



Staying safe from suicide:

Safety assessment and formulation

Dr Jeya Balakrishna, MBBS, FRCPsych, LLM

Specialist Advisor, Patient Safety & Suicide Awareness, RCPsych
Member, National Suicide Prevention Specialist Advisory Group (NSPSAG)

Consultant Psychiatrist, Defence Primary Healthcare, MOD
Chair, Clinical Advisory Group (Significant Events) Defence Medical Services

Associate Registrar for Mentoring & Coaching, RCPsych

today you could be
standing next to someone
who is trying their best
not to fall apart.
so whatever you do today
do it with kindness





“We do not know why people die by suicide. Even those who survive a suicide attempt cannot always fully explain why. There is much uncertainty, of simply not knowing.

We need to be mindful as clinicians that the patient does not tell us everything that goes on in their mind.”

Professor Dame Clare Gerada FRCP, FRCGP, Hon FRCPsych
President, Royal College of General Practitioners
Co-Chair, NHS Assembly
Former Clin Director, NHS Practitioner Health Service

Demographics & rates (UK)

Men are more likely to die by suicide than women (3:1), whereas women self-harm more frequently than men.

Highest suicide rates are in the older age groups, with the biggest rise in 45-64yrs. Highest rate for men 45-49yrs, for women 50-54yrs.

Deprived areas in Scotland and NI had higher rates. NW England was highest in England, London was lowest.

Suicide is the leading cause of death in under-35yrs in UK.

Key points to note

*Self-harm & suicide in adults:
Final report of the Patient
Safety Group. CR229 RCPsych*

- Nearly 75% of those who died by suicide did not have any contact with mental health services. Most cases of completed suicide are linked to mental illness, but at-risk patients are not presenting or being identified and/or offered the mental health treatment that could have prevented their death.
- Self-harm is one of strongest predictors of suicide, including among older people.
- Suicide occurs more frequently with coexistence of psychiatric and physical illness.
- A significant proportion of self-harm behaviour does not lead to presentation to professionals. Voluntary, peer and community counselling organisations plus family and friends can offer significant help. Informal support could be sufficient to help.

NICE updated guidance in Sep 2022 (NG225):

- Do not use risk assessment tools & scales to predict future suicide or repetition of self-harm.
- Do not use risk assessment tools & scales to determine who should and should not be offered treatment or who should be discharged.
- Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.
- Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

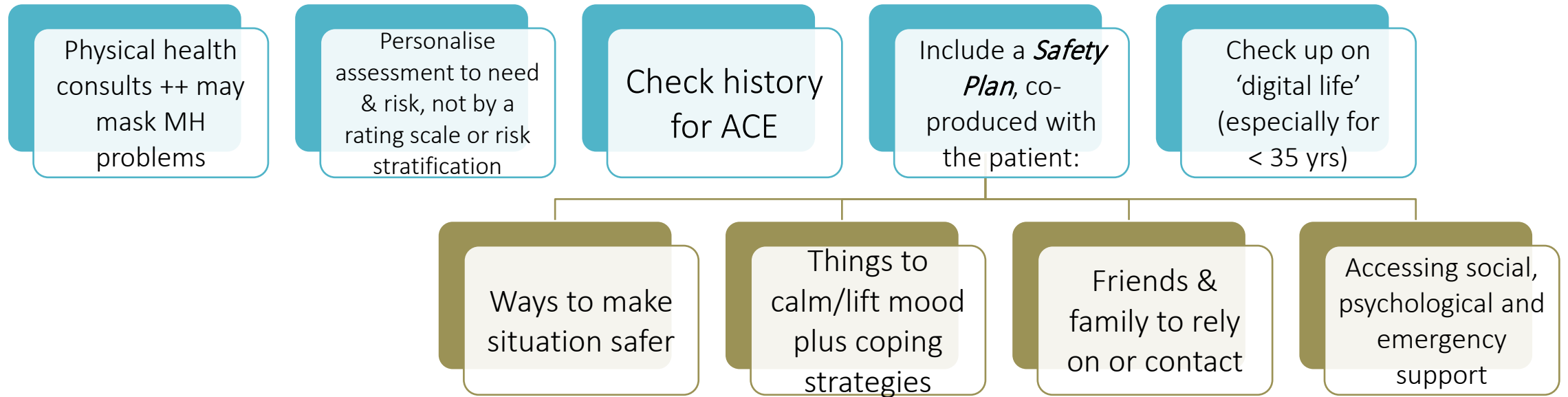
New Best Practice Guidance principles

- Risk prediction is ineffective - move away from risk rating scales and risk stratification
- Biopsychosocial safety assessment, formulation and management – 5Ps
- Safety assessment & formulation – reach shared understanding with individual about safety and the changeable factors that may affect this
- Dynamic understanding - Regularly assess and adapt formulations and safety plans based on the individual's changing needs and circumstances
- Encourage involvement of trusted others
- Relational Safety: Build and maintain trusting, collaborative therapeutic relationships – these are the strongest predictors of good clinical outcomes

All self-harm should be taken seriously

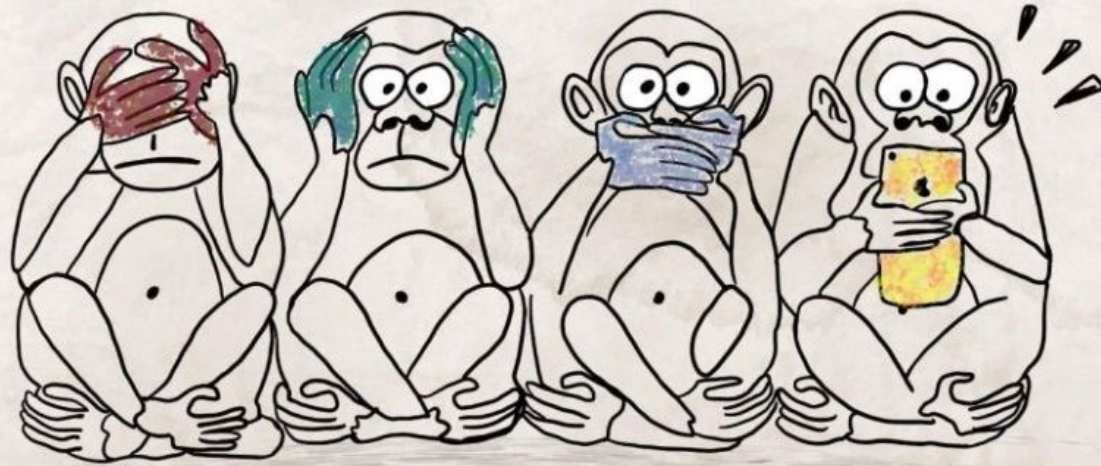
- Create a safe environment to discuss
- Listen carefully, in a calm and compassionate way
- Take a validating and non-judgemental approach
- Empathise – understand thoughts and feelings about issues
- Ask questions that promote discovery and insight
- Help the person to identify their own coping strategies and support network
- Offer information about support services

Best practice in safety management

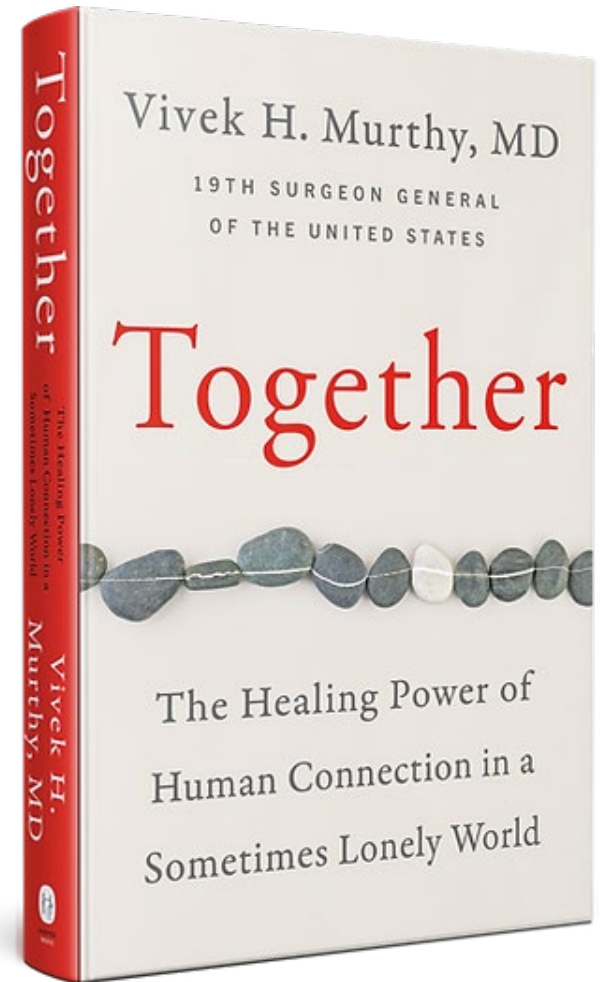


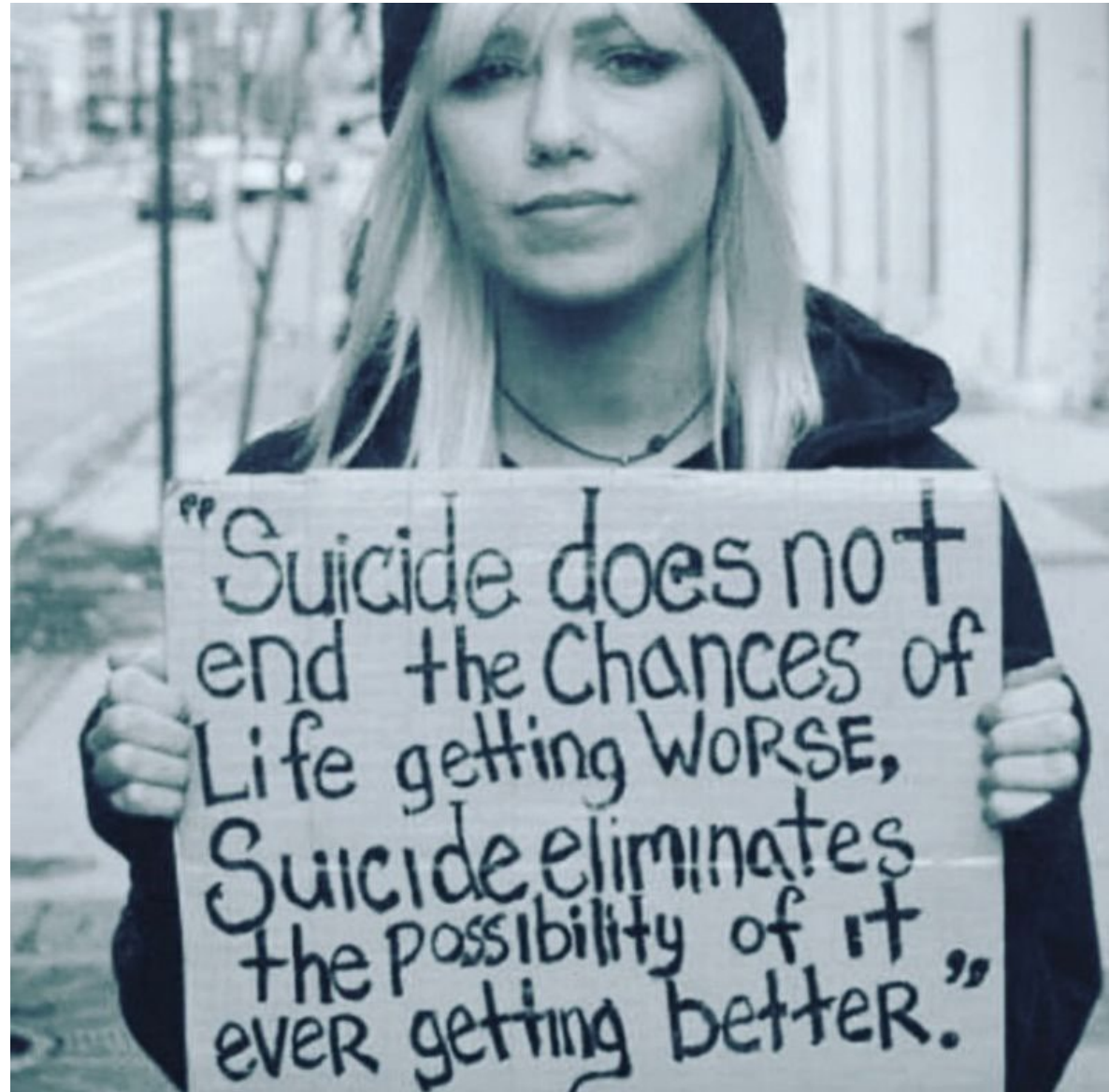
FINALLY THE FOURTH APE!
HE IS THE SUM OF THE FIRST THREE:
HE SEES NOBODY, HEARS NOBODY
AND SPEAKS TO NOBODY

@TERRANCE.MCMAHON



The 21st Surgeon-General of the USA makes a national/global public health case for dealing with loneliness, to help ourselves and each other





"Suicide does not
end the Chances of
Life getting WORSE,
Suicide eliminates
the possibility of it
ever getting better."



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