Safety Planning Training Transcript

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Hello and welcome to our online training for mental health safety planning! We had a lot of success with the launch and initial face-to-face training sessions we delivered at the end of February and early march 2020 and we've decided to record the training and put it on our website so that more people can access it and use it to help them to support individuals with creating mental health safety plans. I'll cover as much as I can in this recording, but if you have any questions please do contact me, my email address will be on the final slide for follow up.

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So I'd like to start with just a welcome to everyone. My name is Hannah Clark, I work in public health at Cornwall Council in the suicide prevention and mental health team. My colleage Paula Chappell is a Public health Practitioner in the same team and we've been working together for a few months now to develop the safety plans and launch the training to everyone. She won't be in the recording today but we've worked together to make sure all the necessary content is in the slides that are going to follow.

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I wanted to also just add a disclaimer here that we will be talking about some sensitive material in the next hour or so around suicide, self-harm and mental health. So please do pause the video if you need a break, and please seek support if you feel uncomfortable or need support because of any of the content I talk about. There are some numbers here that are available to listen if you need it.

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So what are we going to do today? I'm going to start by talking about safety planning and what it is, how to use safety plans and also when not to use them. I'll also talk about what to do in a crisis if safety planning isn't relevant. I know most of you will already have safeguarding procedures in place to support you with this but it's still important that we discuss what to do in various circumstances in case you don't have these procedures in place.

We'll also then have some time to practice. In the face to face sessions we had a lot of feedback about how useful practicing with some case studies was. Obviously you're welcome to do this alone with the video or if you can get a group together either in person or over skype to chat through different scenarios you are more than welcome to do so.

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Before we start, we've also had feedback that its really useful to have a safety plan in front of you while we talk through them. So if you click through the hyperlink to our website and

download and print one of here to have in front of you or on another screen that should be really helpful.

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Alright let's get started.

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It's quite useful to start out by just giving some context around suicide prevention in Cornwall. I've included here some statistics here. So for comparison, (list stats). So we know that these numbers are significantly higher in Cornwall, and we have an ongoing agenda and additional funding in Public Health to support suicide prevention initiatives. We have quite a few projects ongoing at the moment, and this is really where the drive for mental health safety plans has originated.

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Additionally, we know some key information about people who do choose to take their own lives. Within the 12 months before they die we know that a third of people who suicide in cornwall have contact with a specialist mental health service. A third have contact with their GP about either a physical health complaint or their mental health. And we know, most importantly, that a third of people who end their life have no contact with any services at all. So this is the other reason why we're trying to roll mental health safety plans out as a community centred tool, because even those who contact their primary health care service might not mention anything about feeling suicidal, and so therefore more than a third of people who might want to speak to someone about their mental health are either uncomfortable with talking to health professionals or unable to. So we're hoping that mental health safety plans can be the key to having wider conversations about mental health without any stigma throughout the community.

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So, what are safety plans? A safety plan is a tool to support someone with their mental health, and they were designed to be used by people experiencing intense suicidal thoughts, however, as I will re-iterate a lot in the next hour or so, they are not exclusively for individuals who are experiencing thoughts of suicide. The research we have has demonstrated that they are one of the best tools to alleviate future suicidal behaviours.

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Safety plans are assets-based, so they focus on an individuals strengths and unique abilities to support themselves in times of low mental health or mental health crisis.

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If you are interested in reading the research we have, I've linked to the article here. The research is by Dr. Barbara Stanley and Gregory Brown. In this particular case they also

conducted follow up phone calls, which did prove to be beneficial but it's the best evidence we have for the use of safety planning so far.

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An example Dr. Barbara Stanley uses in her work is she compares a mental health safety plan to a plaster cast. For example, if someone broke their arm, you would not expect them to wait 6-12 weeks to be seen by a doctor to set the bone, they would put a cast on the arm then and there to help it heal. Similarly, with mental health, safety plans serve as a way to support individuals who are in crisis right then and there, so that they have something to help them through their difficult feelings as soon as possible and don't have to wait for help. Similarly, another example we like to use is to think of safety plans as a seat belt, a preventative tool to support people with their basic mental health to stop them from reaching crisis in the first place.

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I just wanted to include here some BBC coverage of safety plans for two reasons. Firstly, to demonstrate that they're quite popular across the country at the moment, but secondly to highlight what Simon says here about his experience of making and using a safety plan after self-harming. He says that actually when he found his safety plan to be generic, with little or no relevance to him, and that it was pretty pointless. This sounds quite damning, but actually he then follows it up by saying that for him, the essence of a safety plan is that it's unique to the person and it's tailored to their experience and their strengths. So I'll come back to this a lot in this session, about how important it is to tailor plans to the individuals who are using them so that they don't become a generic tick-box exercise.

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Ok so how and when to use a safety plan.

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While safety plans were originally intended for people struggling with suicidal thoughts, we believe that safety plans can be useful for anyone with mental ill health. They can really help if: you have experienced feelings of anxiety, you have experienced feelings of low mood, you use or have used self-harm as a behaviour to help you cope with your feelings, or you have had thoughts of suicide. we really want to emphasize here that everyone has mental health, and everyone sometimes has poor mental health and safety plans can support anyone within this spectrum of feelings.

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So who can help make a safety plan with an individual?

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A family member, a friend, a professional.

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We've listed all of the above because really anyone in a trusting relationship with the individual can support them to make a safety plan. What I've said before about the plan being individual to the person is really what's key here, if you have a trusting relationship with someone you're more likely to open up and have an honest conversation about your mental health with them. It's ok if this isn't you as a professional, if the person you're supporting feels more comfortable having that conversation with someone else it's more than ok to give them guidance and support around how to fill out the safety plan and use it and allow them to have that conversation with someone else. As I said earlier, the real magic of the safety plan is in its creation, so it's essential that this is done with someone who the individual trusts and feels comfortable with.

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So, as you'll see in front of you the safety plan is designed as a stepped approach, and the theory behind it is that you work through it as a stepped approach until you feel safe again. Obviously, we understand that mental health often doesn't develop in such a way, it can jump from 0 to 100 very quickly, and sometimes you might open up your safety plan and be ok with steps one and two and sometimes you might need to jump straight in at step four or five. The other important thing to remember with safety plans is that they are living documents, so they will change as you use them and it's important to update them. If, for example, you called Margaret last time and she wasn't very helpful, take her off and add someone else in. or if you did something that really helped that you hadn't thought of, add that in afterwards.

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So what does each step on the safety plan actually mean? I'm going to go through and discuss them now, and for the first few I'll ask you to pause the video and have a little brainstorm either by yourself or with others to come up with some ideas of what you or someone you're supporting might put in each step. This can be helpful to just have a list of ideas to offer if people are struggling to come up with suggestions themselves at first.

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So the first step is warning signs. What feelings or actions or thoughts let you know that you're not feeling mentally well or you're on your way to thinking about suicide. So pause the video, have a brainstorm, and we'll come back together in a bit and I'll read out some suggestions we've had.

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Hi welcome back, I hope you had a good brainstorm. So some examples we had come up with here are an argument with a loved one, not getting enough sleep or sleeping too much, dropping your usual activities, self-isolating, or an irregular eating schedule. What we had noticed in almost all of these, and what we got from feedback from the face-to-face sessions is that what it really is is a change in behaviour. For example, if you usually sleep well, then

not sleeping well is a good warning sign. But if you normally don't sleep well and suddenly you're tired all the time and sleep loads, then that would be the change in behaviour for you. The same goes for self-isolating. I know a lot of people who are absolutely fine in their own company, but if suddenly they're not, or a sociable person suddenly cancels all their events, then these would be the changes of behaviour we might notice in them. I'm sure all of you had a lot more, but as I said earlier, it's really good to keep a list of suggestions up your sleeve in case the person you're working with can't immediately bring things to mind.

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So step two is coping strategies. These are things you can do for yourself to take your thoughts away from patters of scary thoughts or suicide. This step does not include bringing anyone else in yet to help, it's just for people to support themselves. So pause me again, have a brainstorm, and come back when you're ready for the next slide.

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Hi welcome back again, I hope you had a good chat or brainstorm alone. Here are some examples we came up with for this step. A distracting activity, physical activity, meditation, breathing exercises, watching your favourite tv show or film. Again it's important here to personalize these steps, I know physical activity or meditation work really well for some people, but I also know people who absolutely would not want anything to do with those things, so it's important to really ask about what they're likely to want to do, and to have lots of ideas up your sleeve if none of them are sticking.

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Step three involves getting other people involved to distract you, or to go out and about to distract yourself. Now I know for a lot of people leaving the house is not a possibility for various reasons, so this step might need to be tailored for specific situations, but some examples we had thought of were to call a close friend or family member or meet up with them where possible. To go for a walk, to go online and watch webcam footage of zoos or of museums, to watch your favourite youtube comedian, to play a game online or on your phone. To read a book or do some crafts. If possible to go to a café or library to just be around people but not necessarily talk to them. This really should be tailored but it's about how we can use other people or places to take our mind away from our thoughts.

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Step four is about people who can help, this can be family or friends, service providers or spiritual people. This is about how you finding someone who you want to speak to about how you are feeling. So up until this point the purpose was to distract and take your thoughts away, and now the steps are about discussing how you're feeling with others.

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This then is if you feel that you don't have any friends or family members to speak to or anyone you feel comfortable opening up to about how you're feeling and you need to speak to a professional instead. On the back of the PDFs and the Z Cards there is a list of numbers of agencies to speak with based on various demographics and also various ways to talk to professionals either over the phone or via text or webchat if that's preferable.

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So we've listed here some examples of professionals, but as I said there are also a lot of numbers on the safety plans themselves as well as on our website.

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The final step, step 6, is the one that's most important for people who are feeling suicidal or are at risk of self-harming. Up until this point safety plans are really good for anyone with any level of low mood or ill mental health, but step six is specifically about how to keep your environment safe. We know from research that the more steps you put between the thought of self-harm and suicide and the action itself the more likely people are to remain safe. So in this sense it's important to have a conversation with someone about whether they've thought about this before or even planned it. We've got some time later in the training to talk about how to ask about suicide, but again this is why it's important that this conversation is had with someone who the person trusts as this can understandably be a sensitive conversation.

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Some examples of how you might be able to keep the environment safe could include taping a blade you use to self-harm with a whole roll of Sellotape to slow down that time between thinking of self-harm and being able to being able to use it. Similarly if you speak to someone and they mention that they are hoarding medicine, how can you safely remove that from the home?

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Some other things to include are here. So the box about reasons for living or life sustaining things are really important, and I'll come back to this but this is one of the main reasons we say not to complete this in a point of crisis is for this box here, that often it's hard to find a reason to live or something that's life sustaining if you're at a point of crisis, but it can be very powerful if you have it there when you need it.

It's also really important to include phone numbers for everyone, at a point of crisis or panic looking for numbers isn't something you want to be worrying about, it's really helpful to just have them all in one place.

Finally, there is a box to fill in about if you no longer fell you can keep yourself safe what you will do. This means that if you have gone through the whole plan, and you no longer feel like you can keep yourself safe, you've called everyone, you've tried to distract yourself and you can't cope anymore, what is it you will do. Is this that you'll check yourself into an a&e,

is it that you will drive to your friends or your mum's, what is it for you that's your final emergency measure.

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So hopefully that's all clear, obviously if you have any questions do get in touch. To move forwards now to talk about when it's not ok to use safety plans and what to do in terms of suicide prevention in a point of crisis.

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So, when is it not ok to make a safety plan? It's not ok to try and make a safety plan if someone is in the middle of a crisis, if they are actively suicidal or psychotic, if they are under the influence of drugs/alcohol, if they have already taken action on their suicidal thoughts.

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Why is this? They shouldn't be made at a point of crisis for the reason I listed earlier, because it's really important that the person has a reason for hope and for living while writing it.

It's important to add though that they can be made in more than one sitting, so if you start to write one and it's not the right time, it's ok to leave it with someone and come back and discuss it later.

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So what should you do in a point of crisis? I know most of you will have already had training on this or will have your own safeguarding procedures in place, but in case you haven't or you need a refresher we thought we'd just take some time now to talk it through.

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We've made a short flowchart here to work through and I'll just talk it through now. So to start when you're talking with someone who's struggling it's really important that you connect with them and listen and validate how they're feeling. When it feels like an appropriate time you need to ask clearly and directly about if they are having thoughts of suicide. It's really important that at this point you reassure them that it's good they feel able to share with you how they feel and that you take this time to build hope for the future with them. It's also important that if they say no at this point it's important that you do ask again, because sometimes people will say no initially. It's also essential that you then ask if they have done something already to harm themselves, sometimes people have already taken action on their thoughts. If they have, then it's important to put aside all thoughts of safety planning and focus on keeping them safe, calling 999 if necessary. It's also important that you take them to hospital if they've taken an overdose even a few days before, the overdose is still in their system and it's important that they are seen by medical professionals.

If no harm has occurred, then it's important to signpost to support agencies where possible, and if you feel confident then it's appropriate to begin creating a safety plan. Again, if urgent rescue is needed safety planning is generally not appropriate.

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Some things to keep in mind if you are having a conversation with someone about suicide:

Time – it's essential this isn't a rushed conversation

Privacy – make sure you have the space to speak privately if necessary

Body language – make sure you look attentive and interested in the conversation and sit next to them.

Try to use appropriate eye contact – obviously depending on the person this might be no eye contact or a lot of eye contact, you will know your client best.

Give them your full attention – this seems a bit superfluous to say but it's important you're not on the phone and you're not busy doing another task.

Stay calm – it's essential you stay calm having this conversation. Many people have been int his position before, and having a calm and attentive conversation is important to building confidence and supporting individuals in the future.

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Be careful of what you say, make sure you don't put down how people are feeling. Try to avoid phrases such as 'surely things aren't that bad?'

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Whatever you do say in response to your friend or client, be sure it is non-judgemental and no-blame. It's also really important you not make them promise to not talk about it to anyone or be annoyed that they're telling you how they really feel. We want to reduce the stigma that stops people from being open about how they feel.

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You're all here and in your job roles because you care about people, be sure that you take this into each conversation and remain patient and kind and compassionate with everyone you interact with.

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I wanted to point out here as well some stigmatizing language we're trying to avoid going forwards. For example, we don't say the phrase committed suicide anymore as this harkens back to when it used to be a crime to take your own life, and it was a crime until 1961. It also implies committing a sin. Instead you can say 'ended their life' 'took their life' or you can use the word suicide as a verb and say somebody 'suicided'. We also don't say successful or

completing a suicide anymore, obviously this implies that this was something we are hoping people to achieve, also this does relate to the phrase ‘failed attempt’ which is similarly unhelpful in equating continuing to live as failing to achieve something.

We also are trying to move away from ‘deliberate self-harm’ this is medically used a lot in hospitals and outpatient centres, but really some self-harm is not done intentionally, and so it’s unhelpful to call it this.

Finally, the phrase suicide epidemic is understandably unhelpful and sensationalist. It doesn’t help raise awareness and really just raises fear and stigma around suicide.

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As I mentioned earlier, it’s important to follow your own procedures in case of an emergency, and if it’s necessary to call emergency services.

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I’ll just show you now where to go for more online training and resources.

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On the mental health safety plan webpage where you found this video we have the healthwatch directory of local resources. Similarly we have some useful training videos and documents if you need more support and guidance remotely.

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If you are able also Healthy Cornwall offer a few suicide prevention and mental health first aid courses that run regularly. They do also offer bespoke training for your organization if they’re fully booked. Earlier in the year they delivered training to mandown, the Falmouth charity for men’s mental health, on a weekend. They also run ASIST training which is applied suicide intervention skills training that runs for two days and is excellent. You can book these online or email the healthy cornwall team in the links on this slide.

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Ok final section now on practice.

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So to start I’ll just show you again how to access plans and then I’ll talk you through some case studies and give you the chance to practice.

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So here again is our webpage with the link to the PDF, and if you’re interested in bulk ordering some z cards if you email the public health desk we’ll see how we can get some to you. We’ll be able to send them through NHS Courier or Local government offices courier as best we can if you let us know where you’d like to pick them up from.

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There are also some safety planning apps we like to signpost people to. They're exactly the same format as our ones but include addages to link directly to phone numbers or to include pictures or songs which can be a nice addition. We've had feedback both ways that some people love to have everything on their phone and some people don't like to look at their phone when they're not feeling great so we want to make sure both options are available.

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So for some practice now I've got three case studies to discuss with you. If you pause on each one and discuss with a colleague or work through it on your own and then play again and I'll add my thoughts on each for you to consider. If you want to also practice working through a case study with someone role playing each part we've had feedback that that might be useful to do so we'd encourage you to do that if you can.

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So here is the first case study, pause the video now and then un-pause when you're ready to discuss.

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So, for this one we've said that it would be relevant to make a safety plan here. Again though, it's about reading and knowing the person you're working with and if they don't seem receptive to making one or you feel they might do better with alternative support that's absolutely up to you.

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So another one here, please just pause the video and start again when you're ready!

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I'm sure you all guessed that safety plans would absolutely not be relevant here. If at follow up they seem more receptive absolutely have a wider conversation about it but for the moment their physical safety is the most important.

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Final example here, same as last time, have a pause and start again when you're ready.

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We've said it would be useful, but we've also noted that there should be a wider conversation around her support network and managing her being able to cope with school work.

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So finally the key points I'd like to draw from this training. Firstly, as you've seen with each of the case studies, it's really essential that we don't use safety plans in isolation. It's really important that we have conversations around other interventions and signposting to other organizations for support if appropriate.

Secondly, the point here about wider conversations about mental health and suicide in order to break down the stigma so that people feel comfortable and confident to discuss it.

Finally, I do want to highlight once again that you are all the professionals in your field, and you know the individuals you're working with.

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I hope this has been useful, I appreciate it's a different format and in face-to-face sessions we've had a lot more opportunity for wider conversations and discussion, so if you do have some underlying questions, please don't hesitate to get in contact and I'll help as best I can or signpost you to someone who can. Thanks again!