PROTECT: Relational Safety based Suicide Prevention Training Frameworks

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Abstract:

Preventing suicide is a global priority and staff training is a core prevention strategy. However frontline pressures make translating training into better care and better outcomes difficult. The aim of the paper is to highlight challenges in suicide risk assessment and management and introduce training frameworks to assist with mindful practice so professionals can strike a balance between risk and recovery. We combined the scientific literature with contemporary practice from two successful initiatives from Cambridgeshire, UK; 333 – a recovery oriented model of inpatient/community crisis care and PROMISE – a programme to reduce coercion in care by enhancing patient experience. The resulting PROTECT (PROactive deTECTion) frameworks operationalise ongoing practice of relational safety in these programmes. PROTECT is a combination of novel concepts and adaptations of well-established therapeutic approaches. It has four training frameworks: AWARE for reflection on clinical decisions; DESPAIR for assessment; ASPIRE for management; NOTES for documentation. PROTECT aims to improve self-awareness of mental shortcuts, risk taking thresholds and increase rigour through time efficient crosschecks. The training frameworks should support a relational approach to self-harm/suicide risk detection, mitigation and documentation, making care safer and person-centred. The goal is to enthuse practitioners with recovery oriented practice that draws on the strengths of the person in distress and their natural circle of support. It will provide the confidence to engage in participatory approaches to seek out unique individualised solutions to the overwhelming psychological pain of suicidal distress. Future collaborative research with people with lived and carer experience is needed for fine-tuning.

Key words/phrases:

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Aims

Training professionals in skills and competencies necessary to assess and support people in suicidal distress is a key suicide prevention strategy. However, there are a number of challenges. The recovery ethos has become the corner stone of person-centred mental health care, but suicide prevention training has not evolved at the same pace. Most still advocate an inquisitorial approach to fact finding along with restrictive and defensive practice. There is an urgent need for a paradigm shift in training, taking practitioners from the traditional "what's the matter with you" to a recovery oriented "what matters to you". What matters to the person is often at the heart of their psychological pain. A genuine attempt to understand this lays the foundation of a relationship that fosters safety and supports recovery. Training has also struggled to keep up with emerging academic literature centred on the futility of risk stratification as high, medium and low for care allocation. Nor does it address the challenges of clinical decision making or the pragmatics of administering lengthy tools in time pressured environments like emergency departments. The aim of this discursive paper is to propose a solution, the PROTECT (PROactive deTECTion) training frameworks, to the challenges in the field of suicide risk assessment and management that current training do not adequately address. The frameworks seek to operationalise seemingly abstract concepts of relational safety into day to day recovery oriented clinical practice.

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Background

A person with suicidal ideation is often trapped in an overwhelming sense of despair (Beck, 1986). Stemming from entrapment, suicide may become the salient solution to life circumstances (O'connor, 2011) and intense psychological pain (Shneidman, 1993). Suicide is a major public health problem with over 800,000 people dying annually worldwide and for each completed suicide there may have been 20 other attempts (World Health Organization, 2014). To support those in suicidal distress, professionals, families and friends strive to

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establish new and alternative ways of coping (Jobes, 2006, p. 122; Owens et al., 2011). However, there is a dissonance between the reality of those experiencing a crisis, for whom suicide is the perceived solution, and those that are caring, who view suicide as the problem (Duffy, 2006). Reconciling these positions is difficult as professionals have to understand the person's pain before they can form a collaborative partnership on the road to recovery (Michel & Jobes, 2011). In a serious suicidal crisis, recovery oriented practice is often sacrificed on the altar of safety and care becomes prescriptive. In our previous work in reducing coercion in care in the acute setting, staff and patients highlighted the difficulties in striking this balance. They described restrictive practice as "it never is very nice… but it is a necessary evil" (Wilson, Rouse, Rae, & Kar Ray, 2017). 86% of study participants highlighted the importance of enhancing relationships through empathic communication as a way of overcoming the challenges posed (Wilson, Rouse, Rae, & Kar Ray, 2018).

This was the most common theme that emerged and formed the foundation of the PROMISE programme which showed that with the right care the person has more control (Lombardo et al., 2018). This way of working calls for compassion and a deeply empathic value set amidst professionals who need to be skilled at identifying and supporting people at risk sometimes in high pressure environments like inpatient wards and emergency departments (Canner, Giuliano, Selvarajah, Hammond, & Schneider, 2018). Although suicide prevention training to gatekeepers, primary care physicians, emergency department staff and mental health professionals has been rolled out (Albright, Timmons-Mitchell, & McMillan, 2018; Gryglewicz et al., 2019; Hodges, Inch, & Silver, 2001), reducing suicide rates remains a challenge (Arensman, 2017). Most packages focus on assessment skills, risk screens and risk factor tools (Mortensen, Agerbo, Erikson, Qin, & Westergaard-Nielsen, 2000) but do not address tensions between divergent views of people in distress and professionals involved and how to build empathic partnerships (Downes, Gill, Doyle, Morrissey, & Higgins, 2016) in time and resource

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poor environments. Risk assessments may become a tick box exercise and fail to capture the narrative of the person's distress (Cole-King & Lepping, 2010). Also, most training programmes focus on which information to collect and do not address biases in thinking and attitudes (Owens et al., 2011) which may considerably influence the outcome.

Design:

In this position paper we describe PROTECT, a training model for suicide risk assessment and management, constructed to address the above concerns. It builds on a model of relational safety and hope vending developed in a highly dynamic inpatient and community crisis care system called 333, running in Cambridgeshire, United Kingdom since 2011 (Kar Ray et al., 2019). 333 outperforms national averages for safety and clinical efficiency measures, like median lengths of stay are one sixth of the national rate. It also hosted the national award-winning PROMISE initiative to decrease coercion in care. In three years, 4591 patients (both voluntary and involuntary), accounting for approximately 75% of inpatients, were surveyed for patient experience. 98% reported staff as polite and friendly, 98% felt involved in their care and treatment discussion, 97% reported that they were made to feel welcome on the ward and 96% felt treated with respect and dignity (Lombardo et al., 2018). The success of 333 and PROMISE, hinges on staff establishing a deeply empathic therapeutic alliance and bringing to life the construct of relational safety (APA Work Group on Psychiatric Evaluation, 2016; Cole-King & Lepping, 2010). Within its recovery oriented scaffold, professionals, the person in distress and their natural circle of support share mutual respect for each other, and work towards shared goals, navigating the care vs control dilemma.

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PROTECT was developed to capture the relational way of working embedded within 333 and PROMISE. Managing the inherent tensions in decision making particularly between

managing risk and supporting recovery is central to the model. As we will illustrate, it is supported by the literature in suicide research, and work undertaken by our team on clinical decision making (KarRay, Lombardo, Hafizi, & Kallivayalil, 2018; Lombardo et al., 2019). We now provide a critical appraisal of the key clinical challenges to contextualise the proposed solution and benefits realisation from PROTECT.

Clinical Challenges in Risk Assessment and Management Practices:

Futility of risk stratification for care allocation:

Currently, most suicide risk assessment tools are based on risk stratification. A comprehensive meta-analysis of risk predicting clinical instruments by Carter et al (2017) showed the futility of such stratifications. Pooled positive predictive value for completed suicide was only 5.5%, so 94.5% of people classified as high risk were false positives. Similarly, Large et al (2016), in a meta-analysis of longitudinal cohort studies showed a pooled sensitivity of a high-risk categorization of 56%, indicating that only over half of the suicides occurred in the high-risk groups. From a care allocation perspective, many patients will either receive unnecessary treatment or be denied treatment. Quinlivan et al (2016) drew similar conclusions regarding scales relating to self-harm.

Furthermore, while risk tools use the presence of risk factors for risk stratification, they do not fully account for the dynamic interaction between them (Higgins et al., 2016). In order to establish person specific opportunities for prevention, Pisani et al (2016) suggest differentiating between risk status (person's risk compared to a population like the general population or outpatients or inpatients) and risk state (person's risk compared to their baseline and other specified time points such as when they are most unwell), an approach established in violence risk assessments (Douglas & Skeem, 2005). Carter et al (2017) suggest that it would be more effective to incorporate risk assessment into a comprehensive clinical assessment. Identification of modifiable risk factors could then guide effective

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interventions (Carter & Spittal, 2018). This approach is consistent with the "Needs based approach" advocated by the National Institute for Health and Care and Excellence (NICE, 2011).

Subjectivity in Clinical Assessments:

There is an assumption that clinicians make decisions based on risk related findings in an assessment. In a previous qualitative study of clinicians, immediately post-assessment, we found that while during the assessment, clinicians collated considerable information, these assessment findings were not processed uniformly (Lombardo et al., 2019). Individuals with similar need and risk profiles got different treatments that varied from inpatient stay to signposting to non-governmental agencies. Clinicians accounted for the variation by using terms like *"common sense"* and "*gut instinct"*. The above study highlights the role of mental shortcuts in decision making, as opposed to decisions firmly rooted in clinical findings from a holistic bio-psycho-social assessment that also draws on a person's cultural, environmental and spiritual context. Other studies highlight a similar lack of awareness of errors and biases that may creep into clinical decision making (Bhugra, Mallaris, & Gupta, 2011; Bhugra, 2008).

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Anxiety Limits Risk Exploration:

Our previous study showed that clinicians have a dual role, one increases anxiety through risk exploration and the other decreases anxiety through instillation of hope and safety reassurances (Lombardo et al., 2019). The two could be at cross purposes. Risk exploration can reveal a range of anxiety heightening dynamic factors as they can be difficult to predict and manage. Many clinicians feel ill-equipped to deal with such expectations. They often veer away from enquiring too deeply about suicide in the fear that if they acknowledge a risk, they will have to manage it without the competencies or resources to do so (Cole-King &

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Lepping, 2010). Instead, clinicians drift towards using recovery language to capture hope and convey all is not lost (Leamy, Bird, Boutillier, Williams, & Slade, 2011). Generally, hope giving is protective and anxiety containing, but it is not a replacement for thorough risk exploration. Actively seeking reassurances like 'I can keep myself safe' without true appreciation of the dynamic nature of risk, may create a misleading veneer of safety. The reassurance relates to the hope captured by the clinician, but the person may remain poorly prepared for emergent adversities ('what if' scenarios), a phenomenon Shea calls premature crisis resolution (2009).

Professionals have the difficult task of striking a balance between actions that increase and actions that decrease anxiety not just for the person in distress and their families, but also for themselves. We concluded that up to a tipping point, anxiety was managed by rationalising risk taking to manage a suicidal person in the community as safe positive risks in line with recovery philosophy (Shepherd, Burns, & Boardman, 2008), beyond it anxiety was contained through conservative and sometimes restrictive treatment options such as inpatient stay (Lombardo et al., 2019).

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Rational Vs Rationalising:

Based on availability, assessments involve a combination of referral information, past notes, collateral information and face to face interaction. Facts in mental health are often subjective as the most important symptoms relate to the inner experiences of an individual. The collated information gets synthesised into a formulation which informs the decision how best to respond to the person's needs and outstanding risks (Cooper & Oates, 2012). However, often before formulation, a hypothesis about appropriate response begins to emerge in the assessor's mind and at a certain point crystallizes as fact. From then on, all clinical activity gets unconsciously skewed to confirm the desired outcome (Lombardo et al., 2019). This

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might influence which questions the assessor asks and how answers are interpreted. Even documentation skews unconsciously, to accommodate for this.

In line with Leon Festinger's (1962) work into cognitive dissonance, we postulate that there are two mental spaces in which clinicians operate, a rational space in which fact finding is followed by decision and a rationalising space where a decision is followed by supportive facts selection. The latter is problematic from a care allocation perspective as relevant information may be overlooked. Furthermore, assessors are often unaware as to whether they are operating in the rational or rationalizing space (KarRay et al., 2018). Also given the rarity of completed suicide, a clinician is frequently reinforced by the accuracy of their clinical decisions. Carter & Spittal (2018) cite how clinical experience in low prevalence disorders encourages confirmation bias. Consequently the professional's risk taking gradually creeps up without conscious awareness of the same (KarRay et al., 2018).

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Method:

The Development of the PROTECT Frameworks:

Having appraised the literature for key/current challenges, we looked for solutions (Lombardo et al., 2019; Wilson et al., 2017, 2018) within the recovery oriented clinical practice of relational safety within 333 (Kar Ray et al., 2019) and PROMISE (Lombardo et al., 2018). We also considered well-established approaches; some were generic like Motivational Interviewing, Problem Solving, Behavioural Activation, Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy. Others were suicide specific like Collaborative Assessment and Management of Suicidality (Jobes, 2006), Chronological Assessment of Suicide Events (Shea, 2011) and Screening Tool for Assessing Risk of Suicide (Hawgood & De Leo, 2016). Novel approaches from PROMISE and 333 were synthesised with these well-established approaches into time efficient, effective tools

and interventions. To facilitate knowledge translation we parcelled our findings into four training frameworks each with a specific focus: reflective practice, assessment, management and documentation. However, there are overarching principles that weave them together: a) establishing a deeply empathic relationship, b) sharing the responsibility for safety through shared decision making, c) coproducing solutions d) emphasis on staying in a rational space rather than rationalising. Clinicians may incorporate the entire approach or draw flexibly on the frameworks based on their training needs.

PROTECT endeavours to construct an in-depth understanding of the person's psychological pain, the dynamic factors, their interactions and how to respond to emergent risk and adversities. To achieve this, professionals, need to work in partnership with the person and their circle of support. The work is relational and involves acknowledging and imagining if not experiencing the darkness that envelopes the suicidal mind. Supporting people to open up and share their narrative provides the building blocks of a meaningful formulation. It calls for in-depth exploration of distress in the suicidal individual. This is a balancing act. Too little exploration results in low confidence in the assessment, too much can begin to overwhelm the person and people involved. The tools in PROTECT help one stay in the relational space and make the judgement calls to put the person first, but at the same time the template retains the gaps in history that need further exploration and provides sequence and structure to the recovery journey. The four frameworks of PROTECT are described below and summarised in Table 1.

-- Insert Table 1 --

***AWARE** (**A**nxiety, **W**eighting, **A**genda, **R**esources and **E**xperience)*

AWARE, a reflective framework for ongoing development of professionals, protects against undue influences in the act of clinical decision making. Intended to make practice safer, its use in clinical supervision (Lombardo, Milne, & Proctor, 2009) or multidisciplinary case

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reviews should bolster practice by making individuals and/or teams who assess people in suicidal crisis, mindful of the implicit effect of the AWARE factors (Table 1). It is based on our qualitative study, in which we conducted semi-structured interviews with clinicians post assessment. Five themes influencing clinical decision making were identified: **A**nxiety linked to the crisis with which people present, **W**eighting of assessment findings by course of illness (acute / chronic / acute on chronic), diagnosis (e.g. substance misuse, personality disorder), aetiology (e.g. social factors), **A**gendas perceived as reasonable or unreasonable (in referrer / person in distress / family), **R**esources (e.g. current work load / bed availability) and **E**xperience (of the same person / people of the same demographic or diagnostic group) (Lombardo et al., 2019). It is well established that clinician attitudes towards suicide (e.g. is it a sin or a right) impacts assessment and treatment negatively (Freedenthal, 2018, pg 5). Contemporary training identifies self-awareness of attitudes, beliefs and emotional reactions to suicide as a core competency (American Association of Suicidology). AWARE builds on the same ethos of mindful practice and provides specifics that often exist in the assessor's blind spot. Routine use of the questions outlined in Table 1 in case discussions, could highlight decisions made through gut instinct and support more clinically grounded practice.

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***DESPAIR** (**D**iagnosis, **E**ntrapment, **S**uicidality, **P**ast attempts, **A**gitation, **I**ntent and **R**isk response)*

DESPAIR is a post-assessment, time efficient, pragmatic crosscheck. It has 7 statements that rate the significance of **D**iagnosis, **E**ntrapment, **S**uicidality (thoughts and plans), **P**ast attempts, **A**gitation, **I**ntent and **R**isk response on a scale of 1 to 5. It is designed to ensure that all the information, necessary to make a safe judgement call on the outcome of an assessment in a person in suicidal distress is collected and considered. The statements map the evolution of suicidal distress and provide a logical sequence and structure to the assessment dialogue. It highlights any gaps in history stemming from the AWARE factors, introducing a degree of

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rigour to the psychiatric assessment. Bryan and Rudd's (2006) comprehensive table for areas of risk assessment should be the basis for the risk formulation as it covers predisposing, precipitating, perpetuating and protective factors. DESPAIR does not seek to recreate the same. It provides a quick crosscheck to ensure that modifiable dynamic factors have been given due consideration in decision making for care allocation. Past attempts is a static factor, but is considered to be the strongest predictor of future behaviour (Joiner et al., 2005; Wingate, Joiner, Walker, Rudd, & Jobes, 2004) and has thus been included in the crosscheck.

There are no additional time requirements as this information should be collated as part of a comprehensive assessment. Time intensive scales are difficult to administer in busy environments like emergency departments and add very little value through risk stratification (Carter et al., 2017; Quinlivan et al., 2016). The purpose of the rating is to force the assessor to give equal weighting to all the collated findings and not emphasise information that might help them rationalise a decision. The ratings have been operationalised and thinking through each item makes the risk formulation and safety planning more nuanced, taking Pisani et al's (2016) approach of person specific opportunities for prevention one step further. Rating each presentation on their own merit should also address desensitisation stemming from the experience of repeatedly assessing the same individual or individuals from the same diagnostic group. Given suicide is a rare outcome, positive risks taken post assessment rarely result in fatality. This could lead to a gradual increase in the acceptability of certain risks. The nuanced rating of each item in DESPAIR could prevent the risk threshold from creeping up. The DESPAIR crosscheck translates the ongoing professional development from the use of AWARE in reflective practice, into each and every clinical assessment.

***ASPIRE** (**A**cceptance, **S**afety planning, **P**erson-centred care, **I**nterventions menu, **R**eview Cycle and **E**nhancing resilience)*

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ASPIRE is a framework to co-create a safe and empowering recovery journey. It embodies the overarching principles of relational safety like collaborative working (Jobes, 2006, p. 65) and shared decision making. Acceptance, by the practitioner that the person's suicidal thoughts and actions are guided by a desire to be pain free is a central principle. ASPIRE provides guidance on how to frame a sensitive conversation using motivational interviewing strategies (Britton, Patrick, Wenzel, & Williams, 2011; Britton, Williams, & Conner, 2008; King, Gipson, Horwitz, & Opperman, 2015). The goal is to engage and overcome ambivalence by conveying that the professional's objectives are aligned to theirs i.e. help them be pain free. This core of **A**cceptance in the professional enables a ring of supported actions in the person in distress, that can be thought of in a chronological sequence: **S**afety planning amid a suicidal crisis, **P**erson-centred care in line with the emerging formulation, followed by appropriate treatments or referral chosen from the **I**nterventions menu. As the crisis settles the **R**eview cycle is used to monitor and reframe ongoing challenges. **E**nhancing resilience for the future is the final step.

Safety planning has a problem solving approach to 'what if' scenarios. These emergent dynamic risk factors are addressed through the unique risk response balance sheet and the "1-2-7" approach (Kar Ray et al., 2019). Other aspects are similar to those in Safety Planning Intervention (B. Stanley & Brown, 2012; B. Stanley et al., 2018). They include restricting access to means (Betz et al., 2018, 2016), alcohol and drugs, establishing role clarity and support from family (Frey & Fulginiti, 2017) and professionals including follow up appointments and ways to safely navigate emergencies (Brodsky, Spruch-Feiner, & Stanley, 2018). Another novel approach is the care compass. It maps the person's current fragility/resilience against the clinician's risk taking. It provides an overview of the recovery journey and may be instrumental in capturing hope and person-centred care delivery. In training, another tool, the care pyramid, is used to bring clarity to the philosophy, process,

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plan and purpose of person-centred care planning. Used with the interventions menu they support shared decision regarding therapeutic options and different care settings in which treatment can be delivered.

Many aspects of ASPIRE are adaptations of well-established therapeutic approaches. Jobes et al's (2015) summary and McCabe's (2018) systematic review provide the evidence for these treatments. ASPIRE includes the Cognitive Behaviour Therapy (Brown et al., 2005) based 'Review Cycle' which aims to reframe and modulate suicidal triggers, thoughts, feelings and behaviours. It's an innovative approach to monitoring in which follow up appointments become an opportunity to strengthen the safety plan. Dialectical Behaviour Therapy based mindfulness strategies and chain analysis (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; Michaela Swales, 2000) and Acceptance and Commitment Therapy based choice point and values guided committed actions (Harris, 2019) are combined to 'Enhance Resilience'. As a training framework ASPIRE seeks to impart a breadth of skills, competencies and knowledge across therapeutic modalities so professionals may flex their style according to the person's needs. This exposure also improves the identification and appropriateness of onward referrals for specific treatments when needed.

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***NOTES** (**N**arrative description, **O**ptions appraisal, **T**herapeutic intervention, **E**scalation plan, **S**hared with)*

NOTES, a framework for documenting risk formulation, meaningfully enhances safety by transforming clinical records into a therapeutic tool. The act of writing about assessment and interventions compels practitioners to analyse clinical decisions, detect omissions and identify areas of improvement (Freedenthal, 2018, p. 102).The focus is on capturing the suicidal **N**arrative, detailing the risk and interplay of dynamic factors. Symptoms both present and absent need to be captured (I. H. Stanley, Simpson, Wortzel, & Joiner, 2019) and the DESPAIR prompts help with this. **O**ptions appraisal display the pros and cons of all the

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available alternatives including hospitalisation (Jobes, 2006, p. 119). This is followed by the **T**herapeutic intervention of choice, the setting in which it is to be delivered and the safety plan with a backup **E**scalation plan if care starts to break down. The formulation should reflect actions to be taken that are proportionate to the level of risk (Matarazzo, Homaifar, & Wortzel, 2014). This then needs to be **S**hared with all those who have a part to play (Rudd, Cukrowicz, & Bryan, 2008). This shared plan becomes a living document, capturing shared activities supported by the person's natural circle, all of which enhance safety and agency. It helps professionals transition from a mindset of 'who is responsible' (i.e. myself) to 'who is responsible for what'. NOTES enhance safety by covering all the pragmatics and provides a safety net for practitioners as it opens a window into the rationale behind the clinical options that were explored and how the chosen outcome was arrived at. It follows the Gutheil (1980) recommendation; the more uncertainty there is, the more one should think out loud in the record.

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Conclusion:

This overview provides the current challenges in working with people who are suicidal and introduces training frameworks that may help overcome them. PROTECT draws heavily on two successful initiatives and combines it with best practice in the scientific literature. It proposes to operationalise the delivery of safe care within the construct of person-centred recovery oriented practice. Risk and recovery can often feel at odds with each other. Both 333 and PROMISE framed care as a relational construct and supported a mindset shift in professionals "from top to tap"(Kar Ray et al., 2019). Understanding and exploring 'What's the matter with you' is often the conventional top down risk management approach in which the professional's clinical expertise trumps the person's experiential knowledge. However when working as partners in care, the professional is a supporting resource that draws on the strengths of the person to arrive at the solution (Shepherd, et al., 2008). The emphasis then

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naturally shifts to a recovery oriented query: 'What matters to you?' The first steps towards safety often lie in this answer as it exposes the genesis of the suicidal psychological pain. The same answer simultaneously, highlights the path the person needs to traverse to reconstruct a life that is meaningful to them. This is a small but important shift which captures the essence of relational safety as it tackles both risk and recovery as two sides of the same coin.

The Medical Research Council state that a sound theoretical model is the first step to develop a complex health intervention. The model has to be then implemented into routine service delivery and evaluated (Moore et al., 2015). Similarly further evaluative research needs to be conducted to ensure that the benefits of PROTECT in terms of enhanced identification, improved assessment and management translates into better and safer care for suicidal people. The goal is sustainable practice change with better outcomes within the scaffolding of relational safety similar to what was achieved in 333 and PROMISE. This research needs to include the expertise of professionals on the frontline as well as people with lived and carer experience.

Through the four frameworks, PROTECT operationalises the working partnership between the professional, the person in distress and their family and friends into the construct of relational safety. We propose a deeply empathic therapeutic alliance as the foundation for a safety formulation that can meaningfully account for the dynamic nature of risk. For that to happen the psychological pain has to be validated. The goal is to reframe suicide as a permanent solution to problems that may be temporary, helping the person to consider new and alternative ways of coping (Britton, Duberstein, et al., 2008; Jobes, 2006). Without risk there is no recovery. Positive risks enhance safety in the long run and are essential for building self-belief and resilience (Stickley & Felton, 2006). However, in the early stages of recovery, this might seem daunting. PROTECT provides a safe and collaborative approach to take these essential risks. Within the non-judgemental construct of relational safety, the

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professional can help the person see for themselves that suicide is not the solution that ends all problems but the problem that ends all solutions (Duffy, 2006, p. 89).

Relevance for Clinical Practice:

Training professionals using PROTECT will make practice reflective and mindful. There will be enhanced rigour in clinical decision making and risk thresholds will not creep up. The acronyms are memorable, easy to remember and provide logical sequence and structure. Trained clinicians will be able to engage in the practice of relational safety as they support people in suicidal distress towards recovery and resilience. PROTECT trains practitioners to develop a nuanced view of risk and recovery and overcome the common pitfalls of training and traditional clinical approaches.

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Table 1: PROTECT Frameworks

Framework - Purpose	Components	Description
AWARE: framework for reflection • Builds on a foundation of awareness of personal attitudes towards suicide • Make the implicit, explicit in reflective practice • Engage in mindful and conscious clinical decisions • Crosscheck judgement calls made regarding need, severity and risk • Avoid rationalising decisions through arbitrary selection of facts • Avoid risk thresholds from creeping up	A – Anxiety	Did anxiety generated / diffused in patient, family, referrer, clinician influence your decision?
	W – Weighting	Could differential weighting of symptoms (due to diagnosis, course of illness, aetiological factors) elicited have influenced your decision?
	A – Agenda	Was your decision influenced by an agenda you perceived in referrer / person in distress / family?
	R – Resources	Did resource availability like beds and team workload influence your decision?
	E – Experiences	Did experience of the same person/ person from same diagnostic group/ same demographic group influence your decision?

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DESPAIR: framework for assessment • Post assessment cross check • Introduces rigour • Logical sequence and structure in the assessment dialogue • Minimal additional time requirement • Identify gaps in history • Consider all relevant findings • Baseline scores to map recovery • Conversation aid for safety planning	D – Diagnosis	Is there significant substance misuse and/or mental illness?
	E – Entrapment	Is there any hope to navigate the entrapment of life's circumstances?
	S – Suicidality	Are there intense suicidal thoughts and/or detailed plan(s)?
	P – Past attempts	Have there been multiple serious suicide attempts?
	A – Agitation	Is there significant psychomotor agitation and/or impulsivity?
	I – Intent	Is there significant current suicidal intent?
	R – Risk Response	Is there significant risk that cannot be adequately responded to?

Table 1 continued on next page

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ASPIRE: framework for management • Foundation for relational safety • Acceptance of the person's psychological pain to establish deep empathy • Sequence of actions from crisis to recovery • Novel tools to enhance safety – risk response balance sheet, care compass • Draws on well-established therapeutic approaches (Motivational Interviewing, Problem Solving, CBT, ACT, DBT)	A – Acceptance	How to foster deep empathy through acceptance of the person's desire to be pain free?
	S – Safety planning	How to use the risk response balance sheet approach to manage safety in the here and now?
	P – Person centred care	How to use the care compass and the bio-psycho-social formulation to deliver person centred care?
	I – Interventions Menu	How to individualise evidence based treatment options for the different diagnostic groups?
	R – Review cycle	How to monitor for triggers, modulate thoughts and feelings and regulate distress?
	E – Enhance resilience	How to help the person move from pain guided desperate measures to values guide committed actions?
NOTES: framework for risk formulation documentation	N – Narrative description	How to capture a meaningful story that adds value in terms of safety?

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• Effectively enhance safety • Provides insight into decision making • Provides role clarity and share responsibility for maintaining safety • Maps out steps in a crisis	O – Options appraisal	Which options did you consider and how did you arrive at your chosen outcome?
	T – Therapeutic Interventions	What proportionate actions in terms of treatment and safety are you proposing to take?
	E – Escalation plan	What to do if the plan starts to break down?
	S – Shared with	Who needs to know and why?

For Review Only