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Safety I and Safety II for suicide prevention – Lessons from how things go wrong and how things go right in community-based mental health services [Abstract]

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Safety I and Safety II for Suicide Prevention – Lessons from How Things Go Wrong and How Things Go Right in Community-based Mental Health Services

Objective

More than 5,000 people committed suicide in 2016 in the UK and suicide is the leading cause of death among young people aged 20-34 years (ONS, 2016). Prevention of patient suicide is a major challenge for mental health services. A current focus of suicide prevention is in risk assessment methods which are used to identify risk factors and initiate appropriate treatment. However, risk assessment does not remove the uncertainty around the potential for suicide (Mulder, 2011). This study applied both safety I and safety II approaches to gain an understanding of the detection and response process for suicide prevention in community mental health care. Outputs from each approach are compared.

Method

For safety I, forty-one suicide incident reports were analysed using a systemic analysis approach. For safety II, interviews with 20 community-based mental health professionals (3 managers, 11 crisis team staff, 6 community team staff) were conducted asking their know-hows to successful suicide risk detection and response.

Results

The key issues found in the analysis of incidents (safety I) were:

- an inherent weakness in the interactions between patient and clinician with the presence of uncertainty in the risk detection (17 cases)
- Poor patients' engagement with services including non-attendance and non-compliance (11 cases)

- Reliance on patients self-presenting in crisis and declining the offered support options (4 cases)
- Delay in treating new patients, with suicides occurring while on waiting lists or having only had initial assessments (7 cases)
- Coordination, communication and process issues within services interrupting patient care (7 cases)

The interviews with staff (safety II) revealed a complex decision-making process with the presence of uncertainty and trade-offs between patient clinical need, patient desire, legal and procedural obligations, and resource considerations. The interviewees were also asked about what helped them to be successful which revealed a strong theme on the importance of peer-support.

Conclusions

Safety I approach identified patient engagement issues and highlighted a problem to a care model reliant on patients adhering to care plans and presenting at times of crisis. Two questions were also raised as to whether the system has the resources to accommodate different patient needs and how services can fit to patient desire. On the other hand, safety II approach found the importance of peer-to-peer learning and support for successful detection and response to suicide risk. The results of this study indicate that safety II approach provides valuable insights into how to strengthen the system performance without challenging systemic issues, while system I approach identifies systemic issues and raise questions how to address them. These findings suggest the potential benefit of applying both approaches to quality and safety improvement in healthcare.

Ref

Office for National Statistics (2016). Suicides in GB, 2016 Registrations - ONS. [online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration [Accessed 7 September 2017].