

# Self-harm and Suicide Prevention Competence Framework

## Adults and older adults

National Collaborating Centre for Mental Health

Self-harm and Suicide Prevention Competence Framework: Adults and Older Adults

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**Authorship Statement**

Stephen Pilling originated the work, along with Health Education England who commissioned it, and oversaw its development together with Shubulade Smith. Anthony Roth devised the competence framework maps and extracted and wrote the competences, with assistance from Kate Sherratt, Caroline Monnery and Jane Boland. Jessica Barrett wrote the background documents with support from Anna Lawes and Anthony Roth. Kasia Furmaniak conducted preliminary literature reviews. The work was edited by Kate Lorrimer, Clare Taylor and Kasia Trojanowska.

## Dedication

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In memory of Sheila Laws, also known as @jlpatient77 on Twitter. Sheila was due to be a member of the Adult Expert Reference Group that contributed to the development of this work, but very sadly she died before the meetings started. This competence framework has been developed with Sheila in mind.

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# 1. About the competence framework

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This document describes a competence framework for [self-harm](#) and [suicide prevention](#) in adults and older adults, recommending skills and knowledge for professionals across a broad range of backgrounds and experiences, including professionals and volunteers who work in mental health, physical health and social care.

## 1.1. Competence and competence frameworks

**Competence** is usually defined as the integration of knowledge, skills and attitudes. Professionals need background knowledge relevant to their practice, but what marks out competence is whether the person has:

- the ability to draw on and apply knowledge in different situations
- the relevant skills and the ability to use them in different situations, and
- an appropriate attitude and set of values.

**Competence frameworks** are a collection of competences that have been outlined for certain professional groups and for specific types of intervention or areas of focus. These frameworks identify and bring together all the relevant knowledge, skills and values that are key to working effectively in the specified area.

## 1.2. Self-harm and suicide prevention competence frameworks

Three parallel competence frameworks have been developed: one for those working with adults and older adults, one for those working with children and young people, and one for those offering support in the community to the wider public. The last is aimed at professionals who will not usually have training in mental health. It will be relevant to individuals carrying out public health initiatives, employers, providers of education and other public services, such as transport or police.

This document focuses on the competences relevant to self-harm and suicide prevention in adults and older adults. An overview of the relevant areas of competence will be provided here.

The detailed competences for all three frameworks can be downloaded from: <https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework> .

*I would like the framework to be a starting point to break down the fear of the unknown of how to speak with someone in a very fragile mental state. [...] I hope this framework encourages people to act with kindness, hope, compassion and humanity.*

Amanda Tuffrey  
Expert by Experience, 2018

A further background document has been written for people who might receive support for self-harm or suicidal ideation. This aims to inform people of the help they can expect from different individuals or professionals when talking about their self-harm, suicidal ideation or distress. This document can be downloaded from:

<https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework> .

*I would like to have guidance or frameworks as something to point to when something isn't going right with my care... I want to know that, when I am not treated well, it is not my fault and I don't blame myself.*

Rachel Rowan  
Expert by Experience, 2017

## 2. Background

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[The Five Year Forward View for Mental Health](#)<sup>1</sup> recommended that the Department of Health, Public Health England and NHS England ‘support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment’. This, along with the [cross-government outcomes strategy to save lives](#)<sup>2</sup> (which aims to reduce the number of people taking their own lives by 10% nationally by 2020/21), led the House of Commons Health Committee to produce a report on [suicide prevention](#).<sup>3</sup> One of its recommendations was that Health Education England’s (HEE) Mental Health workforce strategy should ‘set out what the Government is going to do to ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations [in The Five Year Forward View for Mental Health].’

There are a number of training programmes, assessment tools and implementation toolkits for mental health promotion and prevention, with some particularly tailored to suicide prevention. Public Health England and HEE’s [Mental Health Promotion and Prevention Training Programmes: Emerging Practice Examples](#) document<sup>4</sup> outlines many of these initiatives, as well as core principles and key competences for public mental health. However, these programmes vary greatly in terms of content, approach, delivery and the weight and quality of evidence from which they have been derived. Moreover, the majority are focused on training in healthcare and educational settings. The Samaritans’ slogan ‘suicide is everybody’s business’ suggests that this training should be available and applicable across multiple settings, such as within public services, to employers and to the wider general public.

Based on these recommendations and findings from recent reports, HEE commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop a self-harm and suicide prevention competence framework to sit alongside the ongoing suicide prevention work being completed by other arm’s-length bodies.

The frameworks have a range of applications, supporting:

- developing training curricula for practitioners from a range of clinical and professional backgrounds
- evaluating existing training
- evaluating practice in existing services
- reflecting on and supervising individual professional practice
- identifying good practice and helping those receiving support to understand what they can expect from their care.

### 3. How the competences were identified

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This work was overseen by three separate Expert Reference Groups: one for those working with adults and older adults, one for those working with children and young people and one for those working in the community with the public. [Appendix A](#) lists Expert Reference Group members, which included people with lived experience of self-harm and/or suicidal ideation or behaviours (some with experience of mental health services, others without), people who have been bereaved by suicide, frontline clinicians, non-clinicians who have had contact with people who have self-harmed and/or are suicidal, academics and national experts in the field of self-harm and suicide prevention, and people involved in the development of public health suicide prevention plans.

The NCCMH project team undertook a literature search to identify relevant research and potential resources, including:

- national guidance and policy documents
- training resources
- treatment manuals
- primary research indicating evidence for the efficacy of interventions and/or approaches.

Alongside this, the National Institute for Health and Care Excellence (NICE) guidelines and quality standards were reviewed to identify recommendations relevant to self-harm or suicide prevention. This ensured that competence statements are consistent with NICE guidance. [Appendix B](#) lists relevant NICE guidelines and quality standards, as well as the quality statements that should be considered when working with people who have self-harmed and/or are suicidal.

The process of extracting competences was undertaken by a team of four people, each of whom drew on the resources identified above, along with source materials identified by the Expert Reference Groups. Initial drafts were edited iteratively within the team and then passed to Expert Reference Group members for independent review. There was also collective discussion and debate within Expert Reference Group meetings. Further external reviewers were identified on the basis of their specialist expertise and they were asked to ensure that interventions were described accurately and comprehensively. This process of iterative peer-reviewing was undertaken to provide assurance that the competence statements are clinically relevant and applicable, academically robust, in line with professional standards, written at the right level (and so readily understood by their target audiences), and reflect the stance and values that people with lived experience and families and carers have identified as important.



## 4. Scope of the work

### 4.1. Audience

This competence framework is intended for, and may be used by, many people across several domains. They may wish to use the competences to inform their current practices or to develop curricula and training around self-harm and suicide prevention. Not all competences will be relevant to all staff, so those who are not specialists may require fewer of the listed competences. Staff, employers and professional bodies should pay attention to the competences that are most relevant to them.

Domains	Constituents
<i>Frontline clinical staff</i>	Staff and decision-makers in: <ul style="list-style-type: none"> <li>• mental health services</li> <li>• physical health services, including emergency services</li> <li>• primary care services</li> <li>• social care services</li> <li>• drug and alcohol services</li> <li>• pharmacy</li> <li>• occupational health</li> <li>• care homes</li> </ul>
<i>Frontline non-clinical staff who work with people at risk of self-harm and suicide</i>	Staff, organisations and providers in welfare settings, including: <ul style="list-style-type: none"> <li>• homeless shelters</li> <li>• supported housing</li> <li>• housing associations</li> </ul>
<i>Non-clinical staff and organisations involved in self-harm and suicide prevention</i>	<ul style="list-style-type: none"> <li>• Professional membership bodies for mental health, physical health and social care practitioners, particularly those involved in producing curricula</li> <li>• Organisations that develop and deliver self-harm and suicide prevention and intervention training</li> <li>• Academic institutions</li> </ul>
<i>Other/public</i>	<ul style="list-style-type: none"> <li>• Local authorities implementing their own suicide prevention plans</li> <li>• People who currently harm, or have previously harmed, themselves</li> <li>• People who currently feel, or have previously felt, suicidal</li> <li>• The families, carers and support networks of people who self-harm and are suicidal</li> <li>• People bereaved by suicide, including families, carers, significant others, friends and colleagues</li> <li>• The public</li> </ul>

This framework is largely relevant for professionals working in services where a person might be supported or cared for after presenting with suicidal ideation or after an episode of self-harm. Most people who die by suicide have not previously been in contact with mental health services.<sup>5 6</sup> With that in mind, some areas of the framework identify competences

relevant to working with people outside the context of health services – for example, general communication skills. Other relevant general areas of competence can be found in the [framework for working in the community with the wider public](#).

## 4.2. Populations

This competence framework is applicable to adults aged 18 and over, including older adults, and applies to those who are in contact with mental health services, as well as those who are not.

This framework does not specifically refer to work with serving military personnel or to people in prisons; these populations and contexts have particular characteristics and patterns of self-harm and suicide as well as different systems for service delivery. Although most of the competences in this framework will be relevant to these groups, a number of issues (as set out in the detailed competence documents) need to be considered when adapting work to these contexts, and tailored competence frameworks should be developed in the future.

### 4.2.1. Advancing mental health equality

In the early stages of development, the Expert Reference Group identified several groups of people who might have difficulties accessing support or care for self-harm or suicidal ideation and behaviour:

- older adults
- people with physical disabilities, learning disabilities or neurodevelopmental disorders
- people from the LGBTQ+ community
- people from black, Asian and minority ethnic groups
- men
- people who have been subjected to domestic violence or other forms of abuse or neglect
- people from the traveller community
- refugees and asylum seekers
- people who are homeless or have unstable housing
- survivors of human trafficking
- people for whom English is not their first language
- sex offenders.

Additionally, it was noted that some people may find it difficult to access services or engage with interventions because of the social determinants of their distress, such as socioeconomic status, employment status, housing status, financial problems, and many

other social issues. All professionals should work collaboratively with relevant services to address social issues that contribute to distress. This will also help to ensure that the person can engage with the support and care that is available to them.

These discussions, together with the completion of frequent Equalities Impact Assessments, has ensured that this work has been developed considering a wide range of individuals who might experience inequalities in care. The competences within these frameworks will ensure that all people who have self-harmed or feel suicidal will receive equal support, care and treatment.

Further information about advancing mental health equality through practice can be found in the [Professional competences for healthcare workers](#) section of this document and in the competence framework itself.

***I would like support improving my current social and economic circumstances, not just my current health needs. For instance, when applying for benefits or finding new accommodation. My therapy worked better when I didn't hate where I was living.***

Rachel Rowan  
Expert by Experience, 2017

## 5. The competence framework for self-harm and suicide prevention in adults and older adults

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### 5.1. Clinical and professional issues relevant to supporting people who have self-harmed and/or are suicidal

The Expert Reference Groups identified a number of issues relevant to supporting people who have self-harmed and/or are suicidal. These form the context for the application of the competence groups laid out in [Figure 1](#).

#### 5.1.1. Working collaboratively with the person

All work with people who have self-harmed and/or are suicidal should be undertaken collaboratively. This means developing trusting working relationships from the outset that enable people to make choices and share decision-making around their care, empowering individuals and helping them feel that they have control over the actions related to their care.

***There can't be any collaborative work done if I don't feel listened to or believed. It is the cornerstone of all interactions following self-harm or when I'm feeling suicidal.***

Stella Branthonne-Foster  
Expert by Experience, 2018

It is also important that professionals engage with the person's family, carers or significant others if the person is happy for these people to be involved in their care. This will contribute to the development of a shared understanding of the person's difficulties and help build a collaborative relationship among all those engaged in supporting them. Decisions about the involvement of families, carers or other people should always be discussed with the person before making contact and should be reviewed throughout care because their wishes may change over time.

Assessments and intervention plans should reflect a collaborative process between the professional, the person and (according to the person's wishes) their family, carers or significant others. This collaborative relationship should be reflected in the development of a shared language that accurately reflects the way a person understands their own problems and care. Without a collaborative approach, people can feel that interventions are imposed on them, which then increases the risk of disengagement.<sup>7</sup>

### 5.1.2. Person-centred rather than protocol-centred

When people who have self-harmed present to services, they can experience their care as being 'protocol driven' rather than personalised (for example, being taken through a standardised set of questions or checklists that the organisation uses to assess risk). Negative attitudes of clinical staff towards people who self-harm may also contribute to this experience.<sup>8</sup> This can be an alienating experience for the person, which may lead to them disengaging from care.

Understandably, services will want to follow procedures and record their actions, but frontline staff need training that allows them to translate this into an individualised and therapeutic response. The importance of this response is highlighted by people with lived experience, who consistently report the positive value of receiving care and support from someone who shows a genuine sense of compassion and concern. This highlights the importance of basic communication skills, which should not be assumed when training staff in specialist skills.<sup>9</sup>

*There's nothing worse than people treating you like nothing more than an inconvenience. The response I get is a deal-breaker as to whether I will seek help from that professional or organisation in a similar situation in the future. I understand their protocol has to be followed [...], but it can be done with humanity and compassion.*

Stella Branthonne-Foster  
Expert by Experience, 2018

*Surely we want people to feel safe asking for help? It's incredibly difficult to advocate for yourself when you're in that head space, so the system has to ensure that the response is consistently compassionate, not just if you're lucky that day.*

Stella Branthonne-Foster  
Expert by Experience, 2018

### 5.1.3. Sharing information with families, carers and significant others

Families, carers and significant others who have been bereaved by the suicide of a loved one commonly report that professionals often seem reluctant to share information about a person's risk of suicide. If a person has capacity to make decisions and does not pose a risk to themselves or others, then professionals have a duty to maintain confidentiality. However, there are many instances where deaths may have been prevented by information sharing, not just between services and professionals, but between professionals and the person's family, carers or significant others.

When supporting a person at risk of suicide, there will be circumstances and situations where professionals may need to engage with

*If the purpose of the disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is considered to be in the person's best interest to do so.*

Information Sharing and Suicide Prevention –  
Consensus Statement.  
Department of Health (2014)

a person's family, carer or significant others in order to help keep the person safe. The [Consensus statement on information sharing and suicide prevention](#),<sup>10</sup> developed by the Department of Health with a number of medical colleges and professional bodies, sets out best practice for professionals: to routinely discuss with the person whether they would like their family, carers or significant others to be involved in their care, how they might like them to be involved, and whether this has changed over time. In the absence of these advance discussions, a judgement must be made based on the person's understanding, mental capacity, their previously expressed wishes and their best interests. Professional judgement should then guide what information is disclosed, along with the urgency of the disclosure.

The [Interim Report](#) of the House of Commons Health Committee on suicide prevention calls for individuals to be trained in the message contained within the [Consensus statement](#), along with a review of current practice in relation to confidentiality and information-sharing with a person's family, carers or significant others.

Specific competences around information sharing, confidentiality and consent are included within the 'Professional competences for healthcare workers' part of the competence framework and should be considered alongside the Department of Health's consensus statement.

*Although a patient's right to confidentiality is paramount, there are instances where professionals sharing information – with consent – with a person's trusted family or friends could save their life. Stronger action needs to be taken to raise awareness of the [Consensus statement](#), to train staff in this area (including training on how to seek consent), and to engender a culture shift away from the current presumption that suicidal patients will not want their family or friends to be involved in their recovery.*

Suicide Prevention: Interim Report.  
House of Commons Health Committee (2016)

#### 5.1.4. Managing transitions between services

[Transitions](#) in care may represent periods of risk for people who self-harm and/or are suicidal. Given that discontinuation of care can often happen during transitions, a person can be lost within the system unless the transitions are anticipated and well planned. This is particularly true for transitions from children's and young people's services into adult services,<sup>11 12</sup> but it may also be seen in transitions between different adult services, or between statutory services and voluntary and community sector services, or community organisations.

Transitions of care can be difficult for people because they are made to disengage from those they have come to trust, or because they are required to connect to an unfamiliar service, often without the appropriate support in place to do so. For these reasons, individuals with responsibility for a person's transfer of care should coordinate the transition with the receiving service, support the person in whichever ways are required, and monitor the success of the transition.

It should be noted that transitions from children's and young people's services into adult services are likely to coincide with other transitions in a person's life, for example moving away to university and other challenges associated with early adulthood. During these times, a young person should be supported as much as possible to access help where they need it, especially as such lifestyle changes may mean moving to a new geographical area and, subsequently, a new and unfamiliar care team.

*Many young adults find not just the transitions to child and adolescent mental health services to adult mental health services very messy but the geographical transition to university very difficult too. The onus is placed on the young person to find support in often a new city. Whereas if information was shared appropriately and referrals could be made across the UK, joined up care would be the norm.*

Amanda Tuffrey  
Expert by Experience, 2018

More information on transitions for children and young people can be found in the [Self-harm and Suicide Prevention Competence Framework for Working with Children and Young People](#).

### 5.1.5. Relationship between self-harm and suicide

The relationship between self-harm and suicide is complicated. Although people who self-harm are significantly more likely to die by suicide or to harm themselves using more serious methods than the general population who do not self-harm, people may have many motivations for self-harm and are not always intent on dying.<sup>13</sup> Suicidal intent may not be evident early on, but often emerges over time.<sup>14</sup>

Self-harm should always be taken seriously, as it will inevitably reflect an attempt to manage a high level of psychological distress. Therefore, it is important to work with the person to understand their motivations and to not assume the motivations for self-harm are the same every time.

There are a number of other myths around self-harm and suicide that should be understood. Many of these can be found and explored on the [Samaritans](#) website.

### 5.1.6. Risk assessment

When working with people who have self-harmed or who experience suicidal ideation, it may seem clear that the person's current level of risk to themselves or others should be assessed. However, while there are many factors associated with risk, evidence indicates that our ability to accurately predict risk is limited.<sup>15 16</sup> This means that it is possible to both over-estimate and under-estimate the actual risk of suicide in a person at a given moment in time. Research suggests moving away from prediction to focusing on the needs of the person and seeing assessment as informing management rather than as a stand-alone activity.<sup>17</sup>

In many settings risk classification scales and [risk assessment](#) tools are widely used when assessing risk. Using these in addition to clinical interviewing may make sense, as they can provide a helpful structure and prompt the person who is completing the assessment to ask about current feelings and motivations. However, using tools and scales in isolation from a broader discussion with the person about their life as a whole can be both misleading and possibly unhelpful. As well as the evidence suggesting that risk assessment tools and scales do not have predictive value,<sup>15 16</sup> their use can also cause the person to disengage from support. One reason for this is that these tools tend to be in a checklist format, which means that people may be asked about matters that are not relevant to them and may not be given the opportunity to raise matters of personal significance. This can contribute to feelings of not being listened to or not having an open space in which to discuss concerns.

In some service contexts, checklists of this kind may be used to meet organisational criteria, as a way of demonstrating that risks have been appraised and procedures and protocols have been followed. If this is the rationale, it is likely that the risk assessment activity may not be used constructively. The assessment may be treated as a task undertaken for the benefit of the professional and not shared or discussed with the person, their family or carers. Although professionals need to document how they have evaluated risk, if the process is primarily driven by a concern about following procedures, then the opportunity for a focus on completing a meaningful holistic assessment with the person and promoting their safety could be lost.

In this framework, the emphasis is on a collaborative assessment of risk, needs and strengths, which engages a person in a meaningful dialogue that helps them to consider their difficulties, the context in which these difficulties arise and the resources available to help keep them safe. As indicated by the structure of the competence framework map (see [Figure 1](#)), assessment of risk, needs and strengths is not a stand-alone activity. To be most helpful, it should be combined with some therapeutic strategies, such as those contained in the part of the framework on structured care and intervention, particularly centered around risk management. This can include, for example, a [safety plan](#), sharing plans with others, reducing access to lethal means or means of self-harm and providing the best available evidence-based treatment to meet the needs of that person.

### 5.1.7. Postvention

[‘Postvention’](#) refers to interventions aimed at supporting people who have been directly affected by a death by suicide. These interventions should take the form of individualised support for those close to the person, for example partners, families and friends. It might also refer to interventions offered within an organisation, such as a workplace, school or university, where groups of individuals are offered support and the opportunity to express their feelings regarding the death of a colleague or fellow student. As with exposure to any traumatic event, many individuals may be able to draw on their own strengths and support networks, but some will have significant mental health needs that would benefit from organised support. This is particularly important in contexts where the occurrence of a suicide may lead to more people dying by suicide among those who knew the person.<sup>18 19</sup>



Public Health England has published guidance aimed at helping local authorities develop high-quality suicide bereavement services ([Support after a Suicide: A Guide to Providing Local Services](#)).<sup>20</sup>

### 5.1.8. Conducting inquiries into deaths by suicide and/or serious incidents

After a death by suicide, it is standard practice for health and social care organisations to conduct an independent inquiry into the circumstances that led to the death and to identify any changes that are needed to prevent further deaths or serious incidents. This comprises an internal inquiry as well as a public hearing (inquest). These are carried out by an independent team of skilled investigators who have the training, clinical experience and knowledge to conduct a serious incident investigation. The terms of reference for the scope of the investigation, as well as the timescale for reporting, will be set out before the process begins. The dissemination of any learning that comes out of these investigations should be timely.

Regardless of the possibility of a pending investigation, organisations should not forget to first communicate with the person's family, carers or significant others. Their needs should be met and they should be provided information as quickly as possible.

To enable an organisation to learn from these events, inquiries need to be conducted in a manner that enables family members, significant others and staff to talk openly, give evidence and comment on findings. This might be unlikely if there is any sense that the aim is to apportion blame to individuals. Staff are likely to feel considerable guilt and distress after a death by suicide, and the inquiry process itself can add to this stress if this is not recognised or is poorly managed. Family members, significant others and staff should be helped to understand the process of both an inquiry and an inquest, and should be supported to understand the legal aspects of an inquest.

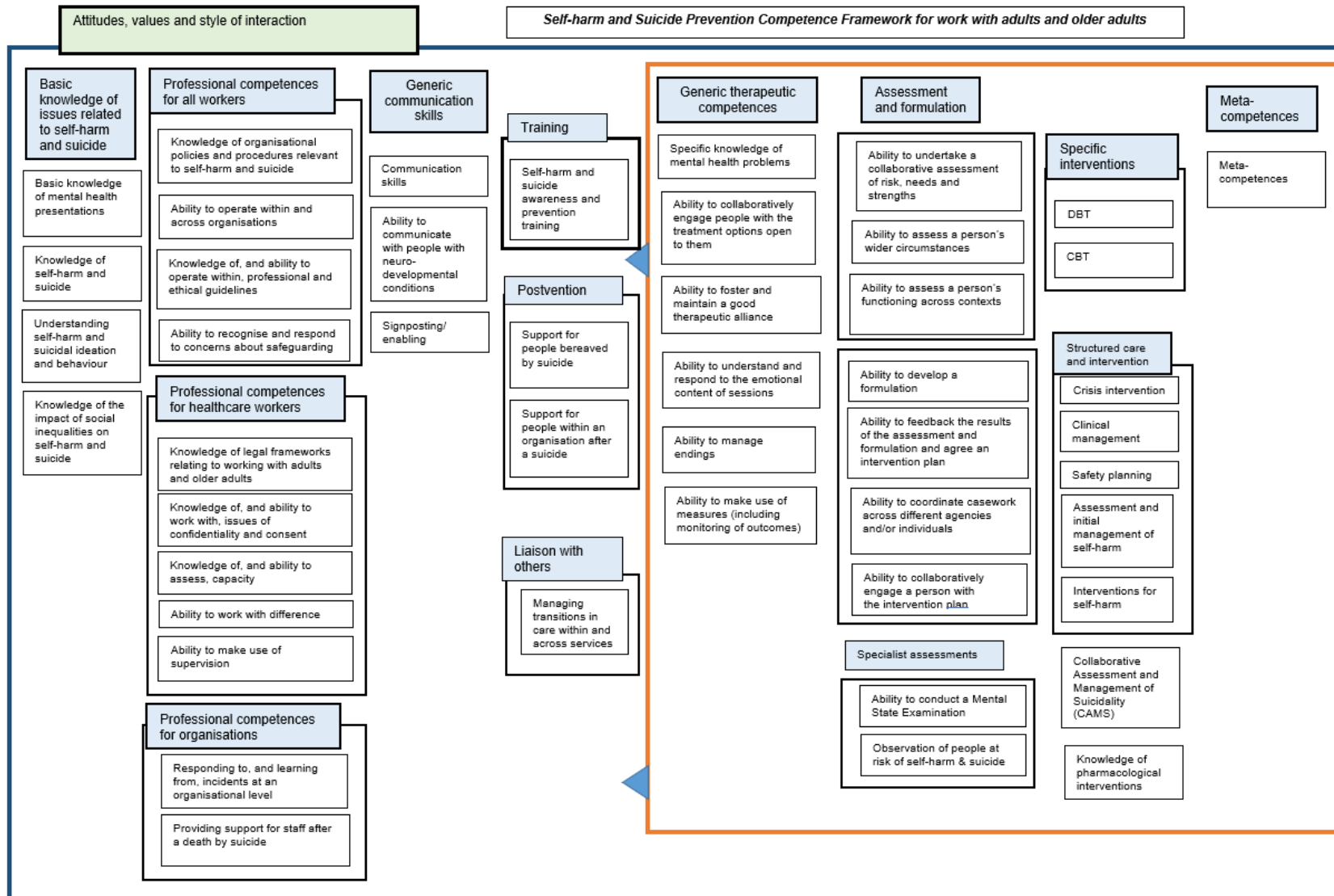
The Royal College of Psychiatrists' [Principles for Full Investigation of Serious Incidents Involving Patients under the Care of Mental Health and Intellectual Disability Provider Organisations](#)<sup>21</sup> lists 24 principles relating to serious investigations that organisations should adhere to.

### 5.1.9. Reflective practice

Reflective practice is the process by which professionals reflect on their own actions, learn from their experience and consider how to make improvements in their practice. This is part of continuous self-learning by professionals and it requires them to be self-aware and appropriately self-critical. There is evidence that this stance can improve the way that care is delivered.<sup>22 23 24</sup> The General Medical Council, together with the Academy of Medical Royal Colleges, have collated [reflective narratives](#) that illustrate the process of reflection and the ways in which this might help a professional to improve their clinical practice.

# SELF-HARM AND SUICIDE PREVENTION COMPETENCE FRAMEWORK

Figure 1: Competence framework map for adults and older adults



## 5.2. Using the competence framework map

The competence framework map is organised into two sections:

1. Core knowledge and skills for all people who might support someone who feels suicidal or who has self-harmed, as well as professional and clinical skills for professionals who might not be providing targeted mental health support (section on the left)
2. Intervention skills for mental health professionals (section on the right).

There is no expectation that all workers will be able to deliver all the competences on the map. However, any professional providing an intervention or engaging in an approach to keep a person safe would be expected to demonstrate all the core skills highlighted on the left side of the map, because these underpin any effective work.

Within these sections, there are several activities on the map that contribute to individual competences. This document provides an overview of each of the activity areas outlined on the map and their related competences, whilst the specific detail of the competences can be found on <https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework>. The level of detail contained within these competences is required to facilitate the development of curricula.

## 5.3. Competences

Competence is usually defined as the integration of knowledge, skills and attitudes. Professionals need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in different situations that marks out competence. Knowledge helps the professional to understand the rationale for applying their skills.

Beyond knowledge and skills, the professional's attitude and stance are also critical. This is more than their attitude towards, and relationship with, a person who has self-harmed and/or is suicidal. It also includes how the contexts in which they work shape the way they approach their work (for example, the organisational, professional, ethical and societal context). All of this needs to be held in mind, since all have an influence on the professional's capacity to deliver interventions that are ethical, meet professional standards and are adapted to a person's strengths, needs and cultural context. This includes seeing the person holistically, while considering their [intersectionality](#), identifying the strengths and needs of each characteristic of their identity, and appreciating how these might interconnect with each other and contribute to the way the person expresses themselves, experiences life or how they are perceived.

### 5.3.1. Attitudes, values and style of interaction when working with people who have self-harmed and/or are suicidal

*I want people to be kind, [to] believe me and [to] tell me what they are doing with my information.*

Rachel Rowan  
Expert by Experience, 2017

Working with people who have self-harmed and/or are suicidal should be grounded in compassion and respect. For this reason, the whole framework is underpinned by the competences within 'Attitudes, values and style of interaction'. This should be the same level of compassion and respect that would be

received by, or given to, anyone else, regardless of whether or not they self-harm or have suicidal thoughts.

Professionals should be able to:

- Demonstrate an empathic understanding and appreciation of the difficulties that a person is experiencing and recognise that these feelings of distress are very real to them
- Locate the distress within the broader context of a person's life
- Demonstrate to a person that their perspective and concerns are respected and being taken seriously, and
- Help a person begin to feel in control of their care by establishing and maintaining a collaborative relationship with them, their family, carers or significant others, and involving them in decisions about their care.

### 5.3.2. Core knowledge and skills

#### *Basic knowledge of issues related to self-harm and suicide*

The part of the framework on 'Basic knowledge of issues related to self-harm and suicide' contains four underpinning areas, starting with 'Basic knowledge of mental health presentations'. This outlines key knowledge about mental health that all professionals should have and draws attention to the fact that mental health stigma can prevent people from seeking help.

The competences within 'Knowledge of self-harm and suicide' set out the knowledge that a professional would be expected to have to aid them in their practice. This includes knowledge on prevalence of self-harm and suicide, and commonly used terminology. These competences also explore the associations between self-harm and suicide, look at the connections between mental health, physical health and social and psychological factors, and describe the impact of self-harm and suicide on others. The next part, 'Understanding self-harm and suicidal ideation and behaviour', describes the factors thought to contribute to the development and maintenance of self-harm, suicidal thoughts and feelings. It also describes the factors that might contribute to a person going from thinking about suicide to actively seeking to end their life.

'Knowledge of the impact of social inequalities on self-harm and suicide' identifies the types of vulnerability linked to social disadvantage, recognising the fact that self-harm and suicide can be influenced by a person's social and economic circumstances.

### *Professional competences*

This part of the framework focuses on professional competences, some applicable to all workers, some to all health and social care workers, and some to organisations.

#### Professional competences for all workers

The first set of competences, applicable to all workers, includes 'Knowledge of organisational policies and procedures relevant to self-harm and suicide' as they relate to the care and support of adults and older adults who self-harm and/or are suicidal. The 'Ability to operate within and across organisations' is an important skill to hold as it requires knowledge of the roles and responsibilities of the professional, their immediate colleagues and other professionals they might work with. It is also important for individuals to know their own organisational policies and procedures. For support to be delivered seamlessly across multiple services in the community, individuals also need to understand local pathways of care and which criteria apply to each service. Knowledge of these will help to ensure that the person can be supported by the most appropriate services and that their experience of accessing them will be smooth and consistent.

All professions and regulatory bodies set out ethical standards that professionals are expected to know and to apply in their practice. The competences within 'Knowledge of, and ability to operate within, professional and ethical guidelines' draw attention to the application of these principles in areas such as autonomy, consent, confidentiality and the minimisation of harm.

Safeguarding refers to the protection of individuals who are at risk of harm from various forms of abuse or neglect. In order to keep people safe from harm, professionals should have an 'Ability to recognise and respond to concerns about safeguarding'. These harms can be experienced by people of any age, so these competences might be key when working with all of the people in the individual's life.

#### Professional competences for healthcare workers

A further set of professional competences applies to all workers in the health and social care system, regardless of the level of support and care that is being provided by the person. The first of these is 'Knowledge of legal frameworks relating to working with adults and older adults'. This is key to working in this area, as knowledge of mental health law and issues such as consent and capacity is required in daily practice. It is particularly important for professionals to be familiar with the legislation that is relevant to their own discipline, or that may apply in different settings in which interventions might be provided. Other critical areas of legislative knowledge include data protection, equality, parental rights and responsibilities, shared decision-making, child protection and human rights. Linked to this is 'Knowledge of, and ability to work with, issues of confidentiality and consent', a potentially complex area which often requires careful judgement about instances in which it is in the person's best interests to maintain or to breach confidentiality, and to whom information is appropriately

passed or withheld from. Related to this is 'Knowledge of, and ability to assess, capacity', a skill that is critically relevant to this area of working. When assessing capacity, health and social care workers should be able to make adjustments to their communication style so that they can make themselves understood; this will reduce the chance of workers making an incorrect capacity judgement (communication skills are discussed in more detail on [page 22](#)). It should also be remembered that capacity refers to a specific issue at a specific time and that any observations of capacity or lack of capacity can be temporary or can fluctuate.

Respecting diversity, promoting equality of opportunity for people receiving care, and challenging inequalities and discrimination, are all important parts of practice. The 'Ability to work with difference' includes the ability to take account of the ways in which people differ, along with how a person's defining characteristics can influence the way they experience life, the way that they present to services and which interventions might be offered to them. All health and social care workers should be able to support and care for people from all backgrounds, including those with [protected characteristics](#) (as set out in the [Equality Act 2010](#)<sup>25</sup>), or additional characteristics that might be relevant, such as socioeconomic status. People who are societally disadvantaged in any way may experience a double burden, with discrimination and stigma not only making them more vulnerable, but also making it harder for them to access healthcare. Wherever professionals do identify inequalities to access and care, they should begin to take necessary steps to overcome these.

Supervision and support for professionals should be the norm, so the final competences in this part of the framework are those relating to the 'Ability to make use of supervision'. This references the skills that professionals need to have in order to get the best out of supervision, and to subsequently gain support and improve the quality of care they deliver through reflection and learning.

### Professional competences for organisations

A final group of professional competences within the framework relate to the response of an organisation to a suicide. The first set of competences reflects the importance of 'Responding to, and learning from, incidents at an organisational level', which involves arranging an independent investigation into the death of the person in compliance with institutional and statutory requirements. This investigation should be completed in a way that does not seek to blame, but is open and thorough, and conducted in a manner that is sensitive to the needs of the family, carers and others who have been bereaved by the suicide, as well as staff who were involved in supporting the person who died. Closely linked to this last point is the need for 'Providing support for staff after a death by suicide', which is a specific form of postvention that recognises the potential impact of a suicide on those who worked with the person who has died.

## Communication skills

The part of the framework titled 'Generic communication skills' applies to all people working with adults and older adults.

'Communication skills' are fundamental to working with people who have self-harmed and/or are feeling suicidal, and this part of the framework identifies the techniques that can be used to encourage open and collaborative discussion. When communicating with a person in such circumstances, professionals should be able to draw on basic communication skills so that people feel that they are:

- being respected, heard and understood
- connected to others by sharing their experience with those involved in their support and care
- able to express themselves in their own words
- able to reflect on what might help them in this situation, with the help of those involved in their care.

Some people will have specific difficulties with communicating, which may be misinterpreted as a reluctance to talk or cooperate. Sometimes this can be explained by the heightened emotions associated with self-harm, but it can also be due to any coexisting conditions that might have an impact on communication style. The competences within 'Ability to communicate with people with neurodevelopmental conditions' identify three conditions that strongly influence the ways in which people interact, namely:

- learning disabilities
- autism spectrum disorders
- attention deficit hyperactivity disorder (ADHD).

However, these competences can also be used when communicating with people with sensory deficits or other speech and language problems. As well as providing specific guidance on communication issues, this part of the framework is also intended to illustrate how workers may need to adapt their approach while considering the reasons for any challenges to communication with the person.

Finally, in this part of the framework, the role of 'Signposting/enabling' is outlined, setting out the competences needed to direct people to resources and sources of support. There is the need not only to identify these sources of support, but also to facilitate their uptake by the person, as well as their family and carers if they require support.

*I find it most helpful when someone speaks to me like a person. Special skills are important but, in some settings, basic communication skills are forgotten.*

Rachel Rowan  
Expert by Experience, 2017

### *Education and training, postvention and liaising with others*

The middle column on the map encompasses three distinct, and unrelated, areas of activity.

The first describes the key content that would be expected in ‘Self-harm and suicide awareness and prevention training’ as well as the procedures for delivering this in practice.

The second area of activity is postvention, a term used to refer to interventions that aim to support people who have been bereaved by suicide. The competences contained within ‘Support for people bereaved by suicide’ address the specific characteristics of the process of grieving after a person’s death by suicide and how these should be kept in mind when supporting bereaved individuals. Another focus of postvention is the organisational response to a death by suicide – for example, in a school, university or workplace, where a number of individuals may be affected by a person’s death. ‘Support for people within an organisation after a suicide’ describes the factors that organisations should consider to support those who have been affected by the person’s death, including their peers, colleagues, and others within the organisation, not just those who were close to the person. These competences highlight the importance of supporting members of staff to resume their duties if they have been affected by the death of a person within the organisation, or someone they have been supporting.

Finally, under the heading ‘Liaison with others’, the processes involved in ‘Managing transitions in care within and across services’ are outlined. This is a critical area of activity aimed at maintaining continuity of care and ensuring that vulnerable people are not forgotten about, or are not engaged with, which has been noted by reports from inquiries. This includes the joining up of processes between statutory commissioned services and voluntary and community sector organisations to ensure that the support provided is seamless. Further information can be found in [Section 5.1.4](#). Managing transitions between services

### **5.3.3. Intervention skills for mental health professionals**

The next parts of the framework outline the knowledge and skills needed to deliver an intervention. They are grouped into four sections:

- [generic therapeutic skills](#)
- [assessment and formulation](#)
- [specific interventions](#)
- [structured care and intervention](#)

#### *Therapeutic competences*

‘Generic therapeutic competences’ are a set of underpinning areas of knowledge and skills common to the delivery of all face-to-face interventions for adults and older adults.

Any professional seeking to deliver interventions for adults and older adults who have self-harmed and/or are suicidal should have ‘Specific knowledge of mental health problems’ from their prior training and experience. This forms the core knowledge that enables professionals to engage in work which specifically focuses on self-harm and suicide.



The decision to begin any intervention has to reflect a collaborative choice between the professional and the person, making the 'Ability to collaboratively engage people with the treatment options open to them' a key first step to any treatment. This ensures that people have agreed with the choice of the intervention and are aware of the other options available to them.

The therapeutic alliance is the capacity to build and maintain a therapeutic relationship in which the professional develops a 'bond' with the person and reaches agreement on the goals and activities related to the [assessment](#) and intervention. Developing the alliance depends on an ability to recognise the ways in which the person, their family, carers or significant others understand themselves and the world around them, as well as their own goals, strengths and needs. This makes the 'Ability to foster and maintain a good therapeutic alliance' a core area of skill.

The 'Ability to understand and respond to the emotional content of sessions' is central to all interactions with a person. The professional should reflect on the meaning of the person's expression of emotion and behaviours, and during interventions should elicit emotions that facilitate change. To understand these emotions fully, the professional should also speak to the person's family, carers or significant others, if the person agrees. The people involved in the person's life may be able to provide insight into any meaning behind changes in behaviour. Throughout both assessment and intervention, the professional should hold in mind the level of emotion that is likely to be helpful, for example containing strong expressions of anger, or helping people raise highly sensitive or painful experiences without being overwhelmed by the feelings these might generate.

The end of treatment and care can be a difficult time for people, as well as their family or carers, health and social care team and the professional, making the 'Ability to manage endings' an important area of competence. Disengaging from treatment is often as significant as engaging with it, therefore this process is an integral part of the therapeutic relationship. The professional should manage both planned and unplanned endings (where the person ends contact with services earlier than planned). Where there is a transition in care, professionals should know that this can be potentially destabilising and could represent times of greater risk of self-harm and/or suicide. Professionals should work to make the transition process as smooth as possible by supporting the person to prepare for a transfer of care. If a person is transferring from a children's and young people's service to an adult service, consideration should be given to ensuring that the new service is suited to their developmental stage and capacity and that the family or carers are involved whenever possible. An important consideration in all endings involves the assessment of any risk to the person from discontinuing contact with the service.

There is considerable value in a person's own views on their problems and any changes they have noticed. It is good practice for professionals to have the 'Ability to make use of measures (including monitoring of outcomes)', so that these changes can be recorded systematically. Measures usually capture phenomena that are common to people with a particular problem, whereas free-text records are a way of helping the person to note down their own concerns in their own way. These can be used in conjunction with assessment, interventions and therapies because they draw on current information.

## Assessment and formulation

*I want my care to include a compassionate assessment, which considers my current needs.*

Rachel Rowan  
Expert by Experience, 2017

The part of the framework on 'Assessment and formulation' starts with the 'Ability to undertake a collaborative assessment of risk, needs and strengths'. This is a key area within the framework and it is important to recognise the limitations of assessment. Through research and practice, a large number of

factors have been identified as associated with risk, but these have limited predictive value, meaning that, at best, assessments can only apply to the short-term outlook and should not be used to plan for the longer term. This is not to say that risk assessments should not be undertaken, but to emphasise that they cannot be solely relied on or used as a way of neglecting ongoing observations and assessments that might identify shifts in the person's mental state and intentions. If risk assessments are undertaken, they should be completed as part of safety planning and not in isolation. A second theme in this part of the framework is the importance of undertaking a collaborative person-centred assessment that considers risk in the context of needs.

The assessment of people presenting with self-harm should include consideration of their history and context. The 'Ability to assess a person's wider circumstances' and the 'Ability to assess a person's functioning across contexts' ensures that the person is seen holistically, making it more likely that the factors that have led to self-harm can be determined and understood.

The 'Ability to develop a formulation' is a key step in the assessment process, as this is the point at which information is gathered together into a coherent account that helps to understand the determinants of self-harm and/or suicidal ideation for the person and the factors that maintain it. Arriving at a [formulation](#) is an exercise that should be shared with the person to test its accuracy and to confirm the person's sense of its relevance. Competences on how to do this are written within 'Ability to feedback the results of the assessment and formulation and agree an intervention plan'. Commonly, the intervention plan will involve other professionals and/or other services, and so the 'Ability to coordinate casework across different agencies and/or individuals' may well be a critical part of the planning process. Although the 'Ability to collaboratively engage a person with the intervention plan' is the final part of the assessment process, this is in no way an afterthought. An intervention plan should not be imposed on a person. Rather, professionals should engage the person (and their family or carers) throughout the decision-making process to give them the ability to explore treatment options and understand each fully. Together with the professionals' guidance, they can develop an intervention plan that all parties agree with and understand. If the person feels a lack of control over decisions relating to care, there is a risk that they will disengage, so this is an important part of ongoing support with an adult or older adult.

Within 'Assessment and formulation' there are two sets of competences for 'Specialist assessments'. The first is the 'Ability to conduct a Mental State Examination', which is usually undertaken by individuals with specialist training. For the effective delivery of mental state examination competences, it is vital to integrate them with the core knowledge and

skills set out on the left-hand side of the framework, in the 'Generic therapeutic competences' and the 'Assessment and formulation'. The second specialist assessment is the 'Observation of people at risk of self-harm and suicide', an activity that can be of importance in maintaining the safety of people known to be at high risk of self-harm and/or suicide. Appropriate training and support need to be available to professionals undertaking this task, which should be seen as part of the clinical intervention rather than a stand-alone, 'tick-box' exercise. The competences required for observation might also be applicable to other health care professionals with responsibility for observation, such as emergency department staff or acute general hospital staff.

### *Specific interventions by mental health professionals*

The next part of the framework focuses on 'Specific interventions' for adults and older adults who have self-harmed and/or are suicidal. Evidence-based practice is essential to ensure that the latest evidence is incorporated into frontline practices when working with people who have self-harmed. The gold-standard method for assessing the effectiveness of interventions is randomised controlled trials (RCTs). Recently, two Cochrane Collaboration systematic reviews synthesised the worldwide RCT evidence on the effectiveness of interventions for self-harm in adults.<sup>26 27</sup> These robust systematic reviews suggest that there is now strong evidence that psychological therapies such as problem solving, dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT) can effectively prevent the repetition of self-harm in adults over the age of 18.<sup>27</sup> These 'talking therapies' have also been shown to reduce the psychological distress related to behaviours associated with self-harm and suicide.<sup>27 28</sup> There is, however, little evidence to support the use of psychopharmacological treatments in reducing the repetition of behaviours related to self-harm.<sup>26</sup>

Because of this evidence, the competences on interventions contain detailed accounts of two modality-specific approaches for working with adults and older adults: DBT and CBT.

### *Structured care and intervention*

In many settings, DBT and CBT may be unavailable because these specialist therapies require specific training. Because of this, many people will be in receipt of care and treatment which could contain elements of CBT, psychodynamic approaches and problem solving, and other therapeutic approaches, in line with NICE guidance.<sup>29</sup> This is described in the competences contained in 'Structured care and intervention'. NICE emphasises that the intervention delivered should be tailored to individual need and be specifically structured for people who have self-harmed. Given that the evidence does not strongly favour one therapeutic approach over another, the structured management of self-harm is important. Five 'components' are included here: 'Crisis intervention', 'Clinical management', 'Safety planning', 'Assessment and initial management of self-harm', and 'Interventions for self-harm'. Although there is inevitable overlap between these areas, each is part of a process, applicable at different points in a person's presentation. Although these may not be the only approaches that work in this context, they have been used in practice and if delivered proactively have been found to contribute to keeping a person safe.

A further approach is the 'Collaborative Assessment and Management of Suicidality (CAMS)', a package of care that overlaps with the previous areas of activity and for which

there is some research evidence.<sup>30 31</sup> There is additional evidence to suggest that a collaborative care approach can be particularly beneficial in reducing suicidal ideation in older adults.<sup>32</sup>

Medication also has a part to play in the treatment regimen of people who have self-harmed and/or are suicidal, most commonly for coexisting mental health problems. The competences contained within 'Knowledge of pharmacological interventions' highlight the importance of understanding the interventions that are recommended for people who have self-harmed and/or are suicidal and the knowledge needed to prescribe medication for coexisting mental health problems.

#### 5.3.4. Meta-competences

The final part of the framework identifies overarching [meta-competences](#), which refer to the use of judgement when carrying out an activity or intervention. These are relevant to all aspects of practice, and professionals often need to make decisions about whether, when or how to carry out an activity. Adapting and updating practice in a way that is tailored to the person and consistent with appropriate principles and evidence is an important marker of competence.

## 6. Applications of the competence framework

There are a number of areas in which this competence framework can be applied. Some of these are outlined below.

### 6.1. Curricula

The framework lends itself to the development of curricula for those entering into professional practice from many different backgrounds, ensuring that professionals will be well versed in the competences required to support people who have self-harm and/or are suicidal, and equipped with the confidence to work with them.

*I would like the frameworks to be adopted by higher education institutions when looking at their curricula for various health professionals.*

Stella Branthonne-Foster  
Expert by Experience, 2018

### 6.2. Training

Effective training is vital to ensuring increased access to well-delivered, psychologically informed approaches and interventions. The framework can support this by providing:

- a clear set of competences that can guide and refine the structure and curriculum of training programmes, including pre- and post-qualification professional training, across all professions, as well as the training offered by independent organisations
- a system for the evaluation of the outcome of training programmes.

### 6.3. Commissioning

Commissioners can use this framework to ensure that the services they commission and the training programmes they provide meet the competences. This will help to inform commissioners about any local policies and procedures that need to be updated or put in place, such that services can operate within the bounds of the framework.

### 6.4. Service organisation

Services should use this framework to evaluate their current practice and processes to ensure that professionals are able to meet the competences set out in the framework. This may include creating safer environments for individuals and ensuring that there is enough capacity within the service. This will mean that professionals can deliver care effectively, which will subsequently enhance and improve both the quality of care and the safety of those receiving it.

## 6.5. Clinical governance

This framework can be used in clinical governance processes by ensuring that the care delivered is in line with the competences. By evaluating existing practice against the framework, services and professionals can begin to improve the quality of care they provide.

## 6.6. Supervision

The competences described in the framework can be used in [supervision](#) by both the person receiving supervision and the supervisor. The person receiving supervision can use the competences in their reflective practice, considering the areas where they could improve their practice in line with the framework. Similarly, the supervisor can use the framework as a tool to guide discussion on reflective practice, identifying areas for growth and learning. This can then be addressed through additional training and support during future supervision.

## 6.7. Research

Research studies and audits can be used to benchmark the degree to which services comply with the competences listed in the framework and how these patterns of service delivery change with time.

## 7. Definitions

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### 7.1. Suicide, self-harm and prevention

Academic, clinical and public health bodies vary in their definitions of suicide, self-harm and prevention. For the purpose of this body of work, we have chosen to use the following definitions.

#### *Prevention*

'Interventions designed to reduce the occurrences of new cases', after the US National Academy of Medicine (formerly the Institute of Medicine).<sup>33</sup>

#### *Self-harm*

We use the National Institute for Health and Care Excellence's (NICE's) definition of self-harm:<sup>29 34 35</sup>

*'[...] any act of non-fatal self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.'*

#### *Suicide*

Suicides are defined as 'deaths by intentional self-harm and deaths of undetermined intent by individuals aged 10 and over', following the 2017 report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).<sup>36</sup>

#### *Suicide attempt*

An act of self-harm in which the person intended to die, and believed that the means and method of the attempt would be fatal.

### 7.2. Other terms used in the framework

#### *Assessment*

A discussion between a person and a professional, usually with a health and social care background (though some other professionals may also conduct assessments) about the person's mental and physical health, family background, everyday life, and any other factors that are important to the person. This discussion helps the professional to understand what the person is experiencing and how complex their problems might be in order to inform plans for support, care and treatment. Family, carers and significant others may also be involved in this discussion with the person's agreement.

*Formulation*

A collaborative process between a person and one or more mental health professional(s) to understand the person's mental health needs. During a formulation the professional will draw on psychological theory, social, environmental and biological factors to develop a series of working hypotheses and formulation of need, including an initial diagnosis.

*Intersectionality*

A theory of intersecting systems of oppression and discrimination. The theory proposes that some people are subject to multiple forms of exclusion because of the complex ways that certain characteristics, including gender, ethnicity, sexual orientation, disability and/or socioeconomic status, intersect.

*Meta-competences*

Overarching competences that guide practice and the implementation of any intervention. Examples include using judgement and adapting interventions according to feedback from people who use mental health services.

*Postvention*

An intervention which takes place after a death by suicide. It involves providing support for those who have been bereaved. This includes family, friends, professionals and peers.

*Protected characteristics*

The nine groups that are protected in the UK under the [Equality Act 2010](#). These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

*Risk assessment*

This refers to the comprehensive assessment of risk by a suitably qualified professional for an individual who is expressing suicidal ideation, or presenting with self-harm or a suicide attempt. It does not refer to the use of a specific risk assessment tool.

*Safety plan*

A co-produced, personalised plan that includes practical ways to help keep a person safe. This might include strategies that are known to help the person during times of distress, details of people or services to contact during a crisis, or reducing access to means to harm oneself.

*Supervision*

An activity that gives professionals the opportunity to review and reflect on their clinical work. This includes talking about areas or events that might have been experienced as difficult or distressing for the professional. The person who provides supervision (the 'supervisor') will be a more senior and/or experienced professional, but some organisations also use peer supervision effectively. Supervision is distinct from line management or case management.



*Transitions*

The planning and process of transfers of care, from the initial planning, through the transfer itself to the follow-up support. This includes transitions between services, transitions from children and young people's services to adult services and transitions from inpatient to community services.

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<sup>36</sup> The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. : Manchester: University of Manchester; 2017.

## Appendix A: Expert Reference Group members

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### Project team

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## Appendix B: NICE guideline evidence search

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NICE guidelines were reviewed to identify any quality statements and recommendations that are relevant to self-harm and suicide prevention in adults and older adults. These guidelines were considered relevant:

- [Antenatal and postnatal mental health: clinical management and service guidance](#)
- [Bipolar disorder: assessment and management](#)
- [Borderline personality disorder: recognition and management](#)
- [Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges](#)
- [Coexisting severe mental illness \(psychosis\) and substance misuse: assessment and management in healthcare settings](#)
- [Coexisting severe mental illness and substance misuse: community health and social care services](#)
- [Depression in adults with a chronic physical health problem: recognition and management](#)
- [Depression in adults: recognition and management](#)
- [Eating disorders: recognition and management](#)
- [Generalised anxiety disorder and panic disorder in adults: management](#)
- [Obsessive-compulsive disorder and body dysmorphic disorder: treatment](#)
- [Post-traumatic stress disorder: management](#)
- [Preventing suicide in community and custodial settings](#)
- [Self-harm in over 8s: long-term management](#)
- [Self-harm in over 8s: short-term management and prevention of recurrence](#)
- [Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services](#)
- [Transition between inpatient mental health settings and community or care home settings](#)

Alongside these NICE guidelines, quality statements from the following quality standards were reviewed

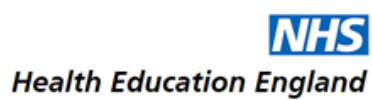
- [Self-harm](#)
- [Service user experience in adult mental health services](#)
- [Transition between inpatient mental health settings and community or care home settings](#)

Table 1 details the main quality statements that should be considered when working with an adult who may currently be experiencing suicidal ideation or be engaging in suicidal behaviour, or who may have recently exhibited suicidal behaviours.

**Table 1: NICE quality statements relevant to self-harm and suicide prevention**

NICE quality statement	NICE quality standard
People using mental health services who may be at risk of crisis are offered a crisis plan.	<a href="#">QS14: Service user experience in adult mental health services, quality statement 9</a>
People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.	<a href="#">QS14: Service user experience in adult mental health services, quality statement 10</a>
People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.	<a href="#">QS34: Self-harm, quality statement 1</a>
People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.	<a href="#">QS34: Self-harm, quality statement 2</a>
People who have self-harmed receive a comprehensive psychosocial assessment.	<a href="#">QS34: Self-harm, quality statement 3</a>
People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.	<a href="#">QS34: Self-harm, quality statement 4</a>
People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.	<a href="#">QS34: Self-harm, quality statement 5</a>
People receiving continuing support for self-harm have a collaboratively developed risk management plan.	<a href="#">QS34: Self-harm, quality statement 6</a>
People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.	<a href="#">QS34: Self-harm, quality statement 7</a>
People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.	<a href="#">QS34: Self-harm, quality statement 8</a>
People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged.	<a href="#">QS159: Transition between inpatient mental health settings and community or care home settings, quality statement 4</a>





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