National
Suicide Prevention
Leadership Group

Time, Space, Compassion

Three simple words, one big difference

Recommendations for improvements in suicidal crisis response

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Introduction

Every Life Matters: Scotland's Suicide Prevention Action Plan (2018) sets out 10 actions which aim to achieve the vision of a Scotland where suicide is preventable and where help and support is available to anyone contemplating suicide and to those who have lost a loved one to suicide. Suicide prevention is everyone's business.

Action 5 of *Every Life Matters* states that the National Suicide Prevention Leadership Group (NSPLG) will use evidence on the effectiveness of differing models of crisis support to make recommendations to service providers and share best practice. Further, it asserts that people in distress, including those who self-harm, need to find a respectful, compassionate response when they present to services for support. This action is at the core of achieving the vision of Every Life Matters, ensuring the right support is available for people in distress and actively contemplating suicide at a time of crisis.

Improvements to suicidal crisis response, wherever that response is found, will contribute to two outcomes. Firstly, that by receiving compassionate, timely support fewer people will go on to attempt, or die by, suicide. Secondly, that because people have a positive experience of response at a time of crisis, they will be supported to develop effective coping skills and be less likely to experience future suicidal crisis. Providing responses which are more accessible and meet the needs of those at risk may ultimately increase the numbers of people who seek help at the point of suicide. This too would be a positive outcome for this work, ultimately saving lives by ensuring more people are able to access help rather than acting on their thoughts of suicide.

Of course, this report now sits in the context of the impact of the COVID pandemic on people's mental health and wellbeing. Whilst there is no evidence of a rise in suicide rates in Scotland since lockdown, we note that the Scottish Government's Mental Health Transition and Recovery plan states*: "One of the early impacts of Covid-19 was a higher level of distress. Over time, there is expected to be a worsening incidence of mental health disorders. Rates of traumatic reactions, substance misuse, self-harm and suicide are expected to increase."*[1] The NSPLG statement on COVID made suicidal crisis a priority area of response in the action plan. This report sets out a number of recommendations which support a medium to long-term change, and also a small number of short-term recommendations to ensure more immediate preparedness for any future increase in suicidal distress.

The report deliberately does not recommend a particular model of crisis support. Instead, it sets out an approach, based on the principles of **Time, Space and Compassion**. These may, on the surface, appear to be simple principles. If embedded effectively into existing and new responses, however, they would radically change the experiences of those who need support at a time of crisis.

[1] https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

Background

In 2020, 805 lives in Scotland were lost to suicide and it is estimated that over the course of a lifetime 1 in 15 people will have attempted suicide[2], that's an estimated 368,500 people in Scotland.

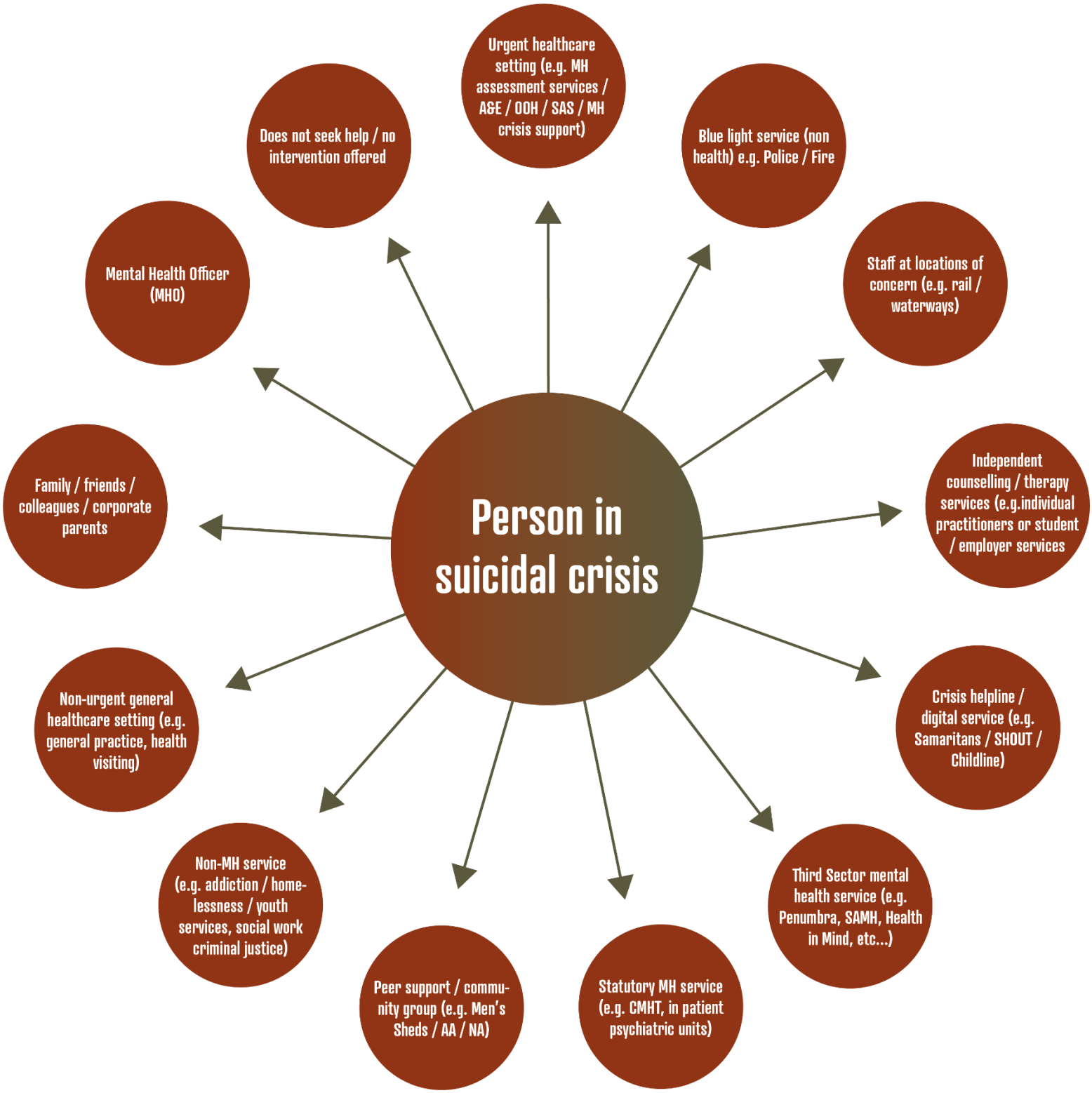
For many of the real people behind these numbers there may well have been opportunities missed to reach out for help or to intervene to offer it. In healthcare settings, for example, data is collected on an individual's contacts with the service in the year prior to a death by suicide. Between 2011 & 2019[3], 77.3% of those who had died by suicide in Scotland had contact with at least one of nine healthcare services in the 12 months prior to their death. Nearly a third (31%) had been discharged from a general hospital setting in the 12 months before death and 30% had attended Accident and Emergency in the three months prior to their death (36% for females and 27% for males). A recent study[4] of middle-aged men who died by suicide in 2017 identified that 82% had been in contact with their GP at some time and 43% had been in recent contact with primary care services. Compared to the general population, people who died by suicide had more contact with the healthcare services where information was available.

This is a partial picture of opportunities for intervention or help-seeking; information is not available which would allow similar information to be provided for contact with non-statutory services, or for contact with social care, criminal justice, housing service and so on.

Figure 1 details a range of potential touchpoints for people in suicidal crisis to seek help or for an intervention to be made. These go far beyond the healthcare settings where data is available and demonstrate the range of potential opportunities where an effective approach to crisis response could be provided and be of benefit to those in need.

[2] https://files.digital.nhs.uk/publicationimport/pub21xxx/pub21748/apms-2014-suicide.pdf
[3] https://beta.isdscotland.org/find-publications-and-data/population-health/mortality/scottish-suicide-information-database/
[4] https://documents.manchester.ac.uk/display.aspx?DocID=55305

Figure 1



This report attempts to provide a unifying approach to improvement in suicidal crisis response which could apply across settings and services and support anyone who seeks help, and anyone who sees the opportunity to offer help.

Methodology

In November 2019, a small working group (Appendix 1) was established to progress the work on Action 5. This included work to define crisis in the context of suicide prevention, identifying best practice and providing evidence of effectiveness of different service models.

Scope

One of the initial tasks was defining the scope of the Action 5 work. The following definition was developed by the working group:

> 'Suicidal crisis is a self-defined episode of high emotional distress, where there is an imminent risk of suicide and where an immediate response is required to keep the person safe'

It was recognised that this was a narrow definition which only considered someone at the acute end of suicidal crisis in imminent danger of taking their own life. The aim in defining suicidal crisis in this way was to highlight interventions which would improve the care and support available to those at the point of life and death decisions. This does not mean that other areas of work are not equally important: these recommendations sit within wider actions being taken forward by the NSPLG. In addition, this report will make reference to opportunities, through any future suicide strategy, for wider improvements around suicide prevention and after-care for people who have attempted suicide.

The recommendations in this report focus on support for people aged 18 and over. There is considerable concern about the number of young people experiencing suicidal crisis in Scotland. Work focused on improving crisis support for 5-24 year olds is being considered through the recently formed Children and Young People's Mental Health & Wellbeing Joint Delivery Board. Learning must be shared between these areas of work.

Finally, in keeping with the wider work of NSPLG, this paper focuses solely on responses to suicidal crisis. Further work would be needed to consider the bespoke crisis needs of those who self-harm and are not at imminent risk of suicide.

Gathering evidence

Views were gathered through a range of consultation opportunities which included two workshops with the NSPLG, three workshops with the NSPLG Lived Experience Panel, six advisory group meetings and a questionnaire completed by 211 respondents who either had lived experience or were service providers.

The Academic Advisory Group (AAG) also undertook a review of the available literature, while the Action 5 Delivery Lead undertook an additional search of grey literature and available guidance.

A draft paper was presented to the NSPLG and the Lived Experience Panel in December 2020 which focused on a range of options. The discussions which

followed helped to establish an approach to crisis response which has shaped the recommendations in this report.

An overview of findings

It was clear from the review of available literature that there is insufficient robust evidence across services for people in suicidal crisis to recommend a single effective model of crisis intervention, care and support for the whole of Scotland. This is not to say that there are no effective models currently operating, rather that there has been little work done to evaluate most of these. Many operate locally and are not well known outside their immediate locale. In addition, having considered potential touchpoints for help-seeking or intervention at the point of suicidal crisis, these recommendations, rightly, go beyond the scope of formal health and care services.

While the research and evidence are not available to recommend a single suicidal crisis service model, there were clear messages from engaging with those with lived experience and those working in the field of suicide prevention which, if translated into an approach across settings, could transform the response to those in suicidal crisis.

In the stakeholder survey, stigma and discrimination, a fear of being a burden and a lack of compassion were identified as the top barriers to help-seeking. Respondents also highlighted the importance of having sufficient time to talk about their feelings and of support being available at the time they need it, including out of hours. Respondents felt that access to confidential safe spaces where people would be seen quickly and privately would encourage people to seek help. They also expressed the view that people providing support at a time of crisis should be suitably trained to respond to suicidal ideation and should be equipped with the knowledge and ability to signpost to appropriate onward support. These messages were reinforced through further discussion with the Lived Experience Panel.

Research conducted by Samaritans[5] into their caller outcomes also supported this, with callers reporting reduced levels of distress following the calls and particularly valuing the 24/7 nature of service, the time to talk things through, someone really listening, offering confidentiality and anonymity and a human connection.

[5] https://www.samaritans.org/scotland/about-samaritans/research-policy/research-our-services/

Quotes from the Action 5 questionnaire

"If they knew they would get a human response, empathy, kindness, someone to listen and help them overcome the difficulties they are facing. If they feel like they have an ally, not necessarily to solve all of their problems for them but someone who can provide support." (Professional stakeholder)

"I'd like someone kind and friendly, maybe in my GP practice but not my GP. I would like to be able to spend time talking about my problems." (Person with lived experience)

"Being able to be seen quickly and privately." (Person with lived experience)

"Adequately trained staff who have the time, skills and compassion to support such individuals." (Professional stakeholder)

"I want to speak to someone kind who will just listen to me and try to really understand. I don't want to be patronised or made to feel stupid." (Person with lived experience)

It is these voices of people with lived experience, and those working on the frontline, which have shaped our approach which sees **suicidal crisis response as a human reaction, not a service model,** and which sets out the principles of **Time, Space and Compassion** as the basis of improvement in support for those in crisis, wherever it is available.

Building on what we have heard, the next section sets out what we understand by Time, Space and Compassion.

Time

At a point of suicidal crisis, people need the time to discuss their feelings and to tell their story about what has led them to feel that acting on their thoughts of suicide is their only option. People in suicidal crisis need the undivided time and attention of those providing support, those working in service settings need to be resourced and trained appropriately to deliver this support, and suicide awareness-raising and listening skills need to be made available more generally to the public.

"I would like to spend time talking about my problems" (person with lived experience)

There is also the need to ensure a response to someone contemplating suicide is available when it is needed. Suicidal crisis is not restricted to the hours of 9-5 Monday to Friday. When someone is at imminent risk of ending their life, they need to be able to get support without delay.

"I think many...people [in suicidal crisis] struggle to access appropriate support quick enough. Waiting times for appointments, counselling are often long and delayed and people struggle in the meantime to cope." (Professional stakeholder)

Space

Physical spaces for people who seek support in suicidal crisis should be accessible, quiet, comfortable, pleasant and take account of emotional and physiological needs. There are strong links with the work to raise awareness of the impacts of trauma, it is therefore critical that spaces where support for those in suicidal crisis are trauma informed. People should feel they have the space to explore the thoughts in their head and the reasons behind their suicidal crisis in the course of a confidential therapeutic conversation.

"If they feel listened to and given appropriate time to talk openly and honestly about their thoughts and feelings without fear or judgement. They need a safe space to talk." (professional stakeholder)

Not all "space" needs to be provided in a physical location. Anyone in suicidal crisis should be able to access support remotely by phone, text or online. The use of approaches through digital technology allow people in crisis access to **Compassionate** support at any **Time** and from any **Space.**

There are a range of crisis services which are not face to face and which provide support to large numbers of people:

From the start of lock down on 23 March 2020 until the 20 December 2020 Samaritans provided emotional support over 1,700,000 times to people struggling to cope, via phone and email.

Over the course of the financial year 2020/21, Breathing Space answered 112,975 calls and the NHS 24 Mental Health Hub answered 102,950 (this service became available 24/7 from July 2020. Suicidal ideation is the highest reason for calling with around 25% of callers expressing this as their main call reason.

Since May 2019, SHOUT have responded to over 550,000 text messages from people in need of immediate support.

Anyone seeking support should have choices available so they are able to access the type of space that suits them best.

Compassion

The definition of compassion used by the Compassionate Mind Foundation is "...a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it[6]." A compassionate response to someone in suicidal distress requires meeting the person where they are with attention, empathy and a desire to assist on their terms.

The stakeholder survey responses identified compassion as being the most important characteristic of support services, with 92 references to compassion, empathy and emotional understanding from 62 participants.

[6] https://www.compassionatemind.co.uk/about

Research into compassion [*published as a supporting document alongside this report*] has identified that, in the short term, those who experience a compassionate response when in suicidal crisis are more likely to disclose details which, in turn, can inform more effective support than those who receive a non-compassionate response. In the longer term, a compassionate response also increases the likelihood of help-seeking behaviour if future suicidal crises are encountered. It will aid the development of trusting relationships with services and lay the foundations for self-compassion, which in turn will reduce the need for support from frontline services in the future.

Connecting people with and supporting them to access support can provide emotional holding which alleviates distress. An example would be Distress Brief Intervention where the person is connected to support within 24 hours of initial referral.

A clinician who is sensitively seeking to understand the causes of self-harm and suicidal thoughts is likely to foster empathy, and so help to contain distress (Smith et al 2015)[7]

In addition, our principle of compassion covers support offered to those who engage with people in suicidal crisis to avoid compassion fatigue, burn out and contagion. This can be achieved by providing direct support for staff for example sufficient staffing, supervision and debriefing / postvention interventions and also ensuring there are well connected, accessible services that are able to share information safely for those they are supporting and caring for, where appropriate.

"…the experience of responding to a suicidal person…can be emotionally disturbing for staff, and its effects can have widespread repercussions." (Smith et al 2015)

Time, Space and Compassion: Recommendations for improvements in suicidal crisis response

Embedding the principles of **Time, Space and Compassion** across responses to suicidal crisis in Scotland will require concerted action across national and local government, and services across sectors, communities and citizens. It is also essential that our evidence base is strengthened so that future action on suicidal crisis, including targeted investment, can benefit from a better understanding of what works. Our recommendations focus on developing a framework that will support mainstreaming these principles, as set out above, into a wide range of suicidal crisis responses and using it to improve our understanding of good practice.

[7] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00051-6/fulltext

Recommendations

Short-term

- Culture change takes time; in the short term we must still act on the urgency of need to reduce the lives lost to suicide particularly given the potential negative impact on mental health and distress arising from COVID-19 and its aftermath. The Scottish Government and CoSLA should work together with local area governance structures such as Community Planning Partnerships (CPP's), Strategic Planning Groups (SPGs) etc to ensure a choice of immediate 24/7 crisis response services (physical and virtual) is available on a sustainable basis, promoted across geographic communities and sensitive to the needs of communities of interest. It will be important to take stock of the work undertaken in response to the pandemic and address any evident gaps. The reorganisation of unscheduled care should also include work to embed the **Time, Space and Compassion** approach.
- The application of existing clinical guidance[8] in frontline health and care settings could support a step change toward the principles of **Time, Space and Compassion**. Specifically, in line with this guidance, health and care staff should be supported to move away from prioritising assessment of risk and eligibility for service, to assessing psychological and social wellbeing and the formulation of safety plans in partnership with those in suicidal distress.
- Planned work on mental health crisis for children and young people must be progressed as a matter of urgency, including a **focus on suicidal crisis and consider the applicability of the principles of Time, Space and Compassion** as set out in this report.
- The mental health assessment centres currently in development must be established following the **Time, Space and Compassion** approach. This will allow the approach to be tested and in turn will influence the development of an assessment framework, as detailed below. This opportunity should not be missed as these centres are likely to be a point of contact for many people in suicidal distress.
- Work to engage those with lived experience and the wider social movement should continue to ensure the **Time, Space and Compassion** principles are embedded further into the work of action 2 (mental health and suicide training) and action 3 (public awareness) particularly within United to Prevent Suicide campaigns.

[8]https://www.research.manchester.ac.uk/portal/files/77517990/REPORT_The_assessment_of_clinical_risk_in_mental_health_services.pdf

Medium-term

- Scottish Government, through the NSPLG[9], should provide funding for a full-time Action 5 implementation lead for two years, to support embedding the principles of **Time**, **Space and Compassion** for suicidal crisis response through:
    - Mapping existing suicidal crisis supports in the post-COVID recovery phase.
    - Leading on developing a collaborative Crisis Care Agreement (action 4) built on the principles of Time, Space and Compassion.
    - Developing a Time, Space and Compassion framework for suicidal crisis response in partnership with people with lived experience, providers and commissioners of services / programmes, and researchers. This framework, applying the definitions set out in this report, should work across different settings and service / programme types and take account of the available evidence including the use of models such as the Integrated Motivational-Volitional (IMV)[10].
    - Supporting the testing of the assessment framework across a selection of existing and new settings, programmes and activities. We specifically recommend that the new mental health assessment centres are included in this early work in order to support design of service specifications for this significant new crisis investment across Scotland.
    - Apply the learning from Action 7 (preventative actions for at risk groups) and pilots associated with Action 10 (reviews into all deaths by suicide), to the development of the **Time, Space and Compassion** framework.
    - Ensure the work of Action 6 (digital technology) supports the development of additional digital resources to fill any gaps which may be identified to ensure support for suicidal crisis is available 24/7
    - Sharing early findings and promoting examples of good practice nationally and with SPGs to inform early improvement in wider services and programmes.
    - Supporting roll-out of the assessment framework in different settings, programmes and activities.
    - Supporting development of methods for sharing evidence and good practice, in order to inform service / programme design, commissioning and delivery in the longer-term.
    - To work with the relevant delivery leads to ensure continued work with people with lived experience and the wider social movement which embeds the **Time, Space and Compassion** principles into ongoing

[9] It is recognised that the future of the NSPLG is not yet secured beyond the life of the current suicide prevention action plan. This post will sit within the NSPLG infrastructure until decisions have been made regarding the future infrastructure for suicide prevention.
[10] https://suicideresearch.info/the-imv/

developments of action 2 (mental health and suicide training) and action 3 (public awareness) to support conversations about suicide – seeking resource as appropriate.

- Work with communities and organisations in remote and rural areas including harnessing the engagement of members of the National Rural Mental Health Forum, to ensure effective responses in these areas.
- Supporting the development of an evaluation framework for the **Time, Space and Compassion** approach.

Longer-term

- The next suicide prevention strategy should include outcomes to improve early intervention and prevention, with appropriate actions to achieve these outcomes.
- The next suicide prevention strategy should include outcomes to improve the provision of after-care for those who have experienced suicidal crisis, with appropriate actions to achieve these outcomes.

Conclusion

Time, Space and Compassion is an approach which can be implemented within all sectors and across our communities. Given what we have heard from those with lived experience of suicide and those providing services, it has the potential to improve the experiences of those who seek help at a time of suicidal crisis. This report does not set out to be critical of existing crisis support but to shape a radically different cultural landscape, requiring a different sort of resourcing, in which to deliver a crisis response shaped by the experiences of those in need.

The recommendations presented in this report should be considered a starting point for work in this area. It focuses, in the first instance, on the practical support and evidence required to make this culture shift collaboratively, as well as ensuring the availability of existing crisis services as we emerge from the pandemic. Future suicide prevention strategies and action plans should ensure they build on the work that is undertaken and include learning from this work.

We should never forget the purpose of improving crisis response is to help save lives, to ensure that those who reach the point of suicidal crisis are able to access support at a **Time** they need it, in an accessible and available **Space,** and are shown **Compassion** by those who are providing the support. Every Life Matters.

Acknowledgements

We would like to thank the members of the NSPLG, the Action 5 working group, the NSPLG Lived Experience Panel and the NSPLG Academic Advisory Group (AAG) for their insights, guidance, patience and contributions to shaping this report. Our meetings with the members of the NSPLG Lived Experience Panel gave us a rich and insightful opportunity to gather their views, experience and critique on the subject of suicidal crisis for which we are very grateful.

We would also like to thank Heather McClelland of the AAG for conducting and analysing the survey. Finally, our sincere thanks go to Ruth Moss, Amy Kirkpatrick and Haylis Smith as Action 5 leads for the significant work they conducted in drafting, redrafting, reviewing, consulting and delivering the final version of this report.

Nigel Henderson, Rachel Cackett and Amy Knighton (NSPLG members and Action 5 sponsors)

Appendix 1

Membership of Action 5 Working group

NHS 24
Police Scotland
Scottish Government
National Rural Mental Health Forum
Penumbra (Co-Sponsor)
Samaritans (Co- Sponsor)
Children & Young Peoples Mental Health Programme Board
Distress Brief Intervention
Academic Advisory Group
RCGP (Co-Sponsor)

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