Article:
Solomon, Josie, Barnes, Rebecca, Maria Barcelos, Ana et al. (2026) Lifeguard Pharmacy - A feasibility trial of a novel pharmacy-based intervention for people experiencing domestic abuse and/or suicidal ideation. Health and Social Care Delivery Research. pp. 1-26. ISSN: 2755-0079

https://doi.org/10.3310/TNFT6414

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Research Article

Lifeguard Pharmacy - A feasibility trial of a novel pharmacy-based intervention for people experiencing domestic abuse and/or suicidal ideation

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Published April 2026
DOI: 10.3310/TNFT6414

Abstract

Background: Domestic abuse and suicidal ideation are highly prevalent in the United Kingdom, often co-occurring. Numerous practical and psychosocial barriers inhibit help-seeking. This study explored whether community pharmacy could offer an accessible setting for a domestic abuse and suicidal ideation response service.

Methods: The design was a randomised cluster feasibility trial. Twelve pharmacies were recruited from one pharmacy organisation, randomised into eight intervention pharmacies and four controls. Thirty-seven pharmacy staff were trained to deliver the Lifeguard Pharmacy intervention, which involved providing a consultation and structured referral or signposting to customers identified as experiencing domestic abuse and/or suicidal ideation. Staff learning from the training was evaluated using the validated Continuing Professional Development reaction questionnaire, analysed using a paired *t*-test. The intervention ran from January to July 2023 and was accompanied by a nested process evaluation consisting of staff focus groups and a multistakeholder final evaluation workshop with a mix of lay, pharmacy staff and representatives from referral organisations. Data were collected on number and category of client contacts from intervention and control pharmacies; descriptive analyses were performed.

Results: After intervention training, pharmacy staff showed statistically significant improvements in their levels of perceived ability, ease and confidence in responding to and referring people in need of help for domestic abuse and suicidal ideation with increased confidence in the ability of other pharmacy staff to support domestic abuse and suicidal ideation. During the intervention period, staff responded to 24 cases in intervention pharmacies: 8 for suicidal ideation, 9 for domestic abuse and 7 for both domestic abuse and suicidal ideation. Of these, 22 were staff-initiated and 2 were client-initiated. Two cases (one suicidal ideation and one domestic abuse) were identified in control pharmacies. Staff participants had a positive perception of the service and its impact on them and their clients. The multistakeholder workshop findings confirmed the feasibility of a staff-initiated response service for both domestic abuse and suicidal ideation in a community pharmacy setting. However, there were challenges marketing and delivering a client-initiated service, and the study was not able to collect all of the information required to inform a future trial.

This article should be referenced as follows:
Solomon J, Barnes R, Barcelos AM, Latham-Green T, Knapp P, Baines D, *et al*. Lifeguard Pharmacy – A feasibility trial of a novel pharmacy-based intervention for people experiencing domestic abuse and/or suicidal ideation [published online ahead of print April 1 2026]. *Health Soc Care Deliv Res* 2026. https://doi.org/10.3310/TNFT6414

Limitations: There were challenges to collecting data and obtaining informed consent from Lifeguard Pharmacy clients, especially when distressed or time-pressured. Consequently, full data sets were only collected from 4 of the 24 people who used the service. All 12 participating pharmacies were located in 1 region of England, hence a future study would need to test implementation across a broader range of settings.
Conclusions: It is feasible to implement a staff-initiated response service for domestic abuse and/or suicidal ideation in selected pharmacies. The combination of staff training, consultation guide, referral tool and client support resources and organisational support empowered staff to proactively identify people experiencing domestic abuse and/or suicidal ideation.
Future work: Further development work would be needed before a client-initiated service could be delivered, and a future implementation study is contingent on finding ways to safely consent and collect data from clients. Some preliminary health economic work was conducted but a full health economic analysis would be needed as part of a future study.
Funding: This article presents independent research funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme as award number NIHR133132.
A plain language summary of this research article is available on the NIHR Journals Library Website https://doi.org/10.3310/TNFT6414.

Background

Domestic abuse (DA) and suicidal ideation (SI) are major public health issues in England and across the wider UK. In year ending March 2022, an estimated 1.7 million women and 699,000 men in England and Wales experienced DA, defined as physical, emotional/psychological, sexual or economic abuse, violent or threatening and/or coercive and controlling behaviour perpetrated by a current or former partner or a family member.[2,3] DA adversely affects a range of health outcomes.[4] The estimated annual cost of DA in the UK is £66B.[5] In 2021, 5583 suicides were registered in England and Wales, three-quarters of which were in men.[6] For both men and women, suicides are most common among 40- to 50-year-olds.[6,7] Each suicide has an estimated economic cost of £1.67M.[8]

Formative public engagement conducted by Josie Solomon (author) on barriers to help-seeking behaviour for DA found high demand for a more informal, drop-in service that would facilitate people's first step to seeking help.[9] Community pharmacies are ideally placed to provide such a service. They provide NHS services to around 1.6 million people a day. Throughout England, over 89% of people have a community pharmacy within a 20-minute walk from home. Within areas of highest deprivation this increases to almost 100%.[10] They are highly accessible by virtue of being a walk-in, no-appointment service with long opening hours.[11] Furthermore, community pharmacies are encouraged to embrace roles as health and well-being hubs beyond traditional medicine supply roles.[12]

The community pharmacy contractual framework in England includes the Pharmacy Quality Scheme (PQS), which requires pharmacy staff to receive safeguarding and suicide prevention training, but this has not yet developed into a formal pharmacy-based suicide prevention service. Community pharmacy responses to DA have progressed further. During the 2020–1 COVID-19 pandemic, the 'Safer Spaces' and 'Ask for ANI' initiatives[13,14] were rapidly implemented in UK pharmacies. Using the code word 'ANI', victims of DA can access support from participating pharmacies to call the police or the National Domestic Abuse Helpline. However, this service has a limited evidence base, is not routinely embedded in local services and does not provide accredited staff training, resources or support. Other studies in the UK[15] and the USA[16] have found that pharmacy staff are willing to support DA victims but require more training and information about onward referral pathways.[15]

Therefore, the aim of this study is to examine the feasibility of a community pharmacy-based response service for people experiencing DA and/or SI. This study is innovative in addressing both DA and SI. The rationale for this is three-fold. Firstly, systematic review evidence[17] and re-analysis of the 2013 Adult Psychiatric Morbidity Survey in England[18] indicate that DA and suicidality often co-occur. Secondly, both issues are difficult to talk about and share a psychological burden of stigma and shame.[19,20] Thirdly, early intervention is critical to ensure safety, improve health and provide access to specialist support.

However, enabling early intervention continues to be a challenge.[21–23]

Methods

The design, scope and resources for the response-service were codeveloped with lived experience and professional stakeholders prior to the feasibility testing phase.[24] The service was named 'Lifeguard Pharmacy' with the strapline of 'Bringing Hope to Life' and accompanying logo of a green and White life-ring (see *Report Supplementary Material 1*). In addition, public acceptability was evaluated in a parallel arm to the feasibility study, consisting of qualitative interviews with pharmacy customers and a public survey[25] and details of pharmacy specification, health economic and cost considerations are reported elsewhere.[26] This paper reports on the main feasibility trial which aimed to deliver the service as a complex intervention in a purposive sample of community pharmacies and collect feasibility data on implementation, intervention usage, acceptability and intervention fidelity (see *Appendix 1*, *Table 3* for overview of study design).

The objectives were:

1. To evaluate the effectiveness of the staff training for the intervention.
2. To evaluate the implementation and usage of the intervention.
3. To evaluate pharmacy staff acceptability towards the intervention.
4. To evaluate intervention fidelity.
5. To identify and evaluate the attitudes of lay people, pharmacy staff and relevant professionals towards the feasibility and future viability of the intervention.

A cluster randomised feasibility trial was designed, clustered at the pharmacy level. This decision was made because it would not have been feasible to run both the Lifeguard Pharmacy service and usual care in the same pharmacy as this would have been confusing for customers and would have caused contamination.

Twelve pharmacies were recruited from one pharmacy organisation in Lincolnshire, a county in the East Midlands region of England. Inclusion criteria were that the pharmacy must have approval from the superintendent pharmacist to participate, must have a private, accessible consultation room and have a functioning working relationship with their local general practitioner (GP) practice (so that referrals to the GP can be made effectively). Exclusion criteria were having insufficient general staffing to meet their opening times obligations; or an inability to recruit a minimum of three staff participants in that pharmacy. The sample size of 12 enabled feasibility to be examined across a range of settings, while being pragmatic about the resources available.

The names and characteristics of 12 pharmacies meeting the inclusion/exclusion criteria were provided by the pharmacy organisation. Pharmacies were then randomised by Lincoln Clinical Trial Unit into eight intervention pharmacies and four control pharmacies, using computer-generated random number allocation. Randomisation was stratified by pharmacy type and setting (matrix of urban/small, urban/large, rural/small and rural/large). There were therefore two intervention pharmacies and one control pharmacy per stratification category, in order to maximise the amount of feasibility data that could be collected from intervention pharmacies (see *Appendix 2*, *Table 4*).

Forty-five staff were recruited but eight withdrew prior to the training and intervention commencement. Thirty-seven staff went on to give informed consent and deliver the Lifeguard Pharmacy intervention (see *Appendix 3*, *Figure 2* for pharmacy and staff participant flow diagram). Inclusion criteria for staff were that they had line management approval to participate, were 18 years old or over and in a patient-facing role in the pharmacy. The service ran for 6 months, from January to July 2023, during which time client data and evaluation data were collected. This consisted of the number of clients assisted per category of DA/SI with subcategorisation for the level of severity as the primary outcome, with secondary outcomes of: organisations referred to, basic client demographics, reasons for choosing to access the service, and length of time of the consultation. Client inclusion criteria were that they were 18 years old or over and experiencing some level of SI or DA.

Health Research Authority research ethics and governance approval was granted on 12 December 2022 for Integrated Research Application System Project ID: 309018/sponsor reference: 112201. The full study protocol can be accessed at www.dev.fundingawards.nihr.ac.uk/award/NIHR133132. The feasibility study is also reported on in an earlier pre-print.[1]

Delivery of the intervention (objectives 1, 2 and 4)

The intervention involved training community pharmacy staff participants ('Lifeguards') to respond to any clients experiencing either SI and/or DA. Consultations could be (1) client-initiated, through handing the cue card either physically or on their phone, or by asking directly; (2) staff-initiated, due to recognition of prompts for help. The

flow of clients into and out of the consultation room was specified by a 'Client Flow Chart'. A consultation guide was used which contained key exploratory questions, followed by shared decision making around plans for signposting or referral, based on categories of severity and urgency as follows: level 1 – 'assistance required', level 2 – 'action required' or level 3 – 'alert emergency service', and finally safety-netting by supplying the client with a discreet, relevant SI and or DA support card and explanation. Control pharmacies delivered usual care which was to manage any instances of SI or DA through their usual safeguarding policy.

Intervention data collection and analysis

The staff participants (known as 'Lifeguards') were required to explain the study to clients and seek informed consent. There were four sections of data, each for different purposes, consent and storage considerations (see further details in *Report Supplementary Material 1*). The control pharmacies were required to keep a log of the number of encounters they had with customers/patients that involved SI and/or DA. These data were entered on to a database created using Castor EDC (New York, NY, USA).[27] The research team visited each intervention pharmacy monthly to collect data and monitor fidelity, including checking on staff well-being and ensuring adherence to safe intervention delivery.

Nested process evaluation (objectives 3 and 5)

Staff participant qualitative focus groups

A topic guide was developed using the Theoretical Framework for Acceptability of Healthcare Interventions[28] (see *Report Supplementary Material 1*). One in-person focus group (n = 4) was held at the University of Lincoln in April 2023. Two online focus groups (with breakout rooms) were hosted on Microsoft Teams (Microsoft Corporation, Redmond, WA, USA) in May and April 2023 (total n = 23). The groups were led by combinations of Josie Solomon, Rebecca Barnes and Ana Maria Barcelos. Participants were encouraged to raise additional issues, including negative feedback, or minority views.

All focus groups were audio-recorded, transcribed, anonymised and coded using QSR NVivo 11 (QSR International, Warrington, UK). One transcript was independently coded by two researchers (Rebecca Barnes and Ana Maria Barcelos), to develop a coding tree, which was added to as coding progressed. Framework Analysis was used because of its capacity to accommodate the numerous deductive codes from the feasibility objectives, while retaining the flexibility to add inductively identified codes.[29]

Multistakeholder feasibility workshop

The workshop was held at the University of Lincoln in June 2023. A topic guide and discussion sheet were developed using the Consolidated Framework for Implementation Research[30] to assess the perspectives of lay, pharmacy and wider professional stakeholders on the feasibility of the service. Presentations were given on the study findings, followed by discussion in six breakout groups, each led by a researcher. The discussion sheets (see *Report Supplementary Material 1*) asked key questions about participants' views on the scope, setting, means of client access and record-keeping aspects of the intervention. Each participant recorded their answers on the discussion sheet. Participants were encouraged to state their own views and not feel pressurised to agree with others. Quantitative response data were analysed using descriptive statistics and free-text comments were analysed qualitatively using thematic coding via QSR NVivo 11.

Patient and public involvement

Public perspectives have been central to the delivery of this study. A public coinvestigator joined the study at the pre-award stage and brought a breadth of relevant lived experience. He acted as a conduit between the Lifeguard Insight Panel (LIP) [the patient and public involvement (PPI) group] and study team and steering group meetings, and also attended the pharmacy staff training. The LIP (coordinated by PPI lead, Rebecca Barnes) included seven members. Members had diverse protected characteristics and lived experience, including of mental ill health, DA and bereavement by suicide. The panel met bimonthly and attended the in-person feasibility evaluation workshop. They helped to shape and sense-check each stage of the study, inputting into intervention design, study materials and the dissemination strategy. Members were paid for their time, were provided with an induction to PPI and training about feasibility studies, and received a Lifeguard Pharmacy T-shirt as an end-of-project memento.

Equality, diversity and inclusion

Equality, diversity and inclusion is integral to this study, with the rationale for developing an intervention in the community pharmacy setting being to widen and expedite access to support for all people experiencing DA and/or SI. 'Equity' was one of the pillars of the intervention codevelopment work[24] and training for pharmacy staff included the risk factors for DA and SI among different

demographic group, barriers to help-seeking faced by different groups and the importance of inclusive language.

The 12 participating community pharmacies were selected purposively to ensure different geographies (e.g. urban, suburban and rural) and levels of socioeconomic deprivation. Although Lincolnshire is less ethnically diverse than the average England and Wales population, there is a sizeable White Eastern European population.

Promotional materials were designed to be dyslexia-friendly and participant information sheets and consent forms were translated into languages reflecting the ethnic composition of Lincolnshire. There has been a choice of online and face-to-face formats for data collection activities and staff training, to maximise flexibility and accessibility.

Ethical approval to collect data about the protected characteristics of pharmacy staff delivering the intervention was refused. We included equality, diversity and inclusion characteristics (gender, age, ethnicity) in our data collection instruments for Lifeguard Pharmacy clients, but these questions were rarely asked due to the wider challenges of data collection for this type of intervention. Of the four clients who consented and provided complete data sets, all were women. Pharmacy staff reported that the majority of the remaining 20 clients were White British women, and a quarter were receiving opioid substitution treatment, which is an under-served group.

Further development work and research is needed to ensure that the Lifeguard Pharmacy is able to engage, and meet the needs of, men, people from different ethnic groups and younger people.

Results

Intervention

Pharmacy and pharmacy staff recruitment

Eight intervention and four control pharmacies were recruited using stratification for rural or urban setting and small or large pharmacy (based on footfall), across a range of Indices of Multiple Deprivation. However, two of the pharmacies that were originally randomised to be intervention pharmacies were moved to controls, due to insufficient staffing levels. Subsequently, two pharmacies in the control group requested to become intervention pharmacies. It was found that pharmacies had strong preferences to be either an intervention or control based on their perceived need for the service in their area. These changes occurred during the period of staff training prior to the launch of the intervention (see *Appendix 2* for details of final allocation of pharmacies).

Initially 45 patient-facing staff were recruited from the intervention pharmacies, but 8 withdrew before the start of the intervention due to failure to complete the training, leaving 37 staff who successfully completed the training and continued with the study. These numbers comprised 11 pharmacists, 2 trainee pharmacists, 3 pharmacy technicians, 17 dispensers and 3 counter assistants (1 participant did not provide details of role title on the questionnaire). Each staff participant was given a unique study ID code. There were four staff participants in the controls.

Seven out of the eight intervention pharmacies (87.5%) remained in the study for the 6 months' duration of the intervention period. One pharmacy was withdrawn from the study in month 5, because the number of trained 'Lifeguard' staff had fallen below the minimum to ensure adequate coverage. Because of this, the total number of intervention staff participants at the end of the intervention was 33 (see *Appendix 3* for a flow chart of pharmacy and staff participant progression).

Staff training results

All 37 staff participants that attended the training completed the first set of 2 Continuing Professional Development (CPD) reaction questionnaires[31] before the training and 56.8% (21 out of 37) completed the second DA questionnaire and 62.2% (23 out of 37) completed the second SI questionnaire after the training staff were individually e-mailed the questionnaires in order to reduce any bias that might have occurred from completing them at the training sessions. Training was mixed, and not cluster-specific.

Both before and after the training, staff reported high levels of good intent (questions 1, 4, 7, 8) to support people with both DA and SI. They agreed that effective response or referral by pharmacy staff is both acceptable (Q10) and beneficial (Q12). Compared to before the training, afterwards staff showed statistically significant improvements in their levels of perceived ability, ease and confidence in responding to and referring people in need of help for SI and DA (questions 3, 5, 11, see *Table 1*).

Intervention implementation results

The service was successfully implemented into the intervention pharmacies. The staff participants (Lifeguards) consistently fed back at monthly site visits that they felt

TABLE 1 Statistically significant results from participant responses to CPD reaction questionnaires for DA and SI

Selected questions from CPD reaction questionnaire for DA/SI[a]		Mean score before	Mean score after	SD	95% CI (lower, upper)	*t*-test score	df	Paired *t*-test 2-sided *p*-value
Q3. I am confident that I could effectively respond and refer (where appropriate) people in danger of DA/SI if I wanted to: *1 = strongly disagree, 7 = strongly agree*	DA	4.9	6	2.064	−2.130 to −0.251	−2.643	20	0.016
	SI	4.9	6.1	1.999	−2.081 to −0.353	−2.921	22	0.008
Q5. For me, effectively responding and referring (where appropriate) people in danger of DA/SI would be: *1 = extremely difficult, 7 = extremely easy*	DA	3.9	5	1.091	−1.591 to −0.599	−4.6	20	< 0.001
	SI	3.9	5	1.296	−1.604 to −0.483	−3.861	22	0.001
Q11. I have the ability to effectively respond and refer (where appropriate) people in danger of DA/SI: *1 = strongly disagree, 7 = strongly agree*	DA	4.7	5.9	1.887	−2.050 to −0.331	−2.891	20	0.009
	SI	5.1	6	1.800	−1.605 to −0.048	−2.201	22	0.039

CI, confidence interval; df, degrees of freedom; SD, standard deviation.
a see *Appendix 4*, *Table 5* for full questionnaire results for all questions.

Notes
Staff's opinion of the ability of other pharmacy staff to support DA (questions 2,6,9) and SI seemed to increase (questions 2,9). Overall, the mean scores obtained were all at or above the mid-point for each response scale and show a preparedness and perceived capability towards responding and referring for both issues.

more confident and empowered to initiate conversations with customers and identify signs of DA/SI. They approached many clients whom they encountered through the normal course of their care, who appeared to be showing signs that could indicate they were experiencing DA and/or SI. Staff reported that they found it cumbersome and contrary to the flow of normal pharmacy activities to ask clients for written consent for the research study, particularly because they may not know the reason for a person's distress at the point at which they approached them, and therefore they could not determine whether the client met the eligibility criteria of experiencing SI and/or DA. This limited the ability of the staff to formally recruit the clients as study participants.

Domestic abuse and suicidal ideation cases in intervention and control pharmacies

Four client participants were fully consented for the research study and the full set of data were collected from them. Since the staff had also been recruited as participants it was possible to collect data on their experiences of using what they learned from their training and their use of the resources in the staff focus groups and field notes from the site visits. Staff found interactions with clients about SI or DA memorable enabling them to describe their experiences in the focus groups. Through these combined data, it was possible to collate basic information for a further 20 cases (*Table 2*), and more general feedback on 33 interactions for other issues. Cases were not evenly distributed among the 8 pharmacies: 3 pharmacies reported no cases, while 1 large pharmacy in a more deprived area reported 11 of the 24 cases.

Results from total cases

Eight cases were for SI, nine for DA and seven were for both DA and SI. Cases were generally at the action or assistance levels (37.5% and 25%, respectively), with only one case (4.2%) at the highest level of alert. It was not possible to determine the level of severity/urgency from the data for seven of the cases. Most clients were female (83.3%). A quarter of all cases were known to involve drugs and/or alcohol misuse.

Of the 24 cases, 22 were staff-initiated and 2 were client-initiated interactions. The cue card was used by one client to initiate a request for a consultation, and this was a female DA case. Eight clients (24%) returned to the pharmacy to speak to staff on at least one occasion after their initial consultation.

Staff reported that they referred clients to: GPs, the mental health crisis team, DA services, the Police, other mental health services, sexual violence services, crisis café, bereavement support charities and other local community support organisations.

Results from the full data set cases

Out of the four cases with full data, one consultation was client-initiated and three were staff-initiated. One consultation was conducted by a pharmacist, one by a technician and the other two were conducted by dispensers. Two of the consultations took 15–30 minutes, one took 30–60 minutes, and a time period was not recorded for the other consultation.

TABLE 2 Details of client cases in intervention pharmacies

	Number of cases collated from staff reports	Number of cases with complete data set	Total number of cases in intervention pharmacies
SI: level 1 – assistance	3	0	3
SI: level 2 – action	4	0	4
SI: level 3 – alert	0	0	0
SI: category not known	1	0	1
Total SI	8 (40%)	0	8 (33.3%)
	Male × 3, female × 4, not known × 1	N/A	Male × 3, female × 4, not known × 1
DA: level 1 – assistance	1	1	2
DA: level 2 –action	2	1	3
DA: level 3 – alert	1	0	1
DA: category not known	3	0	3
Total DA	7 (35%)	2 (50%)	9 (31.5%)
	All female	All female	All female
Both SI and DA: level 1 – assistance	1	1	2
Both SI and DA: level 2 – action	1	1	2
Both SI and DA: level 3 – alert	0	0	0
Both SI and DA: category not known	3	0	3
Total for both SI and DA	5 (25%)	2 (50%)	7 (29.1%)
	All female	All female	All female
Total	20	4	24
	Male × 3, female × 16, ages not known × 1	All female and White British Ages: 25- to 34-year-olds × 1, 55- to 64-year-olds × 2, over 65 years × 1	Male × 3, female × 20, ages not known × 1

All four clients reported that their visit was opportunistic rather than being planned and the stated reasons for using a pharmacy service were: familiarity with staff, rapport with staff, it being a walk-in no appointment service, it being a familiar environment, and it being an in-person service. All agreed to give their personal details. In terms of a future study and whether they would hypothetically be willing to be followed up, one participant said she would definitely be unwilling and three were unsure.

Domestic abuse was involved in all of these four cases, but none of these clients had previously accessed any DA services in the last 3 months. One had accessed mental health services and one had accessed the drugs and alcohol service. Referrals from these four cases were made to DA services (n = 2), GP (n = 2), drugs and alcohol service (n = 1), the crisis team (n = 1) and other charity support services (n = 2). One of the clients was referred to four relevant services.

Results from other customer interactions

Staff reported using their Lifeguard training to provide client support cards and/or signposting in at least 33 additional instances for issues outside of the intervention scope, including for relatives of people experiencing SI, general distress, bereavement, loneliness and other mental health issues.

Control pharmacies

There were two reports of cases in control pharmacies. These occurred in the same pharmacy (1 × DA and 1 × SI). The staff member who identified the cases had

been Lifeguard trained and moved to work in a control pharmacy, so the identification of these cases is likely due to contamination.

Staff support uptake results

Optional and confidential sessions with a psychotherapist were made available for staff in case they wished to debrief about any client consultations. Three staff participants had one support meeting and one had two meetings.

Nested process evaluation

Staff focus groups results

In total, 27 Lifeguards participated, with representation from all 8 intervention pharmacies. Analysis identified 4 main overarching categories of themes of Setting, Impact, Staff Experience and Improvements with 14 subthemes (*Figure 1*).

For the purposes of this analysis a distinction is made between 'customers' who are the people generally using pharmacy services and the 'clients' who are the people that the Lifeguards specifically used Lifeguard resources and had consultations with. A further distinction is made between 'cases' which were cases of clients that met the study criteria of experiencing either DA and/or SI and 'interactions' which were Lifeguards used their learning, skills and Lifeguard support materials for other issues.

Theme 1: impact

Participants discussed their perceptions of the impact of the service and described consultations they had conducted.

Overall value of the service All participants agreed that the service was of overall benefit. They had applied their Lifeguard training to their interactions with customers and found the Lifeguard resources invaluable in giving them a supportive structure to delve deeper and enquire about possible SI and/or DA in those interactions (see quote 1 in *Appendix 5*, *Table 6*). Connections made through these interactions often built over time, with customers returning to continue conversations (see quote 2 in *Appendix 5*, *Table 6*).

Relationship with customers Staff often had very good relationships with their customers, particularly 'regulars' that they knew well. This facilitated identification of signs of distress if somebody looked 'slightly off'. Staff reported seeing clearly what had previously been hiding in plain sight. For example, realising that a woman, whose daily methadone supplies were often collected by her partner, was not receiving them and was experiencing DA. Several staff reported that having Lifeguard consultations with their customers who were already 'regulars' created a bond and improved their relationship with them (see quote 3 in *Appendix 5*, *Table 6*).

Overcoming access barriers Staff spoke about the perceived barriers that clients face in asking for help, such as fear of prejudice and judgement from others and the client's own experiences of shame or pride about asking for help (see quote 4 in *Appendix 5*, *Table 6*). Even when a connection had been made, there could be reluctance to being referred due to fear of possible repercussions such as social services becoming involved. Clients experiencing DA were often in a hurry because their partner was waiting outside. Staff found the Quick Response (QR) code client support cards invaluable in these reluctant or hurried situations.

Substance use disorder Staff spoke extensively about customers who were being treated for substance use disorder. It was notable that staff often had a particularly good relationship with these clients and that they

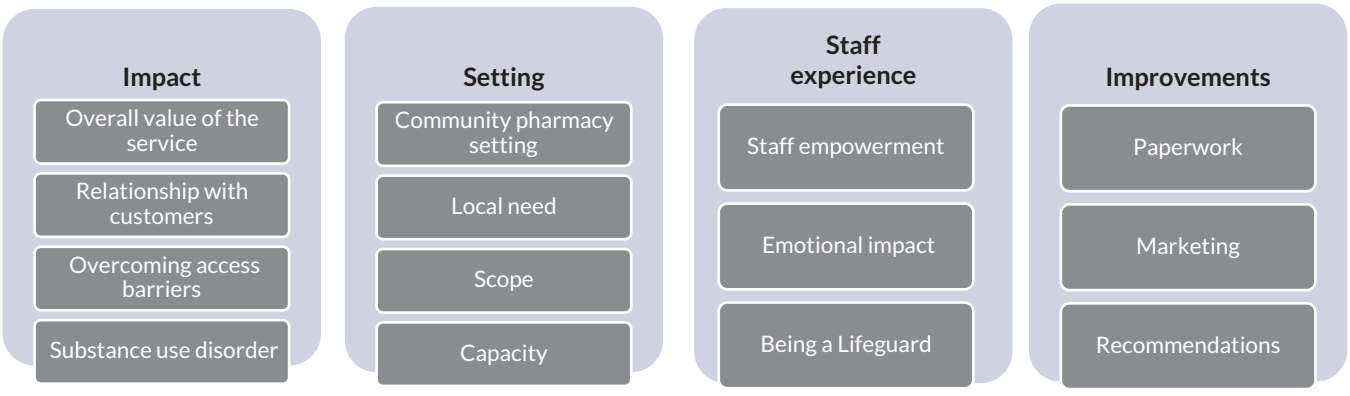

FIGURE 1 Staff focus group themes and subthemes.

recognised that these customers had often had incredibly difficult lives and needed extra attention (see quote 5 in *Appendix 5*, *Table 6*).

Theme 2: setting

Staff considered community pharmacy to be a suitable setting if there was local need, flexibility around the scope of the service and sufficient capacity to deliver the service effectively.

Community pharmacy setting Being drop-in, easily accessible and a neutral environment were considered to be facilitators for help-seeking behaviour (see quote 6 in *Appendix 5*, *Table 6*).

A key enabler was not only that customers could 'drop-in', but that they could also 'drop-out', in that they could leave when they wanted. This facilitated opportunistic conversations for clients in a hurry that may not have been possible in an appointment-based service.

Most cases were identified opportunistically while doing another service or were connected to issues with medicines. Having good links with local GP practices was advantageous (see quote 7 in *Appendix 5*, *Table 6*).

Local need Some pharmacies had requested to be intervention pharmacies because they perceived there to be a local need due to encounters with previous cases of SI. In rural areas, pharmacy services were considered to be more essential because of a lack of other services. However, a counter consideration was the concern that clients may not ask for help from the staff who themselves lived in the small community (see quote 8 in *Appendix 5*, *Table 6*).

Scope Participants described that community pharmacy interactions were completely unfiltered, unpredictable and difficult to fit into neat diagnosable categories. This made it challenging to identify if clients met the study eligibility criteria, for example, whether somebody is currently suicidal and distinguishing between passive and active suicidality (see quote 9 in *Appendix 5*, *Table 6*). Similarly, there were discussions around what counts as DA, for example, does it include abuse from carers, or from gang members.

Capacity The Lifeguard service increased the responsibilities on staff, but also increased their capacity as individuals and a team to handle difficult conversations. The consensus around the length of time needed for a Lifeguard consultation was a minimum of 15 minutes, but ideally 20–30 minutes. It was considered that if you have the correct staffing levels, 30 minutes should be possible (see quote 10 in *Appendix 5*, *Table 6*). Although conducting Lifeguard consultations placed extra time burdens on staff, it was recognised that these encounters can happen anyway; having the structured process Lifeguard Pharmacy in place may actually save time and reduce stress, because staff know how to respond, and enables pharmacists to delegate to others (see quote 11 in *Appendix 5*, *Table 6*).

Theme 3: staff experience

Staff were empowered and felt a sense of duty and pride in being a Lifeguard, but there was a risk of negative emotional impact.

Staff empowerment Staff felt enabled to identify and intervene in suspected cases of SI and/or DA. Having clear referral/signposting pathways, support cards and QR code cards increased confidence and ability because staff now had the tools to refer and support clients (see quote 12 in *Appendix 5*, *Table 6*).

Emotional impact Concerns were expressed about the service blurring into counselling and being a crutch for people, with fears of it being emotionally draining and time consuming. It was also noted that DA and SI conversations could be triggering for staff (see quote 13 in *Appendix 5*, *Table 6*).

Being a Lifeguard It was evident in the way participants spoke that being a Lifeguard had a clear identity, that came with a definite sense of duty, a sense of satisfaction for helping people and also feeling proud of those achievements (see quote 14 in *Appendix 5*, *Table 6*). The key success of the project was seen as being that it has left a legacy of trained and empowered staff (see quote 15 in *Appendix 5*, *Table 6*).

Theme 4: improvements

Suggestions were made for improvements to the paperwork and marketing. Staff were keen that the service should continue and be implemented more widely, and they made recommendations for improvements.

Paperwork Staff participants all reported that they found the study paperwork overwhelming and burdensome. They found it difficult to ask for written consent because most cases were staff initiated and it seemed awkward and disruptive to the flow of a sensitive conversation to ask for consent during a conversation that had arisen opportunistically (see quote 16 in *Appendix 5*, *Table 6*).

Staff reported that some clients found the volume, language and formality of the participant information sheets and consent forms was off-putting.

Marketing Staff participants stated that the Lifeguard Pharmacy resonated with them, but they thought the service had not been sufficiently advertised to the public, and that the marketing was too discreet. They thought that this may account for the lack of client-initiated cases (see quote 17 in *Appendix 5*, *Table 6*).

Recommendations Staff suggested ideas to increase access to the service, which included having referrals into Lifeguard Pharmacy from other organisations, and having an app that clients could use to make an appointment for a Lifeguard consultation. It was noted that the first few months of taking mental health medication is a critical time for patients. This would be a valuable time for Lifeguards to offer support and screen for risk of harm from SI and/or DA (see quote 18 in *Appendix 5*, *Table 6*).

Feasibility workshop results

The workshop included 42 participants, comprising 14 Lifeguards from 6 of the 8 intervention pharmacies, 11 members of the research team, 7 coinvestigators, 6 members of the PPI panel, 2 senior members of staff from the pharmacy organisation and 3 representatives from local mental health organisations (NHS and charity). Two Lifeguards from one pharmacy attended a separate online with two research facilitators (Josie Solomon and Ana Maria Barcelos) and one pharmacy was not represented at either event. Of the 42 participants, 39 completed feedback forms covering the topics of scope, setting, client access and record keeping (see *Appendix 6* for full results).

Topic 1: scope

The responses to questions about the scope of the service (see *Appendix 6*, *Table 7*) showed that 94.9% of participants strongly supported the inclusion of both suicidal feelings and DA in the Lifeguard service, with a majority also agreeing that it could be extended to include other mental health difficulties (79.5%), drugs and alcohol issues (53.9%) and sexual assault (61.5%), as well as a cover a wider remit of health and social care problems (59.0%). These issues were perceived as interconnected with mental health issues commonly seen in pharmacies.

Topic 2: setting

The responses to questions about the setting of the service (see *Appendix 6*, *Table 8*) show that 97.4% of participants considered the pharmacy setting to be a suitable setting for the service with pharmacies' high accessibility, safety and friendly staff being pointed out as the main benefits. It was generally agreed (by 69.2% of participants) that Lifeguard Pharmacy could be a national service for all pharmacies that chose to participate. However, this was qualified by the response of 76.9% of participants who agreed that only pharmacies that are motivated, have enough trained lifeguards, adequate staffing levels and meet specific quality criteria should be accepted. Participants thought that all patient-facing staff should be accepted as Lifeguards not just pharmacists (74.4% agreed). In free-text comments several participants emphasised that there are other characteristics more important than the job role of the candidate, such as being motivated to help others, empathic and approachable.

In relation to the method of delivery of the Lifeguard training, it was considered that it should be facilitator-led (rather than pre-recorded) as interactivity was considered to be essential (only one participant agreed it should be online without a live facilitator). While face-to-face training was preferred 76.9% of participants, the online method was still considered to be an indispensable alternative by 33.3% of participants, citing accessibility and inclusivity.

Topic 3: client access

Participant responses to questions about how clients should access the service (see *Appendix 6*, *Table 9*) found that the vast majority of participants (82.1%) thought that the service should not be staff-initiated only. Free-text comments cited concerns over selection bias and cases being missed if the service was staff-initiated only. Participants thought that it was possible to offer a client-initiated service in the right conditions (89.7% agreed). This view is contrary to the findings of the pilot in which the majority of cases were staff-initiated. The low uptake of client-initiated cases was attributed to ineffective marketing. Most participants (71.8%) thought that the name Lifeguard Pharmacy should be kept but that the marketing should be more explicit (66.7%).

Topic 4: record keeping

In response to questions about obtaining consent and record keeping (see *Appendix 6*, *Table 10*), the majority of participants (64.1%) thought that it would not be necessary to obtain written consent from clients if the Lifeguard Pharmacy became a standard service. Free-text comments indicated that obtaining written consent and collecting demographic data were significant barriers to delivering the service. There was no clear agreement about the preferred consultation data collection method nor around the possibility of obtaining additional demographic

and views and preferences data from clients. A quarter of participants (25.6%) were unsure whether it was advisable to follow-up clients to see how they had progressed.

Discussion

Community pharmacy was considered an ideal setting for an SI/DA response service due to its neutral, accessible healthcare environment in which customers can enter and leave at will. The study found that it is feasible for pharmacy staff to identify, intervene and signpost or refer clients experiencing a range of levels of SI and/or DA to appropriate support organisations in a timely manner, if staff are provided with appropriate training, a consultation guide, referral systems and client support resources. The trained staff ('Lifeguards') embraced the role with a sense of duty, satisfaction and pride. They reported that they had good relationships with their regular customers and that Lifeguard consultations further strengthened them.

The Lifeguard Pharmacy service worked well as a staff-initiated response service. The staff training and comprehensive manual of codeveloped service resources motivated and enabled pharmacy staff to opportunistically identify people experiencing SI and/or DA during their normal pharmacy activities. Because only 2 of the 24 cases of DA and/or SI identified were client-initiated, this indicates that further work is needed to determine whether a client-initiated service is feasible. Insufficient and unclear marketing was a likely barrier, and it was also recognised that a client-initiated service could be challenging to manage in busy pharmacies.

Across all components of the study, there was strong support for Lifeguard Pharmacy to continue to focus on both DA and SI, but for its service scope to potentially expand to include other needs, particularly other mental health conditions. Several identified clients were receiving drug and alcohol support from pharmacies and were recognised as an under-served client group that could, and did, benefit from additional support.

An important part of the intervention that should be taken forward in future implementation was the optional and confidential debrief facility with a psychotherapist for emotional support and the pharmacy specification criteria that ensure that service delivery is safe for clients and staff. Safe delivery is contingent on maintaining sufficient numbers of adequately trained staff to absorb flux in staff changes and working hours, and availability of a private consultation room. There are risks to both client and staff well-being if standards are compromised. Funding needs to be carefully considered to ensure that pharmacies are resourced to deliver the service safely and effectively.[26]

It is notable that during a time where community pharmacy capacity in England was particularly stretched,[32] staff were willing to support people with DA and/or SI. They recognised a need for formal SI support in pharmacy, as exemplified by the pharmacy that requested to be in the intervention arm. There are parallels with the Bloom programme in Canada[33] and AMPLIPHY study in England,[34] which described how consultations about mental health medication often resulted in wider discussions that were unrelated to medication and the disclosure of other problematic life experiences (e.g. bereavement, abuse). The role of Lifeguards in supportive signposting to a wide variety of public and third sector organisations has parallels with other schemes, such as Healthy Living Champions.[35]

Staff participants and stakeholders hoped that the service would continue. They could envisage national roll-out to pharmacies that have been accredited as being suitable. Having a motivated pharmacy team, a supportive organisational culture, and adequate staffing levels were considered to be essential for successful delivery of the service. This resonates with other studies in which trusting relationships between staff and management, and prioritisation of improvement, including commitment to change, have been shown to improve community pharmacy practice.[36] Key features of the service that were considered to be beneficial were the consultation guide and referral resources, including the client support resources which could be accessed via a discreet QR code. The need for well-defined referral pathways to support people with suicide prevention has previously been suggested in England.[37] Understanding local provision was similarly essential in AMPLIPHY and added to staff confidence in potentially challenging conversations.[34]

Limitations of the study

Despite strong engagement and positive feedback from pharmacy staff, and the willingness of members of the public to engage with the service, there were significant challenges to collecting the evidence needed to inform a future trial. Data on service usage are based on a relatively small number of cases (n = 24) over a 6-month period. Staff were not asked to record how many customers were approached but were then deemed not to require the Lifeguard Pharmacy service, or declined to engage in conversations. In hindsight, this information would be useful to inform a future sample size calculation.

Informed consent was difficult to obtain from people who were in distress or very limited on time, and full data sets were only collected from 4 of the 24 participants. Pharmacy staff found informed consent much easier to collect for client-initiated cases, but where staff had initiated conversations with people in distress, they felt that it seemed disruptive to discuss the study with clients and found the paperwork onerous. Similar challenges in recruitment to a community pharmacy trial for brief psychological intervention for depression were found in the CHEMIST study in the North-East of England.[38] Verbal consent would better align with consent for other community pharmacy services,[39] as was also suggested by PPI members. Additionally, verbal consent has been utilised in previous studies where it has been recognised that signed consent form use can be intrusive and unnecessary.[40]

It has not been possible to calculate the intra-cluster correlation coefficient to inform a future sample size calculation, but this could potentially be inferred from studies of comparable community pharmacy interventions. The most appropriate primary outcome needs to be determined too, given the likely challenges to following Lifeguard Pharmacy clients up, especially given the safety implications with DA and given learning from comparable studies.[34] These issues need to be addressed before a larger study, involving a broader range of settings, can be conducted to establish the delivery potential and effectiveness of this intervention.

The CPD reaction questionnaire was adapted for the purpose of this study and so no prior sample size calculation could be undertaken. Despite multiple prompts, only 21 and 23 of the 37 staff members completed the second CPD reaction questionnaire for DA and SI, respectively. It is therefore possible that some null effects on the before-and-after training question items may be due to lack of statistical power, and there is a risk of response bias, given the considerable drop-off between the first and second questionnaires.

Impact of patient and public involvement

The LIP brought valuable public insights to both the design of the Lifeguard Pharmacy intervention and the study design and delivery. Particularly key was that the research team had initially envisioned that Lifeguard Pharmacy would be a purely client-initiated service, but the LIP drew on their lived experiences to caution that people in distress might lack confidence to overtly ask for help. They advised that Lifeguards should be trained to recognise signs of distress and initiate conversations. This was adopted into the intervention protocol and training, and was a critical decision, since the vast majority of Lifeguard consultations were staff-initiated. The LIP also made useful suggestions for how to gain informed consent from people in distress, but this could not be implemented as it was too late in the process to seek an ethics amendment, and the suggested changes are unlikely to have been approved. They will, however, inform the future work that is required to ensure contextually appropriate informed consent processes.

Future work

This study has generated rich and extensive learning, and has highlighted various challenges that need to be addressed before proceeding to a future, larger study to assess effectiveness and implementation. Further work is needed to produce marketing materials that are suitably explicit, but also discrete and sensitive.[41,42] There are challenges to conducting a randomised controlled trial in this area of practice, with the development of safe and sensitive processes for collecting informed consent and outcomes data being particular issues. Learning could be transferred from other rapid or drop-in interventions for people who are time-pressured and/or in distress.

A larger implementation study would be beneficial with a larger sample size, greater variety of demographics and pharmacy organisations and with a longer-term intervention. A future study would also need to include a health economic analysis, which requires either the capacity to follow-up Lifeguard Pharmacy clients, or robust modelling. Codevelopment with a broad range of practice and lived experience stakeholders has been key to the success of this study and should be embedded in future work.

Implications for practice

There is currently no other SI response service in UK pharmacies. Evidence from several high-income countries has shown that pharmacies are places where staff encounter patients with suicidal thoughts and/or behaviours, and they want robust training and referral pathways to support their conversations.[43–47] Through inclusion of the Zero Suicide Alliance training and associated action plan requirements in the 2020–1 PQS, a commitment to the role of pharmacy teams in England was made.[48,49]

A similar commitment, but lack of full process and procedure, exists for DA support in pharmacies in England. Pharmacies participate in the ‘Safe Spaces’ and ‘Ask for ANI’ schemes, which promote pharmacies as safe places where the use of the code name ‘ANI’ can alert staff to the need for help.[14] They involve staff offering the consultation room for people to call either the Police or the National

Domestic Violence Helpline. Lifeguard Pharmacy offers expansion of this model through robust pharmacy-specific, facilitator-led training, with consultation and referral support materials for staff and patients, and with debrief and buddy support for staff.

The findings from this study lay foundations for the provision of a new service, subject to the aforementioned caveats about the importance of a commitment to financially resource appropriate staffing levels, support for staff and consultation room availability to ensure safe service delivery. There may be the potential to align Lifeguard Pharmacy with the New Medicines Service in England, which from October 2025 is expanding to include antidepressants,[50] as has been long called for.[51]

Building and maintaining relationships with external stakeholders is key to expanding the implementation of this intervention. Building a positive and trustworthy reputation could be managed through an independent accreditation role, external to the pharmacy organisation, which would deliver the training and monitor safety standards and staffing levels. This would ensure intervention fidelity, quality standards and appropriate staff support.

Conclusions

This study indicated that it is feasible to implement a staff-initiated response service for DA and/or SI, that is, empowering for staff and could be of benefit to patients. This could provide an accessible avenue for people to access signposting and supported referral for DA and/or SI. To enable this, it would be essential to provide training, staff support, assurances about staffing levels and consultation room availability, in addition to adherence to specified quality criteria in the pharmacy that would ensure that the service is delivered safely and with discretion. Further research is needed to further develop the marketing materials, client consent and data collection processes, before proceeding to test the implementation of the intervention on a larger sample size, with a greater variety of demographics and pharmacy organisations over a longer time period.

Additional information

CRediT contribution statement

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Acknowledgements

All authors read and approved the final manuscript.

The authors thank all the stakeholders for their participation in the study, and the study steering group and LIP for their guidance.

Data-sharing statement

The data sets generated and/or analysed during the current study cannot be shared publicly due to the sensitive nature of the topic and the risk of identification of participants. Further information can be obtained from the corresponding author.

Ethics statement

This study was approved by the North West – Preston NHS Research Ethics Committee (REC number 22/NW/0016, protocol number 21011, IRAS project ID 309018) within the UK Health Research Authority Research Ethics Service on 12 December 2022. All staff participants gave written informed consent to be part of the study.

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Disclosure of interests

Full disclosure of interests: Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/TNFT6414.

Primary conflicts of interest: The authors declare that they have no competing interests.

We endeavour to obtain ICMJE disclosure of interests forms for all named authors. In this case, we have been unable to obtain these forms for every author. Please contact the corresponding author if you have any queries.

Department of Health and Social Care disclaimer

This publication presents independent research commissioned by the National Institute for Health and Care Research (NIHR). The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, MRC, NIHR Coordinating Centre, the Health and Social Care Delivery Research programme or the Department of Health and Social Care.

This article was published based on current knowledge at the time and date of publication. NIHR is committed to being inclusive and will continually monitor best practice and guidance in relation to terminology and language to ensure that we remain relevant to our stakeholders.

Trial registration

This trial is registered as ISRCTN95063724.

Funding

This article presents independent research funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme as award number NIHR133132.

This article reports research award *Responding to people in danger. A development and feasibility study to co-develop a community pharmacy response service for domestic abuse and suicidal ideation*. For more information about this research, please view the award page (www.fundingawards.nihr.ac.uk/award/NIHR133132).

About this article

The contractual start date for this research was in October 2021. This article began editorial review in April 2025 and was accepted for publication in September 2025. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The Health and Social Care Delivery Research editors and publisher have tried to ensure the accuracy of the authors' article and would like to thank the reviewers for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this article.

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List of supplementary material

Report Supplementary Material 1 Study and intervention materials

Supplementary material can be found on the NIHR Journals Library report page (https://doi.org/10.3310/TNFT6414).

Supplementary material has been provided by the authors to support the report, and any files provided at submission will have been seen by peer reviewers, but not extensively reviewed. Any supplementary material provided at a later stage in the process may not have been peer reviewed.

The supplementary materials (which include but are not limited to related publications, patient information leaflets and questionnaires) are provided to support and contextualise the publication. Every effort has been made to obtain the necessary permissions for reproduction, to credit original sources appropriately, and to respect copyright requirements. However, despite our diligence, we acknowledge the possibility of unintentional omissions or errors, and we welcome notifications of any concerns regarding copyright or permissions.

List of abbreviations

CPD	Continuing Professional Development
DA	domestic abuse
GP	general practitioner
LIP	Lifeguard Insight Panel
PPI	patient and public involvement
PQS	Pharmacy Quality Scheme
QR	Quick Response
SI	suicidal ideation

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Appendix 1 Overview of study methods

TABLE 3 Overview of study methods

	Intervention	
	Phase	**Overview**
A	Recruitment of pharmacies	(1) **Organisational consent** – superintendent pharmacist gave written consent to approach pharmacies. The pharmacy organisation was given a token of appreciation payment Pharmacies were recruited from the same pharmacy organisation. They met the criteria of giving a balance of large commercial/small and urban and rural locations over a range of socioeconomic areas (Index of Multiple Deprivation decile) (2) **Stratified sampling** – selection of three pharmacies per category of rural/small pharmacy, rural/large store, urban/small pharmacy, urban/large store, with a spread across different socioeconomic areas (based on deprivation index from Office for National Statistics) (30 **Randomisation** – with stratification by pharmacy type to give two pharmacies from each of the four categories as interventions (total of eight), and one pharmacy from each of the four categories as a control (total of four)
B	Recruitment of staff in pharmacies	(1) **Approach** – all staff that met inclusion criteria given participant information sheet, consent form and explanation of the study (by AMB by phone and follow-on e-mail exchange) (2) **Recruitment** – of a minimum of three members of staff per intervention pharmacies and one per control pharmacy (by AMB). Staff participants in intervention pharmacies consented to research activities: C, D, E, G, H. Support provided (F)
C	Training staff in intervention pharmacies	(1) **Pre-requisite** – completion of the normal training requirement for Suicide Prevention and Safeguarding that are provided for all staff by the pharmacy organisation to fulfil the criteria of the UK. PQS and the organisation's own DA e-learning module that all staff are required to complete[48] (2) **Lifeguard training** – attendance at 6 hours of live facilitator-led training, either as an in-person training event at the University of Lincoln on a Saturday, or 3 × 2-hour evening online events via Microsoft Teams. The training was led by JS, RB and AMB with input from the psychotherapist who was providing emotional support for staff and a person with lived experience. Staff were invited to complete 2 × CPD reaction questionnaires,[31] which is a validated tool (see *Report Supplementary Material 1*). They completed one for SI and one for DA both before and after their training to evaluate the impact of the training. Changes in responses to the before and after CPD reaction questionnaires (one set for SA and one set for DA) were analysed using SPSS software (version 28.0) for paired t-tests (3) **Induction** – engagement in 2 × mock consultations (one for SI and one for DA) in their own pharmacy with a member of the research team (4) **Accreditation** – After successful completion of all training components, staff were awarded a certificate of completion and 'Lifeguard' badge

TABLE 3 Overview of study methods (*continued*)

	Intervention	
	Phase	**Overview**
D	Implementation of the intervention	(1) **Organisational induction** - (JS) led an induction meeting with senior staff in the organisation and staff rota manager. The data protection, marketing department, safeguarding and training leads were involved in the launch of the intervention (2) **Control pharmacies** – in-person induction visits by AMB, delivered usual care (which could include consultations based on the normal company training requirements), kept simple log of number of requests for DA and/or SI. The control pharmacies did not receive any Lifeguard branding or support resources and were not identified as being Lifeguard Pharmacies and the staff did not receive the Lifeguard training (3) **Intervention pharmacies:** • supplied with the intervention resources as listed and study website made available to market the service to potential clients (see *Report Supplementary Material 1*). • Staff were available to deliver the service as required (either client- or staff-initiated). • Staff required to consent client participants and collect data) The intervention pharmacies were clearly identified as 'Lifeguard Pharmacies' with posters in the window, and all trained staff wearing Lifeguard badges
E	Intervention monitoring and data collection	(1) **Intervention pharmacy monitoring** – monthly site visits by AMB to support staff, collect data, check the fidelity of the intervention, and collect feedback from staff about their experiences of delivering the intervention. (5 × visits per pharmacy) (2) **Control pharmacy monitoring** – monthly phone calls by AMB to support staff and collect data A pharmacy specification checklist had been created in the codevelopment phase and was part of the pharmacy operating manual. Fidelity against these items was checked at the monthly visits (by AMB) in addition to checking on the staff's own well being, their experience of delivering the intervention and collecting any feedback
F	Staff support	**Optional support for intervention staff** – confidential mentoring sessions with a psychotherapist in case of emotional distress (30 minutes per participant per month), pairing for peer support with another staff member, access to research team for advice
	Nested process evaluation	
G	Staff focus groups	**Evaluation of staff's experience** – all staff participants in intervention pharmacies were invited to take part in either an in-person or online focus group to evaluate staff's experience of delivering the intervention
H	Feasibility workshop	**Evaluation of feasibility** – summary multistakeholder feasibility workshop to review the Lifeguard Pharmacy intervention and make recommendations for practice and future research. Participants were a selection of staff from each intervention pharmacy, the public and patient engagement panel, representatives from referral organisations and the entire research team All participants had already been connected to the project and received participant information and consent forms prior to the event. Pharmacy staff participants received a £75 fee for participating as a token of appreciation. Public and patient panel members received their usual fee for contributing

AMB, Ana Maria Barcelos; JS, Josie Solomon; RB, Rebecca Barnes.

Appendix 2 Intervention and control pharmacy characteristics

TABLE 4 Intervention and control pharmacy characteristics

Pharmacy ID code	Sampling category	Intervention or control	Index of Multiple Deprivation in decile	Number of staff recruited per pharmacy
A	Large rural	Intervention	6	3
C	Large urban	Intervention	4	6
D	Large urban	Intervention	2	4
E	Small rural	Intervention	3	4
F	Small rural	Intervention	10	6
H	Small urban	Intervention	10	3
I	Small urban	Intervention	3	6
J	Large rural	Intervention	3	5
				Subtotal intervention participants = 37
W	Large rural	Control	10	1
X	Large urban	Control	6	1
B	Large rural	Control	8	1
G	Small urban	Control	1	1
				Subtotal control participants = 4
				Total participants = 41

Appendix 3 Progression of pharmacy and staff participants

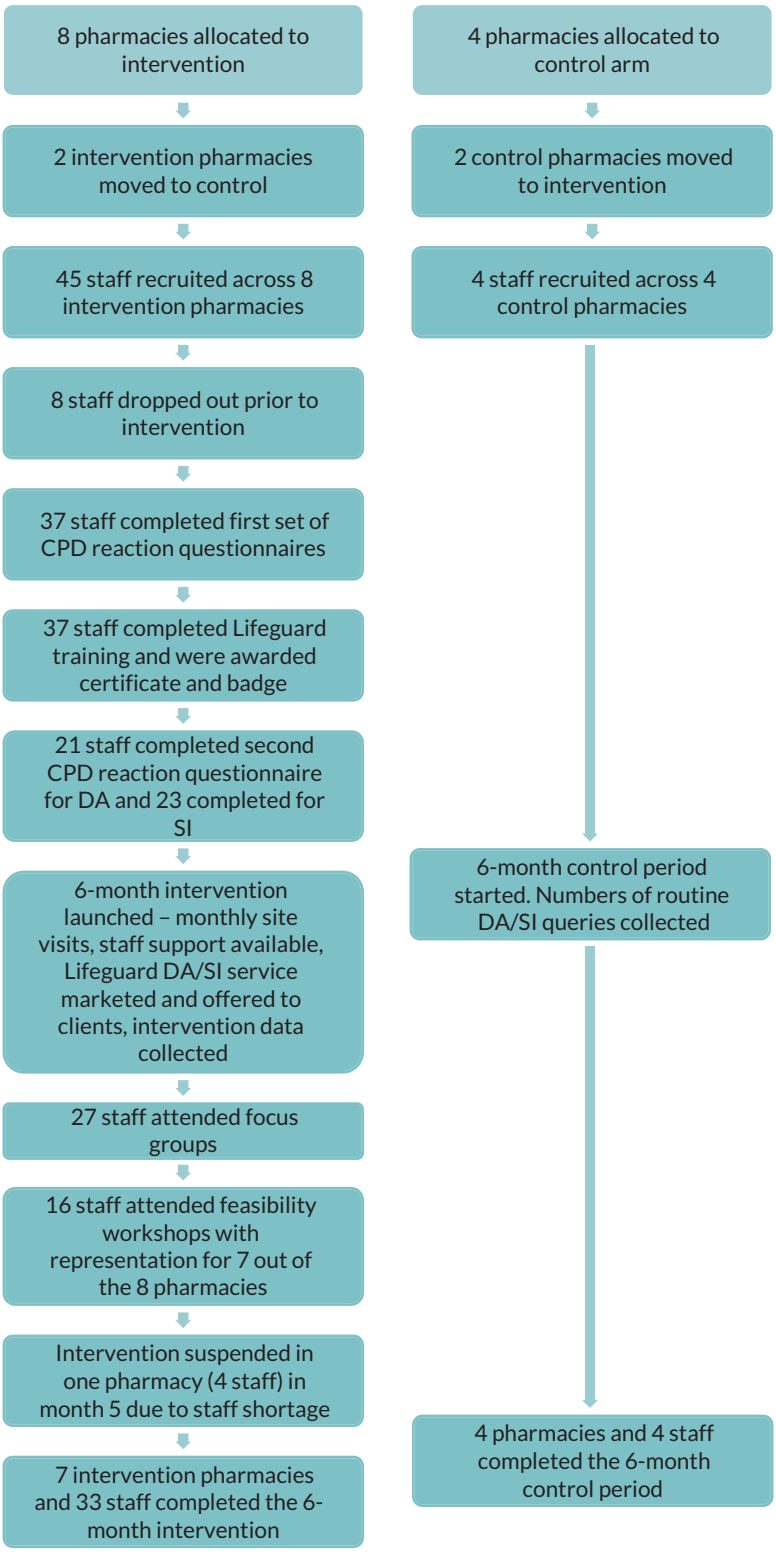

FIGURE 2 Flow chart of pharmacy and staff participant progression.

This article should be referenced as follows:
Solomon J, Barnes R, Barcelos AM, Latham-Green T, Knapp P, Baines D, *et al*. Lifeguard Pharmacy – A feasibility trial of a novel pharmacy-based intervention for people experiencing domestic abuse and/or suicidal ideation [published online ahead of print April 1 2026]. *Health Soc Care Deliv Res* 2026. https://doi.org/10.3310/TNFT6414

Appendix 4 Staff participant responses to Continuing Professional Development reaction questionnaires

TABLE 5 Participant responses to CPD reaction questionnaires for DA and SI

CPD reaction questionnaire questions for DA/SI			Mean score before	Mean score after	SD	95% CI (lower, upper)		*t*-test score	df	Paired *t*-test 2-sided *p*-value
Q1	I intend to effectively respond and refer (where appropriate) people in danger of DA/SI (SI): *1 = strongly disagree, 7 = strongly agree*	DA	6.6	6.5	1.221	−0.460	0.651	0.357	20	0.724
		SI	6.2	6.2	2.306	−0.954	1.041	0.09	22	0.929
Q2	To the best of my knowledge, the percentage of my colleagues who effectively respond and refer (where appropriate) people in danger of DA/SI is: *1 = (0–20%), 2 = (21–40%), 3 = (41–60%), 4 = (61–80%), 5 = (81–100%)*	DA	3.2	4	1.327	−1.414	−0.205	−2.795	20	**0.011**
		SI	3.1	3.7	1.438	−1.230	0.013	−2.03	22	0.055
Q3	I am confident that I could effectively respond and refer (where appropriate) people in danger of DA/SI if I wanted to: *1 = strongly disagree, 7 = strongly agree*	DA	4.9	6	2.064	−2.130	−0.251	−2.643	20	**0.016**
		SI	4.9	6.1	1.999	−2.081	−0.353	−2.921	22	**0.008**
Q4	Effectively responding and referring (where appropriate) people in danger of DA/SI is the ethical thing to do: *1 = strongly disagree, 7 = strongly agree*	DA	6.3	6.5	1.526	−0.837	0.552	−0.429	20	0.673
		SI	6.4	6.4	1.931	−0.835	0.835	0	22	1.00
Q5	For me, effectively responding and referring (where appropriate) people in danger of DA/SI would be: *1 = extremely difficult, 7 = extremely easy*	DA	3.9	5	1.091	−1.591	−0.599	−4.6	20	**< 0.001**
		SI	3.9	5	1.296	−1.604	−0.483	−3.861	22	**0.001**
Q6	Now think about a coworker whom you respect as a professional. In your opinion, does he/she effectively respond and refer (where appropriate) people in danger of DA/SI? *1 = never, 7 = always*	DA	5.1	6	1.327	−1.414	−0.205	−2.795	20	**0.011**
		SI	5	5.5	1.996	−1.428	0.298	−1.358	22	0.188
Q7	I plan to effectively respond and refer (where appropriate) people in danger of DA/SI: *1 = strongly disagree, 7 = strongly agree*	DA	6.6	6.4	1.195	−0.401	0.687	0.548	20	0.590
		SI	6.3	6.4	1.703	−0.824	0.650	−0.245	22	0.809
Q8	Overall, I think that for me, being able to effectively respond and refer (where appropriate) people in danger of DA/SI would be: *1 = useless, 7 = useful*	DA	6.6	6.6	0.669	−0.352	0.257	−0.326	20	0.748
		SI	6.6	6.7	1.065	−0.504	0.417	−0.196	22	0.847
Q9	Most people who are important to me in my profession effectively respond and refer (where appropriate) people in danger of DA/SI: *1 = strongly disagree, 7 = strongly agree*	DA	5.5	6.1	0.921	−1.038	−0.200	−3.081	20	**0.006**
		SI	5.7	6.2	0.945	−0.843	−0.026	−2.206	22	**0.038**
Q10	It is acceptable to effectively respond and refer (where appropriate) people in danger of DA/SI: *1 = strongly disagree, 7 = strongly agree*	DA	6.4	6.5	1.513	−0.784	0.594	−0.288	20	0.776
		SI	6.5	6.5	1.243	−0.538	0.538	0	22	1.00
Q11	I have the ability to effectively respond and refer (where appropriate) people in danger of DA/SI: *1 = strongly disagree, 7 = strongly agree*	DA	4.7	5.9	1.887	−2.050	−0.331	−2.891	20	**0.009**
		SI	5.1	6	1.800	−1.605	−0.048	−2.201	22	**0.039**
Q12	Overall, I think that for me effectively referring/ responding to (where appropriate) people in danger of DA/SI would be: *1 = harmful, 7 = beneficial*	DA	6.4	6.7	0.730	−0.666	< 0.000	−2.092	20	**0.049**
		SI	6.5	6.7	0.650	−0.455	0.107	−1.283	22	0.213

Appendix 5 Illustrative quotes from staff focus groups

TABLE 6 Quotes illustrating themes and subthemes from staff participant focus groups

Quote number	Themes and subthemes	Quotes
Quote 1	Impact/overall value of the service	*... and his [client's] demeanour changed, so I did the same and sort of probed a little further, until basically, asking the right question and him saying 'I'm getting the last few things in order and then I want to do it.' [referring to taking his life] So, it escalated really quickly, over the space of about five minutes. And then, obviously that changed the conversation and we set up a few different things in place* (staff participant – online FG, group 1, 25 April 2023)
Quote 2	Impact/overall value of the service	*I've had one person myself that has actually come back twice to me. First time, it was for suicidal ideation, and the second time it was for domestic abuse. So, because, the first time we met, we made such a good impression and we've been touching base, because it's a village setting and it was, sort of, a case of she'd become familiar and safe with us, she then felt open enough to come and speak about something else she was concerned about and we could help her further* (staff participant – online FG, group 2, 2 May 2023)
Quote 3	Impact/relationships with customers	*... it made a bond that we didn't expect as such. It's stronger somehow ... Yeah, there's no question about it, the clinician-patient relationship jumps a level if you have that interaction* (discussion between two staff participants in in-person FG, 17 April 2023)
Quote 4	Impact/overcoming access barriers	*I think it is so difficult for people to ask for help in the first place. If they've been to their* GP *and they get knocked back, if there's nobody there to fill that little gap and fight for them, they're not going to get the help they need* (staff participant, online FG2 25 April 2023)
Quote 5	Impact/substance use disorder	*A few of ours have been some of our 'blue scripts', which are addict scripts that we've gone in to give them that dose in a private room ... .Because they're people we see day in, day out, you know when something is not right. We tend to be, sort of, 'Are you okay? Is there something wrong? You don't seem yourself today.' That's where the conversation tends to start* (staff participant, online FG, group 2, 25 April 2023)
Quote 6	Setting/community pharmacy setting	*... the perfect place. Because you can walk into a pharmacy and it's not suspicious* (staff participant, in-person FG, 17 April 2023)
Quote 7	Setting/community pharmacy setting	*And as soon as I knew that he wasn't taking his meds, that's where I probably changed my questioning style [...] when he said he wasn't taking his meds, that is automatically like a red flag for me that there's always, usually, a reason for it* (staff participant, online FG, group 1, 25 April 2023)
Quote 8	Setting/local need	*I'd hope it would continue and spread a lot further, because I think it's invaluable. It should be shouted from the rooftops, in my opinion, especially for the rural places who've been in desperate need of mental health because the only place they've got to go to is the GPs. A lot of the time, they don't have time to see them ...* (staff participant, online FG, group 2, 2 May 2023)
Quote 9	Setting/scope	*One sort of older chap come in who struggles with mental health anyway ... He wasn't actively suicidal at the time, but he did say that he has thought in the past about hanging himself. So, we gave him ... in fact, I had already given him the numbers off the green card before that because he'd already been in when he wasn't particularly bad, but I knew he was a bit lonely* (staff participant, online FG, group 1, 25 April 2023)
Quote 10	Setting/capacity	*I'd rather it take longer and the patient feels happy and then be improved and it take 45 mins rather than them be 15 minutes and them not feel any better. I'd rather take 45 minutes and not get (another) job done* (staff participant, online FG, group 2, 2 May 2023)
Quote 11	Setting/capacity	*And so, whereas I would always deal with these myself (as a pharmacist), I now turn to another Lifeguard and go, actually, I need you to deal with this. And you can tell they straighten as if to say, right, time to do something good ... it gives me the confidence and it gives me a mental health sub team* (staff participant, in-person FG, 17 April 2023)
Quote 12	Staff experience/staff empowerment	*I'm much more confident because I do have the facility to signpost people to the correct places they need to be. Also, if I'm not sure, there's all the list of places they can go. I can pass that on to them. Then, if they don't want you to do it themselves, they've got this card where they can take it away, look at it, and then decide what they want to do, rather than an on-the-spot decision* (staff participant, online FG, group 2, 25 April 2023)
Quote 13	Staff experience/emotional impact	*Yeah, but, like [NAME] was saying, they come in week after week after week and where, like how do you stop them? It's draining you emotionally, as well* (staff participant, online FG, group 1, 25 April 2023)

continued

TABLE 6 Quotes illustrating themes and subthemes from staff participant focus groups (*continued*)

Quote number	Themes and subthemes	Quotes
Quote 14	Staff experience/ being a Lifeguard	*I would say that it felt like you had a bit of a title, and you feel like, 'I've got my own arm bands on and being a lifeguard myself … (laughs). Puts a lot of pressure on your shoulders, that, 'I'm a lifeguard'* (staff participant, group 1, 2 May 2023)
Quote 15	Staff experience/ being a Lifeguard	*A lot of people have had well-intentioned schemes that are a dead end, and I think if I made a difference here for me that sets this apart, it's that you haven't made a scheme as such. You've made people* (staff participant, in-person FG, 17 April 2023)
Quote 16	Improvements/ paperwork	*I can't even visualise myself at all having a conversation, a deep conversation with somebody and then saying ohh, then just get some paperwork out and asking them to complete it then* (staff participant, online FG, group 2, 25 April 2023)
Quote 17	Improvements/ marketing	*I just still think it's because it's not advertised anywhere, so if it was advertised, say, on the radio or … I know it needs to be discreet, but I think it's, perhaps, too discreet* (staff participant, online FG, group 2, 25 April 2023)
Quote 18	Improvements/ recommendations	*Yeah, I think at the minute, one of the biggest problems in mental health is that initial support isn't there. Like a doctor will just say 'How are you doing? Shall we carry on?' Whereas, I think, a pharmacist has more of a personal input. So, I think, that'll help* (online FG, group 1, 25 April 2023)

Appendix 6 Feasibility workshop results

TABLE 7 Participant responses to questions about scope of the service

	Participant responses							
	Yes		No		Maybe		Left blank	
Questions about scope of the service		%		%		%		%
A key feature of Lifeguard Pharmacy is that it covers two issues: suicidal feelings and DA. Does it make sense to include both issues?	37	94.9	0	0	2	5.1	0	0.0
Should Lifeguard Pharmacy be extended to include:								
1. other mental health difficulties?	31	79.5	2	5.1	5	12.8	1	2.6
2. drugs and alcohol?	21	53.9	8	20.5	10	25.6	0	0.0
3. sexual assault?	24	61.5	7	17.9	8	20.5	0	5.1
4. a wider remit of mental health and social problems: for example, debt, depression, anxiety, housing, bereavement and so on?	23	59.0	8	20.5	6	15.4	2	5.1

TABLE 8 Participant responses to questions about the setting of the service and training

Questions about setting of the service and training	Participant responses							
	Yes		No		Maybe		Left blank	
		%		%		%		%
Is a community pharmacy a suitable setting for this type of service?	38	97.4	0	0.0	0	0.0	1	2.6
Should Lifeguard Pharmacy be a national service that is available in all pharmacies that chose to participate?	27	69.2	3	7.7	7	17.9	2	5.1
Should Lifeguard Pharmacy be only available in specific pharmacies that meet certain quality criteria, that are committed to maintaining a certain level of staffing and have sufficient numbers of motivated and trained Lifeguards (i.e. premises accredited and individual staff accredited)?	30	76.9	2	5.1	6	15.4	1	2.6
Should Lifeguard Pharmacy be accredited by an external organisation (e.g. the mental health trust or public health at the Council or a specific social enterprise/charity) rather than being internally validated by the pharmacy organisation?	17	43.6	5	12.8	13	33.3	4	10.3
Should staff training be:								
1. in-person with a facilitator?	30	76.9	0	0.0	9	23.1	0	0.0
2. online with a facilitator (i.e. interactive)?	13	33.3	11	28.2	15	38.5	0	0.0
3. online without a facilitator, that is, a digital presentation with interactive exercises?	1	2.6	27	69.2	11	28.2	0	0.0
Should all types of pharmacy staff be accepted as Lifeguards (e.g. counter assistances, dispensers, technicians and pharmacists?	29	74.4	3	7.7	7	17.9	0	0.0
Should it be compulsory that one of the Lifeguards in each pharmacy is a permanent pharmacist at that pharmacy?	10	25.6	22	56.4	6	15.4	1	2.6

TABLE 9 Participant responses to questions about client access to the service

Questions about client access to the service	Participant responses							
	Yes		No		Maybe		Left blank	
		%		%		%		%
Should Lifeguard Pharmacy be a staff-initiated type of service only, and not client-initiated?	3	7.7	32	82.1	4	10.3	0	0.0
Is it possible for Lifeguard Pharmacy to be client-initiated in the right conditions?	35	89.7	0	0.0	4	10.3	0	0.0
Should we use a clearer name, for example, Suicide Prevention and Domestic Abuse service instead of Lifeguard and the symbol?	3	7.7	28	71.8	6	15.4	2	5.1
Should we keep the name but be more explicit in the marketing?	26	66.7	5	12.8	6	15.4	2	5.1
Should we keep the name but add 'safe space' to the marketing?	24	61.5	10	25.6	4	10.3	1	2.6
Should we keep the name and make the marketing more discreet (less explicit)?	2	5.1	31	79.5	3	7.7	3	7.7

TABLE 10 Participant responses to questions about record keeping and consent process

Questions about record keeping and consent process	Participant responses							
	Yes		No		Maybe		Left blank	
		%		%		%		%
It is possible to obtain written consent from clients?	11	28.2	11	28.2	14	35.9	3	7.7
Is it necessary to obtain written consent from clients to provide the service, it became a standard service (rather than a research project)?	3	7.7	25	64.1	10	25.6	1	2.6
Should records be made on paper during the consultation and then entered onto the computer system?	14	35.9	15	38.5	10	25.6	0	0.0
Should records be entered directly onto the desktop computer while conducting the consultation?	8	20.5	17	43.6	14	35.9	0	0.0
Should records be made on to a tablet [e.g. iPad (Apple Inc., Cupertino, CA, USA)] during the consultation?	16	41.0	5	12.8	17	43.6	1	2.6
Should clients be denied the service if they do not consent to their personal details of: name, address, date of birth and GP being recorded?	0	0.0	34	87.2	5	12.8	0	0.0
Is it possible to obtain additional data on demographics (e.g. ethnicity) from clients?	15	38.5	10	25.6	13	33.3	1	2.6
Is it possible to obtain additional data on views and preferences from clients?	10	25.6	11	28.2	15	38.5	3	7.7
Would it be advisable to follow-up clients to see how they progress?	10	25.6	10	25.6	18	46.2	1	2.6
Would it be possible to follow-up clients to see how they progress?	8	20.5	7	17.9	23	59.0	1	2.6