involve trusted other if available
- Review My Safety Plan

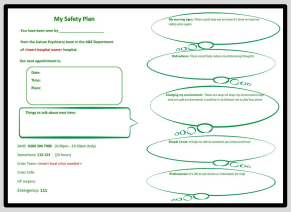
#3 Long term contact over 9 months through regular letters

ED	RAPID FOLLOW-UP	FOLLOW-UP LETTERS

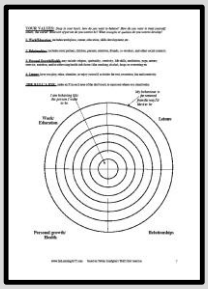
Therapeutic Risk Assessment
Understanding self-harm/suicide
My Safety Plan

Four-Step Approach
Review Safety Plan

ED Meeting → Call to check in within 72 → One Week Follow Up → Four Week Follow Up → Eight Week Follow Up → 3, 6 & 9 Month Letters



My Safety Plan



Bullseye Worksheet

Session Summary

PARTICIPANT ELIGIBILITY CRITERIA

Inclusion criteria	Exclusion criteria
• >16 years of age • presenting in the ED • presenting with self-harm, i.e., an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act on presenting to the ED, can be admitted for a brief admission to the acute hospital • presenting with suicidal thoughts/ behaviour	• admitted to a psychiatric hospital or long-term stay interfering with ability to conduct follow-up sessions. • living out of the borough and under the care of another Trust - can be included if in the same Trust, not high risk and willing to travel • cognitive (e.g. dementia) or other psychiatric difficulties interfering with ability to participate • currently experiencing a psychotic episode (a psychotic disorder diagnosis is NOT an exclusion criteria) • no capacity to provide written informed consent • needing an interpreter • Ministry of Justice persons subject to a restriction

FAQs about eligibility criteria

Q: What if they are being offered support in the community?

A: The follow-ups are part of a research project and are in addition to the person's current care. They are eligible to participate unless in an intensive programme such as DBT/MBT.

Q: What if they have drug/ alcohol dependency issues?

A: These people are eligible to participate and should be offered follow-ups. It should be explained they should not be intoxicated at the follow-up sessions.

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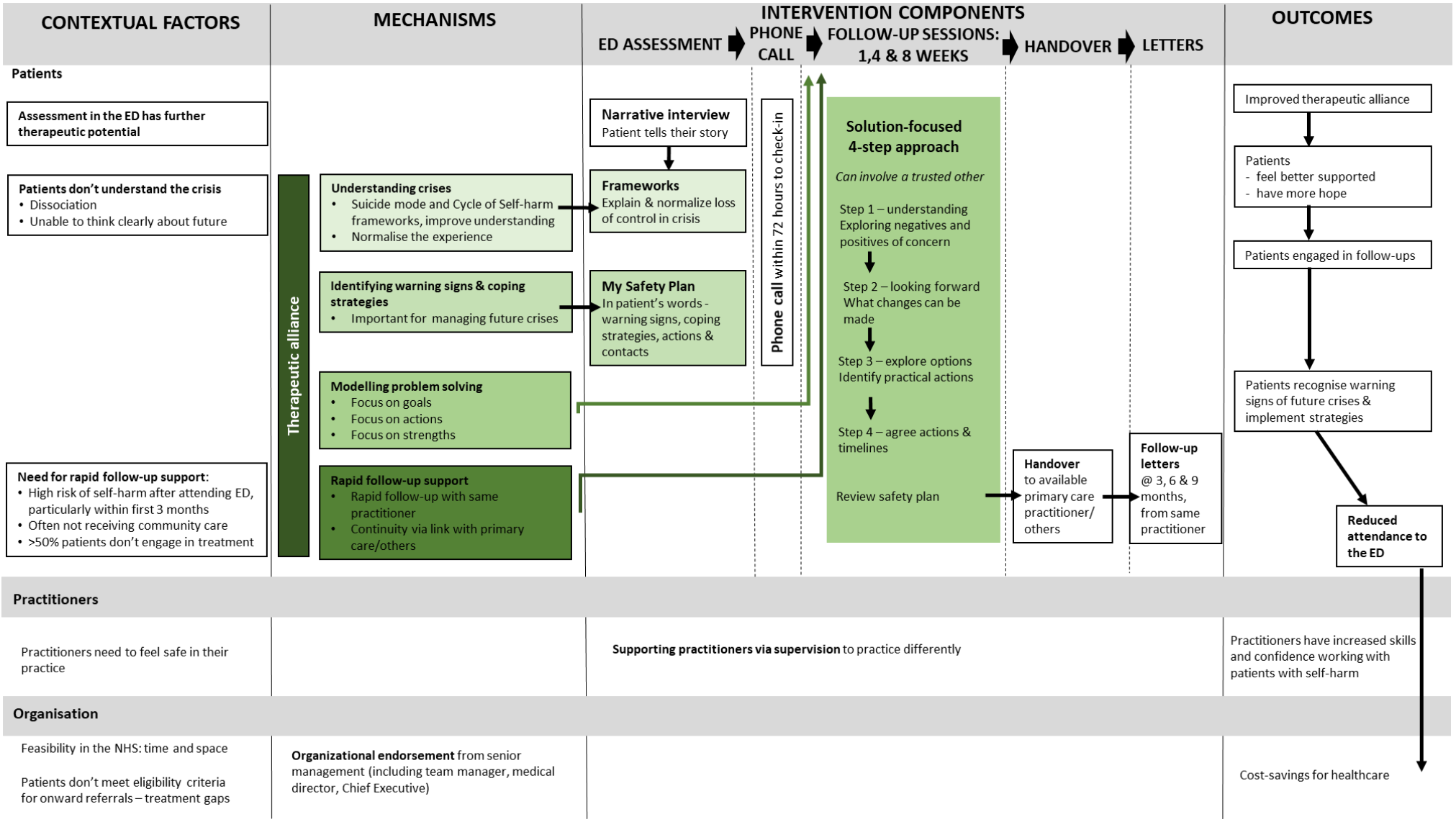
LOGIC MODEL


CONTEXTUAL FACTORS
MECHANISMS
INTERVENTION COMPONENTS
ED ASSESSMENT
PHONE CALL
FOLLOW-UP SESSIONS: 1,4 & 8 WEEKS
HANDOVER
LETTERS
OUTCOMES
Patients
Assessment in the ED has further therapeutic potential
Patients don't understand the crisis
• Dissociation
• Unable to think clearly about future
Need for rapid follow-up support:
• High risk of self-harm after attending ED, particularly within first 3 months
• Often not receiving community care
• >50% patients don't engage in treatment
Therapeutic alliance
Understanding crises
• Suicide mode and Cycle of Self-harm frameworks, improve understanding
• Normalise the experience
Identifying warning signs & coping strategies
• Important for managing future crises
Modelling problem solving
• Focus on goals
• Focus on actions
• Focus on strengths
Rapid follow-up support
• Rapid follow-up with same practitioner
• Continuity via link with primary care/others
Narrative interview
Patient tells their story
Frameworks
Explain & normalize loss of control in crisis
My Safety Plan
In patient's words - warning signs, coping strategies, actions & contacts
Phone call within 72 hours to check-in
Solution-focused 4-step approach
Can involve a trusted other
Step 1 – understanding
Exploring negatives and positives of concern
Step 2 – looking forward
What changes can be made
Step 3 – explore options
Identify practical actions
Step 4 – agree actions & timelines
Review safety plan
Handover
to available primary care practitioner/ others
Follow-up letters
@ 3, 6 & 9 months, from same practitioner
Improved therapeutic alliance
Patients
- feel better supported
- have more hope
Patients engaged in follow-ups
Patients recognise warning signs of future crises & implement strategies
Reduced attendance to the ED
Practitioners
Practitioners need to feel safe in their practice
Supporting practitioners via supervision to practice differently
Practitioners have increased skills and confidence working with patients with self-harm
Organisation
Feasibility in the NHS: time and space
Patients don't meet eligibility criteria for onward referrals – treatment gaps
Organizational endorsement from senior management (including team manager, medical director, Chief Executive)
Cost-savings for healthcare

ED MEETING Overview

Materials to bring:

- ☐ My Safety plan
- ☐ Safety plan guide
- ☐ List of crisis services
- ☐ Self-harm diagram

Remember to:

- ☐ Arrange date and time for phone call within 72 hours
- ☐ Arrange date and time for next session
- ☐ Update electronic patient record system
- ☐ Complete meeting record form (with researcher if possible)

Timeline:

Time	Focus
5 minutes	Introductions
15 minutes	Narrative interview
15 minutes	Risk assessment
10 minutes	Shared understanding (suicide mode/ self-harm cycle)
20 minutes	My Safety Plan (5 steps)
5 minutes	Next steps after ED Arrange the follow-up call within 72 hours Arrange the follow-up session

ED MEETING

Narrative Interview

Why a narrative interview?

- The narrative interview improves the therapeutic alliance, which increases engagement and willingness to follow advice.
- The narrative interview was an integral feature of the ASSIP intervention in Switzerland, which resulted in an 80% reduced risk of attempted suicide.
- Experts by experience often feel that professionals are “following a script” which interferes with trust and disclosure. Disclosure leads to a more valid assessment.
- A person’s narrative is better than a Q&A format for highlighting life events that led to the crisis. This provides a better understanding that is important for later safety planning

Goal of the narrative interview

1) To understand the person’s story

2) To acknowledge and validate the person’s distress

3) When people feel heard, this reduces distress

The goal of the narrative interview is NOT to assess risk. You should avoid asking questions about risk. You will have the opportunity to ask any questions about risk later, once you have had time to build trust and rapport with the person.

Potential outcomes from a narrative interview

- Hearing the person tell their story provides important information for your assessment.
- Simply listening will strengthen therapeutic alliance. This is important in building trust, to help the person feel able to listen to your recommendations and work collaboratively with you.

The narrative interview should take about 15 minutes at the start of the meeting

Opening the narrative interview

"We have about an hour together today and I will see you again in about a week. Most importantly today I want to hear your story. Then, we can talk about how best we can help you. I've had a look at your notes so I know a little about what's happened, but I would like to hear it in your words. Starting from the beginning can you tell me what you've been experiencing, leading up to coming to hospital?"

- Avoid using "why" questions ("Can you tell me why you're here?" or "Why do you think you overdosed last night?") They demand an account for the person's actions, as opposed to a description of the person's experience.
- "What" questions are more effective when trying to understand what was underlying or motivating the person's actions. Instead, ask "What happened to bring you into hospital?"

Asking the person what they've experienced

At this stage, you are letting the person tell their story. Your aim is to encourage the person to elaborate and expand their story. Use these three types of questions:

A. Timeline question *"When did that start?"*

A story has a beginning, middle and end. Ask a timeline question to help the person construct their story.

B. Background question *"Had you experienced that in the past?"*

It is helpful to have context when telling a story. Ask a background question when you want more context to their story.

C. Detail question *"Can you tell me more about…?"/ "Can you help me understand…?"*

In a crisis, the person may not provide enough detail in their account for you to form an assessment. In this case, ask a detail question.

Acknowledging distress in an appropriate way

It is helpful to acknowledge difficult emotions such as shame and give the person some space to talk about it. Remind the person that you are there to help.

- Validate their distress E.g. "That's a really difficult place to be."
- Validate their visit to the ED E.g. "You made the right decision to come."
- Maintain eye contact and engaged body language

Language to avoid

It is best to avoid using the following terms and phrases when speaking to the person. People with experience of going to the emergency department have expressed they find it difficult to hear these phrases. These phrases can indicate a lack of understanding of the person's experiences and can come across as dismissive.

"Superficial"

"you're still alive" as if it is a good thing

"Well you're here now"

"Why are you here?"

"Don't worry, you'll feel better in the morning"

*"Triggers" or "stressors" (*instead say *"what's happening today?")*

"Think of your family and friends"

"We have real emergencies to deal with"

"Attention seeking"

"Manipulative"

Problems that may arise during the narrative interview

Scenario 1. The person's account of what happened is too short

"You have given me a short account of what happened. I would like to know more about the story behind what happened today. Can you tell me more about…"

- Here is a scenario where a '**detail question**' can be used.
- It is important to have a detailed account of the events that led up to a crisis for understanding risk.
- It will also be helpful when formulating the safety plan to understand the moments before the crisis to identify warning signs.

Scenario 2. The person says he or she would rather have the interviewer asking questions

"The Q&A format is what most people are used to. But if we ask questions we only get answers to those questions and we would like to get your personal story behind what happened. You can start wherever you want. I will also help you"

- Here is a scenario where a 'timeline question' (e.g. When did that start?) can be helpful to prompt the person to start their story or a 'background question' (e.g. Had you experienced that in the past?) to help the person provide some context .
- Remember to acknowledge their distress throughout.

Scenario 3. The person has a strong emotional reaction and/ or dissociates during the interview

It isn't uncommon for the person to become emotional or dissociate during the narrative. In this case, it is useful to interrupt the story.

Either… **Validate their distress** and use this as an opportunity to explore what triggered their reaction.

"What was it about X that upset you?"

Or… Use **grounding strategies** such as breathing techniques, asking the person to focus on an object in the room or naming different sensations (smell, sound, touch). Offering a glass of water can also be helpful. It can help bring the person's focus back to the here and now.

If these strategies fail…

it may be a good time to bring up the **follow-up sessions**. You can decide to revisit the narrative in the next follow-up session when the person is out of crisis.

You have now heard the person's story. Because you have used narrative techniques, several topics the person feels is important to them will have been covered.
At this point, continue to explore areas as per your usual practice in the assessment.

Asking the person about areas not yet covered

Telling the person you would like to understand more about X topic. The person is more likely to disclose important information when you state what you are seeking to understand, rather than asking narrow questions.

- *"You've mentioned X – could I hear more about that?"*
    - *E.g. "I know you've mentioned cutting – it would help me to hear more about when and how you've used self-harm as a coping strategy."*
- *"It would help me to understand more about X."*
    - *E.g. "I'd like to understand more about your personal life – your family and your living situation."*
    - *E.g. "It would help for me to know if there are other risky behaviours or unhealthy coping strategies that you worry are making things worse – and what your worries are."*

ED MEETING

Shared Understanding

Some people are a mystery to themselves and struggle to understand where emotional pain is coming from. A helpful tool to help people understand how they feel is to explain the suicidal mode/ cycle of self-harm.

Understanding Beck's suicide mode

The suicidal mode is an acute mental state. It is an *on/off phenomenon* and can be activated from one moment to the next by specific triggers.

"We know that it can be difficult to understand where the emotional pain is coming from. When people feel suicidal four systems are activated in synchrony. These are your cognitive, emotional, physiological and behavioural systems (explain the components of each system, see chart below). These systems can be suddenly activated from one moment to the next by specific triggers, sometimes described as an on-off phenomenon, and can lead to thoughts of suicide.
The triggers can be internal such as thoughts, feelings, and images or external from places, people, things or situations.
However, it is important to remember that thoughts of suicide will eventually pass if you can hold on when it feels too painful.
Together, you and I can think about what these triggers may be and strategies to work through the painful thoughts and feelings."

When a person is in a suicidal crisis, four systems are triggered:

Cognitive
Unlovable, helplessness, poor distress tolerance
"I'm worthless" "Others are better off without me"
"I can't change this"

Emotional
Sadness, anger, anxiety, guilt, depression, hurt, suspiciousness, fearfulness, tenseness, loneliness, embarrassment, humiliation, shame.

Physiological
Arousal: autonomic, motor, sensory, systems activation

Behavioural
Death-related behaviours - preparatory behaviours, planning, rehearsal behaviours, attempts

The systems can be triggered internally (thoughts, feelings, images) or externally (places, people, things, situations).

It is important for the person to understand the changes in their mental and physiological states that lead to the suicidal mode and to learn that the suicidal mode *will eventually pass*.

Learning to recognise specific warning signs to dissipate the crisis and using safety strategies to respond to trigger events will help the person through the suicidal mode.

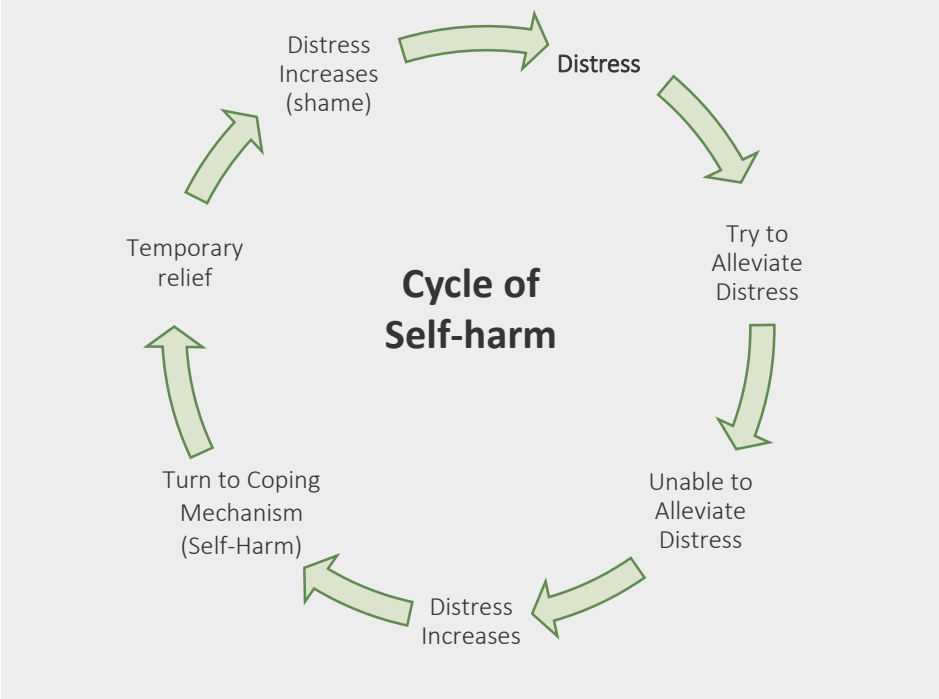
Cycle of self-harm

There is neurobiological evidence that self-harm temporarily relieves psychological distress for some people.

Prior to self-harm, most people feel overwhelming emotions including sadness, anger, anxiety, and racing thoughts.

Self-harming temporarily relieves this psychological distress and immediately after self-harm, most people get a sense of relief or calm.

This is often followed by feelings of shame and secrecy and further distress, which starts the cycle again.



Breaking the cycle

People who broke the cycle reported that their ability to stop was due to talking to loved ones, developing new coping skills and counselling.

In the short-term, it is important to identify triggers that lead to self-harm, express the emotional distress they are feeling to people they trust, ask for help from someone who understands what they're going through and in the long-term identify alternative coping mechanisms.

ED MEETING Safety Planning

The safety plan is for the person to keep as a physical reminder of their warning signs (triggers) and how to cope with their suicidal thoughts/ self-harm.

Remember, the person has told their story of what happened. This will include triggers that led to the self-harm/ suicidal thoughts as well as the people, places or circumstances that are positive aspects of their life.

Use what you both learned from the person's story to help develop the plan.

The safety plan is developed with the person in the person's own words

This will give ownership to the person and s/he will be more likely to use it

You could also suggest the person take a photo of their safety plan so they have it on their phone.

Introducing the safety plan

> *"Coming up with a plan can help when thoughts of suicide or self-harm come back. These steps will help us think together about how to best manage these thoughts and feelings. There are things you can do and there are people who can help you."*

If the person shows resistance

When approaching the safety plan, the person may show some resistance to suggestions.

People often shut down when they feel as though they're being asked to simply "try harder" to manage emotions, symptoms, or coping mechanisms.

"This is what we're going to do" is not well received

Instead say, *"We care about you and we want to help you"*

If they shut down, try:

- Talking about barriers
- Breaking things down into small steps
- Signposting and advice

Use the following five-step guide to collaboratively complete the safety plan…

Step 1 : Recognising warning signs

1. Help the person to identify and pay attention to their warning signs
2. Write down warning signs using the person's own words

"What do you experience when you start to think about suicide or feel extremely distressed?"

Step 2 : Internal coping strategies

Identify specific actions that a person can do without calling others

1. Identify coping strategies

"What can you do on your own if you become suicidal again, to help yourself not act on those thoughts?"

2. Identify the likelihood of using such strategies

"How likely do you think you would be able to do this step during a time of crisis?"

3. Identify barriers and solve problems

"What might prevent you from thinking of these activities or doing these activities even after you think of them"

Step 3 : Changing the environment

Identify ways to change the person's current environment to stay safe and new environments to distract from their thoughts

1. Identify ways to secure or limit access to any potential lethal means in the environment
2. Identify several people and settings that are good "distractors"
3. Identify the likelihood of visiting these people/ places when distressed
4. Identify barriers and solve problems

Examples: drop-in centres, coffee shops, places of worship. Friends, family, acquaintances with whom the person has a cordial, non-controversial relationship.

Step 4 : Contacting a trusted other who may offer help to resolve a crisis

Explicitly identify who they would speak to (outside of professional services) when they are in crisis and need support.

1. Identify several people the person can contact to ask for help
2. Identify the likelihood of contacting support system during crisis
3. Identify barriers and solve problems

Where possible, identify someone close to the person with whom the safety plan can be shared. This person should be named on the plan.

Step 5 : Contacting professional agencies

Explicitly identify they need professional support. Instruct the person to use Step 5 if asking for help from family and friends is not effective.

1. Identify several health care providers or agencies the person can contact
2. Identify the likelihood of contacting these people/ groups during crisis
3. Identify barriers and solve problems.

The person's list may include local urgent care centres, drop-in centres, mental health professionals, charities and/ or support groups .

List of Alternative Crisis Resources

- Shout
  - Text Shout to 85258
  - giveusashout.org
  - Free 24/7 text service for anyone in crisis for immediate help.
- Mind
  - MindInfoline: 0300 123 3393
  - mind.org.uk
  - Suicidal Feelings
  - Elefriends - online support community
  - Call service and online support community for anyone feeling suicidal or in need of help. They also provide a special legal service to the public, lawyers and mental health workers.
- The Listening Place : 020 3906 7676
  - Open 9am and 9pm every day
  - **http://listeningplace.org.uk/**
  - Free face-to-face support for those who feel life is no longer worth living. It is not drop-in but offers people appointments for face-to-face support. They provide on-going support, which can continue over a number of weeks if this is appropriate.
- Maytree
  - Tel: 020 7263 7070
  - maytree.org.uk
  - A place to go for 'rest and reflection' to stay in a calm, safe and relaxed environment. Staff and volunteer spend up to 77 hours with each guest to talk through thoughts, fears, troubles.
  - Support four "guests" at a time and runs 24/7.
- CALM (Campaign Against Living Miserably)
  - Open 5pm – midnight every day
  - Helpline: 0800 58 58 58
  - thecalmzone.net – web-chat
  - Free call or web-chat service for men who are struggling or in crisis and need to talk or find information and support.
- Papyrus
  - HOPELINEUK – 0800 068 4141
  - Under 35
  - papyrus-uk.org
  - Worried about someone? Support for anyone under 35 experiencing thoughts of suicide, or anyone concerned that a young person may be experiencing thoughts of suicide.
- Kooth.com
  - kooth.com
  - 11-25 years old
  - Free online counselling service – advice and support for emotional or mental health problems.
- ChildLine
  - Helpline: 0800 11 11
  - childline.org.uk
  - Coping with suicidal feelings
  - Counselling service for children and young people who need someone to talk to.
  - Helpline, 1-2-1 chat, message boards

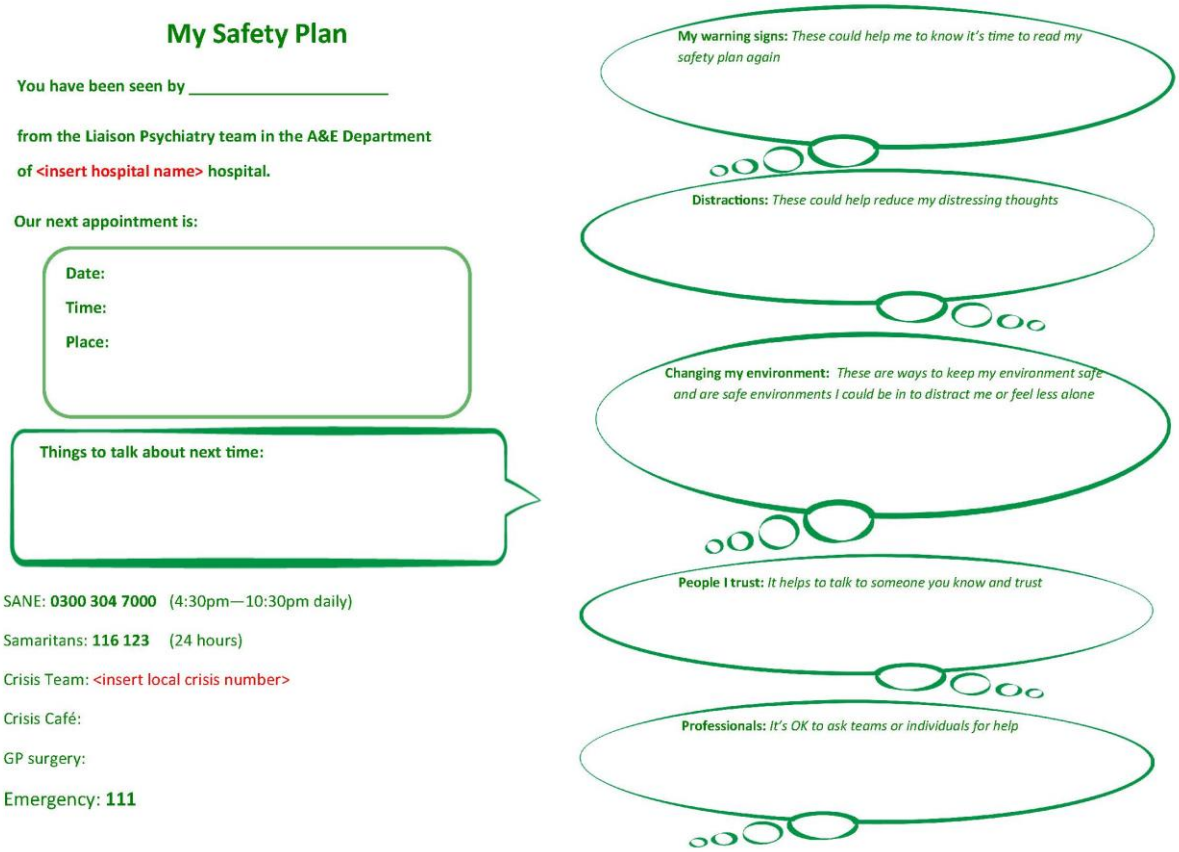
List of Alternative Crisis Resources

- YoungMinds – For carers
  - Helpline: 0808 802 5544
  - youngminds.org.uk
  - Suicidal Feelings
    Parents' Information Service gives advice to parents or carers who may be concerned about the mental health or emotional wellbeing of a child or young person.
- The Mix
  - Helpline: 0808 808 4994
  - themix.org.uk
  - Suicide
  - Whether you're 13, 25, or any age in between, we're here to take on the embarrassing problems, weird questions, and please-don't-make-me-say-it-out-loud thoughts you have. We give you the information and support you need to deal with it all. Because you can. Because you're awesome. We'll connect you to experts and your peers who'll give you the support and tools you need to take on any challenge you're facing – for everything from homelessness to finding a job, from money to mental health, from break-ups to drugs. We're a free and confidential multi-channel service. That means that you choose how you access our support, without the worry of anyone else finding out. Whether it be through our articles and video content online or our phone, email, peer to peer and counselling services – we put the control in your hands. You can even volunteer with us too.
- Students Against Depression
  - Are you depressed or anxious?
  - Self Help Resources
  - Students Against Depression is a website offering advice, information, guidance and resources to those affected by low mood, depression and suicidal thinking. Alongside clinically-validated information and resources it presents the experiences, strategies and advice of students themselves – after all, who are better placed to speak to their peers about how depression can be overcome.

Safety plan five-step guide

Warning Signs	• What do you experience when you start to think about suicide or feel extremely distressed? • How will you know when the safety plan should be used?
Internal Coping Strategies	• What activities could you do to help take your mind off your problems even if it is for a brief period of time? • Addressing barriers: How likely do you think you would be able to do this during a time of crisis?
Changing the Environment	• What would you consider doing if you were to end your life? • How can we secure or limit access to these means? • Who or what social settings help you take your mind off your problems at least for a little while? Who helps you feel better when you socialize with them? • Addressing barriers: What might stand in the way of you doing these activities?
Friends/Family	• Among your family or friends, who do you think you could contact for help during a crisis? Who is supportive of you and who do you feel that you can talk to when you're distressed? • Addressing barriers: How likely is it that would you be willing to contact these people?
Professionals	• Who are the mental health professionals that we should identify to be on your safety plan? Are there other health care providers? • Addressing barriers: How likely is it that would you be willing to contact these individuals?

My Safety Plan to be completed with person in their own words. Suggest taking a picture of the safety plan so they have access on their phones.



My Safety Plan

You have been seen by _____

from the Liaison Psychiatry team in the A&E Department

of <insert hospital name> hospital.

Our next appointment is:

Date:

Time:

Place:

Things to talk about next time:

SANE: **0300 304 7000** (4:30pm—10:30pm daily)

Samaritans: **116 123** (24 hours)

Crisis Team: <insert local crisis number>

Crisis Café:

GP surgery:

Emergency: **111**

My warning signs: *These could help me to know it's time to read my safety plan again*

Distractions: *These could help reduce my distressing thoughts*

Changing my environment: *These are ways to keep my environment safe and are safe environments I could be in to distract me or feel less alone*

People I trust: *It helps to talk to someone you know and trust*

Professionals: *It's OK to ask teams or individuals for help*

ED MEETING

Arranging follow-ups

Arranging the follow-up call within 72hrs

At the end of the assessment: Explain that you will call the person to check in – you can set a date/time. The aim of the phone call is to let the person know you're thinking about them.

- *"I'd like to call you briefly just to touch base with you and see how you are? Is that okay with you? When would be the best time for me to call you this evening /tomorrow/ Monday?"*
- *"Just to let you know, the number that comes up will be a withheld/ unknown number so if you get a call from a withheld number on that day, it may be me."*
- *"If I don't manage to speak to you, I will leave a voicemail reminding you of our follow-up date. Is it alright with you? See you next [week]. I'll look forward to seeing you then"*

Arranging the follow-up sessions

The first follow-up session is to be arranged for one week's time.

- If you will be off rota/on leave, ask the person if they would rather wait to see you when you're back or specify which colleague will see them

Help manage expectations by explaining they may have to wait for a bit or you may have to reschedule because you may be called in to speak to another patient who is experiencing similar troubles to when the person first came to the emergency department.

Ending the ED meeting

"Where would be safe for you right now?" "Is it safe for you to go home?"

"What do you have to deal with when you get home?"

"How will the next few weeks be?"

"Do you have someone to call?" "Is there someone we can call for you?"

If they would like you to call someone:

- Keep it general – *"he/she is here, can you come and meet her?"*
- Repercussions of saying too much – parents/ work finding out

FOLLOW-UP

Overview

Rapid follow-up is critical because people need further support

1) People don't meet referral criteria
2) People experience long waits
3) ED meetings are not the right amount/timing of support

Timeline of follow-up sessions

FOLLOW-UP

Phone call within 72 hours

Aim

The person may still be in crisis after leaving the emergency department. The aim of the phone call within 72 hours is to check-in with the person.

When you call

- *"I'm just calling to touch base with you and find out how you are doing."*
- *"And just to remind you that we agreed to meet on (follow-up date and time)."*
- *"I'll look forward to seeing you then"*

If the person does not pick up, leave a voicemail

- *"Hi, it's (name). I met with you on (day of initial assessment)."*
- *"I just called to check in but didn't manage to catch you."*
- *"I will see you on (follow-up date and time). Please phone me on …. if you won't be able to make our next meeting"*

Follow-up session overview

Materials to bring to every session:

- ☐ My Safety Plan completed at ED meeting
- ☐ Bulls-eye tool
- ☐ Four-step solution-focused approach - guide
- ☐ Meeting summary

At every session, remember to:

- ☐ Arrange date and time for next session (if necessary)
- ☐ Update electronic patient record system
- ☐ Complete meeting record form (with researcher if possible)

One-week follow-up

Time	Focus
5 minutes	Explain there will be 3 sessions and what you will do Outline expectations (DNA policy)
5 minutes	Check in – how are you doing since we met?
5 minutes	Priority concern/s to discuss today
15 minutes	Four-step solution-focused approach 1. Understanding 2. Looking forward 3. Considering options 4. Agreeing on actions When we see each other next, will you tell me how it goes?
10 minutes	Review My Safety Plan
5 minutes	Discuss involving a trusted other

Four-week follow-up

Time	Focus
5 minutes	Check in – how are you doing since we met?
10 minutes	Review actions from last session
5 minutes	Priority concern/s to discuss today
20 minutes	Four-step solution-focused approach 1. Understanding 2. Looking forward 3. Considering options 4. Agreeing on actions When we see each other next, will you tell me how it goes?
10 minutes	Review My Safety Plan

Eight-week follow-up – Final session

Time	Focus
5 minutes	Check in – how are you doing since we met?
5 minutes	Review actions from last session
5 minutes	Priority concern/s to discuss today
10 minutes	Four-step solution-focused approach 1. Understanding 2. Looking forward 3. Considering options 4. Agreeing on actions
10 minutes	Review My Safety Plan
10 minutes	Ending

FOLLOW-UP

Opening the session

Opening remarks

"Hi (name), thank you for coming in today. Last time we met was when you came in to the ED. Today I'd really like to hear about how things have been for you since we last met and we can decide together what to focus on today.

We will meet three times. This is the first appointment and at the end of the session we will arrange our next appointment, which will be in about three weeks time. If you need to reschedule, please let me know in advance. If you don't make it to the session, I will try to contact you to arrange another session - but I will only be able to offer you a total of three appointments, and missed appointments would be included as one of the three appointments."

Check-in

At the beginning of each session ask the person how they've been since the last time you met.

If the person describes struggling since your last meeting, validate and reinforce ways in which they have demonstrated coping – such as that they have made it to the appointment, e.g. "You did really well to come today".

- A key part of the follow-up sessions is **validating the person's experiences and reinforcing how well they are doing** and that they managed to show up today.
- People usually show gratitude at being heard, validated, and this really **enhances their engagement** in the follow ups.

Reviewing actions from the last session

At the beginning of each session

- Acknowledge any actions the person has achieved since the last session.
- If the person hasn't been able to do their action from the last session, emphasise that they have done well to make it to the session

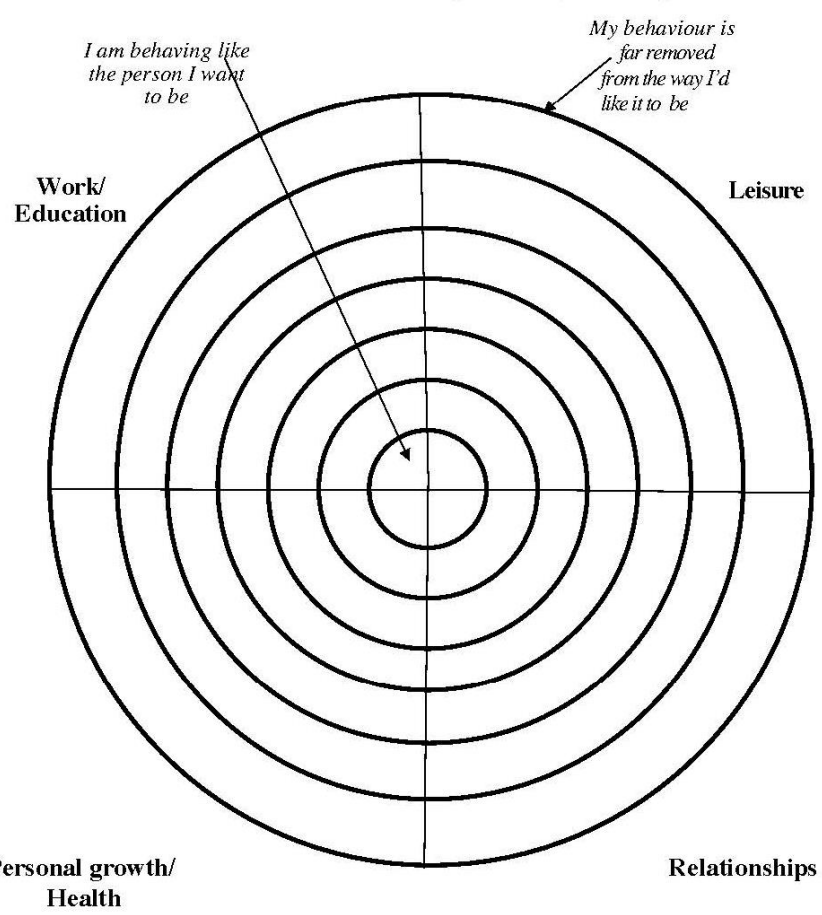
Deciding the focus of the session

After checking in with the person and reviewing actions from the last session the focus of the session may be obvious. However, it is helpful to ask what they would like the focus of the session to be.

"What would you like to focus on today?"

The Bulls-eye tool - Optional

If there are a lot of issues or the person can't easily identify what to focus on, the bulls-eye tool can help the person identify the problem they would like to discuss.



The four quadrants indicate four domains of the person's life they may want to focus on (e.g. Work, leisure, personal growth/ health, relationships)

Ask the person to indicate on the diagram where they feel they are in relation to the domain. The closer to the middle, the more 'on target' the person feels they are.

This tool can help you and the person identify:

- Areas in the person's life they are doing well in (that you can validate and draw positive coping strategies from)
- Areas to focus on in the session…

Step 1: Understanding

The aim of Step 1 is for the person & practitioner to gain a shared understanding of the person's current situation. There are two parts to understanding:

I. Exploring the person's perspective on the problem

- "What is the problem that you are facing?"
- "What is not going well", "How is this affecting you?"
- "What is going well/ what is tolerable/what is going okay?"
- "How would you know things were getting better for you?"

II. Identifying what works

- Acknowledge the positive steps the person has already taken.
- "Are there positive coping strategies or other approaches that have worked well for you?"
- "Although there are times when you feel you can no longer cope, are there are other times when you somehow manage to cope? How"

Step 2: Looking forward

The aim of Step 2 is to encourage the person to think about and describe what an improvement in their situation would look like, and what changes would be a sign of progress. It can be difficult for some people to think about the future - Break this down into small steps – next day/week/month.

I. What is the person's 'best-case scenario'?

- "What is the outcome you would most like to achieve?"
- The best-case scenario is often, but not always, a long-term outcome.

II. What small changes would make a difference?

- "What short-term outcomes could make a meaningful difference to your life?"
- It may be that the best-case scenario previously described cannot occur instantly, or at all.
- "What could create even a small improvement and help in the long-term process of achieving the best-case scenario, where possible?"

The practitioner should seek to elicit a clear picture of the future from the person it should be:

- *Detailed*
- *Characterised by tangible behaviours rather than vague feelings - ask "What would this mean in practice?"*
- *Defined by the presence rather than the absence of something (e.g. "I would have the energy to get a part-time job" rather than "I would not feel as tired all the time").*

Step 3: Exploring options

The aim of Step 3 is to explore options that may help to bring about the desired changes.

I. What can the practitioner do?

- Discuss all signposting and referrals
  The follow-up sessions will give you time and opportunity to manage and support referrals for the person.
  These can include referrals to NHS services but you and the person can discuss signposting and referrals to services outside of the NHS.
- Ask what other support you could provide

Social Prescribing

One possible service is the local Social Prescribing service.
This service is usually linked to GP practices and help to support people with non-medical needs and address social problems that may underlie the person's mental distress.

II. What can others do?

II. Suggest ways other people could support the patient
III. Ask the patient to identify what else others could do

III. What can the person do?

- List small steps the patient can take on their own
- Ask the patient what else they can do on their own

Step 4: Agreeing on actions

The aim of Step 4 is to reach an agreement on what action(s) should be taken, and by whom.

I. Agree on actions

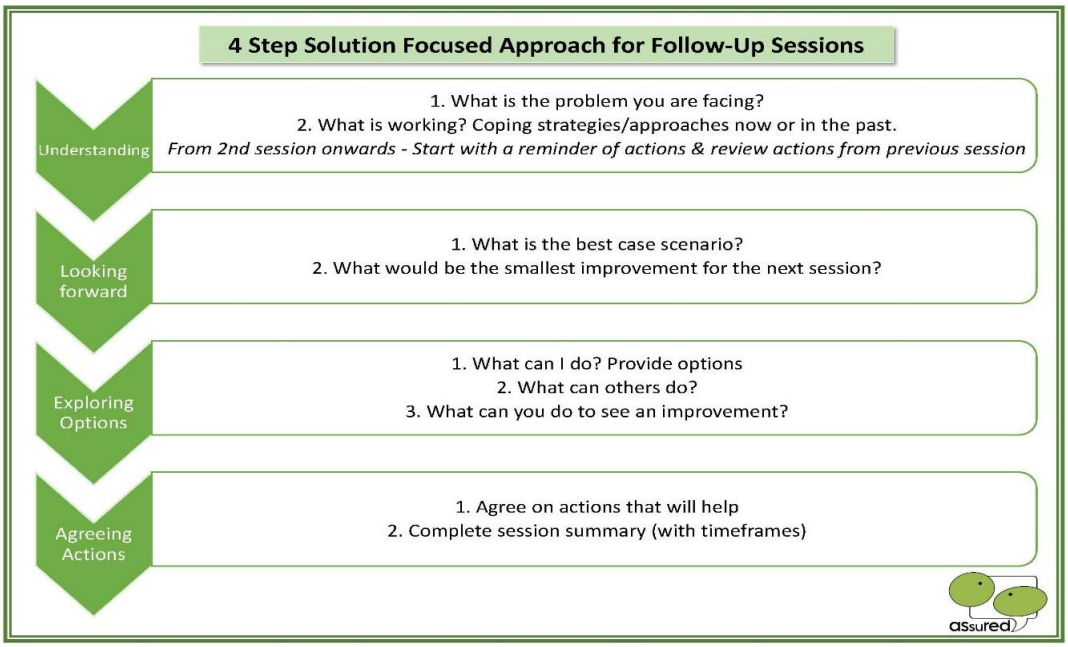
- Ideally, actions for the person should not be contingent on someone else.
- It is helpful to agree on **more than one action** and **to include actions that are easier to achieve** before the next session.

II. Come up with a timeline for each action

You may be at different stages of agreement:

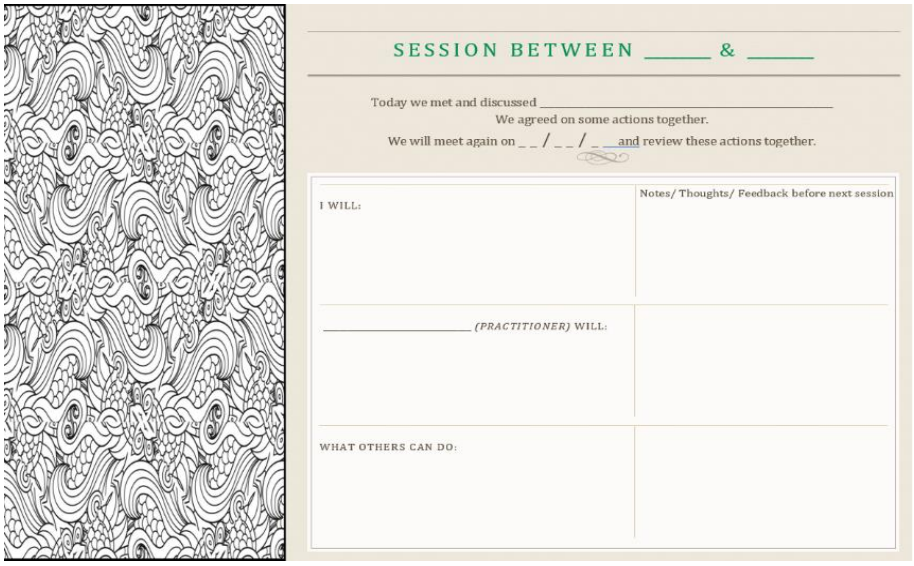
- *The person may have a clear idea of what action should be taken. Invite the person to take the lead with any decision.*
- *The practitioner may have to take the lead in suggesting actions and explore whether the person agrees.*
- *The person and practitioner may not agree on an immediate 'action'. Instead, the person might decide to spend more time thinking about the different options discussed between now and the next meeting.*

Four-step solution-focused approach - guide



Meeting Summary

Once the four steps are complete and an action item has been decided, the practitioner/person should document it in the meeting summary.



Scan the summary for your reference and the person can take away a copy.
In the next follow-up session, you and the person can review progress.

Review My Safety Plan

Review 'My Safety Plan' with the person at the end of the session to ensure the safety strategies developed are still appropriate.
This is a flexible exercise – it may not be necessary to make significant changes but simply reminding the person of their safety strategies can be helpful.

FOLLOW-UP

End of the follow-up sessions

Ending the face-to-face sessions can be difficult for the person. It is important to ensure the person does not feel like they are being abandoned and that they are still being cared for.

1) Acknowledge the sessions will stop

"We have now come to the end of the face-to-face follow-up sessions."

2) Summarise actions and revised safety plan

"Over the course of the three follow-ups you have worked towards/ managed to… (action/s).
We have also reviewed the safety plan together. We've identified and pinpointed things you can do to distract or cope with feelings or thoughts to harm yourself and people you can speak to as well."

Note: if all the actions have yet to be completed, encourage the person to continue working towards their actions.

3) Identify possible handover of safety plan

"It may be helpful to let e.g. your GP/ your community psychiatry nurse/ someone you trust in the community about what we've done so far – especially our work on keeping you safe in the future and your safety plan."

The individual identified for handover can be the person's GP, a community psychiatry nurse, or social prescribing services as well as someone in the community the person trusts

4) Introduce follow-up letters

"I will send you a follow-up letter in one month's time to check in and see how things are for you. Although it's not necessary, you can respond to the letter if you like."

Follow-up letters

After the face-to-face follow-up sessions, you will send 3 letters to the person.

Purpose of the letter

- The letters remind the person that someone cares about them and reminds them about their safety plan and safety strategies.
- It also reminds the person of options they have when in crisis.

Use the following templates for each timepoint as the basis of your letter but feel free to adapt and personalise the letter to the person.

Letter at 3-months [to be sent **one month** after final follow-up session]

Dear [person name],

I hope things are going OK for you at the moment. It's about one month since our last conversation. I hope you have had lots of good days but know you might have had some difficult ones too.

In difficult times, please remember to look at the safety plan which we wrote together and the sorts of things it contains that might help you. If you can, it will help to reach out to the people who you listed on your safety plan. But if you feel you need extra support from someone else, there should be someone in my team here to help. If we aren't available, you can contact the Crisis line team on number _____. They are there 24 hours a day and seven days a week.

You're very welcome to write back to me if you want but there is no need to reply to this letter. I just wanted you to know that I am thinking of you and care about how you are doing.

I will send your next letter in three months' time. Let me know if you no longer wish to have any more letters from me -by phone, letter or email.

Kind Regards

[practitioner's name]

[practitioner's contact details]

Letter at 6-months [to be sent **three months** after previous letter]

Dear [person name],

It's about four months since you and me last met. I really hope things are going well for you.

Even if things do get very difficult for you again, your safety plan- the one we wrote together- really will help. Any crisis you experience will not last forever and the ideas on your safety plan will help you get through tough times. It's always helpful to recognise those warning signs when show you that life is becoming more difficult, when it might be most helpful to talk to someone and put things into perspective. Do try reaching out to people you listed in the safety plan. If they are not available, you can contact the 24-hour Crisis number _____,

There is no need to write back to me. I just wanted you to know I am thinking of you. Let me know if you no longer wish to receive any letters from me -by phone, letter or email.

Kind Regards,

[practitioner's name]

[practitioner's contact details]

Letter at 9-months [to be sent **three months** after previous letter]

Dear [person name],

It has been about another three months since I last wrote to you and around nine months since we first met. I hope you are well and that you have not experienced more tough times. It will still be important for you to be prepared in case another crisis does happen for you. And remember that no matter how bad the situation is, a crisis does not last forever and will subside.

When life is difficult, it really will help to use the safety plan we developed together. If you find it is getting harder to cope, perhaps you could try out the coping strategies we discussed. It often helps to talk to someone to put things into perspective again. I hope there is someone you can talk to, or maybe you could see a GP or get in touch with a support group. The people you listed in your safety plan were those you thought you could contact at any time if you needed to talk to them. There is also the crisis team. They work 24/7 and the crisis line number _____.

This is the last letter you will receive from me. You don't have to reply to it but I would be pleased to hear from you, either in writing or by phone, for a brief feedback on how things have been going for you over the past six months. If we don't touch base again, I hope you are able to use the skills we talked about to keep safe and well in the future.

Best Wishes

[practitioner's name]

[practitioner's contact details]

MISSED SESSIONS

- If the person Does Not Attend (DNA) a session, you should phone them / leave a message.
- If you are able to make contact with the person, a further slot can be offered.
- However, if the person does not attend without cancelling and you are unable to contact them to arrange another session, the DNA will count towards the three appointments and will not be replaced.
- If the person is unable to attend in person, the appointment can be offered over the phone instead.
- If the person contacts you to cancel, arrange a new appointment.

ATTENDING THE ED IN BETWEEN SESSIONS

- If the person attends the ED between appointments, they should be seen as usual – wherever possible by a different practitioner within the liaison team
- This would not affect their participation in the study and they would still receive the follow up appointment with you as planned

DOCUMENTING ON THE ELECTRONIC RECORD SYSTEM (RIO/CARENOTES/ETC.)

- You should record and update the person's records as you usually would (uploading GP letters, completing assessment documentation, etc.)
- Label each contact: ASsuRED assessment; ASsuRED follow-up 1 week, ASsuRED follow-up 4 weeks, ASsuRED final follow-up 8 weeks
- In addition, you should upload the person's consent form and the Research Participation documentation onto the person's record.
- This documentation will clearly state that the person's participation in the study **should not** replace or interfere with any other care the person is entitled to. This includes access to any community mental health care.
- As per usual practice, after every contact (face-to-face, phone, text) you have with the person, please record a summary on their electronic record

SUPERVISION

Purpose of supervision

Practitioners will receive group supervision to:

- Provide an opportunity to discuss their clinical/ professional judgment and to discuss complexities that may arise while seeing people who are being offered the ASsuRED intervention.
- Be supported. You may want to debrief after any particularly upsetting conversations or circumstances.
- Ensure the intervention is following the ASsuRED manual so we can compare across different sites. If there are challenges or queries about the research project, supervision is an opportunity to feed back to the research team.
- It is an essential part of the study to ensure all practitioners are fully supported.

Organising and conducting supervision

- We recommend supervision once per week.
- The supervision should be conducted in groups where possible, but where that isn't practical, may be conducted in pairs.
- Supervision should encourage reflective practice and discussion of new ways of working, challenges and sharing of experiences.
- Note: supervision is funded through the study's excess treatment costs.

WhatsApp group for supervision

- We have organised a WhatsApp group between practitioners, supervisors and the research team.
- At the end of each group supervision, a nominated practitioner should update the group by including a summary of what was discussed in the supervision.
- This can include: questions raised, challenging situations faced, feedback for the research project, as well as general support for members of the group.
- This should not include: confidential information about people, confidential information about practitioners.

THANK YOU

Thank you for all your feedback and support in this study.

By taking part in the pilot, you allow us to refine the intervention to fit the realities of liaison psychiatry in the UK.

This is one of the largest studies to have received funding to improve care in liaison psychiatry.

You will pave the way for a large, national trial that will begin in 2021.