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Lifeguard Pharmacy: the co-development of a new community pharmacy response service for people in danger from domestic abuse or suicidal ideation

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Abstract

Background: Domestic abuse (DA) and suicidal ideation (SI) are prevalent and often co-occur. Numerous practical and psychosocial barriers inhibit help-seeking, including accessibility and confidentiality concerns. Pharmacies are accessible and may be perceived as a discreet venue for a DA and SI response service.

Objective: To co-develop a community pharmacy response service for people experiencing domestic abuse or suicidal ideation.

Methods: Overall, 36 unique individuals contributed at least once to a series of focus groups, interviews or workshops to co-develop the service components. Participants had lived experience of DA/SI or were professionals from DA/SI support services or pharmacies. Audio recordings and field notes from events were thematically analysed. Specific themes were identified and informed the development of the service components.

Key findings: Participants supported the development of this new service and considered community pharmacies to be an ideal setting. They thought of the service as a lifeline, that would offer hope. Under this main concept of hope, five main themes were identified: Safety, Empathy, Empowerment, Equity, and Discretion. Participants' practical considerations were incorporated into the service design, including the name choice of "Lifeguard Pharmacy", the strapline "Bringing Hope to Life", and the development of a "Client Flowchart" outlining how to welcome a client, arrange for a consultation, and then guide clients out of the pharmacy afterwards.

Conclusions: Overall, the findings supported the development and introduction of this pharmacy-based intervention, which may help overcome barriers to help-seeking for DA or SI due to its sense of hope, accessibility, and discretion.

Keywords: co-development; community pharmacy; domestic abuse; mental health; suicidal ideation; suicide prevention

Introduction

One in five adults in England experiences suicidal ideation (SI) at some point in their life [1], and approximately one in five adults in England and Wales have experienced domestic abuse (DA) since the age of 16 years [2]. The severity and prevalence of these issues make them important public health priorities. Most health or social care services provide support for these issues in isolation. However, DA and SI often co-occur and, e.g. people who have ever experienced intimate partner violence are at approximately three times the risk of suicide attempt [3].

People experiencing either SI or DA also encounter some similar challenges, such as feeling hopeless [4], experiencing stigma [5, 6], and difficulties accessing suitable support services [7, 8].

Numerous practical barriers to accessing DA and SI support services have been identified including a perceived lack of services for lower-level problems that are not immediately life-threatening [9], people not knowing which support services are available [7, 10], long waiting times for services such as general practitioners (GPs) and psychological therapies [11], and fewer support services in rural areas, where a lack of available public transport may be a barrier to access [12].

Furthermore, there are psychosocial barriers that may prevent people from accessing services. Both DA and SI can evoke social stigma [8]. People experiencing SI often feel isolated,

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hopeless and a burden to others [13], and DA victims are often fearful of the repercussions of disclosing the abuse and have concerns for their own safety [8]. For both SI and DA, appropriate timing of support is key. Suicidal ideation can escalate significantly in a short period of time and therefore people may need immediate support [14]. Victims/survivors of DA often live under high levels of isolation, surveillance, and control by their abuser, with limited opportunities to seek help, and they therefore need help to be readily available [10, 15]. A service that tackles these accessibility challenges could make it easier for people to seek support and prevent escalation.

Community pharmacies in England are highly accessible, with 89% of the population having one within a short walking distance [16]. They are a frequently visited, general healthcare venue with an expanding provision of patient-centred care beyond traditional dispensing [17]. The Bloom programme for mental health and addiction support in Canada [18], and the AMPLIPHY feasibility study for mental health support in England [19] both provide examples of how patient-centred care can result in non-medicines related disclosures. Overall, a DA/SI service in pharmacies may reduce some accessibility barriers.

The Pharmacy Quality Scheme (PQS) incentivises community pharmacies to produce a suicide action plan and to encourage their staff to complete the 'Zero Suicide Alliance' training [20]. Nationally, over 72 000 staff were trained and almost 11 000 pharmacies completed action plans, but no formal service has resulted and there has been no published evaluation of the impact of the training or the action plans on suicide prevention.

Currently, a support service is available for victims of domestic abuse in some pharmacies, known as 'Ask for ANI' or 'Safe Spaces', consisting of the provision of a safe space where victims can call an external agency for help [21]. There is no published evaluation of this service.

These considerations provided the rationale for a response service for people experiencing DA or SI in community pharmacies, that addresses the practical and psychosocial accessibility barriers described above. This study complements the approach of 'Ask for ANI', by using a co-development process with participants that reflects the intended target populations and those involved in its delivery.

This study therefore aimed to co-develop a community pharmacy response intervention for people in danger from DA or SI. This is the first part of developing a complex intervention, to be followed by a feasibility trial.

Methods

The MRC/NIHR framework for developing and evaluating complex interventions guided the approach taken including the emphasis on meaningful engagement with individuals who are targeted by the intervention and those involved in its delivery [22].

A co-development approach was used to understand and accommodate for accessibility challenges faced by people with lived experience, any delivery challenges that pharmacies may face and any referral issues for referral DA/SI organizations, thus ensuring that the service design is fit for purpose.

Co-development of components of the service

A three-phase series of interviews, focus groups, and workshops were conducted to co-develop the intervention:

1. Three focus groups and one interview with people with lived experience of SI/DA (Focus Groups 1–3 and Interview 1).
2. Five interviews with relevant professionals (Interviews 2–6).
3. Three workshops with people with lived experience and professionals (Workshops 1–3).

Research ethics

This study was approved by the North West Preston Research Ethics Committee (22/NW/0016/AM01) within the UK Health Research Authority. All participants gave written informed consent to be part of the study.

Participants

The study was conducted in Lincolnshire, England. Participants had to be over 18 years old, capable of giving informed consent and meet the criteria of being either a person with lived experience, or working for a relevant organization that pharmacies would be likely to refer DA/SI clients to, or working for a pharmacy organization, and English speaking.

Participant recruitment was conducted through contact with relevant local organizations by e-mail and phone. These organizations included DA, SI, mental health, and drugs and alcohol services and were selected purposively to provide one organization per type of service. All of the representatives that were approached agreed to engage although five preferred to have a research meeting rather than a formal research interview. The organizational representatives were recruited as participants, and in turn, they recruited people with lived experience as lay participants using a snowballing sampling strategy. Because people with lived experience were recruited via the representatives it is not known how many people that were approached declined. Pharmacy staff were recruited through regional pharmacy networks using convenience sampling and all staff approached agreed to participate. Target sample sizes had been set a priori based on the anticipated numbers required to achieve data saturation for each type of participant.

Data collection

A pilot phase was not conducted. However, extensive public and patient engagement work had previously been conducted by JS which informed the development of this study [9].

The co-development process comprised 14 events held in three phases from May to June 2022 (see Figs. 1–3). Phase 1—co-development with people with lived experience from 09 May 2022 to 08 June 2022, Phase 2—co-development with representatives from referral organizations from 11 May 2022 to 14 June 2022 and Phase 3—from 13 June 2022 to 26 June 2022 (see S1 for facilitator details).

The first phase explored the perspectives of people with lived experience. The second phase, running parallel to the first phase, explored the relevant support services, followed by the third phase with people with lived experience and professionals working together to refine the intervention components. Findings from each session fed into future

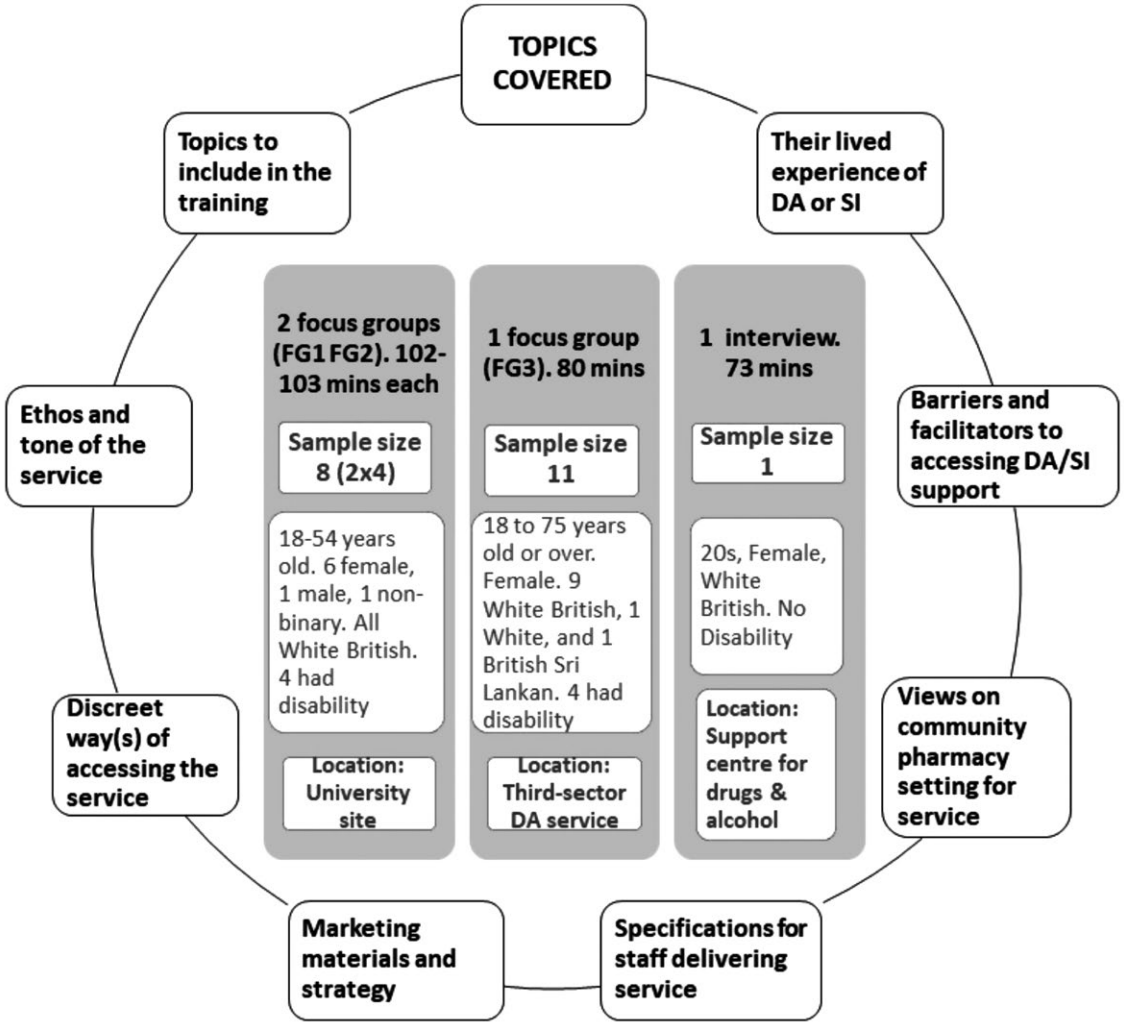

Figure 1. Phase 1—People with lived experience of DA or SI—Overview of focus groups.

sessions as part of the co-development process over several weeks. Repeat interviews were not conducted.

Recruitment and data collection continued until consensus and data saturation were achieved. Predesigned topic guides with questions and prompts were used by the researcher(s) to aid data collection and facilitate interactions. Participants were informed that they were free to withdraw from the study at any time and were given details of relevant local support services. Data were collected through audio recording, plus field notes from flipcharts, post-its, and notes. Five people approached for an audio-recorded interview preferred to have an informal research meeting, and so only research notes were taken from these meetings. They are not included in the total sum of 36 unique participants. Transcripts were not returned to participants due to the sensitive nature of the material.

Theoretical framework and data analysis

A constructivist approach was used to allow for multiple realities of lived experience [23]. Data were analysed using framework analysis to accommodate both emerging themes and preidentified factors [24]. This systematic approach facilitated comprehension of the findings across the co-development events and throughout the refinement process (Figs. 1–3 for events, Table 1 for coding framework and researcher details in Supplementary Fig. S1).

Results

A total of 20 participants with lived experience, 6 representatives from the key referral organizations, and 10 pharmacy staff took part in at least one of the co-development events, making a total of 36 unique individuals. Many participants were involved in more than one event making a total of 68 participant contributions. A further three participants with lived experience were recruited but withdrew before the event due to illness.

Phase 1—The participants with lived experience were supportive of community pharmacy as a setting, including both DA and SI, having both client and staff-initiated access and using a non-medicalized metaphor as a name. However, many participants, particularly those with lived experience of DA, expressed unease regarding discretion in a busy pharmacy. Concerns were also raised about the workload capacity of staff, and how staff would be selected.

The name ‘Lifeguard Pharmacy’, the logo of a life-ring integrated with a green pharmacy cross, marketing poster and the strapline ‘Bringing Hope to Life’ (see Supplementary S2

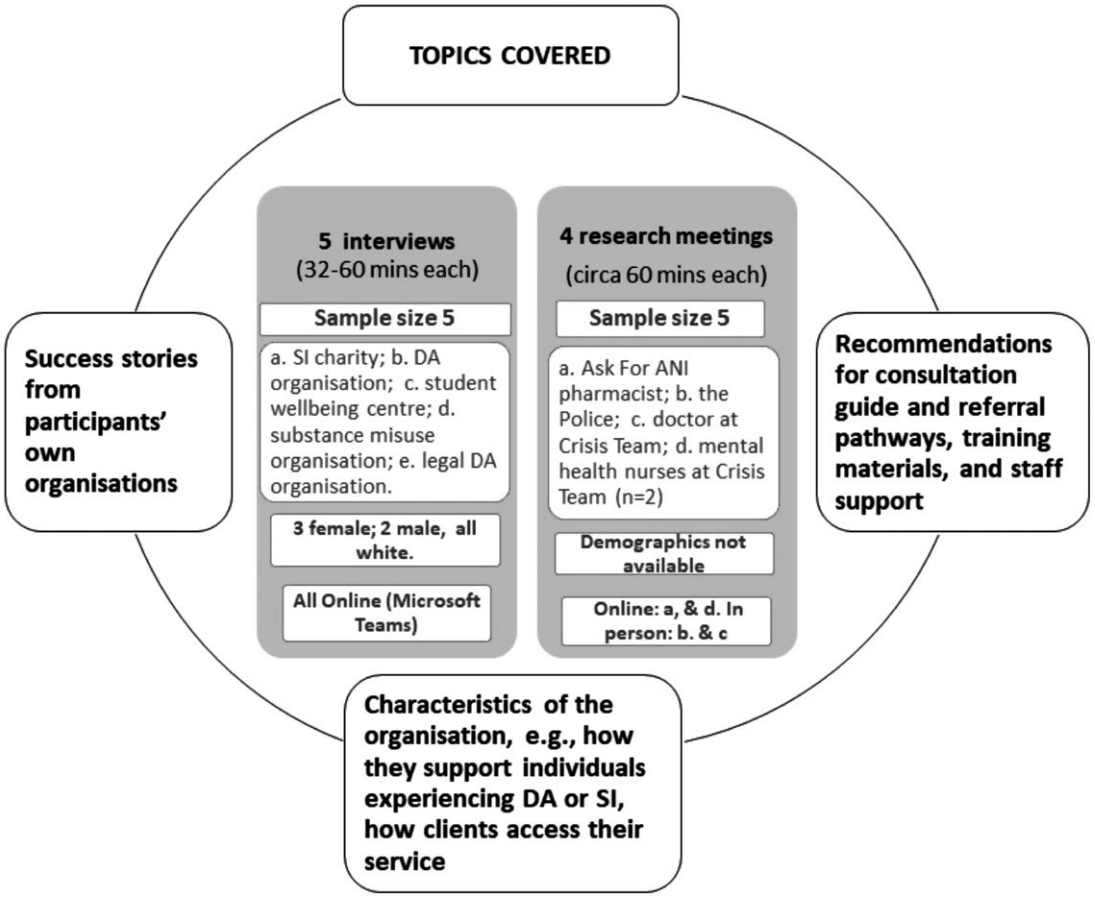

Figure 2. Phase 2—Overview of interviews and meetings with representatives from organizations that offer DA or SI support services.

Figures 1 & 2) were developed in an iterative process across Phase 1. Participants emphasized that the tone of the service should convey hope, by offering a lifeline in situations that seem hopeless.

'*You want to inspire that hope and positivity to that person that you want to come in*'—Participant 7 FG3.

Integral to that concept was that a small change, just a tiny seed, could grow into something substantial over time. Under this umbrella concept of creating hope through connection, five main over-arching themes were identified: Safety; Empathy; Empowerment; Equity; and Discretion, forming the acronym 'S.E.E.E.D.'.

All participant views, including minority views, were accommodated in the co-development process. Any contradictions were resolved through discussion and consensus with participants, e.g. there was debate about whether to include the word 'choose' in the poster; some participants were in favour but some participants thought that people experiencing SI or DA do not have a choice. After discussion, it was agreed to not use the word 'choose', but to emphasize hope.

Phase 2—the representatives from referral organizations were also positive about a community pharmacy setting, including both issues and having a non-medicalized name. They discussed practical issues of when and how to refer. Representatives said they would value having trusted 'Lifeguard' pharmacies that they could contact and refer patients/clients to, e.g. proactively contacting a pharmacy, e.g. the drugs and alcohol support service wishing to alert a pharmacy if concerned about a client.

A coding framework was developed from Phases 1 and 2, which included the five main themes mapped against the intervention components (see Table 1). This was added to in Phase 3.

Phase 3—Participants discussed, reviewed and refined the draft components, adding further practical recommendations for the implementation of the service. There was a groundswell of support of '*let's do this for our community*' (Participant 5, pharmacy staff Workshop 3).

To summarize, the intervention components were designed from participant data through a process of framework analysis across the three phases. All themes, including minority themes, were incorporated into the design of the intervention components. Example quotes and coding for each of the intervention components are shown in Table 2.

Intervention components:

Safety criteria

Participants thought the pharmacies should have the following safety criteria in place: specifications for the consultation room; minimum staffing levels; having a chaperone policy; being able to show written identification rather than having to say your name and address out loud when collecting a prescription and that supervised consumption of substance misuse treatment must be done with the patient alone.

Branding

Participants thought the response service should have a non-medicalized name so that it is less threatening. Participants

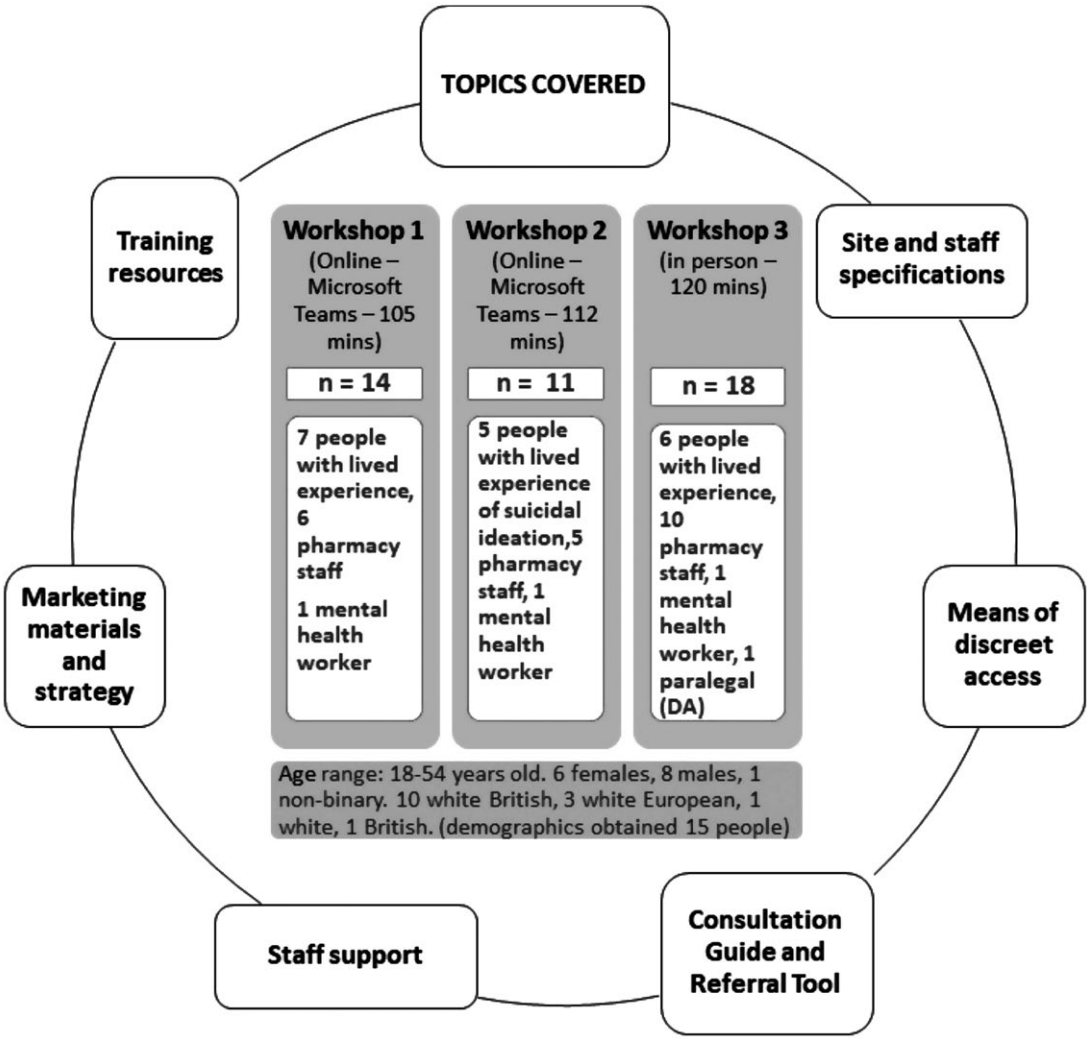

Figure 3. Phase 3—Overview of workshops with people with lived experience and representatives from organizations.

with lived experience of both SI and DA resonated with the life-ring and lifeguard imagery, and developed the strapline "bringing hope to life".

Marketing materials

A poster was developed in an iterative process over the course of Phase 1, with several versions being shown to the participants to discuss and redesign. There was discussion about the choice of wording and that trigger words such as 'abuse' and 'suicide' should not be used.

Staff training

The staff training was developed based on the views of the skills and knowledge that participants thought staff should have, which included active listening skills, empathy and skills in making appropriate and safe referrals (including safeguarding referrals) and how to be discreet.

Client flow-chart

To address concerns about discretion a client flow-chart was developed outlining the process of guiding clients in and out of the consultation room discreetly. People wanting to request support could ask, show the life-ring symbol from the website on their phones, or hand in a cue card at the counter (See S2 Figure 3). Staff could approach people who distressed and invite them to have a consultation to explore further.

Consultation guide

Referral pathways were established through engagement with representatives from relevant referral organizations. The consultation guide was based on the guiding principles of Safety, Empathy, Empowerment, Equity, and Discretion plus an additional 'S' for Safety-netting (S.E.E.E.D.S). Client support cards were created, along with discreet QR code card alternatives. These alternatives did not mention domestic abuse or suicide but following the link took clients to the support webpages (see Supplementary S2 Fig. 4).

Staff support

Having confidential emotional support for staff was considered to be essential. A support package was created which included being paired with another Lifeguard as buddies, access to a psychotherapist, and signposting to an advice helpline.

A 'Pharmacy Operating Manual' was created containing final versions for of the service components and resources in preparation for future feasibility testing.

Table 1. Coding framework: main themes, intervention components, and subthemes.

Intervention components	Main themes				
	Safety	**Empathy**	**Empowerment**	**Equity**	**Discretion**
Quality criteria & pharmacy specifications	Consultation room safety requirements Additional quality criteria	Approachability of pharmacy setting	Familiarity of pharmacy setting	Accessibility of pharmacy setting	Instructions for discreet positioning of intervention resources Ensure verbal discretion (do not be overheard) Confidentiality
Name of service, logo, and strapline	Logo implies safety and help	Nonjudgemental metaphor	Empowering message of strap line	Recognition that logo may be less relevant to non-English speakers	Discreet metaphor
Marketing materials & strategy	Convey moving person to safety	Trained staff to wear lifeguard badges and be welcoming and empathic	Encouragement for people to reach out and ask for help	Translation into other languages	Requests for no marketing inside pharmacy
Staff training	Identifying signs and risks of SI/DA Triage skills Safeguarding Safety-netting	Active listening Empathy skills Unconditional positive regard	Empowering clients is therapeutic in itself	Equality, diversity and inclusion	Understanding need for discretions and processes to ensure it
Client-flow protocol	Ensure capacity of staff workload Ensure consultation room availability	All staff welcoming, clear discreetly guiding clients to consultation	Use of cue card/ logo on phone—for easy access Both staff- and client-initiated pathways	Choice of the gender of Lifeguard (if possible) Accessibility requirements for consultation room	Discreet process after consultation leaving pharmacy and if return
Consultation guide, referral tool and support cards	Triage tool Safeguarding considerations for client and others Always safety-net Client support cards to take away	Empathy key component of consultation guide	Shared decision making included in the consultation Easy to use colour-coded flowchart and mnemonic format of consultation guide	Consideration of any particular requirements in referral	Explain discretion policy to client in consultation
Staff support	Staff security process for the consultation room Helpline for advice	Confidential emotional debrief facility with psychotherapist	Staff paired as 'Lifeguard buddies' for peer support	Training and support available online or in person	Staff support confidential

Discussion

A multi-component pharmacy response intervention for DA or SI was co-developed with 68 participants (36 unique individuals). There was overall support for a pharmacy setting, including both DA and SI and the name 'Lifeguard Pharmacy'. Concerns were raised about discretion and staff capacity. These concerns were accommodated in the design of the components, e.g. the Client Flowchart (outlining how to welcome a client and make arrangements) and the QR code version of the client support card as means of improving discretion.

The use of co-development was a strength by providing views from the people who may be likely to use the intervention and those who may deliver it, thus making it more fit for purpose, but there could be bias towards those who were already in favour of the intervention. The next stage of feasibility testing will be critical for mitigating against any possible biases in the co-development and for providing feasibility data and evidence that would inform a future service delivery and funding model.

A limitation of the study was the limited ethnic diversity of participants and the lack of men participants with lived experience of DA. However, white individuals represent the overwhelming majority of the Lincolnshire population (96.0%) [25], and victims of domestic abuse are predominantly women [2], which makes it challenging to recruit a more diverse study sample. Additionally, there may have been a recruitment bias towards participants who were in favour of a service in pharmacies. However, participants did raise concerns about specific aspects of the pharmacy setting, which were addressed in the service design.

Overall, the service was perceived as creating a lifeline of hope through connection. The need to have a positive hopeful tone, rather than 'abuse' or 'suicide' was a clear directive from the people with lived experience.

Hopelessness and isolation ('thwarted belongingness') are key elements of the interpersonal theory of suicide [13]. Being controlled, isolated and have little hope of change are important in domestic abuse theory [15]. Therefore, a new service that seeks to kindle hope through connection could be effective.

The co-development process provided a strong foundation for the design of this service, and as such it is anticipated that the service may address the practical and psychosocial barriers faced by people experiencing DA or SI, such as stigma and long waiting times [8, 11].

Table 2. Examples of themes informing intervention design.

Intervention component or feature	Participant quotes	Coding
Overall tone of the service	'The hopelessness and worthlessness … that's quite predominant for me… the real hopelessness of life and then not being able to access something… and not feeling worthy enough to, maybe, get help'—Participant 2 FG1	Overarching theme—hope
Checklist of quality criteria and specifications for the pharmacy	'If they [supervised consumption clients] come in daily… a lot of that with drug addicts, they come in together. Especially when it's controlled, "Why are you going on your own?" Like they come in together, and a lot of the time they go into the room together. So, you've got to have a rule in place, a sign-up saying, "Everybody needs to be on their own in the room, drinking it, because it's hard for the staff to supervise you and watch both of you at the same time." For everybody you've got to do it, not just the person who is asking for help. Or just women. It's got to be a rule for everybody, so it wouldn't look obvious, because you've made that rule for everybody. ' Participant interview 1 (lived experience)	Safety/pharmacy specifications, additional quality criteria
The name of the service, logo and strapline	'Yeah, it [suicidal thoughts] would just drown them, yeah. So, that idea of water and that fighting against the tide is such a powerful thing. […] You [the staff member] need to take their weight on. Maybe not permanently but for the time being. While you are both there, together, take the weight on and pull them back.' Participant 3, Focus Group 1 (lived experience)	Safety/name of service, logo implies safety and help
Marketing materials and strategy	'That [an image of a big wave in the shape of a hand about to crush a person] reminds me of a domestic abuse sort of ad, that somebody is helpless and then there's a big hand coming to hurt them, and i.e. like it's looming. I don't know whether for this kind of project, personally, whether, if you were going to use imagery to promote it, it would be better to use imagery focused around helping that person. So, if there was a person in the water but then a person holding out a life thing…' Participant 4 (lived experience) Focus Group 2	Safety/marketing materials, convey moving person to safety
Training package for pharmacy staff	'It's very important if you reach out for help that you know that the person that you're talking to is compassionate and empathetic and actually really cares. Because I think it's almost, it can be more damaging to reach out to somebody who isn't those things, than to not reach out at all.' Participant 1 (lived experience), Workshop 1.	Staff training/empathy, empathy skills & unconditional positive regard
Protocol for guiding the client journey into and out of the consultation	"…if you are struggling with your mental health, you've already got so much going on and you just want a really streamlined, "I'd like to speak to a pharmacist, like a lifeguard pharmacist," or, "Okay, there's a thing there. It says, 'Pick up the card and hand that in.'" Like it needs to be quite simple, while being explicit, on, "Here are your options." Participant 3 (lived experience), Focus Group 1—referring to the "request cue card".	Empowerment/client-flow protocol, use of cue card
Consultation guide, referral tool and support cards	'[…] pharmacy support staff are trained with a sort of mnemonic approach to gathering information from patients and it does make me wonder if there is a place for developing a similar opening set of questions that could be used […] because I think it would give the staff confidence in having those conversations if they've got some questions to ask rather than having to think on their feet about it so much.' Participant 2 (pharmacy staff) Workshop 1	Empowerment/consultation guide, easy-to-use flowchart
Support package for staff	'Yeah. I think what [name of participant] brought up was really good with the [name of service] and doing debriefs, formally and informally would be a good idea. So, there's that sense of community within the pharmacy, and there's that sense of support between each other. But there's also the option to see the [psychotherapist].' Participant 5 (pharmacy staff) Workshop 2	Empathy/staff support, emotional debrief & empowerment/staff support, lifeguard buddies

Community pharmacies in England are under threat and closing due to financial pressures despite providing increased clinical services [17, 26, 27]. This proposed service adds evidence for the potential of pharmacies in a new, more extensive role of providing support to people experiencing DA/SI. Furthermore, it highlights the value of services being delivered by teams embedded within communities. Indeed, community pharmacies are often located in areas of greatest socio-economic need, which is referred to as the 'positive pharmacy care law' [28], providing vital care and support to communities.

Early identification and support for people who might be affected by suicidal behaviours is one of four key pillars of the World Health Organization suicide prevention strategy [29], with healthcare workers and community gatekeepers identified as capacity-building priorities. Community pharmacy teams likely meet both these definitions. This study complements the 'Ask for ANI' initiative [21] by identifying the additional need for embedded local referral pathways, more extensive staff training; formalized staff support, a structured consultation guide, client support resources and a protocol for welcoming clients, making arrangements, and safety criteria within the pharmacy. Further research is required to test the feasibility and effectiveness of this proposed service.

The emphasis by people with lived experience on the tone of the proposed service as conveying hope and the choice of a non-medicalized name has implications for both policy and practice. It is recommended that public health initiatives are framed in an empowering and non-threatening manner so as to engage with the intended recipients and lower access barriers.

Conclusions

The findings supported the concept of this pharmacy-based response service for people experiencing domestic abuse or suicidal ideation. The co-development process enabled the intervention components to be designed to meet the needs of people with lived experience and pharmacy teams. As such it

is anticipated that it will be fit for purpose. This study builds on the foundations of the 'Ask for ANI' initiative [21] by adding more extensive training, a consultation guide, referral resources, consideration of safety criteria, and formalized staff support. The proposed 'Lifeguard Pharmacy' service is unique in including both domestic abuse support and suicide prevention in a combined pharmacy service. Overall, the study findings indicate that the co-developed, discreet, and human-centred nature of this service may facilitate more timely and tailored help-seeking among those experiencing domestic abuse or suicidal ideation.

Supplementary data

Supplementary data is available at *International Journal of Pharmacy Practice* online.

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Author contributions

Ana Maria Barcelos: data curation, formal analysis, investigation, original draft writing, manuscript review and editing; Tracey Latham-Green: investigation, project administration, resources, original draft writing, manuscript review and editing; Rebecca Barnes: conceptualization, formal analysis, investigation, methodology, manuscript review and editing; Hayley Gorton: manuscript review and editing; Mark Gussy: conceptualization, supervision; Claire Henderson: conceptualization, supervision, manuscript review and editing; Mahomed Khatri: supervision; Peter Knapp: methodology, funding acquisition, manuscript review and editing; Josie Solomon: conceptualization, formal analysis, investigation, methodology, project administration, funding acquisition, manuscript review, editing and final draft.

Conflict of interest statement

The author(s) declare that there are no conflicts of interest.

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Data availability

Data cannot be shared for ethical/privacy reasons. The data underlying this article cannot be shared publicly due to the sensitive nature of the topic and the risk of identification of participants.

Data access statement

Data was stored on a shared, password-protected channel of a Teams site accessible to all authors until the end of the project.

Open access requirements

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