#### PROBLEM/RATIONALE High rates of repeat self harm/suicide attempt

### Preconditions

Intervention

Funding

Training

Partner

Venue/Sites

Technology

Participant

Staff

Inputs/Activities

### Safety Planning Intervention (SPI)

(participant and practitioner plan and complete form)

· Experience of suicidal thoughts

Organisations

- · Experience of self harm
- Other eligibility criteria
- Interest in/Motivation to change and future personal safety/wellbeing
- Current mental wellbeing (not immediate suicide intent)
- · Existing coping strategies and engagement with services

# Assessment

· Safety plan co-development work through 6 areas of safety

## Telephone follow-up support sessions (up to 5)

- 1-2-1 'catch up'
- Mood Assessment
- Review of TAU and engagement
- Safety plan re-visit/amendment

## Safety Plan Steps

- 1. Recognising warning signs
- 2. Using Internal Coping Strategies
- 3. Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support
- 4. Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis
- Contacting Professionals and Agencies
- Reducing the Potential for Use of Lethal Means

# Mechanisms of Change

# Practitioner-Participant relationship centred

- · Feeling of being heard/acknowledged
- Therapeutic relationship(s) with SAFETEL practitioners
- Continuity of support/feeling of being "in the system"/"warm handover"
- Sense of ongoing support
- ↑ Self reflection

### Participant centred

- ↑ Self awareness/monitoring
- ↑ Self management
- ↓ Sense of stigma/shame
- 小 Awareness of support resources
- ↑ Positive action planning
- ↑ Sense of empowerment
- ↑ Motivation
- ↑ Self efficacy

#### Safety Plan (SP) centred

- Following of practical steps in SPI leading to individual changes in recognising warning signs, asking for and using support of social and professional network, improving safety of personal space
- · Personalised nature of SP (feels specific/unique/based on own experience)
- Self-developed nature of SP (ownership)
- Process of reflection and adjustment
- Safety plan as token reminder of recent events and of support offered by intervention

#### Outcomes

Reduced Self Harm (admissions to hospital)

> Reduced Suicides

# Contextual factors

## Intervention factors

- · Area of hospital admission
- Support/facilitation from hospital staff
- Timing, location, staff approach in SPI session/staff continuity
- Engagement with SPI
- Acceptability of SPI and Follow up
- Quality of intervention and follow up
- Ease/practicality of use in daily life

#### Participant centred factors

- Past Medical History previous attempts, previous treatment, nature of self harm behaviour, physical illness, other mental illness, current medication
- Capacity to understand and recognise warning signs, existing level of self-reflection
- Emotional literacy level capacity to communicate/convey thoughts and feelings
- Reluctance to openness/honesty
- Resistance to support and/or change
- Perceived social stigma of mental health
- Ethnicity, religious beliefs, gender and sexual identity, disability
- Education/knowledge
- Other risk factors Experience of close family/friend SH/suicide, debt, substance abuse, experience of adversity/abuse/trauma, bereavement

#### Environmental Factors

- Availability/ suitability of support
- Existing NHS pathways and support
- Geographical area - rurality.
- transport links Socioeconomic factors,
- network employment, debt
  - Housing

**Appendix 2:** Proposed Progression Criteria SAFETEL study (v1.0 11.06.2018)

CR	ITERIA	INDICATOR GREEN=Very strong indication to proceed AMBER=Medium indication to proceed. Discuss with TSC and proceed with identified plan to improve performance on indicator in Phase III trial RED=Indication of doubt as to whether to proceed. Discuss with TSC, and only proceed if other indicators are amber/green and there is a clear mitigating strategy	METHOD OF ASSESSMENT
1.	Were hospital-based study procedures feasible to deliver and acceptable to staff involved (hospital staff onsite and study staff delivering)? (e.g. referral, recruitment, assessment, SP session delivery)	Progression to be agreed in conjunction with Trial Steering Committee (TSC) 1 based on qualitative data captured around experienced and potential barriers to delivery.  • No current barriers, or those emerging have been minor, planned for and overcome in the past during the course of the feasibility study  • Some barriers but for which plans have been made/alternatives prepared  • Barriers for which no feasible plan or alternative can be offered/developed	Qualitative data collected in SAFETEL intervention provider focus groups, and clinical staff interviews, analysed as part of the process evaluation and reported on to the TSC.  Barriers identified and changes made to Study Protocol as a result will be reported to TSC.  Given the small number of participants offering qualitative feedback, value will be placed on individual reports of barriers, not simply those barriers that are frequently reported by different participants.
2.	Were study procedures feasible to deliver and acceptable to participants (including control arm)? (e.g. recruitment, consent/information given, assessment, safety planning session, follow up phone calls)	<ul> <li>Progression to be agreed in conjunction with Trial Steering Committee (TSC) based on qualitative data captured around experienced and potential barriers to delivery.</li> <li>No current barriers, or those emerging have been minor, planned for and overcome in the past during the course of the feasibility study</li> <li>Some barriers but for which plans have been made/alternatives prepared</li> <li>Barriers for which no feasible plan or alternative can be offered/developed</li> </ul>	Qualitative data collected in SAFETEL study participant interviews (intervention and control arms) analysed as part of the process evaluation and reported on to the TSC.  Complaints made by participants or relevant Adverse Events will be recorded and reported on to TSC.  Given the small number of participants offering qualitative feedback, value will be placed on individual reports of barriers, not simply those barriers that are frequently reported by different

3.	Was it feasible to deliver Safety Plan in the hospital?	Feasibility of intervention delivery:  Green: > 90% of SAFETY PLANS delivered at hospital Amber: 60-90% Red: <60%	% of safety plans delivered.
4.	Was it feasible to deliver 1 <sup>st</sup> follow up phone call attempt within 72 hours?	<ul> <li>Was the progression criterion met?</li> <li>Green: &gt;90% of first calls made within 72 hours of discharge</li> <li>Amber: 60-90%</li> <li>Red: &lt;60%</li> </ul>	Feasibility of intervention delivery:  % Call attempts made at 1 <sup>st</sup> follow up phone call time point  Was the progression criterion met?  % of 1 <sup>st</sup> Follow up call delivered within 72 hours.  Additional qualitative data from SAFETEL intervention provider focus groups, risk log, changes to study protocol identifying barriers and facilitators to implementation reported to TSC.
5.	Was the target rate of recruitment and retention achieved? (Are appropriate and effective routes of recruitment available to achieve a powered sample size in a full trial?)	Actual Recruitment rate vs. Target Recruitment rate:  Green: >80% of participants Amber: 60-80% Red: <60%	Actual Recruitment rate vs. Target Recruitment rate:  Actual participant recruitment rate and target recruitment rate will be measured to support projection of a powered sample for a full trial.
6.	Was it feasible to attain a minimum dose target required to justify a full trial?	Adherence rates:  • Green: >80%  • Amber: 60% - 80%  • Red: <60%	Feasibility of attaining minimum dose:  % of participants who completed minimum dose participation (i.e. SP+1 Follow up call).
7.	Was a target rate of completed baseline measures achieved?	Completion of core measures:  • Green: >90% data completion  • Amber: 70%- 90%  • Red: <70%	Completion of core measures:  % of participants completed the core questionnaires.  % of missing data from completed core questionnaires.
8.	Are identified barriers and challenges to implementation of and adherence to the intervention planned for and surmountable?	Progression to be agreed in conjunction with Trial Steering Committee based on qualitative data captured around experienced and potential barriers to implementation of and adherence to the intervention beyond those already captured in Criteria 1 and 2.	Process Evaluation report.  SWOT analysis.

<sup>&</sup>lt;sup>1</sup> Trial Steering Committee (TSC)
<sup>2</sup>The Community Health Index (CHI) is a population register, which is used in Scotland for health care purposes. The CHI number uniquely identifies a person on the index.