Personalised Approach to Risk Year Two Launch Event

Monday 30 June, 14:00 – 17:00

Neurodiverse Connection

A warm welcome and housekeeping

Matt Milarski

Head of Quality Improvement, NCCMH

Housekeeping

- Please mute your microphone unless you are speaking.
- We encourage you to have your cameras on.
- If you would like to ask a question or leave a comment, please use the chat function within the meeting or the raising your hand function.
- If you experience any technical difficulties, please email: cultureofcare@rcpsych.ac.uk

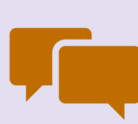
How we want to work together

Collaborative learning – *Make the most out of the session, whatever that looks like for you.*

Respect privacy – *Protect carefully the privacy of the storyteller. Ask what parts, if any, you can share with others.*

Approach with kindness and curiosity – *We've all been through stuff so let's look after each other in this space.*

***Diversity of views* –** *respecting different viewpoints and experiences and being okay with sometimes disagreeing.*



Language is important – *If you want to improve culture, the way you speak to and about the people around you needs to support the building of trusting relationships.*

Be kind to yourself – *take breaks if needed, use our support space.*

We know that discussing some of these topics may be emotive and there may be additional challenges doing that online with a large group of strangers.

Some of the things we have in place to try and help mitigate the emotional toll include:

- A separate online support space for anyone who needs it
- We welcome people to participate in any way that feels comfortable; this will include speaking in the room, using the chat, or emailing ideas after the session. Please be mindful of what you share in the chat, as some content may be triggering for others.
- Colleagues from NCCMH are happy to meet with any attendees after the meeting to provide additional information or support.

Support Space

On-Call Support Space Facilitators:
Tom Ayers and Ros Warby

Join at any time:

Microsoft Teams

Join the meeting now

Meeting ID: 359 952 620 262 2

Passcode: 62YP93SJ

The link to the support space will also be available in the chat.

Today

Time	Item
14:00-14:15	Welcome & Introductions
14:15-14:35	Culture of Care Standards
14:35 – 15:05	Personalised approaches to risk in mental health in-patient settings
15:05 – 15:15	**Break**
15:15 – 15:35	Autism informed personalised risk assessment
15:35 – 15:55	Considering racial equity and risk assessment
15:55 – 16:10	Transforming risk assessment locally: trailblazer site
16:10 – 16:25	Support for organisations on PAR year two
16:25 – 16:35	**Break**
16:35 – 16:50	Discussion and Q&A
16:50 – 17:00	Next Steps
17:00	**Close**

Culture of Care – programme overview

NHS England's standards

Coproduced standards for inpatient care

Evidence-based standards to ensure a safe, compasionate, needs-based culture of care

Guiding principles

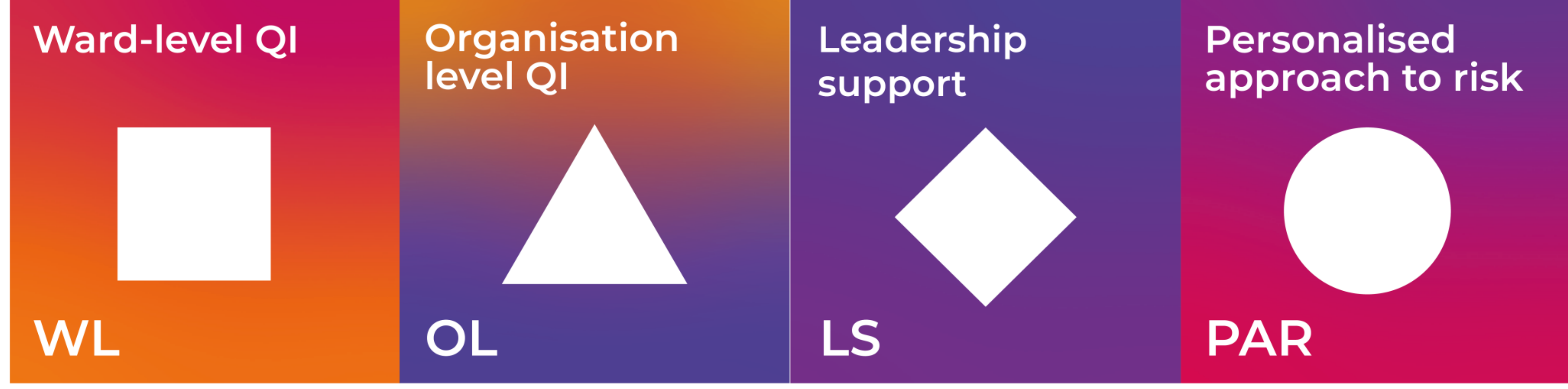
Our approaches — Anti racism, trauma-informed, autism-informed

Lived experience

Leadership, mentoring, coaching, support and challenge

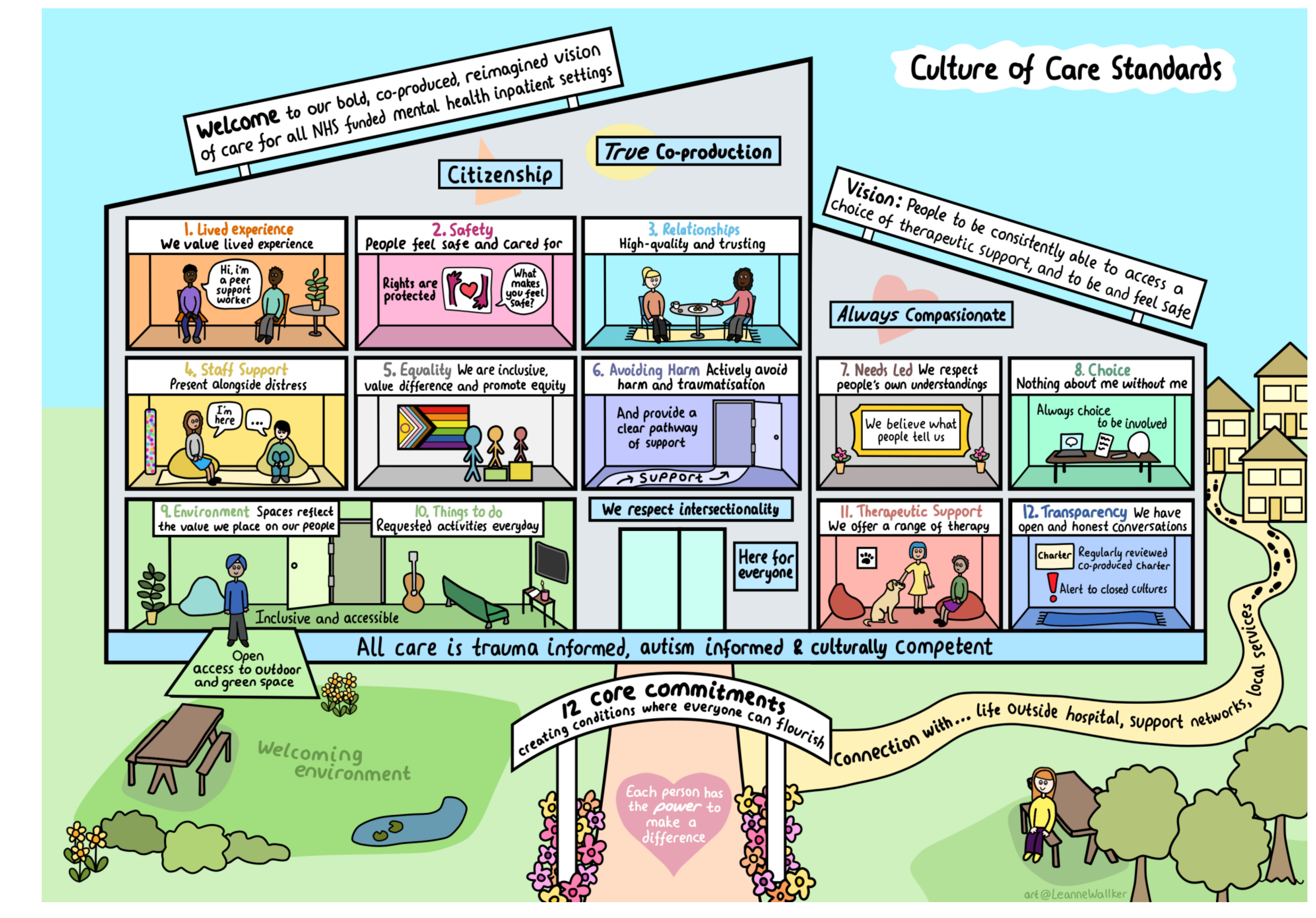
Programme elements

Programme element icons and acronymns



Culture of Care Standards

Pea Meyer-Higgins
Lived Experience Advisor (NHS England), PAR Partner, Co-Facilitator & Safety Delivery Group Member (Culture of Care)


Culture of Care Standards
Welcome to our bold, co-produced, reimagined vision of care for all NHS funded mental health inpatient settings
Citizenship
True Co-production
Vision: People to be consistently able to access a choice of therapeutic support, and to be and feel safe
Always Compassionate
1. Lived experience
We value lived experience
Hi, i'm a peer support worker
2. Safety
People feel safe and cared for
Rights are protected
What makes you feel safe?
3. Relationships
High-quality and trusting
4. Staff Support
Present alongside distress
I'm here
...
5. Equality We are inclusive, value difference and promote equity
6. Avoiding Harm Actively avoid harm and traumatisation
And provide a clear pathway of support
Support
7. Needs Led We respect people's own understandings
We believe what people tell us
8. Choice
Nothing about me without me
Always choice to be involved
9. Environment Spaces reflect the value we place on our people
10. Things to do
Requested activities everyday
Inclusive and accessible
We respect intersectionality
Here for everyone
11. Therapeutic Support
We offer a range of therapy
12. Transparency We have open and honest conversations
Charter
Regularly reviewed co-produced charter
Alert to closed cultures
All care is trauma informed, autism informed & culturally competent
Open access to outdoor and green space
Welcoming environment
12 core commitments
creating conditions where everyone can flourish
Each person has the power to make a difference
Connection with... life outside hospital, support networks, local services
art@LeanneWallker

Personalised approaches to risk in mental health in-patient settings

Year 2 launch event
June 2025

Professor Nav Kapur

Outline

- Context
- Evidence
- Alternatives
- Progress and next steps

https://www.youtube.com/watch?v=deDoBMAtaTo&t=743s

Outline

- **Context**
- Evidence
- Alternatives
- Progress and next steps

Risk assessment for suicide

BMJ 2017;359:j4627 doi: 10.1136/bmj.j4627 (Published 2017 October 17)

PRACTICE

UNCERTAINTIES

Can we usefully stratify patients according to suicide risk?

Matthew Michael Large *conjoint professor*[1], Christopher James Ryan *clinical associate professor*[2], Gregory Carter *conjoint professor*[3], Nav Kapur *professor*[4]

[1]School of Psychiatry, University of New South Wales, NSW, Australia; [2]Discipline of Psychiatry, Westmead Clinical School and Sydney Health Ethics, University of Sydney, Australia; [3]Centre for Brain and Mental Health, Faculty of Health and Medicine, University of Newcastle,; [4]Centre for Suicide Prevention, Manchester Academic Health. Science Centre, University of Manchester, & Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

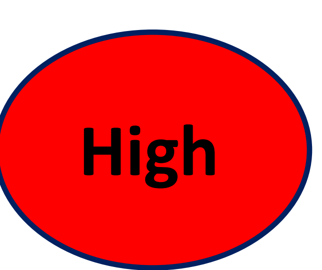
In the UK, one in five adults has considered suicide at some time, and one in 15 has attempted suicide.[1] Half of those who attempt suicide seek help afterwards—a quarter from a GP, a quarter from a hospital or specialist medical or psychiatric service.[1] Suicidal patients; patients who present to health services with suicidal ideas, self harm, or suicide attempts; and patients who present as significantly distressed or mentally ill can be challenging to manage. Doctors are often advised to use suicide risk assessment to help them decide management plans. A wide variety of risk factors have been implicated in the stratification of potentially suicidal patients.[2] This stratification is often expressed in terms of high, medium, or low-risk.[3 4] In practice, doctors commonly give the greatest importance to suicidal ideation.[5 6] In some specialist mental health settings these judgments are aided by local risk assessment forms composed of lists of clinical and demographic factors, while other centres use risk strata derived from validated questionnaires or scales.[7] However, there is little consensus over their use and virtually no evidence that any of the method of suicide risk stratification can contribute to suicide prevention.[8]

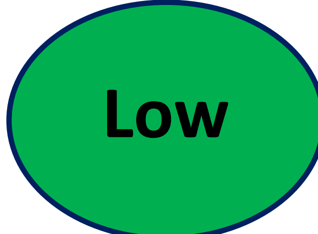
Probably the most important single measure of the accuracy of a suicide risk assessment is its positive predictive value (PPV).[10] PPV is the probability that a patient in the "high risk" stratum will go on to die by suicide. PPV is important because it defines the number of false positive cases who must be treated in order to treat each true positive. Unfortunately, the combination of the modest strength of the statistical association between being a high risk patient and suicide, and the low base rate of suicide places a ceiling on the PPV. This ceiling has made clinicians uncertain of the benefit of risk stratification.

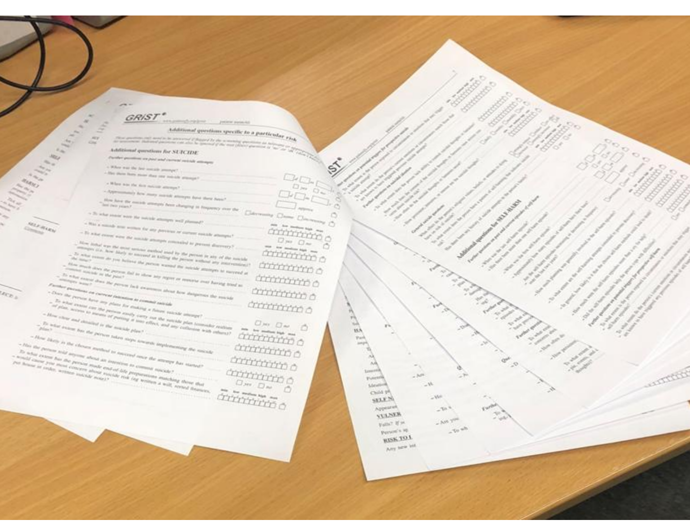
Review of recent meta-analyses

We identified seven recent and relevant meta-analyses (table 1⇓).[11-17] Almost all of the primary research synthesised by the seven studies was conducted among psychiatric patients or people presenting with self harm. Six of the seven meta-analyses can be regarded as of high quality because they adhered to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.[18]

Source: Large M M, Ryan C J, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? BMJ 2017; 359







approach to risk

Implementing a personalised approach to risk

We are supporting mental health organisations to implement a personalised approach to suicide risk assessment. This is part of NHS England's Culture Change Improvement Programme.

https://sites.manchester.ac.uk/ncish/resources/implementing-a-personalised-approach-to-risk/

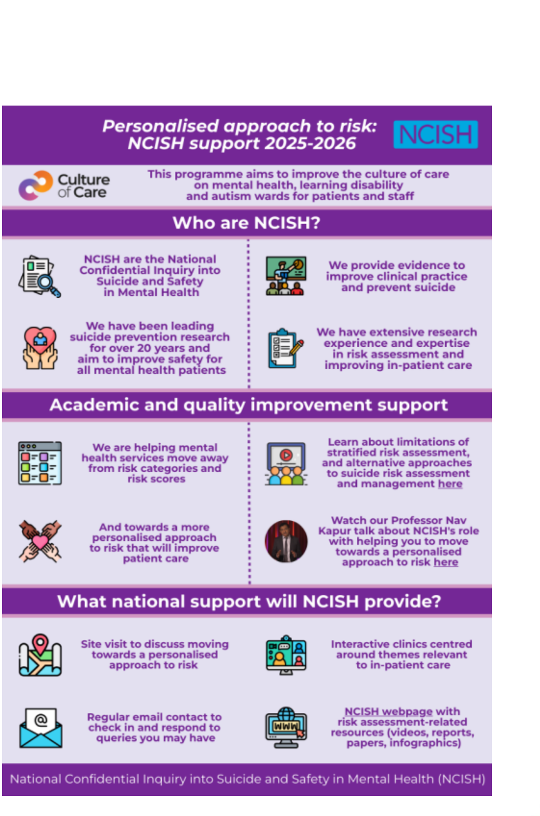
Who are NCISH?

- We have been leading suicide prevention research for over 20 years and aim to improve safety for all mental health patients

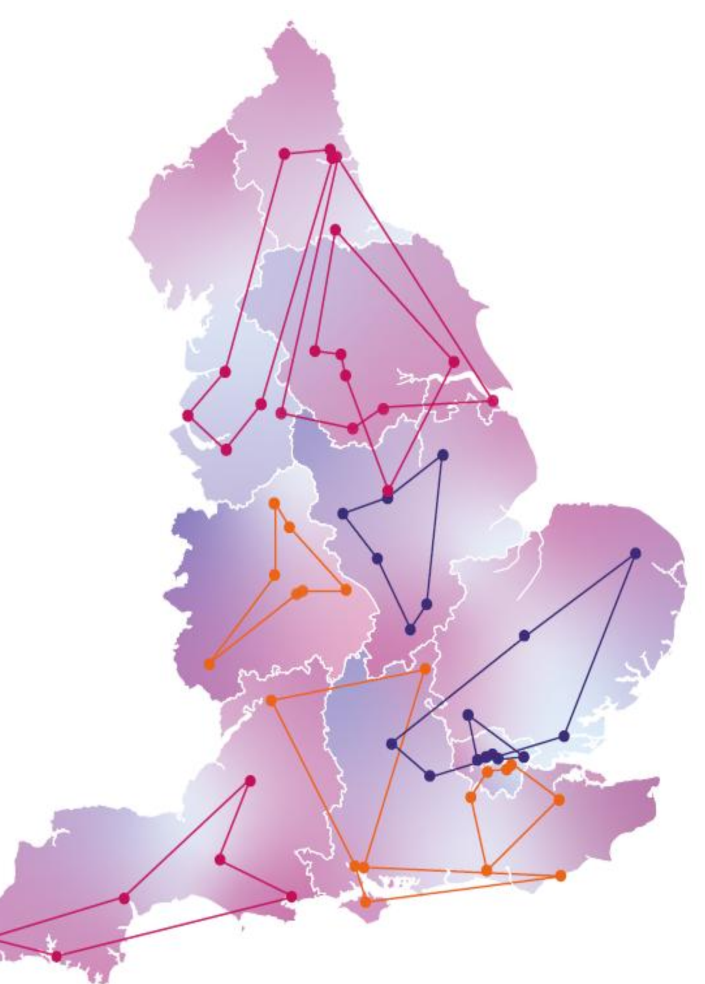
- We provide evidence to improve clinical practice and prevent suicide

- We have extensive research experience and expertise in risk assessment and improving in-patient care

Phase 1



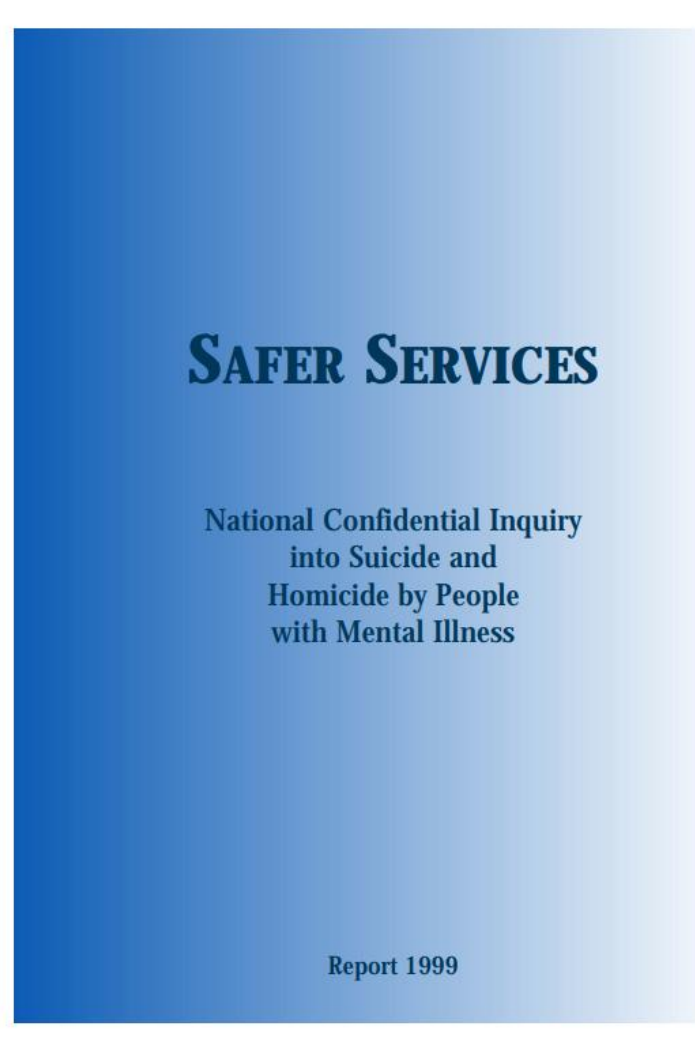
Phase 2



Outline

- Context
- **Evidence**
- Alternatives
- Progress and next steps

Assessment of risk prior to suicide



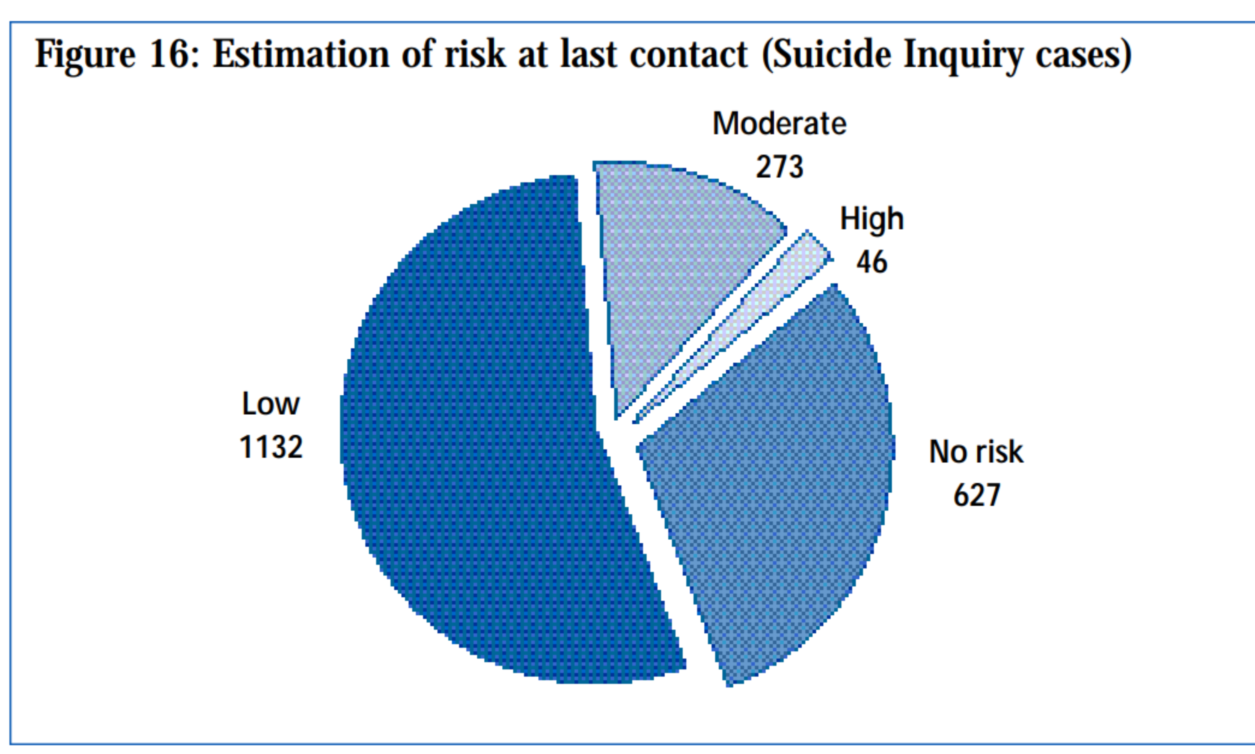
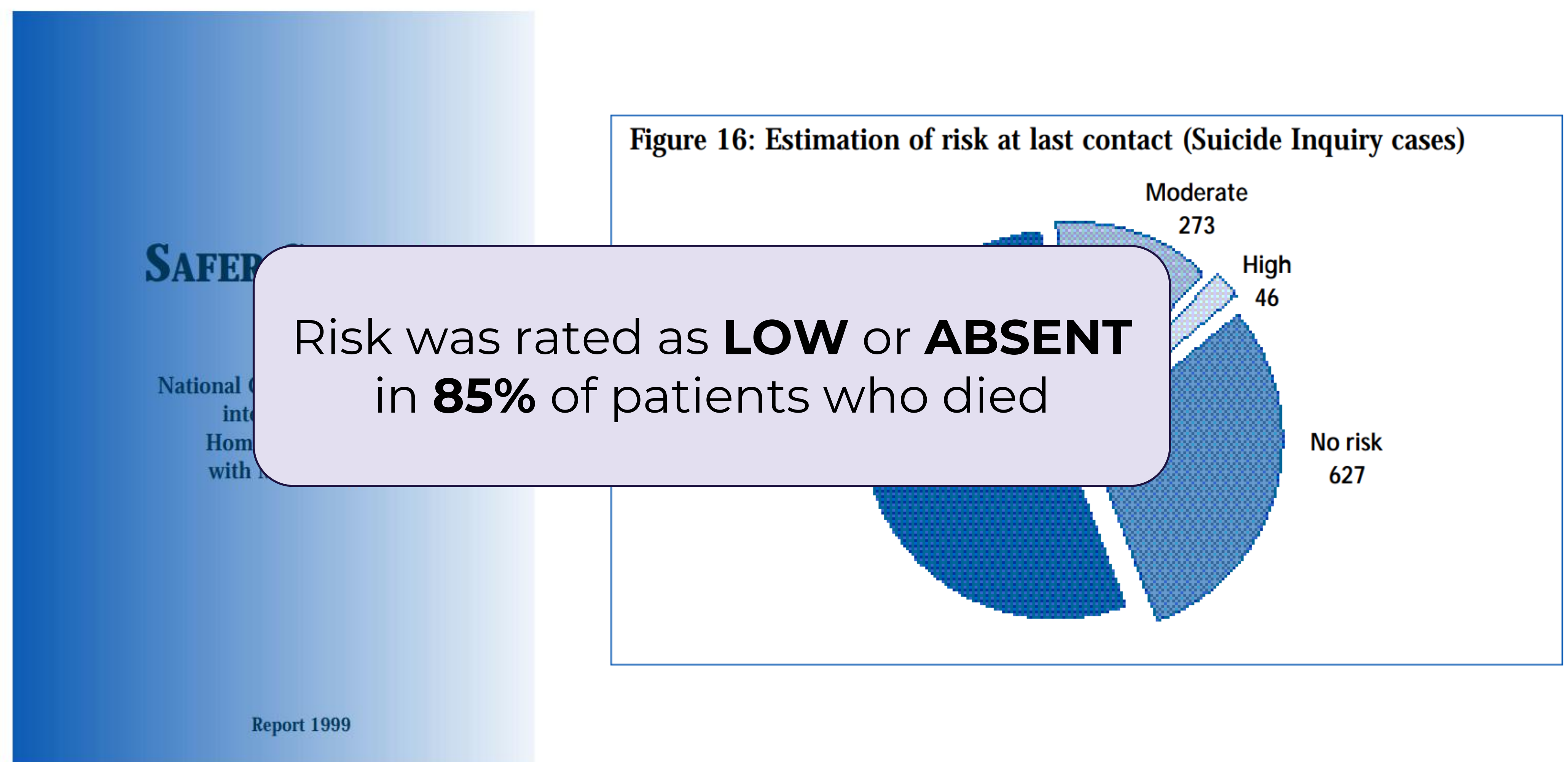


Figure 16: Estimation of risk at last contact (Suicide Inquiry cases)

Source: NCISH, https://documents.manchester.ac.uk/display.aspx?DocID=37604

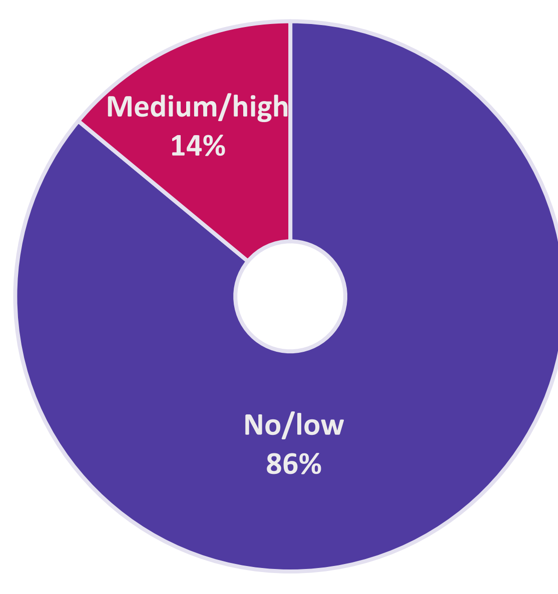
Assessment of risk prior to suicide



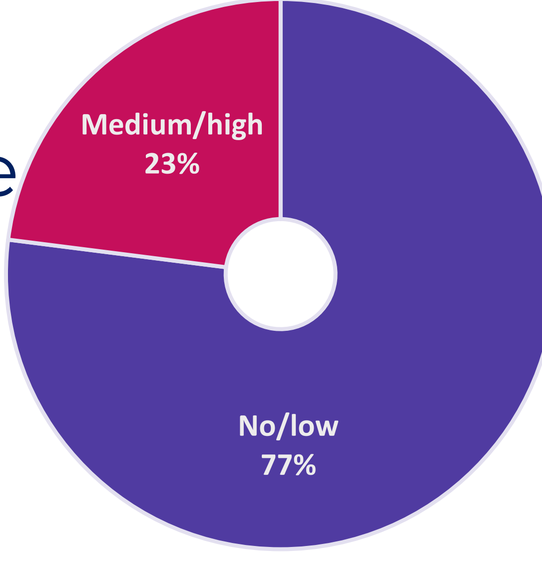
Source: NCISH, https://documents.manchester.ac.uk/display.aspx?DocID=37604

Equity and risk

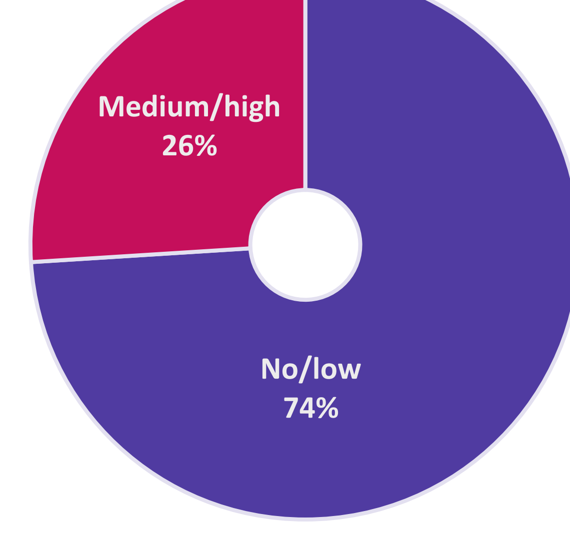
Ethnic minority groups



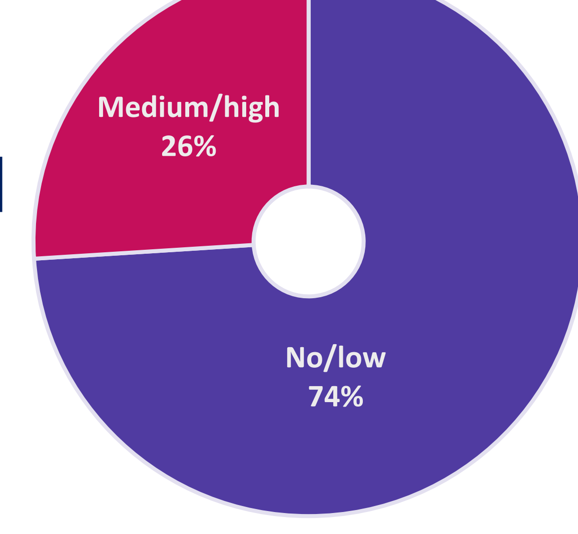
Neurodiverse groups



LGBTQ



Childhood trauma



Source: NCISH

Ethnicity and self-harm

Articles

Self-harm in children and adolescents by ethnic group: an observational cohort study from the Multicentre Study of Self-Harm in England

Bushra Farooq, Caroline Clements, Keith Hawton, Galit Geulayov, Deborah Casey, Keith Waters, Jennifer Ness, Anita Patel, Samantha Kelly, Ellen Townsend, Louis Appleby, Nav Kapur

Lancet Child Adolesc Health 2021; 5: 782–91
Published Online September 20, 2021 https://doi.org/10.1016/S2352-4642(21)00239-X

See Comment page 768

Centre for Mental Health and Safety, School of Health Sciences, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK (B Farooq MSc, C Clements PhD, Prof L Appleby FRCPsych, Prof N Kapur FRCPsych); Department of Psychiatry, Centre for Suicide Research, University of Oxford, Warneford Hospital, Oxford, UK (Prof K Hawton FMedSci, G Geulayov PhD, D Casey BSc); Oxford Health NHS Foundation Trust, Oxford, UK (Prof K Hawton); Centre for Self-harm and Suicide Prevention Research, Derbyshire Healthcare NHS Foundation Trust, Derby, UK (K Waters DipNurs, J Ness MSc, A Patel MSc, S Kelly PhD); School of Psychology, University of Nottingham, Nottingham, UK (Prof E Townsend PhD); Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK (Prof N Kapur); The National Institute for Health Research Greater Manchester Patient Safety Translational Research Centre, Manchester, UK (Prof N Kapur)

Correspondence to: Miss Bushra Farooq, Centre for Mental Health and Safety, School of Health Sciences, Manchester Academic Health Science Centre, The University of Manchester, Manchester M13 9PL, UK bushra.farooq@manchester.ac.uk

Summary

Background Studies report an increasing incidence of self-harm in children and adolescents, but the extent to which this is seen in different ethnic groups is unclear. We aimed to investigate rates of emergency department presentations for self-harm in children and adolescents by ethnicity, as well as to examine their demographic characteristics, clinical characteristics, and outcomes.

Methods In this observational cohort study, we used data on hospital emergency department presentations for self-harm in children and adolescents aged 10–19 years between 2000 and 2016 from the Multicentre Study of Self-harm in England. This study collects data from five general hospitals in Manchester, Oxford, and Derby in the UK, and defines self-harm as any act of intentional self-injury or self-poisoning, regardless of intent. All children and adolescents aged 10–19 years for whom ethnicity data were available were included. Mortality follow-up was available through linkage with mortality records from the Office for National Statistics. Rates of self-harm over time, demographic and clinical characteristics, and self-harm methods were investigated by ethnic group. Risk of repeat self-harm and mortality following an initial presentation for self-harm was compared by ethnic group using Kaplan-Meier curves and Cox proportional hazards models.

Findings Of 14 894 individuals who presented at hospitals with self-harm, 11 906 had data for ethnicity, of whom 10 211 (85·8%) were White, 344 (2·9%) were Black, 619 (5·2%) were South Asian, and 732 (6·1%) were other non-White. Rates of self-harm were highest in White children and adolescents but increased between 2009 and 2016 in all ethnicities. Mean annual rates of self-harm per 100 000 population were 574 for White, 225 for Black, 260 for South Asian, and 344 for other non-White groups. Increases in rates of self-harm between 2009 and 2016 appeared slightly greater in Black groups (incidence rate ratio 1·07 [95% CI 1·03–1·11]), South Asian groups (1·05 [1·01–1·09]), and other non-White groups (1·11 [1·06–1·16]) than in White groups (1·02 [1·00–1·03]). Children and adolescents from a minority ethnic background were more likely to live in areas of high deprivation and were less likely to receive a specialist psychosocial assessment than were White children and adolescents. Children and adolescents from minority ethnic groups were also less likely to repeat self-harm. However, there were no differences in suicide mortality by ethnic group, although the numbers were small.

Interpretation Minority ethnic children and adolescents accounted for an increased proportion of self-harm presentations to hospital over time compared with White ethnic groups. The minority ethnic groups also tended to be more socioeconomically disadvantaged and were less likely to receive a psychosocial assessment. Socioeconomic disparities need to be addressed, and equitable access to culturally sensitive comprehensive psychosocial assessments must be ensured.

Funding UK Department of Health and Social Care.

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Introduction

Self-harm in children and adolescents is a major health and societal issue.[1] Rates of self-harm during adolescence are increasing and estimates suggest that each year in England 200 000 adolescents aged 12–17 years self-harm and do not come to the attention of clinical services, and that a further 21 000 adolescents present to hospital following self-harm.[1,3]

Self-harm is a key area for action in the National Suicide Prevention Strategy for England.[4] All-cause mortality following hospital presentation for self-harm in people aged 10–18 years is 1·4%, and 12-month incidence of suicide in people who self-harm is 30-times higher than in the general population in England.[5] About 27% of people aged 10–18 years who present to hospital for self-harm present again at some point, and 17·7% of people aged 10–19 years repeat self-harm within 12-months of presenting to hospital.[6,7]

Self-harm is an indicator of distress with functions beyond those linked to suicidal intent. It is used variously

Young People from ethnic minority groups:

- ↑ Deprivation
- ↓psychosocial assessment
- ↓mental health care
- ↑ no follow up
- ↓repetition
- Similar incidence of suicide

Farooq B, Clements C, Hawton K, Geulayov G, Casey D, Waters K, Ness J, Patel A, Kelly S, Townsend E, Appleby L. Self-harm in children and adolescents by ethnic group: an observational cohort study from the Multicentre Study of Self-Harm in England. The Lancet Child & Adolescent Health. 2021 Nov 1;5(11):782-91.

How mental health providers will embed anti-racism through the Patient & Carer Race Equality Framework (PCREF)

1 Leadership and Governance

- Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation
- Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans
- Co-develop, implement and review local PCREF plans with racialised communities and your workforce
- Monitor core measures at board level on a regular basis and publish PCREF plans

2 National Organisational Competencies

Cultural awareness | Staff knowledge and awareness | Partnership working | Co-production | Workforce | Co-learning

- Engage with racialised communities to identify and agree core organisational competencies
- Agree on measurable and practical actions to co-develop in local PCREF plans
- Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans

3 Patient and carers feedback mechanism

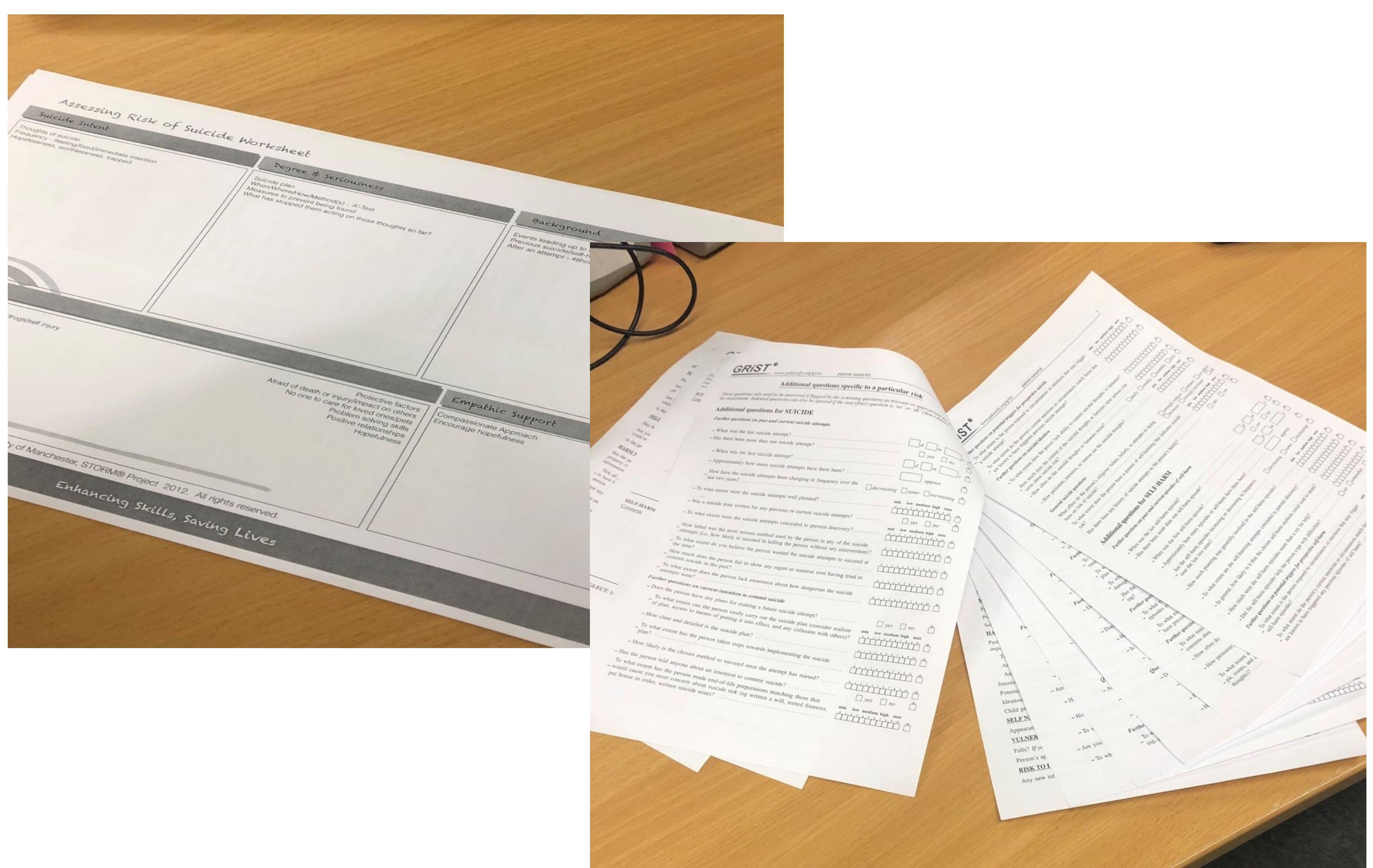
- Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services
- Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities
- Ensure patient experience data is used, monitored & flowed to national data-sets to enable bench-marking, lesson-sharing and service improvement

Considerations: Autism informed

- Check **communication preferences** & avoid assumptions (e.g. autism, protective factors)
- Alexithymia: **difficulty identifying & recognising emotions**
- Masking: acting/appearing or saying something **different to distress**
- Difficulty recalling **past events & thinking of the future**
- **Executive functioning**, organising/ planning (safety plans).

https://www.england.nhs.uk/wp-content/uploads/2023/12/B1800-meeting-the-needs-of-autistic-adults-in-mental-health-services.pdf

Current practice



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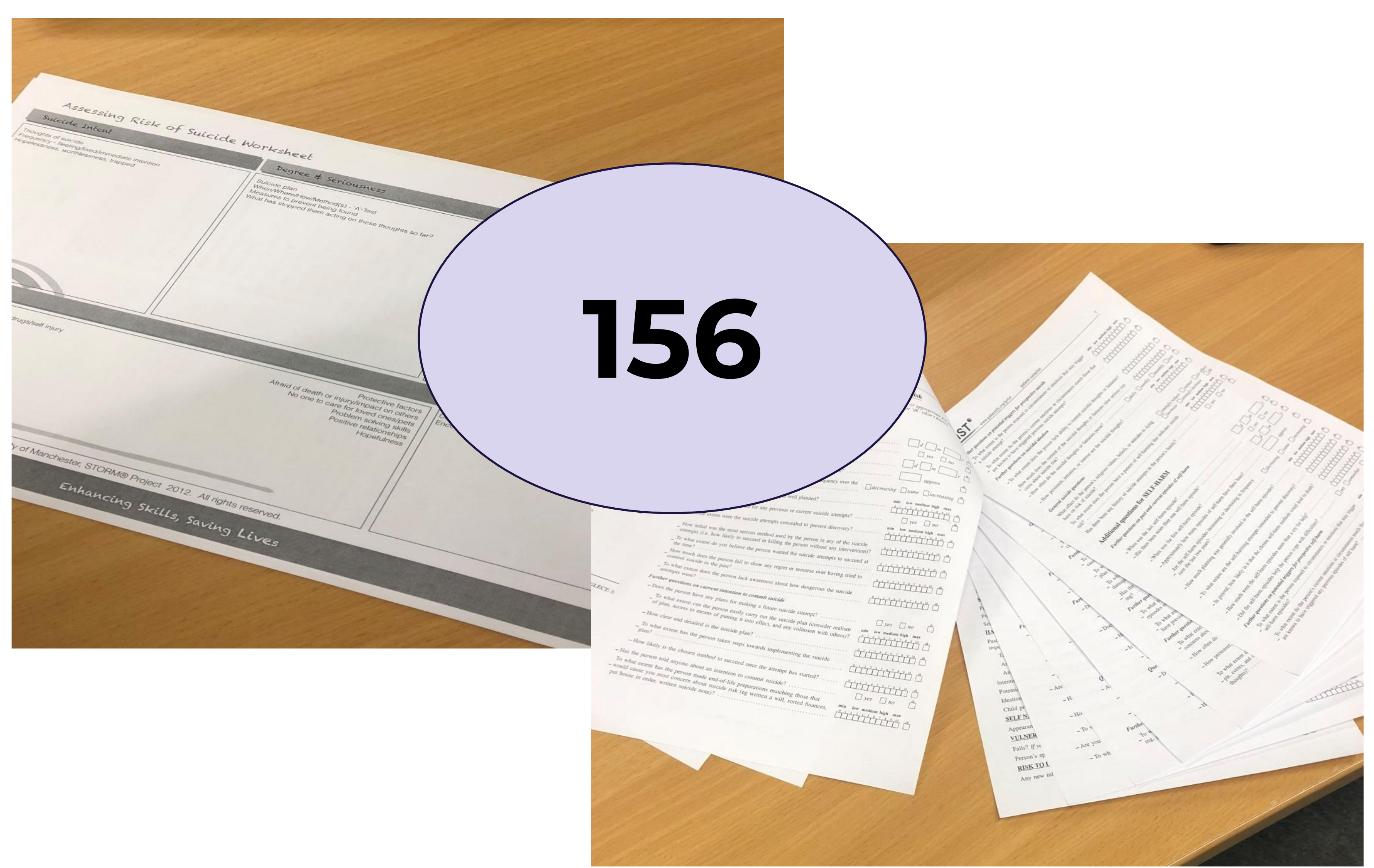

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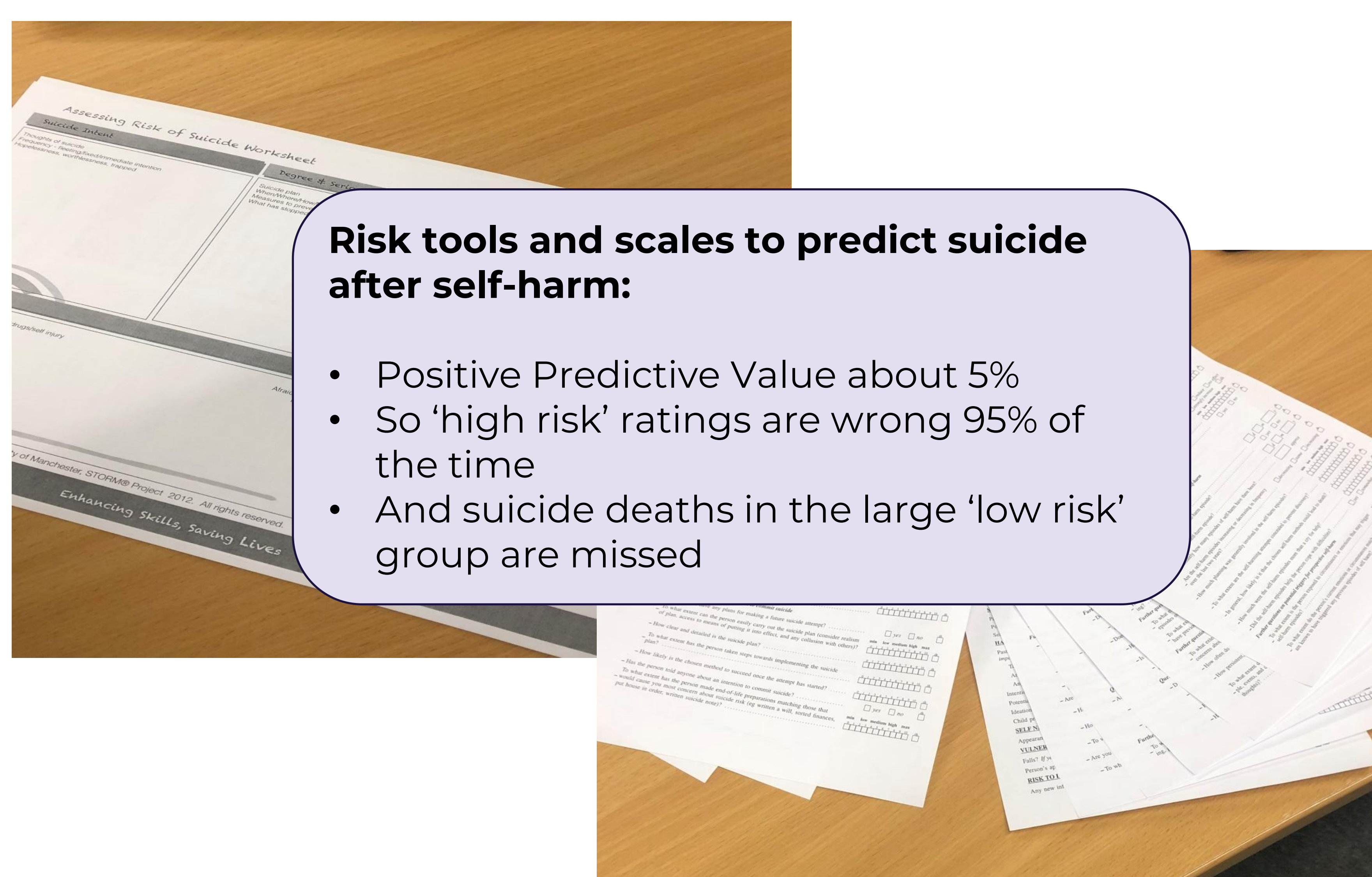


Risk tools and scales to predict suicide after self-harm:

- Positive Predictive Value about 5%
- So ‘high risk’ ratings are wrong 95% of the time
- And suicide deaths in the large ‘low risk’ group are missed

Outline

- Context
- Evidence
- **Alternatives**
- Progress and next steps

Option 1: We don’t need to change …its better than nothing….?

- Distracts from and dehumanises assessment
- Provides false reassurance
- Little consistency

Option 1: We don’t need to change …its better than nothing….?

- Distracts from and dehumanises assessment
- Provides false reassurance
- Little consistency

So why does their use persist?

- Culturally imbedded ritual for decreasing institutional anxiety
- Intended to protect clinicians and health services
- Clinical shorthand or Clinical shortcut
- Helps justify decision making

Option 2: We need to improve things

Patients' suggestions to improve risk assessment

- A personalised approach, not based on the completion of a checklist.
- Assessment by staff who are better trained and who value the answers given.
- To focus on suicidal thoughts, i.e. encourage staff to confidently tackle difficult questions.
- Involve carers/families
- Provide information on local support options

Source: NCISH, https://documents.manchester.ac.uk/display.aspx?DocID=37604

New horizons?

REVIEW

Can machine-learning methods really help predict suicide?

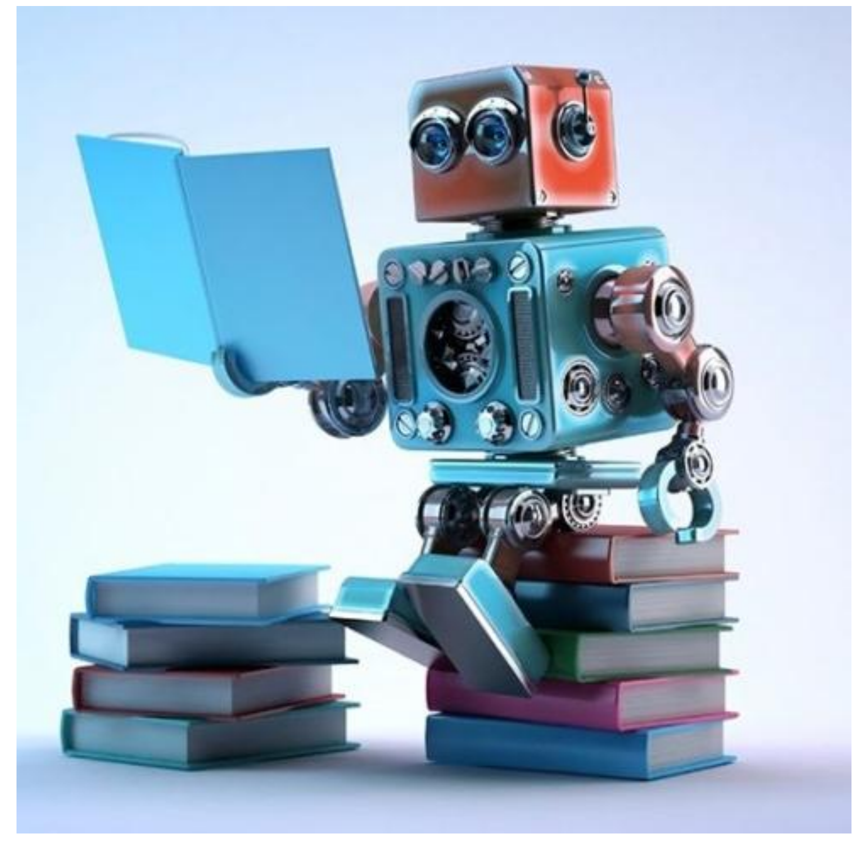
Catherine M. McHugh[a] and Matthew M. Large[b]

Purpose of review
In recent years there has been interest in the use of machine learning in suicide research in reaction to the failure of traditional statistical methods to produce clinically useful models of future suicide. The current review summarizes recent prediction studies in the suicide literature including those using machine learning approaches to understand what value these novel approaches add.

Recent findings
Studies using machine learning to predict suicide deaths report area under the curve that are only modestly greater than, and sensitivities that are equal to, those reported in studies using more conventional predictive methods. Positive predictive value remains around 1% among the cohort studies with a base rate that was not inflated by case–control methodology.

Summary
Machine learning or artificial intelligence may afford opportunities in mental health research and in the clinical care of suicidal patients. However, application of such techniques should be carefully considered to avoid repeating the mistakes of existing methodologies. Prediction studies using machine-learning methods have yet to make a major contribution to our understanding of the field and are unproven as clinically useful tools.

Keywords
artificial intelligence, machine learning, prediction, suicidal behaviour, suicide



Source: McHugh, C. and Large, M. Can machine-learning methods really help predict suicide?. Current Opinion in Psychiatry 33(4): 369-374, 2020

New horizons?

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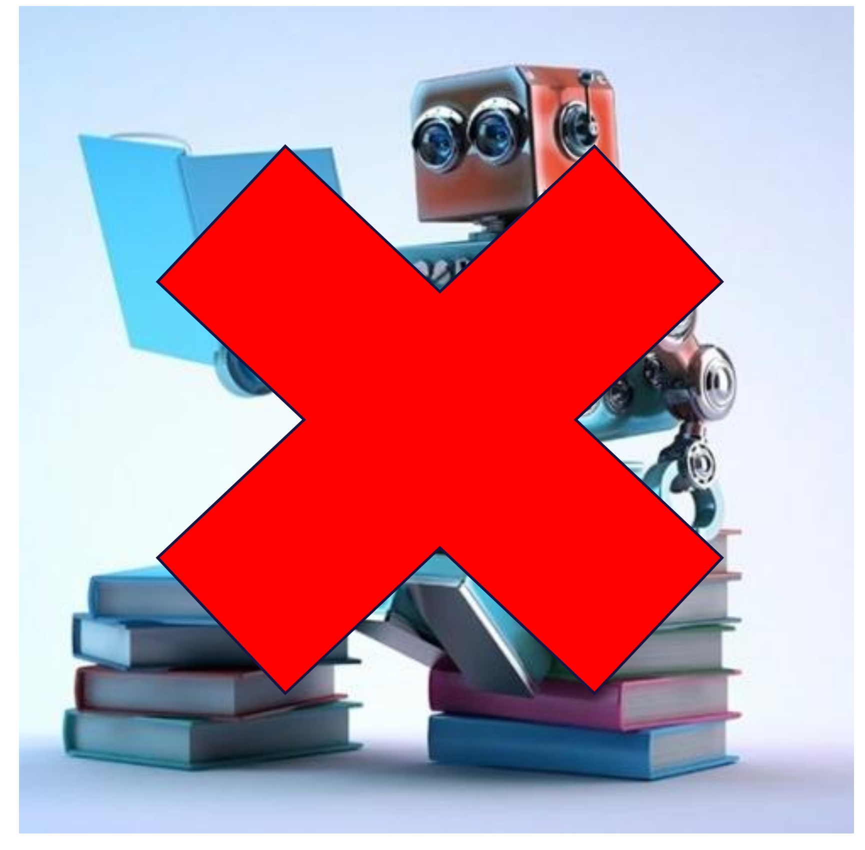
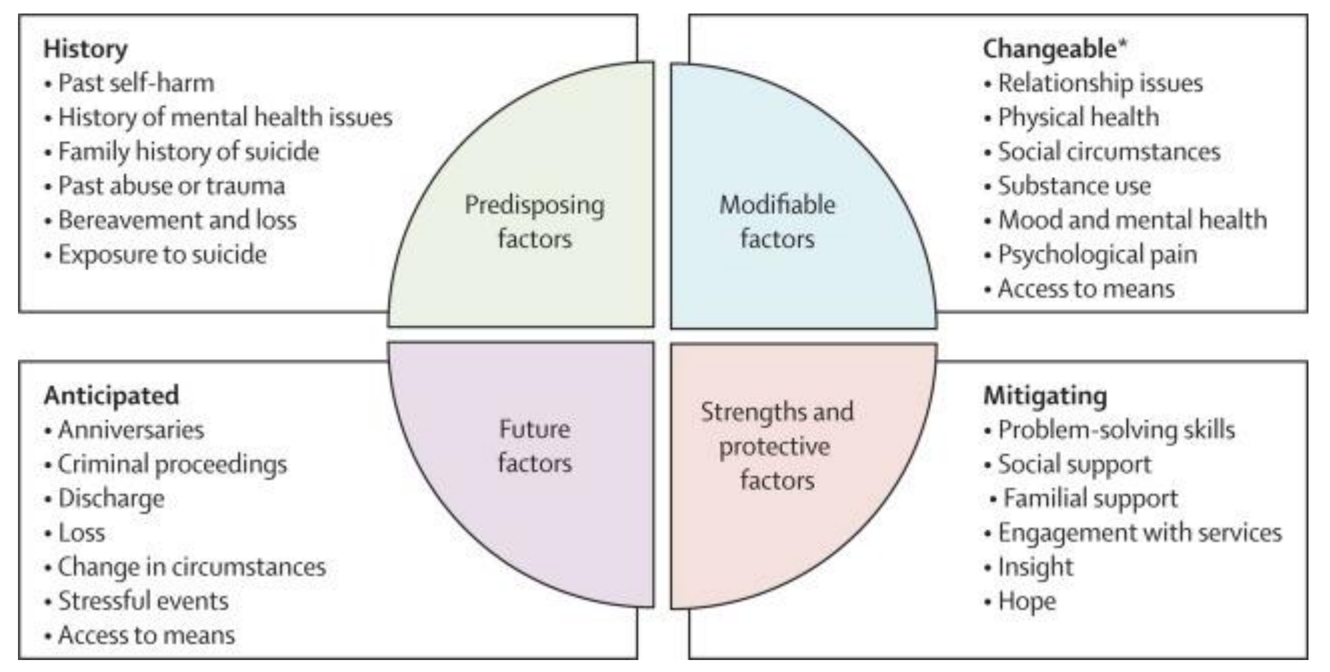


Source: McHugh, C. and Large, M. Can machine-learning methods really help predict suicide?. Current Opinion in Psychiatry 33(4): 369-374, 2020

Option 3: What can do we do instead?

- Recognise that risk prediction is a fallacy
- Address patient needs with an emphasis on modifiable factors
- Focus on the therapeutic aspects of the assessment
- Individualised assessment and assessments which inform management

Therapeutic risk assessment and formulation



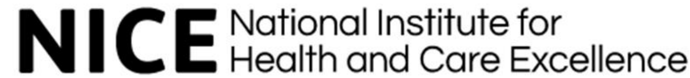
"This approach relies on investing time in gaining therapeutic alliance rather than ticking boxes, leveraging this alliance to uncover unmet needs and identify modifiable risk factors, and building a collaborative care plan as the therapeutic assessment unfolds"

Source: Hawton K, Lascelles K, Pitman A, Gilbert S, Silverman M. Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management. Lancet Psychiatry 2022;9:922-8.

Option 3: What can do we do instead?

- Recognise that risk prediction is a fallacy
- Address patient needs with an emphasis on modifiable factors
- Focus on the therapeutic aspects of the assessment
- Individualised assessment and assessments which inform management
- Use clinical guidelines and make evidence-based treatments available

Risk tools and scales



1.6 Risk assessment tools and scales

1.6.1 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

1.6.2 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

1.6.3 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.

1.6.4 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

1.6.5 Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

1.6.6 Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

Source: NICE, https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales

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- Address patient needs with an emphasis on modifiable factors
- Focus on the therapeutic aspects of the assessment
- Individualised assessment and assessments which inform management
- Use clinical guidelines and make evidence-based treatments available
- Adopt population approaches to prevention – 'something for everyone'

Safer systems

Source: NCISH

Outline

- Context
- Evidence
- Alternatives
- **Progress and next steps**

A new national approach to risk – Inpatient Care pathways & culture

Culture of Care Programme

The Culture of Care Programme is part of NHS England's Quality Transformation Programme.

This programme aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work.

https://www.rcpsych.ac.uk/improving-care/nccmh/culture-of-care-programme

proach to risk

Implementing a personalised approach to risk

https://sites.manchester.ac.uk/ncish/resources/implementing-a-personalised-approach-to-risk/

NCISH: helping you to develop your plans

Lived experience central

Site visits (in-person/virtual) with follow ups

Regular email contact

Help with reviewing your QI plans

Interactive learning events

Outputs – infographics, webpages, resources

Phase 1 sites are at different stages

- Some sites **have implemented their new approach** and are currently evaluating impact

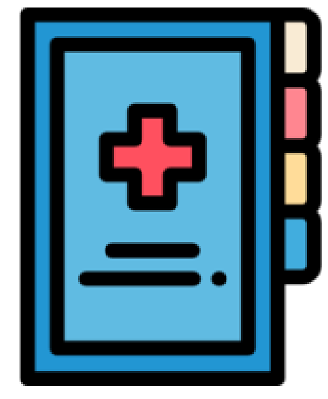
- Some sites in **earlier stages** (e.g. piloting new approach in some services and timeline in place for full implementation, consideration of outcome measures to be used)

- **All sites** - **risk assessment across the care pathway** (not just inpatient settings)

- NCISH **support tailored** to site's needs

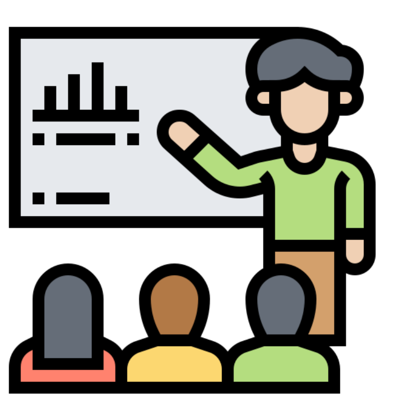
Local approaches - some possible principles

- Simple (including single current version)
- Universal (inpatients → community)
- Accessible (informational continuity)
- Narrative (to facilitate conversations)
- Prompts which can be tailored to individual services
- Co-designed and Collaborative
- Senior organizational buy in



Local approaches - some possible challenges

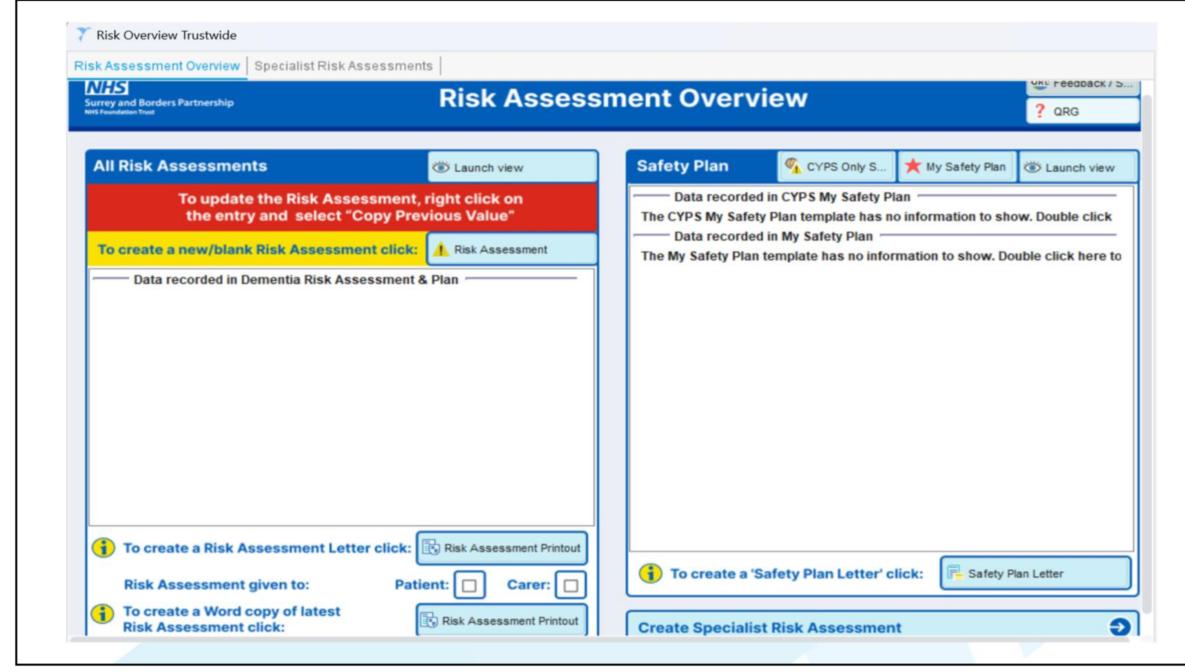
- Content
- A tangible and compelling alternative
- Language matters
- IT and patient records
- Staff engagement and workload
- Risk assessment can't be seen in isolation – part of a much wider process of clinical care
- So training and quality of services are crucial

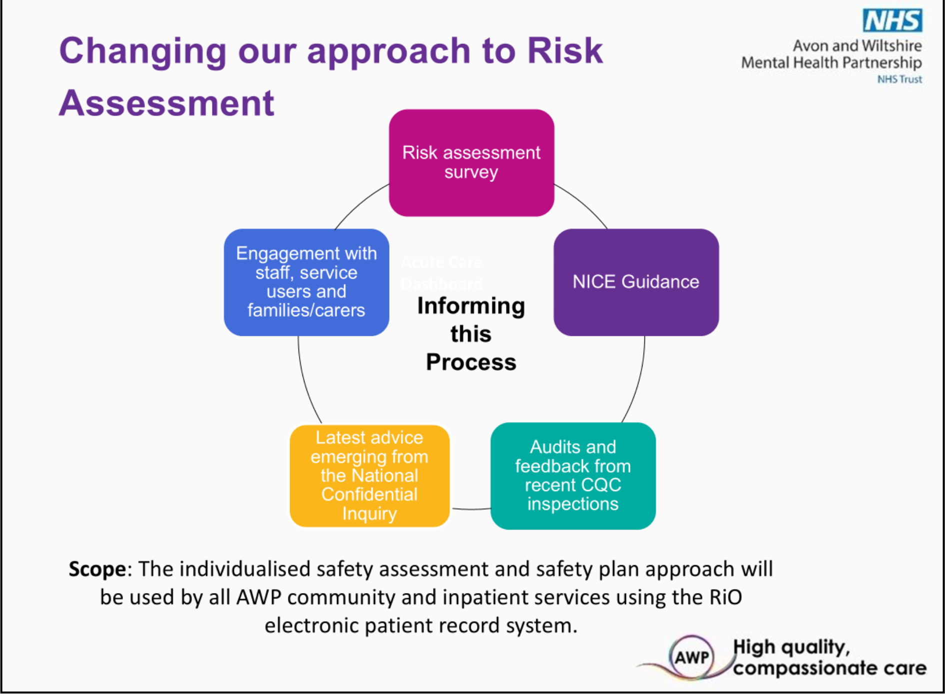


New approaches are possible -Trailblazers

Surrey and Borders Partnership NHS
NHS Foundation Trust

Risk Assessment without stratification, a New Risk Assessment Template within SABP





https://documents.manchester.ac.uk/display.aspx?DocID=74115

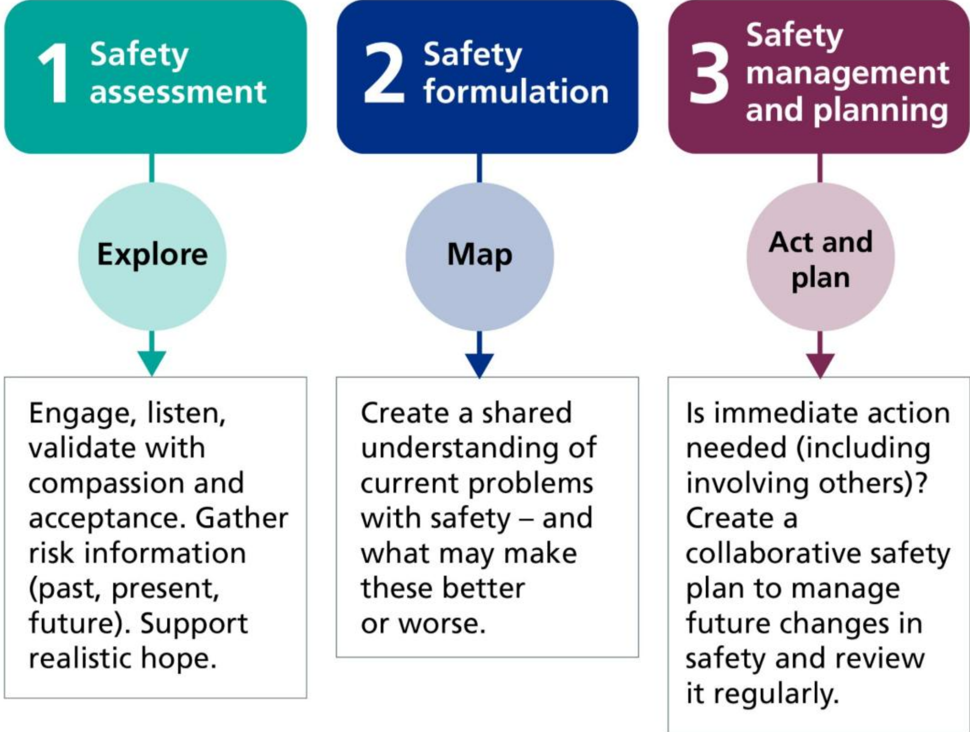
https://www.youtube.com/watch?v=oY2XY_QNayY (from 39 minutes onwards)

https://www.youtube.com/watch?v=iLlI2K9_RyI

“Staying Safe from Suicide” guidance

- New NHS England guidance on safety assessment, formulation and management

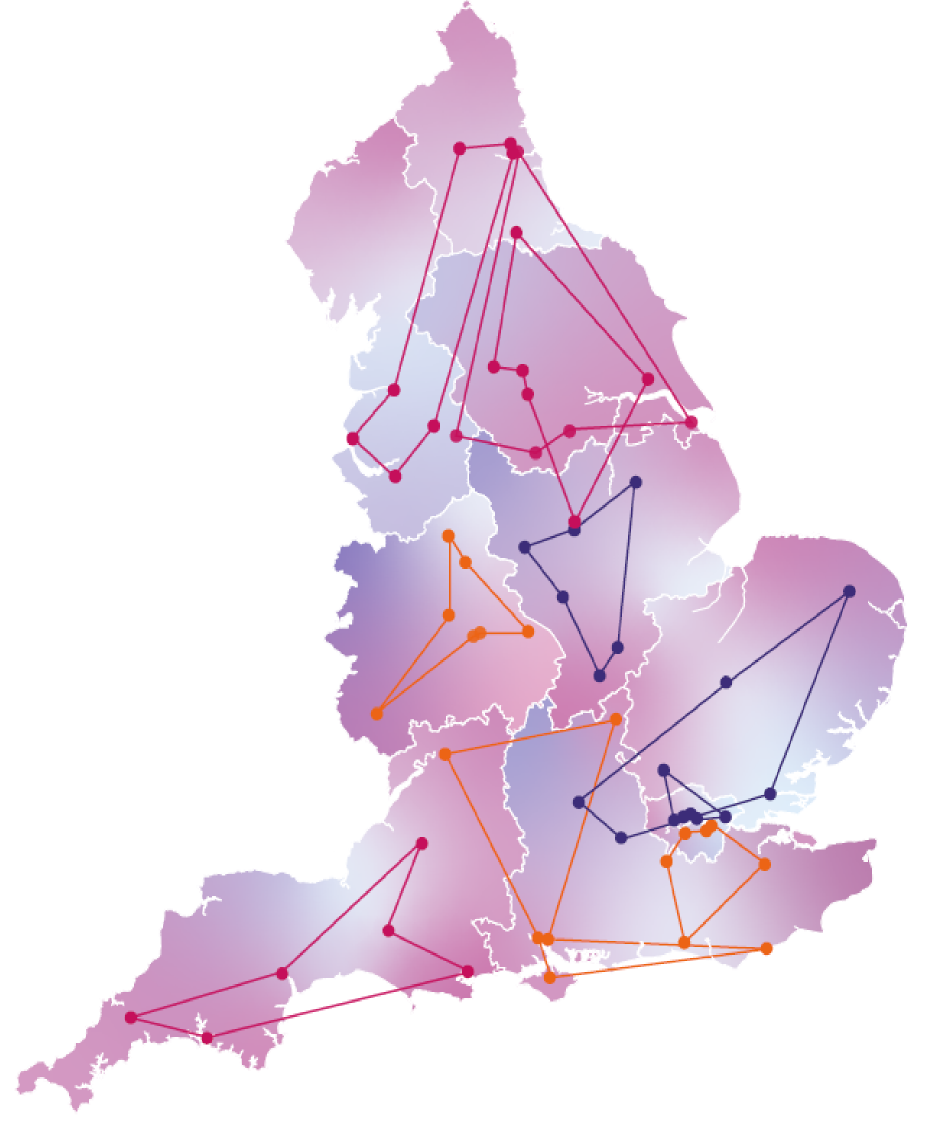
- Builds upon NICE guidelines and promotes shift to personalised approach to risk



https://www.england.nhs.uk/long-read/staying-safe-from-suicide/

Plans going forward

Combination of **in-person and virtual engagement** events based on learning networks



Outline

- Context
- Evidence
- Alternatives
- Progress and next steps

Summary

- Inpatient wards are **key settings** for mental health patient safety
- There is a **lack of consistency** in current approaches to risk assessment
- In clinical studies, most people who die by suicide were **rated as ‘low risk’**
- Risk tools have **poor predictive value** and can lead to people being **excluded** from services
- A **personalised, collaborative, inclusive, comprehensive** approach to assessment and management might be better
- **Clinical guidelines, high quality services, training** are key

Centre for Mental Health and Safety

Break

15:05 – 15:15

Autism informed personalised risk assessment

Lucy Gilbert
Senior Lived Experience Advisor for the Culture of Care Programme and Neurodiverse Connection

Overview

- Why we need to consider an autism informed approach
  - Statistics
  - Research
  - Lived experience insight
- Applying the SPACE framework to risk assessments
- Adapted safety plans

The statistics

- 9 times more likely to die by suicide
- 2 in 3 autistic people have considered taking own life (Cassidy 2014)
- In autistic people without a LD, 34.2% suicidal thoughts, 21.9% suicidal plans, 24.3% attempts (9%, 2-3% in general population) (Newel et al. 2023)
- 80% had contemplated or attempted suicide (Bentum 2024)
- Average of 32 deaths per year (NCISH 2024)

The research

- Risk factors include **thwarted sense of belonging**, **masking** and **perceived sense of burdensomeness** (Cassidy and team)
- Masking highly associated with suicidality (Pearson and Rose 2021)
- Risk factors include depression, higher numbers of autistic traits and additional MH diagnoses (Bentum 2024)
- "People like me don't get support" (Camm-Crosbie et al. 2018)

AUTISTIC

(**Physical** **Processing** **Emotional**)

S — Sensory

P — Predictability

A — Acceptance

C — Communication

E — Empathy

Sensory

Consider how sensory friendly the physical environment is during the assessment

Consider to what extent ‘behaviours’ may be a way of meeting sensory needs

Consider the impact of interoceptive differences

Suggestions:

- Turn off or dim artificial lights
- Quiet rooms as much as possible
- Consider what you bring into the environment
- Consider room temperature
- Provide variety of furniture and fidget items
- Be curious about unmet sensory needs
- Seek to understand ‘baseline’ sensory seeking/avoidant patterns

Predictability

To what extent is not knowing what to expect driving anxiety, overwhelm or burnout

Uncertainty around who, what, where, when and why can fuel unease and internal chaos

Suggestions:

Be clear that this is a risk assessment!

Provide as much information as possible, in advance:

- Why is this being done
- Who will lead the discussion, who will be there, who will see the notes
- Where will this take place, what does the room look like? How will the furniture be laid out?
- When will this happen?
- Plan A, B, C....

Provide questions or prompts in advance

Consistency in approach and outcomes

Acceptance

A holistic approach- recognise strengths and challenges and fluctuations

Be curious about what is underlying what you see and aware of what bias you may hold, or which may accompany preceding notes

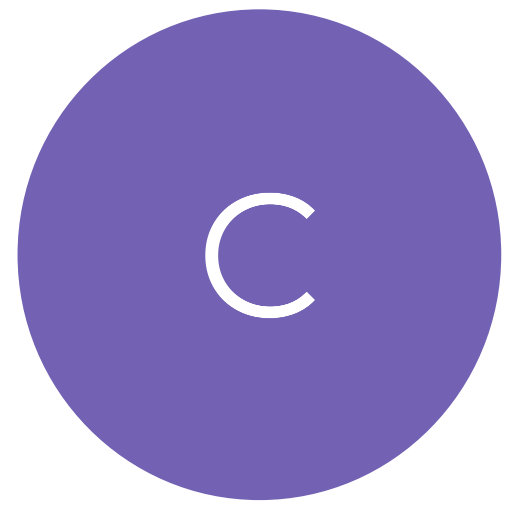
Suggestions:

- Seek family/carer views if appropriate
- Consider spiky profiles and setting dependent fluctuations
- Embrace individual ways of regulating
- Recognise that "behaviours that challenge" are often a response to Autistic needs not being met.
- Consider the impact of Alexithymia- can you personalise mood rating scales?
- Consider unconscious masking behaviours and co-create a safe space to minimise trauma responses. Consider your language use.
- Consider monotropic thinking and looped thinking

Communication

Autistic people may communicate differently: this can change depending on stress levels or sensory overload.

How can you start to bridge the double empathy gap?



Suggestions:

- Allow for non-verbal communication (e.g. use communication cards & allow people to write down their feelings.)
- Avoid jargon, be aware of ambiguity in language & allow for questions to check understanding.
- Do not force eye contact or make assumptions of meaning from body language
- Avoid 'shotgun' questioning
- "Listen to what I say, not how I say it"
- Be aware of your own reliance on reciprocal language

Empathy

Be curious and seek to understand each individual's unique worldview

Be aware of differences in experience and expression of empathy

Suggestions:

- Recognise the double empathy problem and consider how you could re-dress the balance during the assessment
- Appraise and seek to check any assumptions that may have been made before
- Socrative questioning throughout
- Consider autism specific risk factors
- Honesty and transparency needs to go both ways
- Adopt a staff well-being approach first

Adapted safety plans

- Growing research

- Rodgers et al. (2024)- Autism Adapted Safety Plans (ASSP)
  - Clearer wording
  - Sections on how to communicate with during a crisis
  - Resource pack to support co-production

Pilot and Feasibility Studies

STUDY PROTOCOL | Open Access

Adapted suicide safety plans to address self-harm, suicidal ideation, and suicide behaviours in autistic adults: protocol for a pilot randomised controlled trial

Jacqui Rodgers[1*], Jane Goodwin[1], Emma Nielsen[2], Nawaraj Bhattarai[3], Phil Heslop[4], Ehsan Kharatikoopaei[5], Rory C. O'Connor[6], Emmanuel Ogundimu[7], Sheena E. Ramsay[1], Katie Steele[8], Ellen Townsend[9], Luke Vale[3], Emily Walton[8], Colin Wilson[1] and Sarah Cassidy[9]

Abstract

Background Suicide prevention is a national priority for the UK government. Autistic people are at greater risk of experiencing self-harm and suicidal thoughts and behaviours than the general population. Safety plans are widely used in suicide prevention but have not yet been designed with and for autistic people. We developed the first safety plan specifically targeting suicidality in autistic adults: the Autism Adapted Safety Plan (AASP). It consists of a prioritised list of hierarchical steps that can be used prior to or during a crisis to mitigate risk of self-harm and suicidal behaviour. This is a pilot study that aims to assess the feasibility and acceptability of the AASPs and the research processes, including the response rates, potential barriers and reach of AASPs, methods of recruitment, what comprises usual care, and economic evaluation methods/tools.

Methods This is an external pilot randomised controlled trial of a suicide prevention tool aimed at mitigating the risk of self-harm and suicidal behaviour in autistic adults: AASPs. Participants will be assessed at baseline and followed up 1 month and 6 months later. Assessments include questions about self-harm, suicidality, service use, and their experience of the AASP/taking part in the study. Autistic adults who have a clinical autism diagnosis and self-reported history of self-harm, suicidal thoughts, or suicidal behaviours within the last 6 months will be invited to take part in the study. Informed consent will be obtained. Participants will be recruited via community and third sector services (including community settings, autism charities, and mental health charities). They may also "self-refer" into the study through social media recruitment and word of mouth. Ninety participants will be randomised to either develop an AASP or receive their usual care in a 1:1 ratio.

Discussion The present study will provide an evaluation of the suitability of the processes that would be undertaken in a larger definitive study, including recruitment, randomisation, methods, questionnaires, outcome measures, treatment, and follow-up assessments.

Trial registration ISRCTN70594445, Protocol v4: 8/2/22.

Summary

- Compassionate curiosity
  - Kindness
  - Seek to understand
  - Withhold judgement
  - Listen to all voices
- The importance of relationships in building trust and safe spaces
- Adaptions are often small but powerful

Considering racial equity and risk assessment

Cllr. Jacqui Dyer
Director, Black Thrive Global

Jo Green
Lived Experience Advisor, Black Thrive Global

Risk, Race, and the Right to Be Seen: Rehumanising Risk in Mental Health Care

Jacqui Dyer

The Racialised Reality of Risk

Risk as a Cultural and Political Category

- Structural Bias in Risk Tools

Personal and Community Stories

Personalising Risk:
A Rehumanising Alternative

Risk and Relational Repair

Conclusion

Transforming risk assessment locally: trailblazer site

Natasha Bryant
Trustwide Suicide Prevention Lead (Avon and Wiltshire Mental Health Partnership NHS Trust)

From Risk to Safety

Transforming our approach to risk assessment

High quality, compassionate care

Drivers for change

Staff risk surveys

NICE guidelines

The National Confidential Inquiry

Suicide Prevention Strategy

Engagement with staff, service users and carers

Clinical audits and feedback from CQC

Informing this process

Safety Assessment & Formulation

Pre-implementation

Activity & Outcomes

LISTENING
Staff, service user and stakeholder engagement. **Relationships and language matter.**

REVIEWING
Suicide Prevention Strategy, NICE NG225, NCISH, research, evidence and audits.

PLANNING
Board support, project planning, digital input, alignment with care planning transformation programme.

CO-PRODUCING
Development of model, guidance, policy and principles.

TESTING
Interim changes, clinical testing across diverse clinical settings and clinical challenge.

COMMUNICATING
Layered communications, safety champions, further engagement, training and support.

Research, evidence and opinion influencing our new approach

NICE Guideline (NG225) Self-Harm: assessment, management and preventing recurrence

During the psychosocial assessment, explore the following to identify the person's strengths, vulnerabilities and needs:

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

The assessment of clinical risk in mental health services (NCISH)

Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk.

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management

Keith Hawton*, Karen Lascelles*, Alexandra Pitman, Steve Gilbert, Morton Silverman

Suicide prevention in psychiatric practice has been dominated by efforts to predict risk of suicide in individual patients. However, traditional risk prediction measures have been shown repeatedly in studies from high income countries to be ineffective. Several factors might contribute to clinicians' preoccupation with risk prediction, which can have negative effects on patient care and also on clinicians where prediction is seen as failing. The model of therapeutic risk assessment, formulation, and management we outline in this article regards all patients with mental health problems as potentially at increased risk of suicide. It is aimed at reducing risk through use of a person-centred approach. We describe how a move towards therapeutic risk assessment, formulation, and risk management, including collaborative safety planning, could help clinicians develop a more tailored approach to managing risk for all patients, incorporating potentially therapeutic effects as well as helping to identify other risk reduction interventions. Such an approach could lead to enhanced patient safety and quality of care, which is more acceptable to patients.

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Correspondence to: Prof Keith Hawton, Centre for Suicide Research, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, OX3 7JX, UK
keith.hawton@psych.ox.ac.uk

Introduction

Clinical practice and research on suicide and its prevention in patients with psychiatric disorders have long been dominated by attempts to predict who is at risk of suicide and to implement measures to reduce that risk.[1,2] However, risk prediction has been shown repeatedly to be ineffective, owing to the poor positive predictive ability of instruments or approaches used.[1] Despite the limitations of the science, a heavy emphasis on risk prediction persists.[2] A perceived failure to predict suicide can lead to blaming of clinicians involved in the care of patients who die by suicide. Furthermore, current unreasonable expectations of risk prediction can amplify clinicians' sense of responsibility.

In this Personal View, we consider what perpetuates reliance on risk prediction, the evidence that it is ineffective, and why the current state of the science is flawed. We then present a more comprehensive and therapeutic approach to assessing, formulating, and managing risk. The approach we propose is aimed at reducing suicide in patients with psychiatric disorders as a group.[4]

Drivers of the continuing preoccupation with suicide risk prediction

The pressure on mental health clinicians to identify which of their patients might be at greatest risk of suicide and then to try and prevent that outcome is understandable, especially as some studies indicate that at least 90% of individuals who die by suicide have mental disorders.[5] However, the focus on risk prediction has seemingly grown at the expense of attention to efforts to prevent suicide or to build therapeutic alliance. An important factor driving this focus is pressure from hospital organisations to ensure that a risk assessment is documented in patients' notes, including stratification of risk (eg, low, medium, and high). One view is that this pressure arises because hospital organisations hope to protect themselves from criticism or legal action, should an adverse outcome occur; however, such static statements do not reflect the highly changeable nature of risk. Also, interpretations of the low, medium, or high terminology will vary for different populations, such as psychiatric hospital inpatients versus community psychiatric patients,[6] and between clinicians.

Moreover, it has been posited that reliance of both clinicians and organisations on risk prediction and stratification processes arises from uncertainty about which interventions have the best chance of preventing suicide, providing a semblance of control that (thinly) disguises anxiety and dysregulation.[7] This reliance could be reinforced by pressure or expectations of external regulatory agencies (and coroners). Here, we summarise the evidence that this emphasis on risk prediction is misplaced and potentially dangerous.

Evidence that suicide risk prediction is ineffective

There is increasing evidence that suicide risk prediction, whether using clinical judgement or risk prediction tools, is ineffective. In the UK, an estimated 25–30% of individuals who die by suicide had been in contact with psychiatric services within the year before their deaths.[8] In approximately half of this group, the last service contact was in the week before the death. Yet, when mental health clinicians were asked to estimate immediate risk at the last service contact, the vast majority (85%) judged this immediate risk to be low or absent. This low risk paradox was also observed when the clinicians were asked to assess long-term risk, where the majority (59%) also viewed risk in this patient group as low or negligible.[9]

In a US study of 132 psychiatric patients who died by suicide after being evaluated for suicidal ideation within

Principles of new approach

1

Safety assessments and associated safety plans should focus on individual needs and identify situations and circumstances in which a person's safety might be compromised and associated risks elevated, and what might mitigate potential harm at those times

2

Global risk stratification into low, medium or high should not be used to predict future suicide or to determine who should be offered treatment or discharged

3

Safety assessment and formulation is achieved through a clinical conversation, characterised by compassion, curiosity and collaboration

4

Safety is not a number, and a safety assessment is not a checklist

5

Families and carers should have as much involvement as possible

Components of new patient safety log

Date
Calendar

Risk category
Drop down list: harm to self, harm to others, harm from others, accident, other

Location
Drop down list: own home, public place, AWP community base, AWP inpatient (communal area), AWP inpatient (bedroom area), AWP inpatient (out of area), general/acute hospital, care/nursing home, other (specify in context)

Risk incident
Free text 250 characters

Trigger/context
Free text 500 characters

Once entries are made to patient safety event log, they are then **viewable in a chronological list format** to aid formulation (hence strict character limit in order for important information to not get lost over time)

Components of new safety assessment and formulation

Safety Assessment and Formulation

In this section you should focus on individual needs and identify situations and circumstances in which a person's safety might be compromised and risk elevated. The formulation should be a collaborative process with the person and their family (where appropriate). It would typically include historical factors, current safety issues, future or anticipated safety concerns and existing strengths and resources. You should also summarise any concerns of the person's family/support network, as well as what support they need to help keep the person safe. **{hyperlink to further guidance and resources}**

Summary of known history/patient safety events

In this section you should summarise the person's pre-disposing factors and known risk history, including context triggers and outcomes of past patient safety events

Summary of current patient safety concerns, including the person's own views

In this section you should summarise any current patient safety issues, including current problems, triggers and include the person's own views

Protective factors or circumstances. Factors or circumstances making harm less likely

In this section you should summarise mitigating factors or circumstances that make harm less likely

Summary of future safety concerns

In this section you should identify any situations and circumstances in which a person's safety might be compromised and risks elevated

Carer/family/parent view

In this section you should summarise what the carer, family or parent is concerned about and detail what support they need

Safety Assessment & Formulation

Post-implementation

Activity & Outcomes

“Safety and safety assessments are vastly preferrable to risk and risk assessments – the latter feeling punitive, labelling people as ‘risky’, ‘dangerous’, ‘not fit for wider society’”
(Service User)

“The removal of ‘high, medium and low’ is hugely beneficial in all sorts of ways”
(Service User)

“I am in favour of ‘safety’ because its positive and empowering”
(Service User)

“From an inpatient perspective, safety assessments have been a very welcome change. They are patient focussed and encourage collaborative working. We have found that patients have felt actively involved in discussing risk, what they find helpful and how they can be supported to feel safe”
(Ward Manager)

“The new safety assessment helps me to ‘really see and understand the person’ through the individualised narrative”
(Clinician)

“It’s not only a change in how safety/risk assessments are conducted…but in how we THINK about safety/risk”
(Clinician)

Support for organisations on PAR year two

Emily Cannon
Head of Quality Improvement, NCCMH

Personalised approach to risk driver diagram

AIM

Implementing a personalised approach to risk assessment and management in mental health in-patient settings

PRIMARY DRIVERS

- Clarity on what the organisation is moving towards
- Communication
- Presumption of patient, family and loved one involvement
- A culture that supports staff to provide relational care
- Taking action to address systemic inequities
- Leadership

SECONDARY DRIVERS

Clarity on what the organisation is moving towards
- Shared understanding that risk assessment tools do not predict risk
- IT infrastructure that supports the introduction of a new approach
- Clear organisational expectations for formulation, recording & decision making
- Organisational strategy, policies and culture support a personalised approach

Communication
- Agree a common, simple term for the new approach
- Clear, consistent and ongoing communication with staff
- High quality notes and assessments for referrals, GPs, patients and carers
- Communicate with those outside inpatient setting, and external to organisation, on new approach e.g community services, coroners, GPs

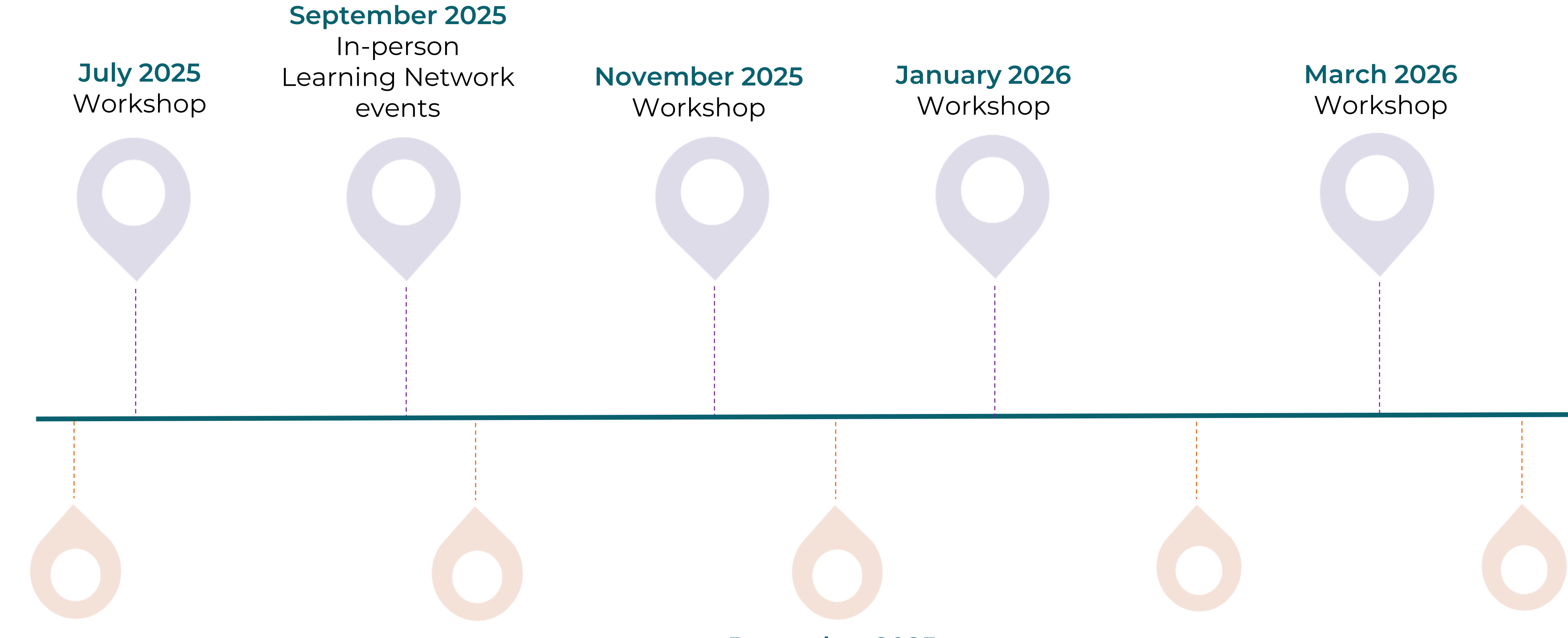
Presumption of patient, family and loved one involvement
- Co-produce new approach with patients, families, loved ones and carers
- Personalised approach that meets patients' needs and supports loved ones
- Reviewing implementation with clinicians and people with lived experience

A culture that supports staff to provide relational care
- Strong support for staff wellbeing
- Honest, psychologically safe and reflective spaces for staff
- Ongoing supervision with space for confidence building and skill development
- Organisational openness towards change and a move away from blame culture
- Provide training with a clear theoretical basis and skills-based learning

Taking action to address systemic inequities
- Creating and maintaining an autism-informed approach
- Creating and maintaining a racial equity approach
- Creating and maintaining a trauma informed approach

Leadership
- Executive and senior leadership buy-in for organisation's chosen approach
- Leadership that actively facilitates change and new ways of working
- Consistency in leadership at all levels of an organisation

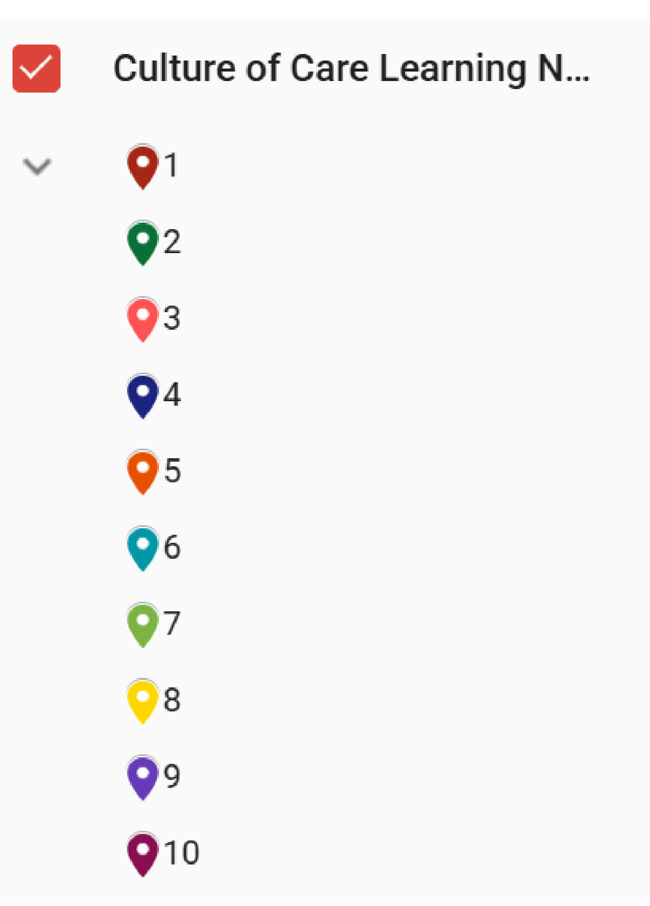
Monthly events



Themes from year 1

- Support with equity principles (anti-racism, autism-informed and trauma informed approaches)
- Support with lived experience involvement to ensure new approach is co-produced
- Engaging with local coroners
- Moving to a more relational approach and building psychological safety for staff
- How to implement (testing small scale vs full implementation, inpatient and community)
- Adaptations for different needs and service types

September learning network events



Learning network pairings

Network 1
- Avon and Wiltshire Mental Health Partnership Trust
- Cornwall Partnership NHS Trust
- Devon Partnership NHS Trust
- Dorset Healthcare
- Livewell Southwest
- Somerset Foundation Trust

Network 6
- Bramley Health
- Elysium Healthcare
- Gloucestershire Health & Care NHS Foundation Trust
- Isle of Wight NHS Trust
- Solent NHS Trust
- Southern Health

Network 4
- Bradford District Care NHS Foundation Trust
- Humber Teaching NHS Foundation Trust
- Leeds & York Partnership NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees Esk and Wear Valley NHS Foundation Trust
- The Priory

Network 7
- Navigo Health and Social Care
- Northumbria Healthcare NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Health and Social Care NHS Trust

Network 2
- Berkshire Healthcare NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Essex Partnership University Trust
- Norfolk and Suffolk NHS Foundation Trust

Network 5
- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- St Andrews Healthcare

Network 8
- Central and North West London NHS Foundation Trust
- East London NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- North East London NHS Foundation Trust
- North London Mental Health NHS Partnership
- West London NHS Trust

Network 9
- Kent and Medway NHS and Social Care Partnership Trust
- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London & St Georges Mental Health Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Network 3
- Birmingham and Solihull
- Birmingham Women's and Children's NHS Trust
- Black Country Healthcare NHS Foundation Trust
- Coventry and Warwickshire Partnership Trust
- Herefordshire & Worcestershire Health & Care Trust
- Midlands Partnership Foundation Trust
- North Staffordshire Combined Health Care

Network 10
- Cheshire & Wirral Partnership NHS Foundation Trust
- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
- Cygnet Health Care
- Gateshead Health NHS Foundation Trust
- Greater Manchester Mental Health Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Merseycare NHS Foundation Trust

September learning network events

- Events are typically 10:00-15:30.
- 13:00-15:30 will be dedicated to PAR, building on the morning session

Learning network pairing	Date	Location	Venue
2 & 5	17th September	Leicester	Leicester Tigers
8 & 9	18th September	London	RCPsych
3 & 10	23rd September	Manchester	MUFC Stadium
4 & 7	25th September	Sheffield	SUFC Stadium
1 & 6	30th September	Bristol	Bristol Pavillion

Break

16:25 – 16:35

Discussion and Q&A

Matt Milarski & Emily Cannon
Heads of Quality Improvement, NCCMH

Next Steps

Matt Milarski & Emily Cannon
Heads of Quality Improvement, NCCMH

Upcoming events in 2025

Dates for your diary

- **7 July:** **National Learning Session** (virtual, 10:00-14:00)
- **22 September:** **Lived Experience Network**(virtual, 13:00-16:00)
- **September Events:** **Learning Network Event** (in-person)
- **22 October:** **PAR Learning Event** (10:00 – 12:30)
- **30 October:** **National Learning Session** (13:00 – 15:00)

*****The calendar of all our events and trainings can be found on our website.**

Reminder about training for ward staff

Dialogical and Relational Training Taster Days (DARTT)	Autism Informed Training	Anti Racism Training	Preventing Sexual Harm Training
• 16 July 2025 09:30 – 16:30 • 18 Sept 2025 09:30 – 16:30	• 20 August 2025 13:00 – 16:00 • 23 Oct 2025 13:00 – 16:00	• 4 Sept 2025 14:00 – 16:00 • 17 Nov 2025 10:00 – 12:00	• 22 July 2025 10:00 – 12:00 • 11 Nov 2025 10:30 – 12:30

These training sessions are delivered virtually.

Please visit our website for more information & how to register:
www.rcpsych.ac.uk/improving-care/nccmh/culture-of-care-programme/learning-events

With gratitude

- Thank you so much for coming today and for the work you continue to do to influence services and try to improve things for patients and families.

- If you could kindly scan the QR code and provide your feedback.

Close