National Institute for Health and Care Excellence

Draft for consultation

Self-harm: assessment, management and preventing recurrence

[P] Evidence review for skills required by staff in specialist settings

NICE guideline number tbc

Evidence reviews underpinning recommendations .10.5-6, 1.13.1-1.13.4 in the NICE guideline

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Draft for consultation

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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Contents

Skills required by staff in specialist settings ... 6
Review question ... 6
Introduction ... 6
Summary of the protocol ... 6
Methods and process ... 7
Qualitative evidence ... 7
Summary of included studies ... 9
Summary of the evidence ... 34
Economic evidence ... 38
Economic model ... 39
Evidence statements ... 39
The committee's discussion and interpretation of the evidence ... 39
Recommendations supported by this evidence review ... 46
References – included studies ... 47
Appendices ... 49
Appendix A Review protocols ... 49
Review protocol for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? ... 49
Appendix B Literature search strategies ... 54
Literature search strategies for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? ... 54
Appendix C Qualitative evidence study selection ... 75
Study selection for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? ... 75
Appendix D Evidence tables ... 76
Evidence tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? ... 76
Appendix E Forest plots ... 248
Forest plots for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in

specialist mental health settings who assess and treat people who have self-harmed? 248

Appendix F GRADE-CERQual tables 249

GRADE tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 249

Appendix G Economic evidence study selection 277

Study selection for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 277

Appendix H Economic evidence tables 278

Economic evidence tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 278

Appendix I Economic model 279

Economic model for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 279

Appendix J Excluded studies 280

Excluded studies for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 280

Appendix K Research recommendations – full details 294

Research recommendations for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 294

Appendix L Qualitative quotes 295

Qualitative quotes for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed? 295

Skills required by staff in specialist settings

Review question

What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Introduction

Specialist mental health staff are likely to work with people who self-harm and require a range of specific skills in order to ensure a high quality of care. Therefore, the objective of this review is to identify the views and preferences of specialist staff, people who have self-harmed and their family members/carers about what skills are required for specialist staff who assess and treat people who have self-harmed.

Summary of the protocol

See **Error! Reference source not found.** for a summary of Population, Phenomenon of interest and Context (PPC) characteristics of this review.

Table 1: Summary of the protocol (PPC table)

Population	Inclusion: • Staff in specialist mental health settings that assess and/or treat people who have self-harmed • People who have self-harmed and been assessed and/or treated in specialist mental health settings, including people who have self-harmed and have a mental health problem, neurodevelopmental disorder or a learning disability • Family members/carers of people who have self-harmed and been assessed and/or treated in specialist mental health settings, including people who have self-harmed and have a mental health problem, neurodevelopmental disorder or a learning disability. Exclusion: People displaying repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability
Phenomenon of interest	Views and preferences of the population about staff skills regarded as required/ not required or important/ not important Themes will be identified from the literature, but may include: • Empathy • Knowledge • Language

	• Communication style
Context	Settings - Inclusion: All specialist mental health settings

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Qualitative evidence

Included studies

The qualitative aspects of 4 mixed-methods studies (Berger 2014, Hom 2020a, Hom 2020b, Idenfors 2015) and 32 qualitative studies in 34 articles (Alonzo 2017, Awenat 2017, Behrman 2019, Berg 2020, Borrill 2005, Christianson 2008, Craigen 2009, de Stefano 2012, Dunkley 2014, Dunkley 2018, Hagen 2017a, Hagen 2017b, Hagen 2018, Karman 2015, Kelada 2017, Kool 2009, Lahoz 2020, Lees 2014, Lindgren 2004, Littlewood 2019, Long 2010, McGough 2021, Mughal 2021, O'Donovan 2007, Omerov 2020, Rissanen 2012, Rowe 2017, Simoes 2020, Storey 2005, Talseth 2001, Te Maro 2019, Vatne 2016, Wadman 2018, Wilstrand 2007) were included for this review. Two articles reported results from the same study (Dunkley 2014, Dunkley 2018), and another 2 articles reported results from overlapping populations from the same study (Hagen 2017a, Hagen 2017b).

The included studies are summarised in Table 2.

The studies were carried out in the following countries: UK (Awenat 2017, Borrill 2005, Dunkley 2014, Dunkley 2018, Littlewood 2019, Long 2010, Mughal 2021, Storey 2005, Wadman 2018); Australia (Berger 2014, Kelada 2017, Lees 2014, McGough 2021); Canada (Christianson 2008, de Stefano 2012); Denmark (Lahoz 2020); Finland (Rissanen 2012); Ireland (O'Donovan 2007); the Netherlands (Karman 2015, Kool 2009); New Zealand (Rowe 2017, Te Maro 2019); Norway (Berg 2020, Hagen 2017a, Hagen 2017b, Hagen 2018, Talseth 2001, Vatne 2016); Portugal (Simoes 2020); Sweden (Idenfors 2015, Lindgren 2004, Omerov 2020, Wilstrand 2007); USA (Alonzo 2017, Behrman 2019, Craigen 2009, Hom 2020a, Homa 2020b).

Studies exploring views and preferences regarding skills of specialist mental health staff regardless of setting were included in this review. At the time of agreeing the protocol, the objective of the review was to identify the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed. However, the committee later agreed the best way to summarise evidence regarding staff skills would be according to the specialty of the staff rather than the setting, because some non-specialist staff may work in specialist settings, and it would be inappropriate to suggest they should have the same skillset as specialist mental health staff. Therefore, this review summarised evidence regarding skills required by specialist mental health staff, while another review was conducted to summarise evidence regarding skills required by non-specialist staff (see Evidence Report R). A sense check was done to see whether summarising the evidence according to setting would have shown an important difference between the skills required by staff in specialist settings and those required by staff in non-specialist settings, however this instead showed significant overlap between

groups. On the other hand, while the requested training and desired skills of specialist and non-specialist staff were similar, the specialty of the staff member determined many of the subtle differences between themes, such as their understanding of why people self-harm and need for training in this area.

Of the specialist settings, the following were represented in the included studies:

- inpatient healthcare:
    - open and locked psychiatric wards including acute wards, crisis units, general psychiatric wards, rehabilitation wards, units for psychosis, adolescent psychiatry departments, or other specialized wards: Berg 2020, Hagen 2017a, Hagen 2017b, Hagen 2018, O'Donovan 2007, Rissanen 2012, Vatne 2016, Wilstrand 2007
    - psychiatric inpatient hospitals: Talseth 2001
    - mental health clinics: Awenat 2017
    - suicide prevention clinics: Lahoz 2020
- outpatient healthcare:
    - mental health clinics: Alonzo 2017
    - psychiatric outpatient care: Omerov 2020
    - voluntary and private counselling sectors: Long 2010
- inpatient and outpatient healthcare:
    - psychiatric intensive treatment centre with an inpatient and an outpatient clinic: Kool 2009
    - inpatient and outpatient mental health facilities: Karman 2015
    - inpatient & outpatient psychiatric care: Lindgren 2004

The following non-specialist settings were represented in the included studies:

- healthcare:
    - primary care: Mughal 2021
    - emergency departments (EDs): Storey 2015
    - inpatient service rooms or outpatient consultation offices: Simoes 2020
- community:
    - residential settings or in the community: Hom 2020a, Hom 2020b, Rowe 2017
    - foster care or residential homes for looked after children and young people: Wadman 2018
- education:
    - secondary education: Berger 2014, Te Maro 2019
    - state and private schools: Kelada 2017
    - university: Christianson 2008, Craigen 2009
- prison: Borrill 2005

Six studies represented mixed settings:

- mixed non-specialist:
    - healthcare - outpatient (primary care) and community: Behrman 2019
    - community (addictions services) and education (high schools; university counselling centres; community colleges; specialised schools for students with behavioural problems): De Stefano 2012
- mixed specialist:
    - adult community and inpatient settings within a public mental health service: Lees 2014
    - community (crisis and home treatment teams; community mental health teams), inpatient (mental health units), and outpatient (psychological services): Littlewood 2019
    - community (mental health community treatment teams; an assessment and brief intervention team; an assertive outreach team), inpatient (psychiatric inpatient units; a psychiatric intensive care unit; a mother and baby mental

health inpatient unit), and outpatient (psychological therapies services): Dunkley 2014, Dunkley 2018

- mixed specialist and non-specialist:
    - ED, psychiatric emergency services, child and adolescent psychiatry clinic, and a psychiatric inpatient ward: Idenfors 2015

One study did not explicitly report the setting and it was unclear from the information reported (McGough 2021).

The studies included people in the following population groups:

- specialist staff who worked with people who have self-harmed: Berger 2014, de Stefano 2012, Karman 2015, Long 2010, McGough 2021, O'Donovan 2007, Rissanen 2012, Te Maro 2019, Wilstrand 2007
- specialist staff who worked with suicidal patients, including those with suicidal ideation: Alonzo 2017, Awenat 2017, Berg 2020, Christianson 2008, Hagen 2017a, Hagen 2017b, Lahoz 2020, Littlewood 2019, Omerov 2020, Talseth 2001
- people who have self-harmed: Borrill 2005, Craigen 2009, Hom 2020a, Hom 2020b, Idenfors 2015, Kool 2009, Lindgren 2004, Mughal 2021, Rowe 2017, Storey 2005, Vatne 2016, Wadman 2018
- people with suicidal ideation or attempt: Hagen 2018, Simoes 2020
- mixed populations:
    - specialist staff who work with people who have self-harmed and parents/ carers of people who have self-harmed: Kelada 2017
    - people who have self-harmed and specialist staff who worked with suicidal patients, including those with suicidal ideation: Dunkley 2014, Dunkley 2018
    - people with suicidal ideation or attempt and specialist staff who worked with suicidal patients, including those with suicidal ideation: Lees 2014
    - people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients, including those with suicidal ideation: Behrman 2019

Any studies including family members/ carers of people with suicidal ideation or who had died by suicide, people with suicidal ideation or attempt (which did not specify whether the patients had self-harmed), or specialist staff who worked with suicidal patients (which did not specify whether the patients had self-harmed) were marked down for relevance, but not excluded if it was unclear whether the patients had self-harmed.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix J.

Summary of included studies

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies

Study and aim of the study	Population	Methods	Author themes
Alonzo 2017 **Aim of the study:** To examine the	N=36 clinicians **Mean age (SD):** 39.07 (9.47)	**Study dates:** Not reported.	• Definition of Treatment Engagement

Study and aim of the study	Population	Methods	Author themes
perspective of practicing outpatient mental health clinicians who work on a daily basis with clients at high risk for suicide. **Country:** USA	**Sex (female/ male):** 29/ 7 **Role:** Outpatient mental-health clinician: 36 **Setting:** Outpatient mental-health clinic **Mean years in post/ experience (SD):** 9.9 (9.05) **Client group (adults, children/ CYP):** Not reported	**Data collection and analysis:** Four focus groups lasting 1.5 hours on average were held, using a semi-structured interview guide. Discussions were audio-recorded and field notes were taken by two of the authors, which were all transcribed verbatim. Data were analysed thematically using inductive content analysis.	• Indicators of Client Engagement • Facilitators of Treatment Engagement
Awenat 2017 **Aim of the study:** To investigate staff experiences of working with in-patients who are suicidal **Country:** UK	N= 20 healthcare staff **Mean age (SD):** Not reported **Sex (female/ male):** 14/ 6 **Role:** Nurses: 8 Nursing assistants/ support workers: 2 Psychiatrists: 4* Allied health professionals (including clinical psychologists, clinical social workers and occupational therapists): 6* *Only data from these groups of participants were extracted **Setting:** Inpatient mental-health clinics **Range of years in post/ experience:** 4-38 **Client group (adults, children/ CYP):** Not reported.	**Study dates:** Not reported **Data collection and analysis:** Semi-structured interviews (average of 64 minutes) using a flexible topic guide. Interviews were audio-recorded and transcribed verbatim, and data were analysed using thematic analysis.	• Talking about suicide

Study and aim of the study	Population	Methods	Author themes
Behrman 2019 **Aim of the study:** To identify what parents, adolescent, and physicians believe paediatricians should know about adolescent depression and anxiety to detect early signs of suicidal intent. **Country:** USA	N=45 (n=19 healthcare staff; n=11 people with histories of suicidal ideation/attempt; n=15 parents of people who died by suicide or are receiving behavioural health services for depression/anxiety) **Staff participants:** **Mean age (SD):** Not reported **Sex (female/ male):** 13/ 6 **Role:** Paediatric residents: 8 Adolescent behavioural healthcare providers (including clinical social workers, psychologists, and licensed professional counsellors): 11* *Of the staff participants, only data from this group of participants were extracted **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported. Paediatric residents had 3 or more years of clinical practice **Client group (adults, children/ CYP):** Children and young people. **People who have self-harmed:** **Mean age (range):** Not reported (14-18 years) **Sex (female/male):** Not reported. Authors	**Study dates:** Not reported **Data collection and analysis:** Five focus groups were conducted with paediatric residents, adolescents, parents of adolescents who died by suicide, parents with adolescents in the mental health system, and community mental health professionals. 2 researchers coded the transcripts in several stages with constant comparisons between the researchers. First, themes were identified from each focus group and then were compared with other groups to identify themes that overlapped. The research team compared their interpretations of themes, individually and then as a group, to agree the final list of themes.	• Broken mental health care system • Importance of communication • Stigma associated with mental health care • Addressing medications and substance abuse

Study and aim of the study	Population	Methods	Author themes
	stated that patients were 'equally mixed male and female'. **Ethnicity:** Caucasian: 10 African-American: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported **Family members/ carers:** **Mean age (SD):** Not reported **Sex (female/male):** Not reported **Relationship to person who has self-harmed:** Parent: 15.		
Berg 2020 **Aim of the study:** To understand healthcare professionals' capacities to adapt to challenges and changes in clinical care for suicidal patients hospitalised in mental health wards **Country:** Norway	N= 32 mental healthcare professionals **Mean age (SD):** Not reported **Sex (female/male):** 28/7 **Role:** Registered mental health nurses: 14 in focus groups; 11 in interviews Physicians and consultant psychiatrists: 6 in focus groups; 4 in interviews Psychologists: 5 in focus groups; 3 in interviews	**Study dates:** May to December 2016 **Data collection and analysis:** Focus groups (90 minutes) with open-ended questions and individual interviews to explore themes generated during focus groups. Interviews were audio-recorded and transcribed verbatim, and data were analyses by thematic analysis	• Managing uncertainty - Building mutual collegial trust and support

Study and aim of the study	Population	Methods	Author themes
	Setting: 9 inpatient specialist mental health care wards. The locked wards specialised in: Psychosis: 1 Affective disorders: 1 Acute care: 2. The open wards specialised in: Rehabilitation: 3 Short term stabilisation during crisis: 2 **Range of years in post/ experience:** 1-24 **Client group (adults, children/ CYP):** Adults		
Berger 2014 **Aim of the study:** To explore the response and training needs of Australian secondary school staff towards NSSI among adolescents. **Country:** Australia	N=768 school staff **Mean age (SD):** Not reported **Sex (female/ male):** 556/ 212 **Role:** Student teachers: 267 Teachers: 261 School mental health workers (counsellors, psychologists and welfare coordinators): 106* School leaders & deputies: 83 Administrative and support staff (school nurses, teacher aides and office staff): 52 *Only data from these groups of participants were extracted **Setting:** Secondary education **Mean years in post/ experience (SD):** For	**Study dates:** Not reported. **Data collection and analysis:** The online questionnaire took between 30 and 40 min to complete. Participants were asked several open-ended questions to understand how they respond to students who self-injure and their training needs. Themes were developed from these open-ended responses. Responses were re-read and re-coded to verify themes, and to validate any new themes or merge existing themes.	• Perceived confidence in response to students who self-injure • Barriers to responding to students who self-injure • Directions for future training

Study and aim of the study	Population	Methods	Author themes
	in-service teachers & staff 14.75 (11.01) years; the student teachers had between 2 to 22 weeks of school placement **Client group (adults, children/ CYP):** Children (12 to 18 years)		
Borrill 2005 **Aim of the study:** To explore the prediction that female prisoners self-harm in response to events and experiences rather than primarily for symptomatic relief, and to learn lessons that could prevent future incidents and improve care. **Country:** UK	N=15 women who had self-harmed in prison **Mean age (range):** not reported (19-50 years) **Sex (female/male):** 15/ 0 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** at least 1 attempt: 15	**Study dates:** 2002-2003 **Data collection and analysis:** Participants had individual semi-structured interviews focusing on their recent suicide attempt. The first stage of analysis was open coding of each interview. These codes were then examined and grouped into key themes with illustrative quotes. Common themes and individual differences within the group of women were explored. The analysis was carried out by one of the researchers and checked by the other interviewers.	• Vulnerability Factors and Precipitating Factors • What Makes a Difference?
Christianson 2008 **Aim of the study:** To explore the experiences of school counsellors who have lost students to suicide **Country:** Canada	N= 7 school counsellors **Mean age (SD):** not reported **Sex (female/male):** 3/4 **Role:** School counsellor: 7 **Setting:** Education – schools **Range of years in post/ experience:** 15-31	**Study dates:** not reported **Data collection and analysis:** Individual in-depth telephone interviews conducted (two interviews, between 1-2 hours) using semi-structured interview questions. Interviews transcribed and sent to participants for clarification and verification. Data examined inductively using a grounded theory	• National Training/ Practice Standards • Self-care

Study and aim of the study	Population	Methods	Author themes
	Client group (adults, children/ CYP): Children	approach. Constant comparative method used to identify major themes, which were linked together into higher-order categories.	
Craigen 2009 **Aim of the study:** To explore the counselling experiences of young adult women with a history of self-injury **Country:** USA	N=10 university students with a history of self-harm **Mean age (SD):** Not reported **Sex (female/male):** 10/ 0 **Ethnicity:** White European-American: 8 African-American: 1 Latina: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported.	**Study dates:** Not reported. **Data collection and analysis:** Two 2 hour face-to-face semi-structured interviews were conducted with each participant using an interview guide with open-ended questions, and recorded. Data collection continued until saturation was achieved, and data were analysed using a phenomenological method.	• My counsellor • The counselling process • Counselling reflections
de Stefano 2012 **Aim of the study:** to explore the experiences of counsellors in training who work with people who self-harm **Country:** Canada	N= 12 counselling psychology students **Mean age (range):** Not reported (23-37 years) **Sex (female/ male):** 12/ 0 **Role:** Counselling psychology students: 12 **Setting:** Education - university. Students interned at the following sites: High schools: 7 University counselling centres: 2 Community college: 1	**Study dates:** not reported **Data collection and analysis**: Semi-structured interviews (45-60 minutes) with open-ended questions. Consensual qualitative research method used. Cross-case analysis used to compare and categorise core ideas across all participants and consensus used to discuss emerging themes.	• Trainees use common sense to construct a basic model of NSSI despite lack of previous knowledge of the phenomenon • Work with NSSI stress and challenge trainees at many levels • Experience provides new but incomplete learning

Study and aim of the study	Population	Methods	Author themes
	Addictions service: 1 Specialised high school for students with behavioural problems: 1 **Range of years in post/ experience:** 0 **Client group (adults, children/ CYP):** Adults and CYP (most students interned at high schools, colleges and university counselling centres).		
Dunkley 2014 **Aim of the study:** 1. To investigate what suicidal patients identify as being 'in emotional pain' and how they perceive staff will know that this is their experience 2. To explore what mental health professionals recognise and understand as 'emotional pain' in their patients, and how they identify when a patient is in emotional pain 3. To identify and explore factors that that hinder or facilitate emotional pain communication between staff and patients 4. To capture insights within the data that might inform practice and identify further areas of research. 5 To inform and advance the development of emotional pain as a theoretical concept **Country:** UK	N=35 patients and staff members (n = 26 staff members; n = 9 suicidal patients (10 patient participants were recruited, but 1 withdrew before the formal interview was held)). **Staff participants:** **Mean age (SD):** Not reported. A variety of ages was represented. **Sex (female/ male):** Not reported. The groups of nurses and psychologists were all female and the other groups were mixed gender groups. **Role:** Occupational therapists: 6 Community mental health nurses: 5 Clinical social workers: 5 Psychologists: 5 Psychiatrists: 5 **Setting:** Clinical groups represented were: Community: 7 (Mental health community treatment teams: 5;	**Study dates:** Not reported. **Data collection and analysis:** Focus groups were held with mental healthcare staff using a brief inventory as a prompt sheet, as well as a second printed sheet containing a list of items based on DeCoster's (1997) research into the reactions of general practitioners when confronted with emotional communication from their patients. This was introduced towards the end of the focus groups to prompt further discussion. Individual interviews lasting from 45 minutes to 1.5 hours were held with patients who had self-harmed using an interview schedule, and contact details given to participants to provide further comments after the interview as needed. All groups and interviews were digitally recorded.	• Unspoken and Unheard • Spoken and Unheard • Spoken and also heard • Unspoken but still heard

Study and aim of the study	Population	Methods	Author themes
	assessment and brief intervention team: 1; assertive outreach team: 1) Inpatient: 4 (psychiatric inpatient units: 2; psychiatric intensive care unit: 1; mother and baby mental health inpatient unit: 1) Outpatient: 2 (psychological therapies services) **Range of years in post/ experience:** Not reported. A variety of years of experience was represented. **Client group (adults, children/ CYP):** Adults. **Patient participants:** **Mean age (range):** Not reported (27-58 years) **Sex (female/male):** 9/ 0 **Ethnicity:** Not reported **Co-morbidity:** Diagnoses were not mutually exclusive: Depression: 8 Anxiety: 7 Severe physical health or disability problem: 6 Personality disorder: 5 Schizophrenia: 2 Anorexia Nervosa: 2 Obsessive Compulsive Disorder: 2 Phobia: 2 **Duration of self-harm:** Not reported **Suicide attempts:**	Data from patients and staff members were combined and analysed using iterative, inductive thematic analysis with a critical realist approach, whereby fragments of transcripts were coded into categories, which then merged into overarching themes.	

Study and aim of the study	Population	Methods	Author themes
	At least 1 medically serious suicide attempt: 9		
Dunkley 2018 See Dunkley 2014.	See Dunkley 2014.	See Dunkley 2014.	• Unspoken Communication – Alienated and Wordless • Spoken But Unheard – Misaligned • Spoken and Unheard/Heard: Depersonalized Versus Individualized
Hagen 2017a **Aim of the study:** To explore and compare therapists' and mental health nurses' experiences of caring for suicidal inpatients **Country:** Norway	N=16 mental health professionals **Mean age (range):** Not reported (28-60 years) **Sex (female/ male):** 10/ 6 **Role:** Psychiatrists: 4 Psychologists: 4 Mental health nurses: 8 **Setting:** Psychiatric wards, including: Acute ward or crisis unit: 11 Other (general psychiatric ward, rehabilitation ward, unit for psychosis, or another specialised ward): 5 **Range of years in post/ experience:** 2-30 years **Client group (adults, children/ CYP):** Not reported.	**Study dates:** Not reported **Data collection and analysis:** Semi-structured interviews conducted and confirmatory questions used to clarify experiences and views. Interviews recorded and transcribed verbatim. Data analysed using thematic framework analysis.	• Connection and care • Duty and control
Hagen 2017b See Hagen 2017a	N=8 mental health nurses **Mean age (range):** 43-60 years	See Hagen 2017a	• Alertness to Suicidal Cues • Relieving Psychological Pain and Inspiring Hope

Study and aim of the study	Population	Methods	Author themes
	Sex (female/ male): 7/ 1 **Role:** Mental health nurses: 8 **Setting:** Psychiatric wards, including: Acute ward: 5 Acute/ crisis unit: 1 Specialised ward: 1 Rehabilitation ward: 1 **Range of years in post/ experience:** 5-25 years **Client group (adults, children/ CYP):** Not reported.		• Regulation of Emotions and Emotional Expressions • Balancing Emotional Involvement and Professional Distance
Hagen 2018 **Aim of the study:** To explore how former suicidal inpatients experienced treatment and care in psychiatric wards in Norway following the implementation of the National guidelines for prevention of suicide in mental health care. **Country:** Norway	N=5 former psychiatric inpatients **Mean age (range):** Not reported (33-54 years) **Sex (female/male):** 4/ 1 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Admitted to acute ward because of a suicide attempt: 3 Admitted to acute ward because they were close to attempting suicide: 2	**Study dates:** Not reported. **Data collection and analysis:** In-depth, individual semi-structured interviews lasting 31 to 114 minutes were held, using an interview schedule to guide the interview if necessary. Interviews were recorded and transcribed verbatim. Data were analysed using interpretative phenomenological analysis.	• Seeking a sense of companionship to feel safe to share their suffering and suicidality • Seeking individualized treatment and care to feel recognized as a valuable person
Hom 2020a **Aim of the study:** To identify and synthesize suicide attempt	N=329 suicide attempt survivors **Mean age (SD):** 35.07 (12.18) years	**Study dates:** Not reported **Data collection and analysis:** Participants	• Provider interactions • Intake and treatment planning • Treatment delivery • Structural issues

Study and aim of the study	Population	Methods	Author themes
survivors' recommendations for how to enhance mental health treatment experiences for attempt survivors. **Country:** USA	**Gender:** Female: 268 Male: 33 Transgender, non-binary: 12 Transgender female: 0 Transgender male: 7 Other: 8 Did not state: 1 **Race:** White/ Caucasian: 283 Asian/Pacific Islander: 14 Black/ African American: 6 Native American or Alaska Native: 5 Other: 21 **Co-morbidity*:** Mean number of psychiatric diagnoses per person: 4.61 (2.09) Anxiety disorder: 239 Bipolar disorder: 106 Borderline personality disorder: 81 Depressive disorder: 273 Eating disorder: 59 Post-traumatic stress disorder (PTSD): 159 Schizophrenia: 8 Substance use disorder: 42 Other: 66 None: 16 *Self-reported. Categories are not mutually exclusive **Suicide attempts:** Mean number of suicide attempts per person (SD): 3.47 (4.89) Single attempt: 96 Multiple attempts: 232 Missing data: 1	completed a brief web-based self-report survey, which included an open-ended response question. Data were extracted into a Microsoft Excel worksheet and an initial list of themes was created and reviewed. The finalised coding scheme was then used to code all of the written responses independently.	

Study and aim of the study	Population	Methods	Author themes
Hom 2020b **Aim of the study:** To examine attempt survivors' experiences interfacing with mental health care services. **Country:** USA	N=96 suicide attempt survivors **Mean age (SD):** 35.05 (11.43) years **Gender:** Female: 64 Male: 31 Gender non-conforming: 1 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** At least 1 suicide attempt: 96	**Study dates:** 2011-2017 **Data collection and analysis:** Authors analysed transcripts from unstructured interviews lasting between 120-150 minutes, held during the Live Through This project. Interviews were recorded, transcribed, and analysed using quantitative and qualitative processes.	• Positive factors: Provider-related factors • Positive factors: Treatment-related factors • Negative factors: Provider-related factors • Negative factors: Treatment-related factors
Idenfors 2015 **Aim of the study:** To explore young people's perceptions of care and support during a 6-month period following their first contact for DSH. **Country:** Sweden	N=9 young people who had self-harmed (n = 10 were initially interviewed but 1 declined participation in the follow-up interview) **Mean age (range):** 20 (17-24) years **Sex (female/male):** 5/4 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported. All participants had first self-harmed at most 6 months before data were collected. **Suicide attempts:** Not reported.	**Study dates:** 2009-2011 **Data collection and analysis:** Individual structured interviews using open-ended questions were held 6 months after the person's first healthcare contact for deliberate self-harm. Data were analysed into meaning units, which were then condensed and assigned a code. The codes were refined into categories and continuously checked against the original interview texts. Common themes were constructed from the categories.	• Having trust in the care of the professionals

Study and aim of the study	Population	Methods	Author themes
Karman 2015 **Aim of the study:** To investigate professional behaviour of mental health nurses with positively changed attitudes after following a training program. **Country:** The Netherlands	N=11 mental health nurses **Mean age (range):** 41.6 (26-57) years **Sex (female/ male):** 9/ 2 **Role:** Mental health nurses: 11 **Setting:** Clinical groups represented were: Inpatient mental health care facilities: 6 Outpatient mental health care facilities: 5 **Mean number of years in post/ experience (range):** 17.2 (4-32) years **Client group (adults, children/ CYP):** Not reported.	**Study dates:** Not reported. **Data collection and analysis:** Semi-structured interviews using open-ended questions were held using an interview guide that was informed by the emerging conceptual model, and lasted between 40 to 60 minutes. Interviews were digitally recorded and transcribed verbatim. Data were analysed using a systematic constant comparison approach consistent with grounded theory methods	• Behavioural changes • Influence of the Training Program on Nurses' Attitudes Towards Self-Harm
Kelada 2017 **Aim of the study:** to understand how school mental health staff and parents of secondary school students view self-harm to determine how parent-school communication and responses to self-harm can be improved **Country:** Australia	N=29 (n= 10 parents of adolescents who had self-harmed; n = 19 school mental health staff) **Staff participants:** **Mean age (SD):** Not reported **Sex (female/ male):** 14/ 5 **Role:** Wellbeing/ welfare coordinators: 12 School counsellors: 4 School psychologists: 3 **Setting:** School types represented were: State schools: 15 Private schools: 4	**Study dates:** Not reported **Data collection and analysis:** Semi-structured interviews conducted (approx. 30 minutes) with open-ended questions (4 conducted face-to-face and 15 conducted via telephone). Interviews recorded and transcribed verbatim. Data analysed by thematic analysis.	• Future sector-wide policy • Support for school mental health staff

Study and aim of the study	Population	Methods	Author themes
	Mean years in post/ experience (SD): 12.53 (9.05) years **Client group (adults, children/ CYP):** Children **Parent participants:** **Mean age (SD):** 45.20 (3.52) years **Sex (female/male):** 10/ 0 **Relationship to person who has self-harmed:** Mother: 10		
Kool 2009 **Aim of the study:** To study behavioural change in cases of self-injury, based on the following key questions: 1. How does the process of reducing or stopping self-injury develop in patients with a history of severe self-injury? 2. What factors play a role in that process? **Country:** The Netherlands	N=12 women with a history of self-harm **Mean age (range):** 39 (26-60) years **Sex (female/male):** 12/ 0 **Ethnicity:** Not reported **Co-morbidity:** Not reported in the data but participants were excluded if they had comorbid psychotic symptoms **Mean duration of self-harm (range):** 22 (6-46) years **Suicide attempts:** Not reported.	**Study dates:** Not reported. **Data collection and analysis:** Individual semi-structured interviews were held. Interviews were audio recorded and transcribed verbatim. Data were analysed using a grounded theory approach in WINMAX qualitative text analysis software.	• Limit setting and connecting • Self-esteem • Negative factors
Lahoz 2020 **Aim of the study:** To give a qualitative description of the treatment approach applied at Danish suicide prevention clinics from the	N=10 volunteer clinicians **Mean age (range):** Not reported (age groups ranged from 30-39 to 60-69 years)	**Study dates:** Not reported. **Data collection and analysis:** Semi-structured interviews were held, lasting about an hour. Interviews were	• Meaningful vs. formal treatment approach • Patient- vs. therapist-oriented treatment • Direct vs. indirect treatment

Study and aim of the study	Population	Methods	Author themes
perspective of the clinician. **Country:** Denmark	**Sex (female/ male):** 7/ 3 **Role:** Psychologist: 6 Mental health nurse: 2 Psychiatrist: 1 Clinical social worker: 1 **Setting:** Suicide prevention clinics **Mean years in post/ experience (SD):** Years of experience: 20.2 (10.87) Years of experience in the field: 11.1 (9.44) **Client group (adults, children/ CYP):** Not reported	recorded and transcribed verbatim, with quotes translated from Danish to English. Authenticity was preserved during translation by prioritising closeness to the text and choice of words over lingual fluency. Data were analysed using phenomenological condensation of meaning.	
Lees 2014 **Aim of the study:** To explore the experiences and needs that mental health-care consumers had of suicidal crisis, the degree to which those needs were met, the role that mental health nurse engagement played in that context, and the key factors suggested to impact on the quality of care. **Country:** Australia	N=96 nurses and people who had suicidal crises (n=87 mental health nurses were surveyed and of these, n=11 went on to complete the interview stage; n = 9 people who had recovered from recent suicidal crises during which they had received mental health nursing care) **Staff participants (data reported for those who were interviewed only):** **Mean age (SD):** 48 (not reported) years **Sex (female/ male):** 6/ 5 **Role:** Mental health nurses: 11 **Setting:**	**Study dates:** Not reported. **Data collection and analysis:** The first part of the study included a survey of mental health nurses (n = 87) in order to identify key issues, contextual data, and as a way to invite nurses to the interview stage. In-depth semi-structured interviews were then held with a subsection of the surveyed nurses. In-depth semi-structured interviews were also held with people who had recovered from recent suicidal crises during which they had received mental health nursing care. Data were analysed using constant comparative and classical content analysis. Themes were developed iteratively	• Consumer service needs • Prominent interventions • Nature of therapeutic engagement • Consumer service needs

Study and aim of the study	Population	Methods	Author themes
	Adult hospital inpatient mental health services: 7 Adult community mental health services: 4 **Mean years in post/ experience (SD):** 12 years (not reported) **Client group (adults, children/ CYP):** Adults **Patient participants:** **Mean age (SD):** 41 years (not reported) **Sex (female/male):** 6/ 3 **Co-morbidity:** Not reported **Ethnicity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported.	using both survey and interview data, though survey data were contained to 'descriptive statistics' in order to prioritise data from the interviews.	
Lindgren 2004 **Aim of the study:** To describe how people who self-harm experience received care and their desired care. **Country:** Sweden	N=9 people with a history of self-harm **Mean age (range):** 25 (19-35) years **Sex (female/male):** 9/ 0 **Ethnicity:** Not reported **Co-morbidity:** Co-morbidities were self-reported: Borderline personality disorder: 5 Anxiety syndrome: 1 Depression: 1 Declined to report: 2	**Study dates:** Not reported. **Data collection and analysis:** Individual structured interviews including 4 open-ended questions, ranging from 40 to 50 min, were recorded and transcribed verbatim. 2 researchers read & re-read the transcripts before dividing them into meaning units, which were then refined and grouped according to the 4 interview questions, and classified as positive or negative.	• Expecting to be confirmed while being confirmed fosters hopefulness • Expecting to be confirmed while not being confirmed stifles hopefulness

Study and aim of the study	Population	Methods	Author themes
	Duration of self-harm: Not reported **Suicide attempts:** Not reported	Through further abstractions, two themes were formulated each with five sub-themes. During the analysis, the authors compared and contrasted the categories, codes, sub-themes, and themes with the original text until consensus was reached.	
Littlewood 2019 **Aim of the study:** To explore clinicians' views of good practice in mental healthcare services in the context of suicide prevention **Country:** UK	N= 2331 staff members working at mental health service providers **Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role:** Consultant psychiatrists: 232 Service managers: 131 Mental health practitioners: 63 Doctors: 47 Psychologists: 37 Other: 16 Not specified: 1804 **Setting:** Of the 62 mental health providers that submitted responses: NHS mental health service providers: 57 (2286/ 2331 responses) Independent providers: 5 (45/ 2331 responses) **Range of years in post/ experience:** Not reported	**Study dates:** January 2011 to December 2016 **Data collection and analysis:** Qualitative data on clinicians' view of good practice within mental healthcare services collected systematically via questionnaire by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Thematic analysis used to analyse data within a thematic framework developed from the NCISH '10 Key Elements To Improve Safety' and the NICE Self-harm Quality Standard - QS34.	• Patient safety and the importance of good practice in mental healthcare services • Develop strong relationships with patients and family/carers • Provide timely access to tailored and appropriate care • Facilitates seamless transitions • Establish a sufficiently skilled, resourced and supported staff team

Study and aim of the study	Population	Methods	Author themes
	Client group (adults, children/ CYP): Not reported.		
Long 2010 **Aim of the study:** To gain insight into counsellors' experiences of and ideas about self-harm, and to develop understanding of relational depth when working with clients who self-harm. **Country:** UK	N=8 counsellors **Mean age (SD):** 43.75 (14.39) years **Sex (female/ male):** 7/1 **Role:** Counsellor: 8 **Setting:** Voluntary and private counselling sectors: Voluntary: 6 Voluntary and private practice: 1 Not reported: 1 **Mean (SD) of years in post/ experience:** 9.13 (6.6) **Client group (adults, children/ CYP):** Not reported	**Study dates:** Not reported. **Data collection and analysis:** Semi-structured interviews lasting about 45 minutes were held using an interview guide that was adjusted to incorporate themes as data were collected. Data were transcribed and analysed using grounded theory methodology until theoretical saturation was obtained.	• The role of the therapeutic relationship for clients who self-harm • Counsellors' skills and qualities for working with self-harm •
McGough 2021 **Aim of the study:** To explore mental health nurses' (MHNs) experience of working with people who self-harm. **Country:** Australia	N=14 mental health nurses **Mean age (SD):** 43.21 (9.85) years **Sex (female/ male):** 9/ 5 **Role:** Mental health nurse (registered nurse): 13 Mental health nurse (enrolled nurse): 1 **Setting:** Not reported. **Years in post/ experience:** More than 10 years: 5 6-10 years: 4 1-5 years: 5	**Study dates:** Not reported. **Data collection and analysis:** Semi-structured interviews using an interview guide were held via telephone, lasting an average of 35 minutes. Interviews were digitally recorded and transcribed verbatim. Data were analysed using inductive content analysis to identify categories from the data.	• Level of comfort to care for people who self-harm • Nursing role • Barriers and facilitators to providing care • Education and training • Appropriateness of current pathways to care and how the healthcare system supports people with self-harm

Study and aim of the study	Population	Methods	Author themes
	Client group (adults, children/ CYP): Adults: 9 All age groups: 4 Adolescents: 1		
Mughal 2021 **Aim of the study:** To explore the help-seeking behaviours, experiences of GP care, and access to general practice for young people who self-harm. **Country:** UK	N=13 people who had self-harmed **Mean age (range):** 22 (19-25 years) **Sex (female/ transgender male):** 12/ 1 **Ethnicity:** (Self-identified): White British: 7 White American: 1 Asian British: 1 Mixed: 3 Did not disclose: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported	**Study dates:** 2019 **Data collection and analysis:** Individual semi-structured interviews were held, which were recorded and transcribed. Interview data were analysed using reflexive thematic analysis applying principles of constant comparison, compatible with a critical realist stance.	• NHS services
O'Donovan 2007 **Aim of the study:** To gain an understanding of the practices of psychiatric nurses in relation to people who self-harm, but who are not considered suicidal. **Country:** Ireland	N=8 psychiatric nurses **Mean age (range):** Not reported (25-55 years) **Sex (female/ male):** 6/ 2 **Role:** Psychiatric nurses: 8 **Setting:** Acute psychiatric inpatient units **Range of years in post/ experience:** 6 months - 15 years	**Study dates:** Not reported. **Data collection and analysis:** In-depth semi-structured interviews were held using an interview schedule. Data were analysed using content analysis and theme analysis, whereby categories were developed from the raw data, connected and evolved into themes.	• Physical safety and prevention of self-harm • Intervention strategies

Study and aim of the study	Population	Methods	Author themes
	Client group (adults, children/ CYP): Not reported		
Omerov 2020 **Aim of the study:** To explore how nurses may contribute to suicide prevention through a caring science perspective **Country:** Sweden	N= 6 mental health staff **Mean age (SD):** Not reported **Sex (female/ male):** 4/ 2 **Role:** Qualified nurse with psychiatric training: 1 General medical doctor with psychiatric training: 1 Psychiatrists: 2 Child psychiatrist: 1 Allied health professionals (including clinical psychologists, clinical social workers and occupational therapists): 1 **Setting:** Psychiatric outpatient care **Mean years in post/ experience (SD):** At least 10 years of clinical experience: 6 **Client group (adults, children/ CYP):** Not reported	**Study dates:** 2015 **Data collection and analysis:** Individual interviews with open-ended questions. Interviews were recorded and transcribed. Data were analysed using thematic analysis.	• Engagement necessary but demanding • Acknowledgement of warnings signs • Supportive relationship
Rissanen 2012 **Aim of the study:** To describe Finnish nurses' conceptions and experiences of helping adolescents who self-mutilate. **Country:** Finland	N=9 psychiatric nurses (n=5 focus groups; n=2 individual interviews; n=2 written descriptions) **Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role:** Qualified nurses: 9	**Study dates:** April to May 2005 **Data collection and analysis:** The data were collected using focus group interviews, individual interviews, and written descriptions. The transcriptions were coded for meaningful words and phrases. These codes were grouped into	• Helpers • Helping and caring

Study and aim of the study	Population	Methods	Author themes
	Setting: Inpatient adolescent mental-health wards **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Adolescents	categories and subcategories. During the analysis, the researchers discussed the process and categories that emerged, agreeing any changes.	
Rowe 2017 **Aim of the study:** To investigate the aspects of professional, social, familial and romantic relationships that people who have self-harmed identified as having a positive and constructive effect on their self-harm behaviour. **Country:** New Zealand	N=12 people who had self-harmed **Mean age (range):** Not reported (19-70 years) **Sex (female/male):** 9/ 3 **Ethnicity:** New Zealand European: 11 Māori: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported	**Study dates:** Not reported **Data collection and analysis:** Each participant was interviewed once, using a semi-structured interview guide. Interviews were transcribed and thematic analysis was done by coding the text according to the questions in the interview guide. These codes were then grouped into categories. Regular meetings between the investigators ensured agreement on the final themes that emerged from the data.	• 'Seeing of me' • Relationship-centred care
Simoes 2020 **Aim of the study:** To identify the protective factors of recurrent suicidal behaviours in adolescents; To describe the family and the expectations for future involvement; To know the most important aspects of hospitalization and discuss expectations of nursing care follow-up after hospital discharge. **Country:** Portugal	N=33 adolescents with suicidal behaviour **Mean age (SD):** 15.91 (1.18) years **Sex (female/male):** 24/ 9 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported	**Study dates:** May 2018 to May 2019 **Data collection and analysis:** Semi-structured interviews were held, lasting an average of 45 minutes. Interviews were recorded and transcribed. Data were analysed using content analysis without a category chart, whereby content was studied to identify categories, which were	• Most important aspects of hospitalization • Suggestions for service improvement

Study and aim of the study	Population	Methods	Author themes
	Suicide attempts: At least 1 suicide attempt: 31 Not reported: 2	then grouped for analysis.	
Storey 2005 **Aim of the study:** Not clearly stated. **Country:** UK	N=38 people who had self-harmed (n=74 were interviewed but only data from those who said they had self-harmed before they were 16 years old during their interview were reported) **Mean age (range):** Not reported (16-22 years) **Sex (female/ male):** Not reported **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Mean age of index episode for women: 14 years Mean age of index episode for men: 15 years Self-harm history: Participants with index self-harm episode between the ages of 13 and 16 years: 34 Participants with index self-harm episode at the age of 12 years or younger: 4 **Suicide attempts:** Not reported	**Study dates:** Not reported **Data collection and analysis:** Interviews were held with participants. No other information is given.	• Experiences of services
Talseth 2001 **Aim of the study:** To illuminate the meaning of the lived experience	N=19 psychiatric inpatients **Mean age (SD):** Not reported	**Study dates:** Not reported. **Data collection and analysis:** Narrative	• Listening to patients without prejudice • Trusting each other • Respecting patients' integrity

Study and aim of the study	Population	Methods	Author themes
of being treated by physicians, as narrated by suicidal psychiatric inpatients in interviews. **Country:** Norway	**Sex (female/ male):** 9/ 10 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Attempted suicide: 11	interviews were held in the meeting room in the ward when patients' primary health nurses were not present, and lasted between 30 and 60 minutes. Interviews were tape-recorded and transcribed verbatim. Data were analysed using a phenomenological-hermeneutic method.	• Mistrusting each other • Not respecting patients' integrity
Te Maro 2019 **Aim of the study:** To explore the experience of school staff managing self-harm, and to obtain their views on the use of guidelines in their work **Country:** New Zealand	N=28 school pastoral care providers **Mean age (SD):** Not reported **Sex (female/ male):** 21/7 **Role:** Trained counsellors*: 26 Chaplin: 1 Social worker: 1 *Only data from this group of participants were extracted **Setting:** Education - secondary schools **Mean years in post/ experience (SD):** 9.9 (9.05) **Client group (adults, children/ CYP):** Children (12 - 18 years)	**Study dates:** Not reported but likely 2018 or later **Data collection and analysis:** Individual interviews conducted (45 - 80 minutes). Interviews were recorded and transcribed verbatim. Thematic analysis used to analyse data.	• Discrepancy — Differences in the Way That Self-Harm is Managed • Need for Guidelines
Vatne 2016 **Aim of the study:** To develop a deeper understanding of suicidal patients in the aftermath of suicidal attempts.	N=10 people who had attempted suicide **Mean age (range):** Not reported (21-52 years)	**Study dates:** Not reported **Data collection and analysis:** Participants were interviewed using a semi-structured guide 2 weeks after a	• Someone who cares

Study and aim of the study	Population	Methods	Author themes
Country: Norway	**Sex (female/ male):** 6/ 4 **Ethnicity:** Not reported **Co-morbidity:** Not reported. Authors reported all participants were non-psychotic **Duration of self-harm:** Not reported **Suicide attempts:** At least 1 attempt: 10	suicide attempt and in a place of their choice. After repeated listening to recordings of the interviews, they were transcribed and tentative themes noted. These were reviewed and checked against the interviews, with verbatim statements selected to support each theme.	
Wadman 2018 **Aim of the study:** To gain insight into looked-after young people's perceptions and experiences of factors related to self-harm, and of interventions and services received, in order to improve future service provision. **Country:** UK	N=24 young people with experience of living in foster care or residential homes who had self-harmed **Mean age (range):** 16 (14-21) years **Sex (female/ male):** 20/ 4 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported	**Study dates:** March 2014 and April 2015 **Data collection and analysis:** Individual semi-structured interviews were held. The interviews were recorded, transcribed, and subjected to interpretive phenomenological analysis.	• Experience of Clinical Services
Wilstrand 2007 **Aim of the study:** To describe nurses' experience caring for psychiatric patients who self-harm. **Country:** Sweden	N=6 psychiatric nurses **Sex (female/ male):** 3/ 3 **Role:** Specialist psychiatric nurses: 4 Generalist nurses: 2 **Setting:** Acute psychiatric inpatient wards	**Study dates:** Spring 2002 **Data collection and analysis:** Narrative interviews lasting between 40 to 50 minutes were held. Interviews were audiotaped and transcribed verbatim. Data were analysed using qualitative	• Balancing professional boundaries

Study and aim of the study	Population	Methods	Author themes
	Mean (range) of years in post/ experience: 9.4 (1-18) **Client group (adults, children/ CYP):** Not reported	content analysis, whereby texts were divided into meaning units, which were then condensed, sorted into categories, and abstracted into themes.	

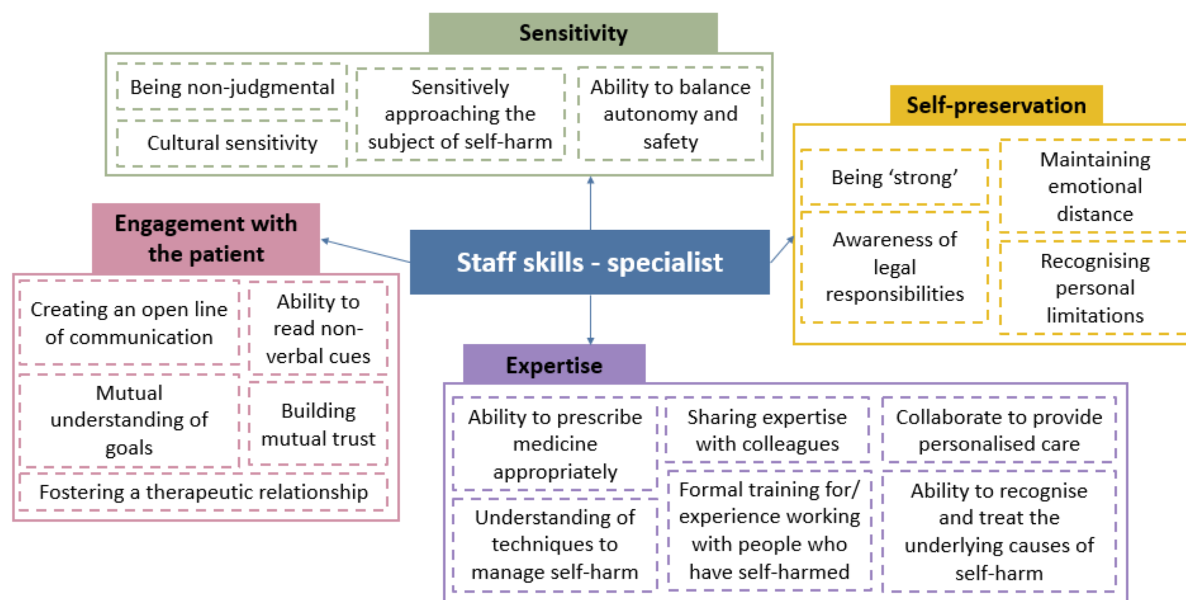
1 *CYP: children and young people; DSH: deliberate self-harm; GP: general practitioner; N: Number; NICE: National*
2 *Institute for Health and Care Excellence; NHS: National Health Service; NSSI: non-suicidal self-injury; SD:*
3 *standard deviation; UK: United Kingdom; USA: United States of America*

4 See the full evidence tables in appendix D.

5 Summary of the evidence

6 The required skills identified in the included studies fell under 4 main themes – expertise,
7 engagement with the patient, sensitivity, and self-preservation. A total of 19 subthemes were
8 associated with the 4 main themes, and these are all illustrated in Figure 1 and summarised
9 in Table 3. All subgroups were represented in the evidence: specialist staff who worked with
10 people who have self-harmed; specialist staff who worked with suicidal patients; people who
11 have self-harmed; people with suicidal ideation or attempt; family members/ carers of people
12 who have self-harmed; family members/ carers of people who had died by suicide or were
13 receiving mental health care. Family members/ carers were the least well represented
14 amongst the studies identified, and were only represented in mixed populations.

15 **Figure 1: Theme chart**



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17 **Table 3: Summary of subthemes and subgroups**

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
1. Expertise				
	1.1 Formal training for/ experience	Moderate	19	**Population group:** specialist staff who worked with people who have self-harmed (8); specialist staff who worked with

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
	working with people who have self-harmed			suicidal patients (4); people who have self-harmed (3); people with suicidal ideation or attempt (0); mixed populations (specialist staff who work with people who have self-harmed and family members/ carers of people who have self-harmed: 1; people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
	1.2 Ability to recognise and treat the underlying causes of self-harm	Very low	16	**Population group:** specialist staff who worked with people who have self-harmed (3); specialist staff who worked with suicidal patients (4); people who have self-harmed (5); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
	1.3 Understanding of techniques to manage self-harm	Low	14	**Population group:** specialist staff who worked with people who have self-harmed (5); specialist staff who worked with suicidal patients (3); people who have self-harmed (4); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1)
	1.4 Collaborating to provide personalised care	Low	10	**Population group:** specialist staff who worked with people who have self-harmed (1); specialist staff who worked with suicidal patients (5); people who have self-harmed (1); people with suicidal ideation or attempt (2); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1)
	1.5 Ability to prescribe medication appropriately	Moderate	9	**Population group:** specialist staff who worked with people who have self-harmed (0); specialist staff who worked with suicidal patients (0); people who have self-harmed (4); people with suicidal ideation or attempt (2); mixed populations (people who have self-harmed and

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
	1.6 Sharing expertise with colleagues	Moderate	9	**Population group:** specialist staff who worked with people who have self-harmed (4); specialist staff who worked with suicidal patients (4); people who have self-harmed (0); people with suicidal ideation or attempt (0); mixed populations (people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
2. Engagement with the patient				
	2.1 Creating an open line of communication	Moderate	25	**Population group:** specialist staff who worked with people who have self-harmed (4); specialist staff who worked with suicidal patients (5); people who have self-harmed (11); people with suicidal ideation or attempt (2); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
	2.2 Fostering a therapeutic relationship	Moderate	23	**Population group:** specialist staff who worked with people who have self-harmed (6); specialist staff who worked with suicidal patients (7); people who have self-harmed (7); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1)
	2.3 Building mutual trust	Moderate	19	**Population group:** specialist staff who worked with people who have self-harmed (2); specialist staff who worked with suicidal patients (5); people who have self-harmed (9); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1)
	2.4 Mutual understanding of goals	Moderate	12	**Population group:** specialist staff who worked with people who have self-harmed (3); specialist staff who worked with suicidal patients (3); people who have self-harmed (5); people with suicidal ideation or attempt (1); mixed populations (0)
	2.5 Ability to read non-verbal cues	Low	7	**Population group:** specialist staff who worked with people who have self-harmed (1); specialist staff who worked with suicidal patients (3); people who have self-harmed (2); people with suicidal ideation or attempt (0); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1)
3. Sensitivity				
	3.1 Being non-judgmental	Moderate	19	**Population group:** specialist staff who worked with people who have self-harmed (6); specialist staff who worked with suicidal patients (3); people who have self-harmed (8); people with suicidal ideation or attempt (0); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
	3.2 Sensitively approaching the subject of self-harm	Moderate	15	**Population group:** specialist staff who worked with people who have self-harmed (4); specialist staff who worked with suicidal patients (4); people who have self-harmed (4); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1)
	3.3 Ability to balance autonomy and safety	Low	14	**Population group:** specialist staff who worked with people who have self-harmed (5); specialist staff who worked with suicidal patients (3); people who have self-harmed (4); people with suicidal ideation or attempt (1); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1)
	3.4 Cultural sensitivity	Low	3	**Population group:** specialist staff who worked with people who have self-harmed

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				(0); specialist staff who worked with suicidal patients (0); people who have self-harmed (2); people with suicidal ideation or attempt (0); mixed populations (people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and specialist staff who worked with suicidal patients: 1)
4. Self-preservation				
	4.1 Maintaining emotional distance	Low	8	**Population group:** specialist staff who worked with people who have self-harmed (4); specialist staff who worked with suicidal patients (2); people who have self-harmed (0); people with suicidal ideation or attempt (0); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1; people with suicidal ideation or attempt and specialist staff who worked with suicidal patients: 1)
	4.2 Being 'strong'	Low	5	**Population group:** specialist staff who worked with people who have self-harmed (1); specialist staff who worked with suicidal patients (3); people who have self-harmed (0); people with suicidal ideation or attempt (0); mixed populations (people who have self-harmed and specialist staff who worked with suicidal patients: 1)
	4.3 Recognising personal limitations	Low	2	**Population group:** specialist staff who worked with people who have self-harmed (1); specialist staff who worked with suicidal patients (1); people who have self-harmed (0); people with suicidal ideation or attempt (0); mixed populations (0)
	4.4 Awareness of legal responsibilities	Moderate	5	**Population group:** specialist staff who worked with people who have self-harmed (1); specialist staff who worked with suicidal patients (1); people who have self-harmed (2); people with suicidal ideation or attempt (0); mixed populations (specialist staff who work with people who have self-harmed and family members/ carers of people who have self-harmed: 1)

1 See appendix F for full GRADE CERQual tables.

2 Economic evidence

3 Included studies

4 A single economic search was undertaken for all topics included in the scope of this
5 guideline but no economic studies were identified which were applicable to this review

question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

Economic studies not included in the guideline economic literature review are listed, and reasons for their exclusion are provided in appendix J.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Economic

No economic studies were identified which were applicable to this review question.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

The aim of this review question was to identify what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed. The committee agreed that any differentiation between required skills would likely be due to staff specialty rather than setting specialty, because specialist staff may work in non-specialist settings. As a result, the views of people who have self-harmed, specialist staff who assess and treat them, and their family members/ carers were considered the most important for this question. The committee suggested potential themes which may have arisen from the evidence such as empathy and knowledge but did not want to constrain the question; therefore, any views and preferences about specialist staff skills regarded as useful/ not useful or important/ not important by the population were included.

The quality of the evidence

When assessed using GRADE CERQual methodology the evidence was found to range in quality from very low to moderate quality, with most of the evidence being of moderate quality. The recommendations were drafted mostly based on the evidence but in some parts supplemented accordingly with the committee's own expertise.

In some cases, the evidence was downgraded due to poor applicability where the themes were not based on any research from a UK context, or where studies included the following participants: specialist staff who worked with suicidal patients (which did not specify whether the patients had self-harmed); people with suicidal ideation or attempt (which did not specify whether they had self-harmed); family members/ carers of people who had died by suicide or were receiving mental health care. It was noted where studies were conducted in non-specialist settings, but studies were not downgraded for applicability solely due to this. Some downgrading for adequacy occurred when the richness or quantity of the data was low. Other issues resulting in downgrading were methodological problems that may have had an impact on the findings (for example due to ethical issues, lack of discussion of author reflexivity, and/ or bias arising through study design, recruitment or data collection processes), and/ or for incoherence within the findings.

The committee discussed the fact that some of the evidence came from specialist staff who worked in settings where they were likely to work with people who had self-harmed, but had

not expressly done so, and found that the majority of themes that were reported by staff who worked with suicidal patients more generally were also reported by staff who had specifically worked with people who had self-harmed. Additionally, themes identified in studies with moderate or serious methodological issues were also found in studies with little to no methodological issues, and reflected the committee's own knowledge and experience. For this reason, the committee felt comfortable making recommendations based on the themes identified within this review.

Benefits and harms

The recommendations about training for staff who work with people who have self-harmed were based on the evidence from both specialist and non-specialist staff (see evidence review R), which showed there was a significant overlap between the kind of training both specialist mental health and non-specialist professionals wanted when working with people who have self-harmed. Many of the identified themes and sub-themes in this review were similar to those identified in the non-specialist staff review, with some differences between sub-themes relating to the level of detail or specific needs of more specialist staff. Both reviews found that specialist and non-specialist staff wanted formal training on how to work with people who have self-harmed, as evidenced by the sub-themes 'formal training for/ experience working with people who have self-harmed' from the specialist review, and 'formal training on working with people who have self-harmed' from the non-specialist review. The committee discussed the fact that even specialist staff felt unequipped to care for people who had self-harmed effectively because their mental health training had not specifically addressed self-harm and agreed this carried risks of specialist staff providing inadequate care. As a result, the committee agreed that all staff who work with people who self-harm should receive regular, ongoing training to address the areas where people felt their skills needed developing. The recommendation that training should be delivered in a range of formats was also based on evidence from the sub-themes 'formal training for/ experience working with people who have self-harmed' from the specialist review, and 'formal training on working with people who have self-harmed' from the non-specialist review, which showed that specialist and non-specialist staff wanted training to be available in a number of different formats, including through the provision of resources in plain language. Non-specialist staff emphasised the utility of role-playing in particular as an important training tool that allowed them to empathise and communicate with patients more effectively. The committee supplemented this evidence with their experience of training and agreed that it should be provided in multiple formats to both specialist and non-specialist staff, because different formats enhance different skills, and to ensure training is accessible for all. The recommendation that families and carers should be involved in the development and delivery of training was based on the evidence overall, which showed that many people who had self-harmed and their family members/ carers had strong opinions on the skills they felt specialist and non-specialist staff should have, and that they often felt staff delivery of care was inadequate due to a lack of training. The committee agreed that there should be service user input on the content of training, to ensure that staff receive the necessary training to improve care delivery and service user satisfaction. The committee also agreed that the staff receiving the training should be included in its planning and delivery based on the evidence, which broadly showed that many staff did not have the skills that the committee felt should be standard practice, or were dissatisfied with the training they were currently receiving. There was some low quality evidence from the theme 'cultural sensitivity' which showed people who had self-harmed and specialist staff wanted staff to be culturally competent and able to recognise when the person's background may intersect with their self-harm. The committee discussed the fact that this included religious, racial, cultural, sex and gender identity, educational, and economic factors, and agreed that these were likely to influence how a person would react to care. The committee therefore agreed that the training that staff working with people who have self-harmed receive should be culturally competent so they would be able to recognise these factors and provide sensitive care, despite the low quality of the evidence. The committee agreed that training for all staff working with people who had

self-harmed should explore any biases, so they can be eradicated in order for staff to be able to deliver compassionate care. This recommendation was based on the evidence from both this and the non-specialist skills reviews, which showed that some judgmental attitudes and stigma still persisted in some staff members, and their knowledge that these views largely caused harm to people who have self-harmed.

The committee discussed the overlap between the specialist and non-specialist skills reviews and agreed that, while the evidence showed that similar skills were required by mental healthcare staff, non-mental healthcare staff, and non-healthcare staff, there would be different levels of skill required for each group of people. For example, teachers and other educational staff would not be expected to have in-depth mental health training in the way that school counsellors would. The committee agreed that it would be unreasonable and impractical to expect all staff who work with people who have self-harmed to receive the same training, as this might provide some less specialised staff members with an inappropriate level of responsibility. The committee agreed that the list of topics they recommended training should cover addressed all of the skills that both specialist and non-specialist staff indicated they needed in the evidence, however they agreed that this list should be considered by those running the training to ensure the training would be appropriate to their level of responsibility.

The recommendation listing topics to cover in training was based on the evidence, which showed there was a multitude of skills that both specialist and non-specialist staff felt they needed. The evidence showed that communication was a key skill that affected every aspect of care from the perspective of specialist and non-specialist staff, patients, and their family/ carers, as evidenced in the theme ‘creating an open line of communication’ present in both reviews. The theme ‘building mutual trust’ from the specialist review also showed that people who had self-harmed and specialist staff found that good communication and mutual honesty was key to building trust between service users and caregivers. The evidence also showed that the reverse was true; mutual trust allowed people who had self-harmed to communicate more openly with staff. Participants in the majority of studies referenced active listening as a key skill that allowed staff to fully understand and engage with patients, and allowed people who had self-harmed and their family members/ carers to be more open and honest about their experiences and feel as though they had been understood, which facilitated their engagement with treatment. Empathy, positivity, and hopeful communication were considered important by staff and patient participants in both this and the non-specialist skills review. The committee used this evidence to inform recommendations throughout the entire review, including the recommendation that information and support should be given to people who have self-harmed in a sensitive and empathetic manner, and in the spirit of hope and expectation of recovery. The committee agreed that staff should be trained to communicated compassionately, which they agreed should encompass the principles of empathy, sensitivity, and positivity. Evidence from the theme ‘fostering a therapeutic relationship’ also showed that open communication between staff and patients facilitated the creation of a personal connection, which provided a therapeutic benefit in its own right. Evidence from this theme also showed that specialist staff thought that ending the therapeutic relationship was an important skill. The committee agreed that the ending of a therapeutic relationship is a core competence for the delivery of any psychosocial intervention and therefore any specialist staff trained to provide therapy would have this skill. The committee also discussed evidence from the theme ‘ability to read non-verbal cues’, and agreed that training around communication should cover non-verbal communication so staff would be able to interpret cues from patients more effectively, improving communication skills and allowing staff to more easily detect indicators of distress.

The recommendation about openly discussing self-harm with the person was informed by evidence from the themes ‘sensitively approaching the subject of self-harm’ from the specialist review, and ‘evasive versus candid’ from the non-specialist review. Specialist staff had mixed feelings regarding the best method to approach sensitive subjects but they mostly agreed that being risk-averse by avoiding discussing self-harm or suicidality was a barrier to

effective care. Some non-specialist staff agreed that it was important to discuss sensitive topics openly, but others expressed that they were fearful of causing distress or being responsible for repeat self-harm or suicide, or lacked the confidence to address the issue at all. The committee discussed the potential risks of openly discussing self-harm with patients, such as increasing distress for those who wanted to avoid the subject, but agreed that the risks of staff not openly discussing self-harm as found in the evidence (such as a lack of engagement with care, patient dissatisfaction, and repeat self-harm or suicide if these topics were not adequately explored with patients at risk) outweighed these. The committee also agreed that the recommendation that people who have self-harmed should receive follow-up aftercare would mitigate the risk of distress after openly discussing self-harm with staff. People who had self-harmed largely agreed that they wanted to talk about their feeling regarding self-harm or suicidality and that being encouraged to do so by staff had the benefit of de-stigmatising sensitive topics and allowing them to engage with the staff member and thereby, their care. The recommendation about open discussion of the reasons for self-harm was also based on the themes 'ability to recognise and treat the underlying causes of self-harm' from the specialist review, and 'ability to recognise the underlying causes of self-harm' from the non-specialist review, which showed that most people who had self-harmed often found it therapeutic when staff attempted to understand their reasoning for self-harm and allowed them to receive the appropriate care. Although specialist staff had conflicted views about whether care should follow formal treatment approaches or take into account the individual's underlying causes, most specialist and non-specialist staff agreed that it was important to address potential triggers or issues that might be meaningful for the patient. Non-specialist staff additionally wanted general training on the reasons why people self-harm. The committee agreed that training should include general information about self-harm, such as why people self-harm, as this would help tackle any existing stigma that staff members may have. They agreed this would also help staff develop the skill to explore the reasons for each episode of self-harm, which would allow them to address this more effectively during care.

The committee also discussed the evidence from the themes 'being non-judgmental' from the specialist review, and 'positive attitude' from the non-specialist review, which showed that people who had self-harmed wanted to be treated with dignity and felt that compassionate care was an important skill for staff to have, including the avoidance of stigmatising, accusatory, or negative views that could otherwise cause distress or discourage the disclosure of self-harm. Specialist staff agreed that overcoming any negative perceptions of self-harm was an important part of their training, and that it allowed them to deliver a better quality of care to people who had self-harmed. Non-specialist staff also felt it was important to develop their personal attitudes towards self-harm, and that a change in attitude to be more understanding improved their caring ability and communication skills. The committee discussed the need for training to address myths surrounding self-harm, such as the myth that talking about self-harm could 'plant' the idea of self-harm or encourage it in patients, which was an idea expressed by non-specialist staff in evidence from the non-specialist skills review. The recommendation that staff should receive training about the stigma associated with self-harm was therefore based on the evidence and these discussions.

Both specialist and non-specialist staff indicated the need for risk assessment skills when working with people who have self-harmed. In the non-specialist review, the theme 'ability to accurately assess risk of self-harm' showed that non-specialist staff considered risk assessment to be a pivotal part of their role in order to recognise when people had self-harmed or were at risk for self-harm. The committee agreed that risk assessment skills were important for non-specialist staff to develop, including early detection which could allow staff to help young patients develop safer methods to process emotional distress, potentially reducing the likelihood of repeat self-harm later in life. The committee also agreed that non-specialist staff having risk assessment skills would allow them to correctly identify self-harm and therefore provide appropriate care in a variety of settings such as community pharmacies, EDs and primary care. There was evidence that people who had self-harmed also thought it was important for non-specialist staff to be able to detect high levels of

distress, suicidal behaviour or ideation that could lead to self-harm, and the committee agreed this should be a part of any training regarding risk assessment, so staff can act preventatively. In the specialist staff review, specialist staff referred to the need to assess risk of self-harm accurately in a number of themes, including 'formal training for/ experience working with people who have self-harmed' and 'ability to read non-verbal cues', and spoke about assessment, including risk assessment, broadly as an important factor that enabled them to provide care more effectively at every stage. The committee agreed that specialist staff needed risk assessment skills but discussed the fact that they also needed to have the ability to provide a psychosocial assessment, which included an assessment of risk as part of a wider investigation. As a result, the committee recommended that specialist staff should also receive additional training about how to conduct a psychosocial assessment that the committee agreed would not usually be within the responsibility of non-specialist staff.

The recommendation about formal processes was based on the themes 'awareness of legal responsibilities' from the specialist review, and 'knowledge of formal processes' and 'ensuring continuity of care paths' from the non-specialist review. The evidence showed that specialist staff thought it was important to be aware of their legal responsibilities and which procedures they were legally required to do when caring for people who had self-harmed, although staff participants had mixed feelings about how helpful legal procedures were for the patients themselves. Despite the mixed evidence, the committee agreed that it was important for staff to be aware of relevant legislation in case of an adverse event and to ensure that staff feel confident in their provision of care when working with people who have self-harmed. Some specialist staff additionally wanted clearer information regarding setting-specific policies, in particular mental health staff who worked in schools. Non-specialist staff similarly wanted training on mental health legislation and setting-specific policies when working with people who had self-harmed, including information on sedation and how to balance legal requirements with knowledge of best practise. The committee agreed that it was important for staff to be aware of any setting-specific policies regarding self-harm to ensure consistency of care for all patients and improve staff confidence levels. Non-specialist staff additionally wanted more information about care pathways, including how, when, and who to refer patients who had self-harmed on to. These participants as well as people who had self-harmed wanted to ensure that there were no gaps between services to ensure continuity of care, seamless transition between services, and that people receive the correct care as appropriate for them. People who had self-harmed additionally felt dismissed when they were signposted to other healthcare services unnecessarily after presentation for self-harm, which the committee agreed would be resolved by training about when referral was and was not appropriate. The committee added that people should have training on the layout of settings based on their knowledge that familiarity with a setting improved staff confidence when working within specific settings.

The recommendation that staff should have training in treating and managing self-harm was based on evidence from the themes 'understanding of techniques to manage self-harm' from the specialist review and 'ability to recommend coping techniques' from the non-specialist review. Specialist staff and the patients they worked felt it was important for specialist staff to be able to supplement an interpersonal or therapeutic alliance strategy with symptom reduction techniques, including coping techniques. Specialist staff had a nuanced consideration for the need to balance 'direct' treatment, which focuses on preventing self-harm, with 'indirect' treatment, which focuses on managing the desire to self-harm by focusing on underlying issues related to self-harm. People who had self-harmed agreed that staff should have the skills to explore multiple different management techniques. Non-specialist staff echoed the need on training to be able to recommend coping strategies or provide brief therapeutic interventions, though they were less specific about what they thought this type of training should entail. People who had self-harmed agreed that non-specialist staff should be able to provide advice regarding the management of self-harm. The committee agreed that all staff should have training on how to treat or manage an episode of self-harm in order to provide staff with the tools to prevent repeat self-harm, but agreed that this training would be far more detailed for specialist staff, who would primarily be

responsible for delivering this kind of care. The committee also discussed the theme 'preventing further self-harm during care' from the non-specialist review, which found that non-specialist staff wanted training in de-escalation, and agreed that this was a useful skill for non-specialist staff to have because of their likelihood to encounter people who were distressed or aggressive. The committee agreed that training in de-escalation would result in lower levels of distress and a reduced risk of self-harm or other violence without resorting to restrictive measures.

The themes 'collaborating to provide personalised care' from the specialist review and 'being collaborative' from the non-specialist review showed that people who had self-harmed wanted to be involved in decisions regarding their care and that standardised care which did not take into account their individual needs and preferences were unhelpful and felt impersonal. Most specialist staff also felt that care that was tailored to the patient provided important benefits, and that personalised care was an important skill to develop. The theme 'mutual understanding of goals' further provided evidence that specialist staff and people who had self-harmed valued joint decision-making and collaboratively working towards goals, because this provided the benefit of improved care that utilised the individual's abilities. The committee agreed that all staff should be trained in providing collaborative care and involving people in decision-making in order to improve service user satisfaction and engagement with care. The theme 'making time for the patient' from the non-specialist review also showed that both people who had self-harmed and non-specialist staff felt it was important that adequate time was allocated to discussing self-harm and decision-making. The committee agreed that training on why this was important and how to balance time constraints with the necessity of addressing peoples' concerns regarding self-harm or suicidality would allow patients to feel heard and understood without being rushed.

The recommendation about training on comorbidities was based on the evidence from the themes 'ability to recognise and treat the underlying causes of self-harm' from the specialist review, and 'ability to recognise the underlying causes of self-harm' from the non-specialist review. Specialist and non-specialist staff, people who had self-harmed, and their family members/ carers all had mixed opinions regarding the utility of diagnosis of comorbidities. The committee discussed the risks of a reliance on diagnosis when treating self-harm as identified by the evidence, which included the potential for misdiagnosis, dismissing patient concerns, and diminishing the impact of self-harm to merely a symptom of another comorbidity. The committee agreed based on their knowledge and expertise that self-harm should be treated as a phenomenon in its own right in order for care to be provided that specifically address managing self-harm instead of a comorbidity. However, the evidence showed that some people who had self-harmed found it validating to receive a diagnosis and empowering to have the vocabulary to describe their experienced. Non-specialist staff also felt that diagnostic skills with relation to self-harm would improve their ability to assess risk of self-harm and provide the appropriate treatment for potential comorbidities. Both specialist and non-specialist staff also wanted training in identifying dual diagnoses, including drug or alcohol abuse. The committee agreed that training all staff who worked with people who have self-harmed on the impact of other diagnoses would provide significant benefits, including the ability to recognise both the benefits and limitations of diagnosing comorbidities when someone has presented for self-harm.

The themes 'ability to balance autonomy and safety' from the specialist review and 'preventing further self-harm during care' showed that all staff who worked with people who had self-harmed often found it difficult to balance the need to uphold the patient's autonomy while maintaining their physical safety. Staff had mixed views, which highlighted the risks and benefits of both overly coercive/ risk-averse measures and under-protective measures. Non-specialist staff in particular said they often prioritised the prevention of further self-harm over preservation of the patient's autonomy and dignity, which usually required staff to use coercive measures. The committee discussed the fact that being overly risk-averse could prevent repeat self-harm and suicidality in the short-term, and provided the benefit of setting behavioural limits and establishing consequences for people who might not feel capable of

setting limits for themselves. However, the committee agreed this approach usually came at the expense of the person's autonomy and dignity, which could result in raised levels of distress, patient dissatisfaction, an unwillingness to engage with care, and potentially repeat self-harm in the long-term. The committee also felt that coercive measures could lead to a higher risk of suicide if the person who had self-harmed was less likely to engage with services out of fear of being subject to coercion. The evidence from people who had self-harmed supported this conclusion, as they expressed that coercive measures to prevent self-harm such as forced hospitalisation, coercion and loss of confidentiality often broke their trust in services or staff members and dissuaded them from engaging with services in the future. Additionally, the theme 'building mutual trust' showed that people who had self-harmed felt that trust could be broken when staff members used restrictive or coercive measures. People who had self-harmed also felt valued when less restrictive measures such as positive risk-taking were used, and felt this could help prevent repeat self-harm in the long term because they were invited to take responsibility for their own actions, which helped them learn how to continue to resist self-harm in daily life without the involvement of staff. The committee also discussed the evidence that less restrictive measure encouraged help-seeking in people who had self-harmed, and helped dissuade patients from lying about their risk of repeat self-harm for fear of negative repercussions. Overall, the committee agreed that all staff who worked with people who have self-harmed should have training to help them understand the fact that there needed to be a balance between using restrictive measures to forcefully prevent the patient hurting themselves, and allowing patients the opportunity to manage self-harm by themselves. The committee agreed that this should provide non-specialist staff in particular with information about least restrictive measures, potentially lowering the risk of repeat self-harm while maintaining the person's autonomy.

The committee discussed the usage of security staff for observation of people who have self-harmed, and agreed that this was an inappropriate measure, usually resulting in patients feeling intimidated and distressed. They agreed, based on their knowledge and experience, that training in observation methods that promoted therapeutic engagement and rapport building would allow staff undertaking clinical observation to do so in a way that was least distressing for patients.

The themes 'ability to prescribe medicine appropriately' from the specialist review and 'ability to provide medication appropriately' from the non-specialist review showed that people who had self-harmed had mixed feelings towards being prescribed medication as treatment. Some participants felt that their medication helped them maintain good mental health and thereby prevented self-harm, however most patient participants felt dismissed or had suffered adverse effects when they were prescribed medication, and wanted staff to be aware of the limitations of a reliance on medication for treatment of self-harm. The evidence also showed that some people valued the exploration of other therapeutic options over standalone pharmacological interventions. The committee discussed this evidence alongside the quantitative evidence from the review on pharmacological interventions (Evidence Report K), which showed an uncertain effect of newer generation antidepressants or antipsychotics on repetition of self-harm, and no evidence of effect of mood stabilisers or for natural products on repetition of self-harm. This evidence therefore informed the recommendation that drug treatment should not be offered as a specific intervention to reduce self-harm. The committee discussed the qualitative evidence from some participants who felt positively towards medication and agreed that medication may have benefits for people who have self-harmed and have additional diagnoses. They therefore recommended that any treatment planning should take into account any related conditions, for which medication may be an appropriate treatment. The evidence from this review also showed that people who have self-harmed want any decisions regarding medication to be made collaboratively with the patient, which informed the recommendation that staff should work collaboratively with the person when planning interventions, and the recommendation that shared decision-making should be used to discuss limiting the quantity of medicines. The theme 'cultural sensitivity' informed the recommendation that information and support may need to be adapted for people subject to other forms of discrimination. The themes 'sharing formal expertise with colleagues' from

the specialist review and ‘sharing information with colleagues’ showed that all staff and people who had self-harmed thought it was important for staff to communicate with each other within and across settings. The committee agreed that communication between staff members provided important benefits such as the sharing of information about the patient and learned skills, and the facilitation of smooth transitions between services. As a result, the committee agreed that communication sharing was an important principle throughout all aspects of care, and used evidence from these themes to inform all recommendations on the guideline. For example, this principle was used to inform the recommendation that staff working with people who have self-harmed should have access to specialist advice from other staff members, and the recommendation that staff members should recognise the limits of confidentiality and therefore when it may be beneficial to share information with colleagues for the sake of the person’s care.

The themes ‘Being ‘strong’’, ‘Maintaining emotional distance’, and ‘Recognising personal limitations’ showed that specialist staff members felt emotionally impacted when working closely with people who had self-harmed, and thought that maintaining a professional distance while still empathising with patients was an important skill to develop. The committee discussed their knowledge of ‘professional empathy’, whereby the caregiver will go to appropriate lengths to resolve the person’s emotional pain but recognise what is within the sphere of the staff member’s influence and that the emotions belong to the patient. The committee agreed that these skills were usually developed over time and with experience, and committee therefore did not make any training recommendations based on this evidence. However, the committee recognised the risk of staff being overwhelmed by the emotional impact of their work, and therefore used evidence from these themes to inform the recommendation that staff working with people who have self-harmed should have access to emotional support services to mitigate the risk of staff struggling from mental health issues.

Cost effectiveness and resource use

The committee noted that no relevant published economic evaluations had been identified in the literature review. In addition, a bespoke economic model in this area of the guideline was not prioritised, as potential changes in current practice caused by the drafted recommendations were not expected to result in significant resource impact. When drafting the recommendations, the committee noted small cost implications resulting from training staff in specialist mental health settings who assess and treat people who have self-harmed, as most training services are already in place in all care settings both at organisational and team levels. These additional costs are likely to be offset by better health outcomes for people who have self-harmed by improving their care and quality of life.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.10.5-6, 1.13.1-1.13.4. Other evidence supporting these recommendations can be found in the evidence reviews on skills in non-specialist settings (evidence report R) and supporting people to be safe (evidence report N).

1 # References – included studies

2 ## Qualitative

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Lees, David; Procter, Nicholas; Fassett, Denise (2014) Therapeutic engagement between consumers in suicidal crisis and mental health nurses. International journal of mental health nursing 23: 306-15
Lindgren, B. M., Wilstrand, C., Glue, F. et al. (2004) Struggling for hopefulness: a qualitative study of Swedish women who self-harm. Journal of Psychiatric & Mental Health Nursing (Wiley-Blackwell) 11: 284-291
Littlewood, Donna L., Quinlivan, Leah, Graney, Jane et al. (2019) Learning from clinicians' views of good quality practice in mental healthcare services in the context of suicide prevention: a qualitative study. BMC psychiatry 19: 346
Long, M. and Jenkins, M. (2010) Counsellors' perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm. Counselling and Psychotherapy Research 10: 192-200
McGough, S., Wynaden, D., Ngune, I. et al. (2021) Mental health nurses' perspectives of people who self-harm. International journal of mental health nursing 30: 62-71
O'Donovan, A. (2007) Pragmatism rules: The intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. Journal of Psychiatric and Mental Health Nursing 14: 64-71
Rissanen, Marja-Liisa; Kylma, Jari; Laukkanen, Eila (2012) Helping self-mutilating adolescents: descriptions of Finnish nurses. Issues in mental health nursing 33: 251-62
Simoes, R. M. P.; Dos Santos, J. C. P.; Martinho, M. J. C. M. (2020) Adolescents with Suicidal Behaviours: a qualitative study about the assessment of Inpatient Service and Transition to Community. Journal of psychiatric and mental health nursing
Talseth, A. G.; Jacobsson, L.; Norberg, A. (2001) The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. Journal of advanced nursing 34: 96-106
Vatne, May and Naden, Dagfinn (2016) Crucial resources to strengthen the desire to live: Experiences of suicidal patients. Nursing ethics 23: 294-307
Wilstrand, C., Lindgren, B. M., Gilje, F. et al. (2007) Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm. Journal of psychiatric and mental health nursing 14: 72-8

1 **Economic**

2 No studies were identified that met the inclusion criteria.

1 # Appendices

2 ## Appendix A Review protocols

3 **Review protocol for review question: What are the views and preferences of staff in specialist mental health settings,**
4 **people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental**
5 **health settings who assess and treat people who have self-harmed?**

6 **Table 4: Review protocol**

Field	Content
PROSPERO registration number	CRD42021220478
Review title	Skills required for staff in specialist mental health settings who assess and treat people who have self-harmed
Review question	What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?
Objective	To identify the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about the skills that are required for staff in specialist mental health settings who assess and treat people who have self-harmed
Searches	The following databases will be searched: • Applied Social Sciences Index and Abstracts (ASSIA) • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Database of Abstracts of Reviews of Effects (DARE) • Embase • Emcare • International Health Technology Assessment (IHTA) database • MEDLINE & MEDLINE In-Process • PsycINFO • Web of Science (WoS) Searches will be restricted by: • Qualitative/patient issues study filter • English language studies • Human studies • Date: 2000 onwards. The GC felt that a date limit of 2000 was reasonable and would capture all the relevant studies while also ensuring the data within them was still in-date/relevant.

Field	Content
	Other searches: • Inclusion lists of systematic reviews • Reference lists of included studies • Forward and backward citation searches of key studies • Country: The committee wished to prioritise evidence from settings which most closely reflect the UK practice context. They therefore agreed to include studies from high income European countries according to the World Bank (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519; i.e., Andorra, Austria, Belgium, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Greenland, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lichtenstein, Lithuania, Luxembourg, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and UK), Canada, US, Australia and New Zealand, which would be sufficiently transferable. Priority will be given to UK studies, however data from studies conducted in other high-income countries will be added if new themes arise that are not captured in the UK evidence. The full search strategies will be published in the final review.
Condition or domain being studied	All people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability. 'Self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act. This does not include repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability.
Population	Inclusion: • Staff in specialist mental health settings that assess and/or treat people who have self-harmed • People who have self-harmed and been assessed and/or treated in specialist mental health settings, including people who have self-harmed and have a mental health problem, neurodevelopmental disorder or a learning disability. • Family members/carers of people who have self-harmed and been assessed and/or treated in specialist mental health settings, including people who have self-harmed and have a mental health problem, neurodevelopmental disorder or a learning disability. Exclusion: People displaying repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability
Phenomenon of interest	Views and preferences of the population about staff skills regarded as required/ not required or important/ not important Themes will be identified from the literature, but may include: • Empathy • Knowledge • Language • Communication style
Comparator/Reference standard/Confounding factors	Not applicable
Types of study to be included	• Systematic reviews of qualitative studies • Qualitative studies (for example, semi-structured and structured interviews, focus groups, observations, and surveys with free text questions)

Field	Content
Other exclusion criteria	Studies will not be included for the following reasons: Study design: • Purely quantitative studies (including surveys with only descriptive quantitative data) Language: • Non-English Publication status: • Abstract only
Context	Settings - Inclusion: All specialist mental health settings
Primary outcomes (critical outcomes)	Please see potential themes under Phenomenon of interest
Secondary outcomes (important outcomes)	Please see potential themes under Phenomenon of interest
Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into EPPI and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. Dual sifting will be performed on 10% of records; 90% agreement is required. Disagreements will be resolved via discussion between the two reviewers, and consultation with senior staff if necessary. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. The following data will be extracted: study details (reference, country where study was carried out, type and dates), participant characteristics, details of research questions and methods (including analytical and data collection technique), relevant key themes/ findings, risk of bias and source of funding. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer.
Risk of bias (quality) assessment	Risk of bias of systematic reviews of qualitative studies will be assessed using the scale by Flemming (2012) (https://www.sbu.se/contentassets/14570b8112c5464cbb2c256c11674025/methodological_limitations_qualitative_evidence_synthesis.pdf) and risk of bias of original qualitative studies will be assessed using the CASP qualitative checklist as described in Developing NICE guidelines: the manual.
Strategy for data synthesis	EPPI will be used for generating bibliographies/citations, study sifting and data extraction. Studies will be reviewed chronologically from most recent first to oldest. Thematic analysis of the data will be conducted and findings presented. The quality of the evidence will be assessed using GRADE-CERQual for each theme.

Field	Content
Analysis of sub-groups	Formal subgroup analyses are not appropriate for this question due to qualitative data, but the evidence from the following groups will be considered separately if there is inconsistency or incoherence in the results for a given theme: • People who have self-harmed (adults, children); • Staff in specialist mental health settings who assess and/or treat people (adults/children) who have self-harmed • Family members/carers of people who have self-harmed
Type and method of review	Qualitative
Language	English
Country	England
Anticipated or actual start date	11/11/2020
Anticipated completion date	26/01/2022
Stage of review at time of this submission	**Review stage** / **Started** / **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐ Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐
Named contact	5a. Named contact: National Guideline Alliance 5b Named contact e-mail: selfharm@nice.org.uk 5e Organisational affiliation of the review: National Institute for Health and Care Excellence (NICE) and National Guideline Alliance
Review team members	National Guideline Alliance

Field	Content
Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10105
Other registration details	None
URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=220478
Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • notifying registered stakeholders of publication • publicising the guideline through NICE's newsletter and alerts • issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.
Keywords	Self-harm, assessment, management, prevention, support needs, families and carers, health care
Details of existing review of same topic by same authors	None
Current review status	Ongoing
Additional information	Not applicable
Details of final publication	www.nice.org.uk

CASP: Critical Appraisal Skills Programme; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CERQual: Confidence in the Evidence from Reviews of Qualitative Research; GRADE: Grading of Recommendations Assessment, Development and Evaluation; NGA: National Guideline Alliance; NICE: National Institute for Health and Care Excellence

Appendix B Literature search strategies

Literature search strategies for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Clinical

Database(s): MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily – OVID interface
Date of last search: 3rd March 2021

#	searches
1	poisoning/ or exp self-injurious behavior/ or self mutilation/ or suicide/ or suicidal ideation/ or suicide, attempted/ or suicide, completed/
2	(automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*).ti,ab.
3	or/1-2
4	clinical supervision/ or exp education, professional/ or exp inservice training/ or learning/ or mentoring/ or mentors/ or models, educational/ or nursing supervisory/ or exp professional competence/
5	advanced practice nursing/ or nurse clinicians/
6	exp Professional-Patient Relations/
7	ed.fs.
8	(*patient safety/ or "personnel staffing and scheduling"/ or shift work schedule/ or work schedule tolerance/ or (health manpower/ or exp health personnel/ or health workforce/ or nurse practitioners/ or nursing service, hospital/ or nursing staff, hospital/ or nursing staff/ or nursing team/ or exp patient care team/ or patient safety/ or exp personnel management/ or safety/ or exp safety management/ or work-life balance/ or workload/)) and (curricul* or development or educat* or learn* or module* or support* or teach* or train* or workshop* or work shop*).ti,ab.
9	or/4-8
10	((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (mentor* or skill* or supervi*)).ti,ab.

#	searches
11	((curricul* or educat* or elearn* or learn* or module* or skill* or teach* or train* or workshop*) adj3 (((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or ((engag* or speak* or talk*) adj2 (nonjud* or non jud*)) or empath* or engag* or language or listen* or professionalism or respect* or speak* or talk* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding)).ti,ab.
12	((((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or empath* or language or professionalism or respect* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding or (((engag* or listen* or speak* or talk*) adj2 patient*) or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) or ((how* to* or nonjud* or non jud*) adj2 (engag* or listen* or speak* or talk*))) and (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (curricul* or educat* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)).ti,ab.
13	((mentor* or skill* or supervi*) adj3 (acquire or acquisition or curricul* or educat* or elearn* or knowledge or learn* or module* or support* or teach* or train* or workshop*)).ti,ab.
14	(((clinical or management or peer) adj2 supervi*) or ((education or essential or practical) adj2 skill*) or (reflect* adj2 practice) or skillset* or skill* set* or (skill* adj2 supervis*)).ti,ab.
15	(((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj5 (cpd or curricul* or DEVELOPMENT or educat* or elearn* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and ((cpd or curricul* or educat* or elearn* or knowledge or learn* or module* or skill* or teach* or train* or workshop* or work shop*) adj3 (intervention* or program* or strateg*)))).ti,ab.
16	(buddy or buddies or ((colleague* or peer*) adj2 support*)).ti,ab.

#	searches
17	(care coordinator* or ((charge or lead) adj2 nurs*) or nurs* manag*).ti,ab.
18	(in service or inservice).ti,ab.
19	((develop* adj2 (abilit* or knowledge or professional* or skill*)) or (self adj (awareness or development))).ti,ab.
20	((cme and education) or (continuing adj2 (development or education*))).ti,ab.
21	((education* or mentor* or skill* or supervi*) adj2 (intervention* or program* or hospital? or office? or ward*)).ti,ab.
22	(((clinician* or nurs* or personnel or physician* or practitioner* or professional* or psychiatrist* or psychologist* or therapist*) adj patient) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or worker*) adj3 patient* adj3 (communicat* or relation*))).ti,ab.
23	(therapeutic adj (alliance* or engagement or relation*)).ti,ab.
24	(collaborative adj (care or working)).ti,ab.
25	(active learning or didactic* or roleplay* or role play*).ti,ab.
26	((patient* or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) adj5 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*) adj5 (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*)).ti,ab.
27	or/9-26
28	anthropology, cultural/ or cluster analysis/ or focus groups/ or grounded theory/ or health care surveys/ or interview.pt. or "interviews as topic"/ or narration/ or nursing methodology research/ or observation/ or "personal narratives as topic"/ or narrative/ or qualitative research/ or "surveys and questionnaires"/ or sampling studies/ or tape recording/ or videodisc recording/
29	focus group*.ti,ab.
30	(qualitative* or interview* or questionnaire* or narrative* or narration* or survey*).ti,ab.

#	searches
31	(ethno* or emic or etic or phenomenolog* or grounded theory or constant compar* or (thematic adj4 analys*) or theoretical sampl* or purposive sampl*).tw.
32	(hermeneutic* or heidegger* or husser* or colaizzi* or van kaam* or van manen* or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau*).tw.
33	(metasynthes* or meta synthes* or metasummar* or meta summar* or metastud* or meta stud* or metathem* or meta them*).tw.
34	(critical interpretive synthes* or (realist adj (review* or synthes*)) or (noblit and hare) or (meta adj (method or triangulation)) or (cerqual or conqual) or ((thematic or framework) adj synthes*)).tw.
35	((brother* or carer* or caregiv* or care giv* or famil* or father* or husband* or mother* or parent* or partner* or relative* or sibling* or sister* or spous* or mother* or parent* or wife* or wive* or consumer* or inpatient* or man or men or patient* or person or people or population or user* or women or woman or advisor* or clinician* or coordinator* or counsel* or doctor* or gp or health visitor* or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or intra disciplin* or multi disciplin* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj6 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*)).ti,ab.
36	or/28-35
37	3 and 27 and 36
38	letter/ or editorial/ or news/ or exp historical article/ or anecdotes as topic/ or comment/ or case report/ or (letter or comment*).ti. or (animals not humans).sh. or exp animals, laboratory/ or exp animal experimentation/ or exp models, animal/ or exp rodentia/ or (rat or rats or mouse or mice).ti.
39	37 not 38
40	limit 39 to english language
41	limit 40 to yr="2000 -Current"

Database(s): Embase and Emcare – OVID interface
Date of last search: 3rd March 2021

#	searches
1	automutilation/ or exp suicidal behavior/
2	(automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*).ti,ab.

#	searches
3	or/1-2
4	clinical supervision/ or vocational education/ or inservice training/ or learning/ or mentoring/ or mentor/ or educational model/ or nursing/ or professional competence/
5	advanced practice nursing/ or clinical nurse specialist/
6	exp Professional-Patient Relationship/
7	education.hw.
8	(health workforce/ or exp health care personnel/ or health workforce/ or nurse practitioner/ or nursing/ or nursing staff / or team nursing/ or patient care / or patient safety/ or exp personnel management/ or safety/ or shift schedule/ or team nursing/ or work-life balance/ or workload/ or work schedule/ or (personnel management/ and "organization and management"/)) and (curricul* or development or educat* or learn* or module* or support* or teach* or train* or workshop* or work shop*).ti,ab.
9	or/4-8
10	((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (mentor* or skill* or supervi*)).ti,ab.
11	((curricul* or educat* or elearn* or learn* or module* or skill* or teach* or train* or workshop*) adj3 (((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or ((engag* or speak* or talk*) adj2 (nonjud* or non jud*)) or empath* or engag* or language or listen* or professionalism or respect* or speak* or talk* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding)).ti,ab.
12	((((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or empath* or language or professionalism or respect* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding or (((engag* or listen* or speak* or talk*) adj2 patient*) or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) or ((how* to* or nonjud* or non jud*) adj2 (engag* or listen* or speak* or talk*))) and (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (curricul* or educat* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)).ti,ab.

#	searches
13	((mentor* or skill* or supervi*) adj3 (acquire or acquisition or curricul* or educat* or elearn* or knowledge or learn* or module* or support* or teach* or train* or workshop*)).ti,ab.
14	(((clinical or management or peer) adj2 supervi*) or ((education or essential or practical) adj2 skill*) or (reflect* adj2 practice) or skillset* or skill* set* or (skill* adj2 supervis*)).ti,ab.
15	(((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj5 (cpd or curricul* or DEVELOPMENT or educat* or elearn* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and ((cpd or curricul* or educat* or elearn* or knowledge or learn* or module* or skill* or teach* or train* or workshop* or work shop*) adj3 (intervention* or program* or strateg*)))).ti,ab.
16	(buddy or buddies or ((colleague* or peer*) adj2 support*)).ti,ab.
17	(care coordinator* or ((charge or lead) adj2 nurs*) or nurs* manag*).ti,ab.
18	(in service or inservice).ti,ab.
19	((develop* adj2 (abilit* or knowledge or professional* or skill*)) or (self adj (awareness or development))).ti,ab.
20	((cme and education) or (continuing adj2 (development or education*))).ti,ab.
21	((education* or mentor* or skill* or supervi*) adj2 (intervention* or program* or hospital? or office? or ward*)).ti,ab.
22	(((clinician* or nurs* or personnel or physician* or practitioner* or professional* or psychiatrist* or psychologist* or therapist*) adj patient) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or worker*) adj3 patient* adj3 (communicat* or relation*))).ti,ab.
23	(therapeutic adj (alliance* or engagement or relation*)).ti,ab.
24	(collaborative adj (care or working)).ti,ab.

#	searches
25	(active learning or didactic* or roleplay* or role play*).ti,ab.
26	((patient* or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) adj5 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*) adj5 (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*)).ti,ab.
27	or/9-26
28	cultural anthropology/ or cluster analysis/ or grounded theory/ or health care survey/ or information processing/ or interview/ or narrative/ or nursing methodology research/ or observation/ or qualitative research/ or questionnaire/ or recording/ or verbal communication/ or videorecording/
29	focus group*.ti,ab.
30	(qualitative* or interview* or questionnaire* or narrative* or narration* or survey*).ti,ab.
31	(ethno* or emic or etic or phenomenolog* or grounded theory or constant compar* or (thematic adj4 analys*) or theoretical sampl* or purposive sampl*).tw.
32	(hermeneutic* or heidegger* or husser* or colaizzi* or van kaam* or van manen* or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau*).tw.
33	(metasynthes* or meta synthes* or metasummar* or meta summar* or metastud* or meta stud* or metathem* or meta them*).tw.
34	(critical interpretive synthes* or (realist adj (review* or synthes*)) or (noblit and hare) or (meta adj (method or triangulation)) or (cerqual or conqual) or ((thematic or framework) adj synthes*)).tw.
35	((brother* or carer* or caregiv* or care giv* or famil* or father* or husband* or mother* or parent* or partner* or relative* or sibling* or sister* or spous* or mother* or parent* or wife* or wive* or consumer* or inpatient* or man or men or patient* or person or people or population or user* or women or woman or advisor* or clinician* or coordinator* or counsel* or doctor* or gp or health visitor* or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or intra disciplin* or multi disciplin* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj6 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or

#	searches
	opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*)).ti,ab.
36	or/28-35
37	3 and 27 and 36
38	(animal/ not human/) or exp Animal Experiment/ or animal model/ or exp Experimental Animal/ or nonhuman/ or exp Rodent/ or (rat or rats or mouse or mice).ti.
39	37 not 38
40	limit 39 to english language
41	limit 40 to yr="2000 -Current"

Database(s): PsycINFO – OVID interface
Date of last search: 3rd March 2021

#	searches
1	self-injurious behavior/ or self-destructive behavior/ or self-inflicted wounds/ or self-mutilation/ or self-poisoning/ or exp suicide/ or suicidal ideation/
2	(automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*).ti,ab.
3	or/1-2
4	exp inservice training/
5	learning/ or mentor/
6	exp professional competence/ or professional development/ or exp professional supervision/
7	education.hw.
8	(exp observation methods/ or *patient safety/ or (medical personnel and human resource management).sh. or exp working conditions/ or work scheduling/ or exp *health personnel/ or *nurses/ or (*nursing/ and teams.hw.) or exp *human resource management/ or *safety/ or exp *occupational safety/ or *work-life balance/ or *work load/) and (curricul* or development or educat* or learn* or module* or support* or teach* or train* or workshop* or work shop*).ti,ab.
9	or/4-8
10	((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team

#	searches
	or teams or therapist* or warden* or worker*) and (mentor* or skill* or supervi*)).ti,ab.
11	((curricul* or educat* or elearn* or learn* or module* or skill* or teach* or train* or workshop*) adj3 (((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or ((engag* or speak* or talk*) adj2 (nonjud* or non jud*)) or empath* or engag* or language or listen* or professionalism or respect* or speak* or talk* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding)).ti,ab.
12	((((choos* or choice) adj2 word*) or communicat* or compassion* or consultation* or (cultur* adj2 aware*) or (decision* adj2 mak*) or empath* or language or professionalism or respect* or (time adj2 manag*) or trust* or (understand* adj2 (behav* or patient*)) or understanding or (((engag* or listen* or speak* or talk*) adj2 patient*) or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) or ((how* to* or nonjud* or non jud*) adj2 (engag* or listen* or speak* or talk*))) and (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (curricul* or educat* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)).ti,ab.
13	((mentor* or skill* or supervi*) adj3 (acquire or acquisition or curricul* or educat* or elearn* or knowledge or learn* or module* or support* or teach* or train* or workshop*)).ti,ab.
14	(((clinical or management or peer) adj2 supervi*) or ((education or essential or practical) adj2 skill*) or (reflect* adj2 practice) or skillset* or skill* set* or (skill* adj2 supervis*)).ti,ab.
15	(((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj5 (cpd or curricul* or DEVELOPMENT or educat* or elearn* or knowledge or learn* or module* or teach* or train* or workshop* or work shop*)) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) and ((cpd or curricul* or educat* or elearn* or knowledge or learn* or module* or skill* or teach* or train* or workshop* or work shop*) adj3 (intervention* or program* or strateg*)))).ti,ab.

#	searches
16	(buddy or buddies or ((colleague* or peer*) adj2 support*)).ti,ab.
17	(care coordinator* or ((charge or lead) adj2 nurs*) or nurs* manag*).ti,ab.
18	(in service or inservice).ti,ab.
19	((develop* adj2 (abilit* or knowledge or professional* or skill*)) or (self adj (awareness or development))).ti,ab.
20	((cme and education) or (continuing adj2 (development or education*))).ti,ab.
21	((education* or mentor* or skill* or supervi*) adj2 (intervention* or program* or hospital? or office? or ward*)).ti,ab.
22	(((clinician* or nurs* or personnel or physician* or practitioner* or professional* or psychiatrist* or psychologist* or therapist*) adj patient) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or worker*) adj3 patient* adj3 (communicat* or relation*))).ti,ab.
23	(therapeutic adj (alliance* or engagement or relation*)).ti,ab.
24	(collaborative adj (care or working)).ti,ab.
25	(active learning or didactic* or roleplay* or role play*).ti,ab.
26	((patient* or ((people* or men or population* or women) adj2 (automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*))) adj5 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*) adj5 (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or multi disciplin* or health visitor* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*)).ti,ab.
27	or/9-26
28	cluster analysis/ or focus group/ or grounded theory/ or surveys/ or intervies/ or narratives/ or qualitative methods/ or questionnaires/ or tape recorders/
29	focus group*.ti,ab.
30	(qualitative* or interview* or questionnaire* or narrative* or narration* or survey*).ti,ab.

#	searches
31	(ethno* or emic or etic or phenomenolog* or grounded theory or constant compar* or (thematic adj4 analys*) or theoretical sampl* or purposive sampl*).tw.
32	(hermeneutic* or heidegger* or husser* or colaizzi* or van kaam* or van manen* or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau*).tw.
33	(metasynthes* or meta synthes* or metasummar* or meta summar* or metastud* or meta stud* or metathem* or meta them*).tw.
34	(critical interpretive synthes* or (realist adj (review* or synthes*)) or (noblit and hare) or (meta adj (method or triangulation)) or (cerqual or conqual) or ((thematic or framework) adj synthes*)).tw.
35	((brother* or carer* or caregiv* or care giv* or famil* or father* or husband* or mother* or parent* or partner* or relative* or sibling* or sister* or spous* or mother* or parent* or wife* or wive* or consumer* or inpatient* or man or men or patient* or person or people or population or user* or women or woman or advisor* or clinician* or coordinator* or counsel* or doctor* or gp or health visitor* or interdisciplin* or inter disciplin* or intradisciplin* or intra disciplin* or multidisciplin* or intra disciplin* or multi disciplin* or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or personal assistant* or personnel or pharmacist* or physician* or police* or practitioner* or prison officer* or professional* or psychiatrist* or psychologist* or psychotherapist* or psycho therapist* or social worker* or staff* or teacher* or team or teams or therapist* or warden* or worker*) adj6 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*)).ti,ab.
36	or/28-35
37	3 and 27 and 36
38	limit 37 to english language
39	limit 38 to yr="2000 -Current"

Database(s): Cochrane Library – Wiley interface
Cochrane Database of Systematic Reviews, Issue 3 of 12, March 2021; Cochrane Central Register of Controlled Trials, Issue 3 of 12, March 2021
Date of last search: 3rd March 2021

#	searches
1	MeSH descriptor: [poisoning] this term only
2	MeSH descriptor: [self-injurious behavior] explode all trees
3	MeSH descriptor: [self mutilation] this term only
4	MeSH descriptor: [suicide] this term only
5	MeSH descriptor: [suicidal ideation] this term only
6	MeSH descriptor: [suicide, attempted] this term only
7	MeSH descriptor: [suicide, completed] this term only

#	searches
8	(automutilat* or “auto mutilat*” or cutt* or (self near/2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*):ti,ab.
9	{or #1-#8}
10	MeSH descriptor: [clinical supervision] this term only
11	MeSH descriptor: [education, professional] this term only
12	MeSH descriptor: [inservice training] explode all trees
13	MeSH descriptor: [learning] this term only
14	MeSH descriptor: [mentoring] this term only
15	MeSH descriptor: [mentors] this term only
16	MeSH descriptor: [models, educational] this term only
17	MeSH descriptor: [nursing supervisory] this term only
18	MeSH descriptor: [professional competence] explode all trees
19	MeSH descriptor: [advanced practice nursing] this term only
20	MeSH descriptor: [nurse clinicians] this term only
21	MeSH descriptor: [Professional-Patient Relations] explode all trees
22	MeSH descriptor: [patient safety] this term only
23	MeSH descriptor: [personnel staffing and scheduling] this term only
24	MeSH descriptor: [shift work schedule] this term only
25	MeSH descriptor: [work schedule tolerance] this term only
26	MeSH descriptor: [health manpower] this term only
27	MeSH descriptor: [health personnel] explode all trees
28	MeSH descriptor: [health workforce] this term only
29	MeSH descriptor: [nurse practitioners] this term only
30	MeSH descriptor: [nursing service, hospital] this term only
31	MeSH descriptor: [nursing staff, hospital] this term only
32	MeSH descriptor: [nursing staff] this term only
33	MeSH descriptor: [nursing team] this term only
34	MeSH descriptor: [patient care team] this term only
35	MeSH descriptor: [patient safety] this term only

#	searches
36	MeSH descriptor: [personnel management] explode all trees
37	MeSH descriptor: [safety] this term only
38	MeSH descriptor: [safety management] explode all trees
39	MeSH descriptor: [work-life balance] this term only
40	MeSH descriptor: [workload] this term only
41	{OR #22-#40}
42	(curricul* or development or educat* or learn* or module* or support* or teach* or train* or workshop* or “work shop*”):ti,ab.
43	#41 and #42
44	{OR #10-#21}
45	#43 or #44
46	((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor*” or neuropsychol* or nurs* or officer* or paramedic* or peer worker* or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (mentor* or skill* or supervi*)):ti,ab.
47	((curricul* or educat* or elearn* or learn* or module* or skill* or teach* or train* or workshop*) near/3 (((choos* or choice) near/2 word*) or communicat* or compassion* or consultation* or (cultur* near/2 aware*) or (decision* near/2 mak*) or ((engag* or speak* or talk*) near/2 (nonjud* or non jud*)) or empath* or engag* or language or listen* or professionalism or respect* or speak* or talk* or (time near/2 manag*) or trust* or (understand* near/2 (behav* or patient*)) or understanding)):ti,ab.
48	((((choos* or choice) near/2 word*) or communicat* or compassion* or consultation* or (cultur* near/2 aware*) or (decision* near/2 mak*) or empath* or language or professionalism or respect* or (time near/2 manag*) or trust* or (understand* near/2 (behav* or patient*)) or understanding or (((engag* or listen* or speak* or talk*) near/2 patient*) or ((people* or men or population* or women) near/2 (automutilat* or “auto mutilat*” or cutt* or (self near/2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*))) or ((“how* to*” or nonjud* or non jud*) near/2 (engag* or listen* or speak* or talk*))) and (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor*” or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*) and (curricul* or educat* or

#	searches
	knowledge or learn* or module* or teach* or train* or workshop* or “work shop*”)):ti,ab.
49	((mentor* or skill* or supervi*) near/3 (acquire or acquisition or curricul* or educat* or elearn* or knowledge or learn* or module* or support* or teach* or train* or workshop*)):ti,ab.
50	(((clinical or management or peer) near/2 supervi*) or ((education or essential or practical) near/2 skill*) or (reflect* near/2 practice) or skillset* or skill* set* or (skill* near/2 supervis*)):ti,ab.
51	(((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor*” or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*) near/5 (cpd or curricul* or DEVELOPMENT or educat* or elearn* or knowledge or learn* or module* or teach* or train* or workshop* or “work shop*”)) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor*” or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*) and ((cpd or curricul* or educat* or elearn* or knowledge or learn* or module* or skill* or teach* or train* or workshop* or work shop*) near/3 (intervention* or program* or strateg*)))):ti,ab.
52	(buddy or buddies or ((colleague* or peer*) near/2 support*)):ti,ab.
53	(“care coordinator*” or ((charge or lead) near/2 nurs*) or “nurs* manag*”):ti,ab.
54	(“in service” or inservice):ti,ab.
55	((develop* near/2 (abilit* or knowledge or professional* or skill*)) or (self next (awareness or development))):ti,ab.
56	((cme and education) or (continuing near/2 (development or education*))):ti,ab.
57	((education* or mentor* or skill* or supervi*) near/2 (intervention* or program* or hospital? or office? or ward*)):ti,ab.
58	(((clinician* or nurs* or personnel or physician* or practitioner* or professional* or psychiatrist* or psychologist* or therapist*) next patient) or ((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor*” or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or worker*) near/3 patient* near/3 (communicat* or relation*))):ti,ab.
59	(therapeutic next (alliance* or engagement or relation*)):ti,ab.

#	searches
60	(collaborative next (care or working)):ti,ab.
61	(“active learning” or didactic* or roleplay* or “role play*”):ti,ab.
62	((patient* or ((people* or men or population* or women) near/2 (automutilat* or “auto mutilat*” or cutt* or (self near/2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*))) near/5 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*) near/5 (advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “multi disciplin*” or “health visitor”* or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*” or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*)):ti,ab.
63	{OR #46-#62}
64	#45 or #63
65	MeSH descriptor: [anthropology, cultural] this term only
66	MeSH descriptor: [cluster analysis] this term only
67	MeSH descriptor: [focus groups] this term only
68	MeSH descriptor: [grounded theory] this term only
69	MeSH descriptor: [health care surveys] this term only
70	(interview):pt.
71	MeSH descriptor: [interviews as topic] this term only
72	MeSH descriptor: [narration] this term only
73	MeSH descriptor: [nursing methodology research] this term only
74	MeSH descriptor: [observation] this term only
75	MeSH descriptor: [personal narratives as topic
76	MeSH descriptor: [narrative] this term only
77	MeSH descriptor: [qualitative research] this term only
78	MeSH descriptor: [surveys and questionnaires] this term only
79	MeSH descriptor: [sampling studies] this term only
80	MeSH descriptor: [tape recording] this term only
81	MeSH descriptor: [videodisc recording] this term only

#	searches
82	“focus group*”:ti,ab.
83	(qualitative* or interview* or questionnaire* or narrative* or narration* or survey*):ti,ab.
84	(ethno* or emic or etic or phenomenolog* or “grounded theory” or “constant compar*” or (thematic near/4 analys*) or “theoretical sampl*” or “purposive sampl*”):ti,ab.
85	(hermeneutic* or heidegger* or husser* or colaizzi* or van kaam* or “van manen*” or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau*):ti,ab.
86	(metasynthes* or “meta synthes*“ or metasummar* or “meta summar*” or metastud* or “meta stud*” or metathem* or “meta them*”):ti,ab.
87	(“critical interpretive synthes*” or (realist next (review* or synthes*)) or (noblit and hare) or (meta next (method or triangulation)) or (cerqual or conqual) or ((thematic or framework) next synthes*)):ti,ab.
88	((brother* or carer* or caregiv* or “care giv*” or famil* or father* or husband* or mother* or parent* or partner* or relative* or sibling* or sister* or spous* or mother* or parent* or wife* or wive* or consumer* or inpatient* or man or men or patient* or person or people or population or user* or women or woman or advisor* or clinician* or coordinator* or counsel* or doctor* or gp or “health visitor*” or interdisciplin* or “inter disciplin*” or intradisciplin* or “intra disciplin*” or multidisciplin* or “intra disciplin*” or “multi disciplin*” or neuropsychol* or nurs* or officer* or paramedic* or “peer worker*” or “personal assistant*” or personnel or pharmacist* or physician* or police* or practitioner* or “prison officer*“ or professional* or psychiatrist* or psychologist* or psychotherapist* or “psycho therapist*” or “social worker*” or staff* or teacher* or team or teams or therapist* or warden* or worker*) near/6 (anx* or attitude* or aware* or belief* or concern* or emotion* or experience* or fear* or feeling* or felt* or know* or opinion* or perception* or perspective* or preference* or satisfact* or stress* or thought* or uncertain* or understand* or unsure or view*)):ti,ab.
89	{OR #65-#88}
90	(#9 and #64 and #89) with Cochrane Library publication date Between Jan 2000 and Mar 2021

Database(s): CDSR and HTA – CRD interface
Date of last search: 3rd March 2021

#	Searches
1	MeSH descriptor: poisoning IN CDSR, HTA
2	MeSH descriptor: self-injurious behavior EXPLODE ALL TREES IN CDSR, HTA
3	MeSH descriptor: self mutilation IN CDSR, HTA
4	MeSH descriptor: suicide IN CDSR, HTA
5	MeSH descriptor: suicidal ideation IN CDSR, HTA
6	MeSH descriptor: suicide, attempted IN CDSR, HTA
7	MeSH descriptor: suicide, completed IN CDSR, HTA

#	Searches
8	(automutilat* or “auto mutilat*” or cutt* or (self near2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*) IN CDSR, HTA
9	(#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8) from 2000 to 2021

Database(s): ASSIA - Proquest interface
Date of last search: 3rd March 2021

#	Searches
S7	(S1 and s4 and s5 and s6) with limits
S6	(MAINSUBJECT.EXACT("Cluster analysis") or MAINSUBJECT.EXACT("Focus groups") or MAINSUBJECT.EXACT("Grounded theory") or MAINSUBJECT.EXACT("Narration") or MAINSUBJECT.EXACT("Personal narratives") or MAINSUBJECT.EXACT("Qualitative research") or MAINSUBJECT.EXACT("Social surveys") or MAINSUBJECT.EXACT("Surveys") or MAINSUBJECT.EXACT("Tape recordings") or MAINSUBJECT.EXACT("Videotape recording")) OR noft(“focus group*” or qualitative* or interview* or focus or questionnaire* or narrative* or narration* or survey* or ethno* or emic or etic or phenomenolog* or “grounded theory” or “constant compar*” or (thematic near/4 analys*) or “theoretical sampl*” or “purposive sampl*” or hermeneutic* or heidegger* or husser* or colaizzi* or “van kaam*” or “van manen*” or giorgi* or glaser* or strauss* or ricoeur* or spiegelberg* or merleau* or metasynthes* or “meta-synthes*” or metasummar* or “meta-summar*” or metastud* or “meta-stud*” or metathem* or “meta-them*” “critical interpretive synthes*” or “realist synthes*” or “thematic framework” or “thematic synthes*”)
S5	su(attitude* or perspective* or view*) OR noft(attitude* or experience* or opinion* or perspective* or view*)
S4	S2 or s3
S3	noft((advisor* or clinician* or coordinator* or counsel* or doctor* or gp or interdisciplin* or "inter disciplin*" or intradisciplin* or "intra disciplin*" or multidisciplin* or "multi disciplin*" or "health visitor*" or neuropsychol* or nurs* or officer* or paramedic* or "peer worker*" or "personal assistant*" or personnel or pharmacist* or physician* or police* or practitioner* or "prison officer*" or professional* or psychiatrist* or psychologist* or psychotherapist* or "psycho therapist*" or "social worker*" or staff* or teacher* or team or teams or therapist* or warden* or worker*)) AND noft((mentor* or skill* or supervi*))
S2	MAINSUBJECT.EXACT("Advanced practice nurses") or MAINSUBJECT.EXACT("Clinical supervision") or MAINSUBJECT.EXACT("Collaborative learning") or MAINSUBJECT.EXACT("Inservice training") or MAINSUBJECT.EXACT("Mentoring") or MAINSUBJECT.EXACT("Mentors") or MAINSUBJECT.EXACT("Multiprofessional education") or MAINSUBJECT.EXACT("Nurse managers") or MAINSUBJECT.EXACT("Nursing models") or MAINSUBJECT.EXACT("Professional competence") or MAINSUBJECT.EXACT("Health professional-Patient relationships")
S1	(MAINSUBJECT.EXACT("Poisoning") or MAINSUBJECT.EXACT("Selfdestructive behaviour") or MAINSUBJECT.EXACT("Suicide") or

#	Searches
	MAINSUBJECT.EXACT("Violent suicide")) OR noft((selfharm* or “self harm*” or suicid*))

Database(s): SSCI - Clarivate interface
Date of last search: 3rd March 2021
[forward citation searches conducted for selected references found in the systematic database search, above]

Economic

A global, population based search was undertaken to find for economic evidence covering all parts of the guideline.

Database(s): MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily – OVID interface
Date of last search: 12th August 2021

#	Searches
1	poisoning/ or exp self-injurious behavior/ or self mutilation/ or suicide/ or suicidal ideation/ or suicide, attempted/ or suicide, completed/
2	(automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*).ti,ab.
3	or/1-2
4	Economics/
5	Value of life/
6	exp "Costs and Cost Analysis"/
7	exp Economics, Hospital/
8	exp Economics, Medical/
9	Economics, Nursing/
10	Economics, Pharmaceutical/
11	exp "Fees and Charges"/
12	exp Budgets/
13	budget*.ti,ab.
14	cost*.ti.
15	(economic* or pharmaco?economic*).ti.
16	(price* or pricing*).ti,ab.
17	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
18	(financ* or fee or fees).ti,ab.
19	(value adj2 (money or monetary)).ti,ab.
20	Quality-Adjusted Life Years/
21	Or/4-20
22	3 and 21
23	limit 22 to yr="2000 -current"

Database(s): Embase and Emcare – OVID interface
Date of last search: 12th August 2021

#	searches
1	automutilation/ or exp suicidal behavior/
2	(auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*).ti,ab.
3	or/1-2
4	health economics/
5	exp economic evaluation/
6	exp health care cost/
7	exp fee/
8	budget/
9	funding/
10	budget*.ti,ab.
11	cost*.ti.
12	(economic* or pharmaco?economic*).ti.
13	(price* or pricing*).ti,ab.
14	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
15	(financ* or fee or fees).ti,ab.
16	(value adj2 (money or monetary)).ti,ab.
17	Quality-Adjusted Life Year/
18	Or/4-17
19	3 and 18
20	limit 19 to yr="2000 -current"

Database(s): Cochrane Library - Wiley interface
Cochrane Central Register of Controlled Trials, Issue 8 of 12, August 2021
Date of last search: 12th August 2021

#	Searches
1	MeSH descriptor: [poisoning] this term only
2	MeSH descriptor: [self-injurious behavior] explode all trees
3	MeSH descriptor: [self mutilation] this term only
4	MeSH descriptor: [suicide] this term only
5	MeSH descriptor: [suicidal ideation] this term only

#	Searches
6	MeSH descriptor: [suicide, attempted] this term only
7	MeSH descriptor: [suicide, completed] this term only
8	(automutilat* or "auto mutilat*" or cutt* or (self near/2 cut*) or selfdestruct* or "self destruct*" or selfharm* or "self harm*" or selfimmolat* or "self immolat*" or selfinflict* or "self inflict*" or selfinjur* or "self injur*" or selfmutilat* or "self mutilat*" or selfpoison* or "self poison*" or selfwound* or "self wound*" or suicid*):ti,ab.
9	{or #1-#8}
10	MeSH descriptor: [Economics] this term only
11	MeSH descriptor: [Value of life] this term only
12	MeSH descriptor: [Costs and Cost Analysis] explode all trees
13	MeSH descriptor: [Economics, Hospital] explode all trees
14	MeSH descriptor: [Economics, Medical] explode all trees
15	MeSH descriptor: [Economics, Nursing] this term only
16	MeSH descriptor: [Economics, Pharmaceutical] this term only
17	MeSH descriptor: [Fees and Charges"]
18	MeSH descriptor: [Budgets] this term only
19	budget*:ti,ab.
20	cost*.ti.
21	(economic* or pharmaco?economic*):ti.
22	(price* or pricing*):ti,ab.
23	(cost* near/2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)):ab.
24	(financ* or fee or fees):ti,ab.
25	(value near/2 (money or monetary)):ti,ab.
26	MeSH descriptor: [Quality-Adjusted Life Years] this term only
27	{OR #10-#26}
28	(#9 and #27) with Cochrane Library publication date Between Jan 2000 and Aug 2021

Database(s): NHS EED and HTA – CRD interface
Date of last search: 12th August 2021

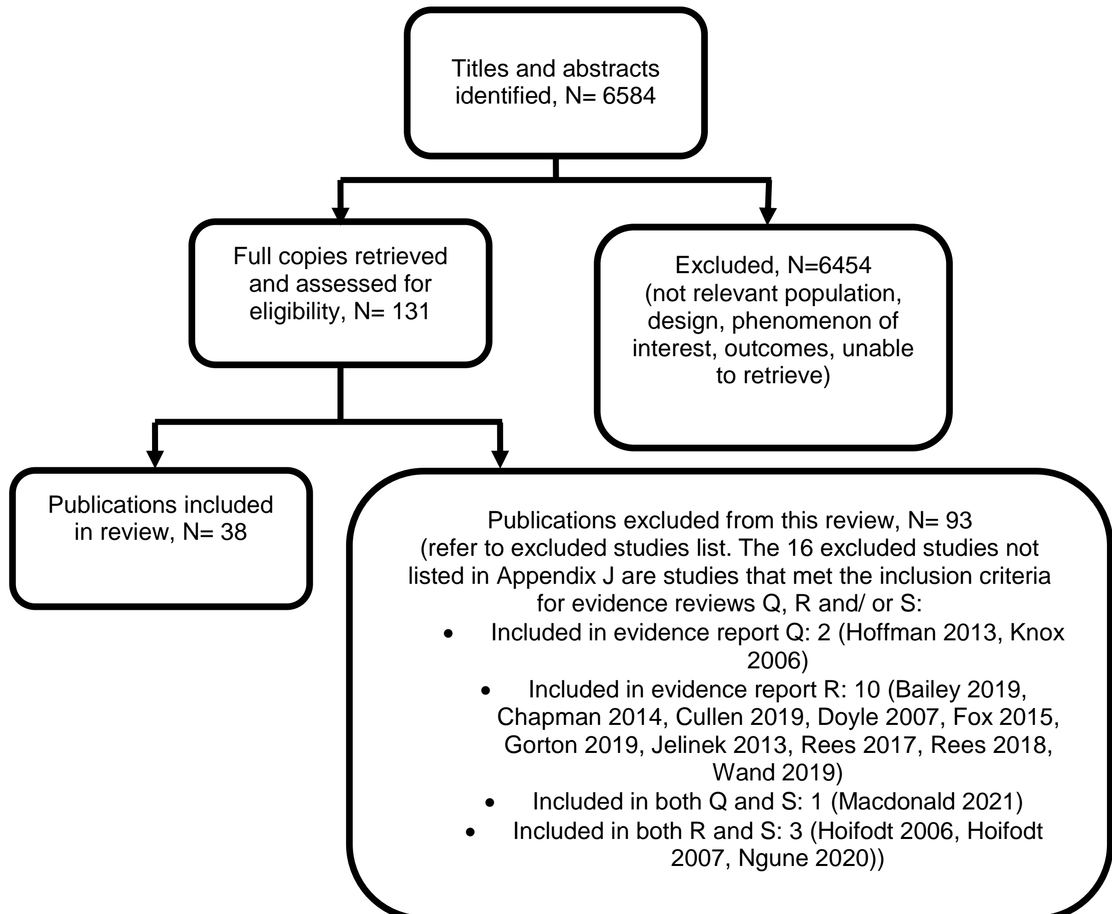
#	Searches
1	MeSH descriptor: poisoning IN NHSEED, HTA
2	MeSH descriptor: self-injurious behavior EXPLODE ALL TREES IN NHSEED, HTA
3	MeSH descriptor: self mutilation IN NHSEED, HTA
4	MeSH descriptor: suicide IN NHSEED, HTA
5	MeSH descriptor: suicidal ideation IN NHSEED, HTA
6	MeSH descriptor: suicide, attempted IN NHSEED, HTA
7	MeSH descriptor: suicide, completed IN NHSEED, HTA
8	(automutilat* or "auto mutilat*" or cutt* or (self near2 cut*) or selfdestruct* or "self destruct*" or selfharm* or "self harm*" or selfimmolat* or "self immolat*" or selfinflict* or "self inflict*" or selfinjur* or "self injur*" or selfmutilat* or "self mutilat*" or selfpoison* or "self poison*" or selfwound* or "self wound*" or suicid*) IN NHSEED, HTA

#	Searches
9	(#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8) from 2000 to 2021

Appendix C Qualitative evidence study selection

Study selection for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Figure 2: Study selection flow chart



Appendix D Evidence tables

Evidence tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Table 5: Evidence tables

Alonzo, 2017

Bibliographic Reference	Alonzo, D.; Moravec, C.; Kaufman, B.; Individuals at risk for suicide: Mental health clinicians' perspectives on barriers to and facilitators of treatment engagement; Crisis; 2017; vol. 38; 158-167

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	USA
Setting	Healthcare – outpatient mental-health clinic
Data collection and analysis	Four focus groups lasting 1.5 hours on average were held, using a semi-structured interview guide. Discussions were audio-recorded and field notes were taken by two of the authors, which were all transcribed verbatim. Data were analysed thematically using inductive content analysis.
Recruitment strategy	The authors contacted the directors of 3 non-profit outpatient mental-health clinics, who identified potential participants for the study. These clinicians were then approached by the study authors to take part.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • Be clinicians working at 1 of 3 non-profit outpatient mental health clinics • Work with clients deemed to be at high risk of engaging in suicidal behaviour, based on:

	○ referral to the clinic as a result of suicidal behaviour ○ current reported suicidal ideation ○ prior history of suicidal behaviour ○ visit to a psychiatric emergency room within the past year ○ inpatient psychiatric hospitalization within the past year
Exclusion criteria	Not reported.
Sample size	N = 36 clinicians
Participant characteristics	**Mean age (SD):** 39.07 (9.47) **Sex (female/ male):** 29/ 7 **Role**: Outpatient mental-health clinician: 36 **Setting:** Outpatient mental-health clinic **Mean years in post/ experience (SD):** 9.9 (9.05) **Client group (adults, children/ CYP):** Not reported
Results	Author theme: Definition of Treatment Engagement

	Example quote: "The whole issue of engagement brings up your own sense of competency in terms of, "Do I have the skills to engage this client?… Can I really help this person?... What am I bringing to the table in terms of competency?"... I think those issues play a part in the engagement process." p. 161 Author theme: Indicators of Client Engagement *Example quote: "I think it's complex… their posture in the room, are they verbal, are they nonverbal, are they withholding, are they checking us out? I mean, you can tell sometimes, when a client has something to say, and they're not sure they're going to give you that information." p. 161* Author theme: Facilitators of Treatment Engagement *Example quote: "You need to approach clients with a lack of judgment and take some time in the engagement process, in understanding and thinking about the (client's) issues. You have to be careful about how you ask questions; you can't be like a robot. If you take the time to engage with the client and you feel that engagement as the social worker, the client will be more likely to want to come to treatment with you." p. 164* *"Just having that warmth and that realness, you know, a personal touch, means a lot and just helps them to keep coming." p. 164* *"I may not be able to give an aspirin today, to cure your voices or cure your depression, but I'm giving you a bit of hope, I'm giving you that nurturing... that many of our consumers, many people don't have... why is it important to do that? Because people don't have a voice, they don't have the forum or environment where it's okay to speak up." p. 164*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Authors did not justify their use of focus groups to collect data, and minor concerns regarding lack of adequate discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are people working on psychiatric wards with people who have suicidal behaviour; as this includes suicidal ideation, therefore participants are not required to have worked with people who have previously self-harmed. Study not conducted in the UK.)*

Awenat, 2017

Bibliographic Reference	Awenat, Yvonne; Peters, Sarah; Shaw-Nunez, Emma; Gooding, Patricia; Pratt, Daniel; Haddock, Gillian; Staff experiences and perceptions of working with in-patients who are suicidal: qualitative analysis; The British journal of psychiatry : the journal of mental science; 2017; vol. 211; 103-108

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Healthcare – inpatient mental-health clinics
Data collection and analysis	Semi-structured interviews were held for an average of 64 minutes with participants using a flexible topic guide. Interviews were audio-recorded and transcribed verbatim, and data were thematically analysed using a systemic method of identifying patterns.
Recruitment strategy	Participants were purposively sampled from an NHS mental health trust in Northern England and recruited from ward- and community-based clinical teams.
Study dates	Not reported.
Sources of funding	This study was funded by NIHR Research for Patient Benefit programme (PB-PG-111-26026).

Inclusion criteria	Participants had to: • Work with psychiatric in-patients
Exclusion criteria	Not reported.
Sample size	N = 20 healthcare staff members
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** 14/ 6 **Role**: Nurses: 8 Nursing assistants/ support workers: 2 Psychiatrists: 4* Allied health professionals (including clinical psychologists, social workers and occupational therapists): 6* *Only data from these groups of participants were extracted **Setting:** Inpatient mental-health clinics

	Range of years in post/ experience: 4-38 **Client group (adults, children/ CYP):** Not reported. *Only data from these groups of participants were extracted
Results	Author theme: Talking about suicide *Example quote: "Should I ask? Shouldn't I ask? What kind of question should I ask? What kind of question shouldn't I ask?" (AHP:08)' p. 105* *"I haven't had any specific training with [suicidal patients] because that would be my role to kind of, ehm, do that." (AHP: 09)' p. 105* *"I don't think it erm it negatively impacts on a patient… in fact, erm being more open and bringing that, you know, bring those words into the conversation makes it real and makes it easier for the patient to talk about it." (Psychiatrist: 11)' p. 105*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Section	Question	Answer
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns regarding lack of adequate discussion of researcher reflexivity and ethical issues.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are people working on psychiatric wards with people who have*

Section	Question	Answer
		suicidal behaviour; as this includes suicidal ideation, therefore participants are not required to have worked with people who have previously self-harmed.)

Behrman, 2019

Bibliographic Reference	Behrman, G. U.; Secrest, S.; Ballew, P.; Matthieu, M. M.; Glowinski, A. L.; Scherrer, J. F.; Improving pediatricians' knowledge and skills in suicide prevention: Opportunities for social work; Qualitative Social Work; 2019; vol. 18; 868-885

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	USA
Setting	Primary care / community
Data collection and analysis	Five focus groups were conducted with paediatric residents, adolescents, parents of adolescents who died by suicide, parents with adolescents in the mental health system, and community mental health professionals. Each group met once for around 2 hours. The groups were asked the same open-ended questions - but the healthcare professionals received additional questions. Audio recordings of each group were transcribed and 2 researchers coded the transcripts in several stages with constant comparisons between the researchers. First, themes were identified from each focus group and then were compared with other groups to identify themes that overlapped. The research team compared their interpretations of themes, individually and then as a group, to agree the final list of themes.
Recruitment strategy	For the first focus group, a recruitment e-mail was sent to all current Saint Louis University (SLU) School of Medicine paediatric residents who serve St. Louis County describing the study and seeking volunteers. Recruits for the other four focus groups were drawn from Communities Healing Adolescent Depression and Suicide (CHADS) mailing/ client lists and professional contacts who collaborate with CHADS in serving St. Louis County adolescents. Non-random purposive sampling groups were then created from current SLU paediatric residents; adolescents with histories of suicidal ideation/attempt and seen by their paediatrician within the past year); parents whose adolescent

	son/daughter died by suicide; parents whose adolescent son/daughter are currently receiving behavioural health services for depression/anxiety; and St. Louis County community adolescent behavioural health care providers.
Study dates	November 2014 and January 2015
Sources of funding	Supported by a St. Louis County Children's Service Fund grant.
Inclusion criteria	For the first focus group: paediatricians had to be currently enrolled in the SLU residency program and providing clinical services to St. Louis County residents. For the other four focus groups, adolescent participants had to be St. Louis County residents with a history of suicidal ideation/attempt; parents who either lost a child to suicide or have/had a child receiving mental health services for suicidal ideation/attempt and residents of St. Louis County. Mental health providers had to be licensed and practicing in St. Louis County.
Exclusion criteria	Not reported
Sample size	5 focus groups: 1. current paediatric residents (n=8) 2. adolescents with histories of suicidal ideation/attempt and seen by their paediatrician within the past year (n=11) 3. parents whose adolescent son/daughter died by suicide (n= 5) 4. parents whose adolescent son/daughter are currently receiving behavioural health services for depression/anxiety (n=10) 5. community adolescent behavioural health care providers (n=11)
Participant characteristics	**Staff participants:** **Mean age (SD):** Not reported **Sex (female/ male):** 13/ 6

	Role: Paediatric residents: 8 Adolescent behavioural healthcare providers (including social workers, psychologists, and licensed professional counsellors)*: 11 *Of the staff participants, only data from these groups of participants were extracted **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported. Paediatric residents had 3 or more years of clinical practice **Client group (adults, children/ CYP):** Children and young people. **People who have self-harmed:** **Mean age (range):** Not reported (14-18 years) **Sex (female/male):** Not reported. Authors stated that patients were 'equally mixed male and female'.

	Ethnicity: Caucasian: 10 African-American: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported **Family members/ carers:** **Mean age (SD):** Not reported **Sex (female/male):** Not reported **Relationship to person who has self-harmed:**

	Parent: 15.
Results	Author theme: Broken mental health care system *Example quote: “they (providers) don’t talk to each other.” p. 876* *“The mental health care system is so out of whack, there are so many holes in the safety net.” p. 876* Author theme: Importance of communication *Example quote: “Kids won’t be honest with the pediatrician if the parents are sitting there,” p. 876* *"Doctors need to realize that treating the adolescent who has two parents, secure home and income, and a good school, are very different from the kid who comes from a broken home, has limited resources, and a struggling school system." p. 877* Author theme: Stigma associated with mental health care *Example quote: “They (psychiatrist) look at your records and say, ‘you have depression, and then they like dope you up with medications’, cried one female adolescent.” p. 877* *“They tell me what’s wrong with me, then they give me medicine” p. 877*

	"It takes a doctor (psychiatrist) five minutes to give me a diagnosis and put me on a med" p. 878 *"I'm pretty normal; it was so embarrassing. I hate that if you have some kind of issue, you're labeled mentally ill." p. 878* Author theme: Addressing medications and substance abuse *Example quote: Parents who had a child in the mental health system and community health professionals noted the importance of "understanding medications, their side effects, and adhering to prescriptions." p. 879*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Can't tell
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Data presented do not always support the explanation of the theme.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Staff participants are those who have worked with people who have suicidal behaviour; as this includes suicidal ideation, staff participants are not required to have worked with people who have previously self-harmed. Patient participants were included if they were receiving mental health services for suicidal ideation or attempt, and parent participants were included if they had either lost a child to suicide or had a child receiving mental health services for suicidal ideation or attempt. Therefore, these participants were also not required to have self-harmed or care for a person who has self-harmed. Study was conducted in a non-specialist setting but included specialist staff and patients/ family members/ carers providing data regarding skills for specialist staff. Study not conducted in the UK.)*

Berg, 2020

Bibliographic Reference	Berg, Siv Hilde; Rortveit, Kristine; Walby, Fredrik A.; Aase, Karina; Adaptive capacities for safe clinical practice for patients hospitalised during a suicidal crisis: a qualitative study; BMC psychiatry; 2020; vol. 20; 316

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Norway
Setting	Healthcare - university hospital that provides specialised mental health services.
Data collection and analysis	5 focus groups were held using a semi-structured interview guide, lasting 90 minutes and involving open-ended questions. Individual interviews were also held on the five themes generated by the focus group interviews. Data from both the focus groups and interviews were audio-recorded, transcribed, and analysed sequentially using qualitative content analysis consistent with a phenomenological hermeneutic point of view. Themes from the focus groups and interviews were integrated to form the final results.
Recruitment strategy	A purposeful sampling strategy was used to recruit healthcare professionals who had different levels of expertise and diverse professional backgrounds, and were working in open or locked wards in specialised mental health care settings for adults.
Study dates	May to December 2016
Sources of funding	Western Norway Regional Health Authority, grant number 911846.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=32 overall; n=25 healthcare professionals in focus groups; n=18 healthcare professionals in individual interviews (n=8 participated in both focus groups & interviews).
Participant characteristics	**Mean age (SD):** Not reported

	Sex (female/ male): 28/7 **Role:** Registered mental health nurses: 14 in focus groups; 11 in interviews Physicians and consultant psychiatrists: 6 in focus groups; 4 in interviews Psychologists: 5 in focus groups; 3 in interviews **Setting**: 9 inpatient specialised mental health care wards. The locked wards specialised in: Psychosis: 1 Affective disorders: 1 Acute care: 2. The open wards specialised in: Rehabilitation: 3 Short term stabilisation during crisis: 2 **Range of years in post/ experience:** 1-24

	Client group (adults, children/ CYP): Adults
Results	Author theme: Setting aside the forms and checklist to prioritise trust *Example quote: '"I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to 'when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?' I try to make a natural transition and create some trust during the conversation so the patient feels it's safe to open up and talk about things along the way" (1 year of experience, locked wards).' p. 4* Author theme: Making judgements based on more than patients' spoken words *Example quote: '"It's often a gut feeling you get, and that is what makes it difficult. You should be able to document this in a suicide risk assessment. But it is, in a way, what happens in a meeting with the patient, their spoken and unspoken words, their background, their history, everything, in a way, the overall picture" (1 year of experience, locked wards).' pp. 4-5* Author theme: Improving understanding by seeking others' perspectives *Example quote: '"We always talk with the patient together when assessing suicide. Then, we are two persons who can calibrate each other's experience afterwards, to talk about it and assess the risk together" (female nurse, 1.5 years of experience, short-term stabilisation ward).' p. 5* Author theme: Creating individual clinical pathways

	Example quote: '"I work with the individual patients' underlying feelings about suicidality… Through gaining insight, the patients find other ways to express their emotions" (male psychologist with specialisation, 15 years of experience, open rehabilitation ward).' p. 6 Author theme: Making trade-offs between under- and over-protection *Example quote: '"I feel damned if I do and damned if I don't. Society criticises us (specialised mental health care) for using too many physical constraints and calls for more autonomy (for the patient), but at the same time, we are made accountable for the suicides and are told that we should have done more to prevent them. They (members of society) don't truly comprehend the complexity of this task" (10 years of experience, locked ward).' p. 6* *"If there is a chronic suicidal patient, one should not talk about suicidality all the time. Therefore, I don't want to ask if the patient has thoughts of suicide before I let that patient out unless the patient says very clearly that he or she has suicidal plans. If I see that the patient struggles, I would ask the patient, 'Do you think it is okay for you to go out now?', and then you will get some gut feeling about this. It has been difficult at times to risk locking out patients, especially at night and on weekends, when you are alone there. However, there is an assessment the therapist has done, and we have to stick to the plan, especially with emotionally unstable patients with chronic suicidality. You have to give them responsibility back, and it is challenging" (female mental health nurse, 4 years of experience, locked acute ward).' p. 7*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	No
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias due to lack of discussion of the relationship between researchers and participants and ethical considerations.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are working with people who have suicidal behaviour; as this includes suicidal ideation, participants are not required to have worked with people who have previously self-harmed.)*

Berger, 2014

Bibliographic Reference	Berger, Emily; Hasking, Penelope; Reupert, Andrea; Response and training needs of school staff towards student self-injury; Teaching and Teacher Education; 2014; vol. 44; 25-34

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	Australia
Setting	Secondary education
Data collection and analysis	The online questionnaire took between 30 and 40 min to complete. Participants were asked several open-ended questions to understand how they respond to students who self-injure and their training needs. Themes were developed from these open-ended responses. Responses were re-read and re-coded to verify themes, and to validate any new themes or merge existing themes.
Recruitment strategy	School principals were asked to distribute information sheets about the study to teachers and staff. The study was also advertised to school psychologists on the Australian Psychological Society (APS) website. Information sheets invited in-service teachers, other school staff, and pre-service teachers to access the online questionnaire though a URL link. Participants were invited to enter a draw to win cinema tickets as compensation for their time.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=768
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** 556/ 212 **Role:** Student teachers: 267

	Teachers: 261 School mental health workers (counsellors, psychologists and welfare coordinators): 106* School leaders & deputies: 83 Administrative and support staff (school nurses, teacher aides and office staff): 52 *Only data from these groups of participants were extracted **Setting:** Secondary education **Mean years in post/ experience (SD):** For in-service teachers & staff 14.75 (11.01) years; the student teachers had between 2 to 22 weeks of school placement **Client group (adults, children/ CYP):** Children (12 to 18 years)
Results	Author theme: Perceived confidence in response to students who self-injure *Example quote: "The first student was hard to comprehend why and to not respond negatively towards the action they had inflicted, but I have gained more advice and experience in my responses to students and feel more confident in responding appropriately" (Mental health worker)' p. 29* Author theme: Barriers to responding to students who self-injure

	Example quote: "Some staff are still hard to convince not to make a big deal in front of students in regard to self-harm concerns. Some people still believe it is just an attention seeking device!!" (Mental health worker)' p. 30 Author theme: Directions for future training *Example quote: "It is important to get as much information as possible, particularly being in a remote area with very few accessible resources" (Mental health worker)' p. 31*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Inadequate discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included specialist staff. Little data provided regarding specialist staff. Study not conducted in the UK.)*

Borrill, 2005

Bibliographic Reference	Borrill, Jo; Snow, Louisa; Medlicott, Diana; Teers, Rebecca; Paton, Jo; Learning from 'Near Misses': Interviews with Women who Survived an Incident of Severe Self-Harm in Prison; Howard Journal of Criminal Justice; 2005; vol. 44; 57-69

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Prison
Data collection and analysis	Participants had individual semi-structured interviews focusing on their recent suicide attempt. Interviews were recorded (where possible) and transcribed verbatim - or from the researcher's notes where recording was not possible. The first stage of analysis was open coding of each interview. These codes were then examined and grouped into key themes with illustrative quotes. Common themes and individual differences within the group of women were explored. The analysis was carried out by one of the researchers and checked by the other interviewers.

Recruitment strategy	Participants were identified from the Prison Service database of self-harm incidents as having received oxygen/resuscitation or treatment at an outside hospital, and were then approached by suicide prevention co-ordinators at each establishment to discuss participation in the study. Since the use of outside hospital varies according to the prison medical facilities, all incidents were checked to exclude women whose acts were not potentially lethal.
Study dates	2002 to 2003
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=15
Participant characteristics	**Mean age (range):** not reported (19-50 years) **Sex (female/male)**: 15/ 0 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** at least 1 attempt: 15
Results	Author theme: Vulnerability Factors and Precipitating Factors

	Example quote: "two weeks before I came in I saw a psychiatrist who said I didn't need medication any more and stopped giving it to me.. since then (self-harm) got really bad" p. 61 Author theme: What makes a difference? *Example quote: "The counsellor listens to me - I can express anger by swearing and she doesn't mind ... she doesn't judge you, she's there to listen to you" p. 65* *"'..it didn't help ... sitting talking about it and then going back to my cell.. it started off nightmares, flashbacks, all over again" p. 65*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Some concerns regarding researcher reflexivity and insufficient information about the data analysis process.)*
Overall risk of bias and relevance	Relevance	Highly relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist staff)*

Christianson, 2008

Bibliographic Reference	Christianson, Carley L.; Everall, Robin D.; Constructing bridges of support: School counsellors' experiences of student suicide; Canadian Journal of Counselling; 2008; vol. 42; 209-221

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	Canada

Setting	Education - university
Data collection and analysis	Semi-structured individual telephone interviews were held, lasting between 1-2 hours. Interviews were digitally recorded and transcribed, then data were analysed using a grounded theory approach.
Recruitment strategy	Potential participants were recruited through e-mails, newsletters, personal contacts and a website. Those interested in participating had to contact the researcher.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be/ have been a school counsellor • have lost a personal, not academic, counselling client to suicide • have received training in educational psychology or a counselling-related field
Exclusion criteria	Not reported.
Sample size	N = 7 school counsellors
Participant characteristics	**Mean age (SD):** Not reported. **Sex (female/ male):** 3/ 4 **Role**: School counsellor: 7 **Setting:** Education - schools

	Range of years in post/ experience: 15-31 **Client group (adults, children/ CYP):** Adults
Results	Author theme: National Training/ Practice Standards *Example quote: "What I see happening now is the training programs are shorter. They seem to have much less practicum time, they're putting people in schools to do practicums where they're basically throwing them into school to do the job and having a fellow counsellor kind of oversee them, but not the same kind of intense focus on the counselling process." p. 213* Author theme: Self-care *Example quote: "I had to be strong for everybody else right? I had to be strong for the students and I had to put my grieving aside so I could do that." p. 215* *"Again, I think that eventually I had to understand that there is no control in a lot of those situations and in that whole process that I had to take ownership of myself and let everything else go I think was important. That ceremony that I had in my backyard where I took all of [her] letters and basically said prayers and burnt them up, that really helped me understand and work through that." p. 216* *"I think it's important information for other people to have, that these are some of the things that can happen, that you don't have control of the situation when the student's not with you. I think it's important that we share those experiences with others." p. 216*

	"I take care of myself and take quiet time for myself. I do all of the things that I know I'm supposed to do to look after myself. I have a therapist that I've seen on and off over the years. I haven't seen her for a couple of years, but I know she's there in case I ever need to go back and see her. I'm not hesitant to get help if I need help." p. 216

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias due to inadequate description of recruitment strategy, consideration of researcher reflexivity and ethics.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are school counsellors who have lost a patient to suicide; therefore participants are not required to have worked with people who have previously self-harmed. Study was conducted in a non-specialist setting but included specialist staff. Study not conducted in the UK.)*

Craigen, 2009

Bibliographic Reference	Craigen, Laurie M.; Foster, Victoria; "It was like a partnership of the two of us against the cutting": Investigating the counseling experiences of young adult women who self-injure; Journal of Mental Health Counseling; 2009; vol. 31; 76-94

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	USA
Setting	Education - university

Data collection and analysis	Two 2-hour face-to-face semi-structured interviews were conducted with each participant using an interview guide with open-ended questions, and recorded. Data collection continued until saturation was achieved, and data were analysed using a phenomenological method.
Recruitment strategy	Flyers were distributed and throughout a small public university and an advert was posted on the university's student website giving information about the study and contact information. Potential participants had to contact the researcher by phone or email to take part.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N = 10 university students with a history of self-harm
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/male)**: 10/ 0 **Ethnicity:** White European-American: 8 African-American: 1 Latina: 1 **Co-morbidity:** Not reported

	Duration of self-harm: Not reported **Suicide attempts:** Not reported.
Results	Author theme: My counselor *Example quote: "[My counselor] was just a really good listener and I think that was very beneficial." p. 82* *"I think a personal connection is really key in any therapist/ patient relationship." pp. 82-83* *"I didn't really appreciate the handing out of the scripture verses to tell me that I am loved no matter which way I am and I have to accept myself for who I am." p. 83* Author theme: The counseling process *Example quote: "You can't strip someone of their old clothes until you have a new set available." p.85* *"The underlying issues are really the key to the behaviour. Instead of just putting a Band-aid on the issue, if you could treat the actual thing that is causing it, that is better." p. 85*

	"There were periods where I managed to assuage the need to self-injure by picking up another healthy or acceptable behaviour, at the urging of a counselor … if that makes sense. It didn't really last too long because they were terribly simplistic behaviours that were sort of short-term answers." p. 84 Author theme: Counseling reflections *Example quote: "I had one [counselor] convinced that I was fine… it was great, except that I was getting worse." p. 86* *"I think the bottom line is try not to alienate them further. Because there is already the knowledge that what you are doing is very bizarre and not normal, and you need to be careful of inadvertently stigmatizing them further." p. 87*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns regarding lack of adequate discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist staff. Study not conducted in the UK.)*

De Stefano, 2012

Bibliographic Reference	de Stefano, J.; Atkins, S.; Noble, R. N.; Heath, N.; Am I competent enough to be doing this?: A qualitative study of trainees' experiences working with clients who self-injure; Counselling Psychology Quarterly; 2012; vol. 25; 289-305

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada

Setting	Education - university. Participants interned at high schools, university counselling centres, colleges, and addictions services.
Data collection and analysis	Semi-structured interviews were held using open-ended questions, lasting 45-60 minutes. Interviews were audio-recorded and transcribed for analysis. Data were analysed using a consensual qualitative research method influenced by grounded theory, involving constant comparison and consensus between researchers.
Recruitment strategy	Potential participants were invited to participate during an address to a MA student cohort in class. Project consent forms were placed in student mailboxes and interested students had to return the forms to a research assistant.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants were second-year counselling psychology MA students. They had to: • Have worked with one of more clients who had engaged in some form of self-injury within the last 9 months.
Exclusion criteria	Not reported.
Sample size	N = 12 counselling psychology students
Participant characteristics	**Mean age (range):** Not reported (23-37 years) **Sex (female/ male):** 12/ 0 **Role**: Counselling psychology students: 12 **Setting:** Education - university. Students interned at the following sites:

	High schools: 7 University counselling centres: 2 Community college: 1 Addictions service: 1 Specialised high school for students with behavioural problems: 1 **Range of years in post/ experience:** 0 **Client group (adults, children/ CYP):** Adults and CYP (most students interned at high schools, colleges and university counselling centres).
Results	Author theme: Trainees use common sense to construct a basic model of NSSI despite lack of previous knowledge of the phenomenon *Example quote: "I really wanted to make sure that I was making her feel okay about talking to me about it. I knew that other people have probably had a reaction of fear towards her, and I really wanted to make sure that even though she wasn't a hundred percent comfortable talking to me about it, I really wanted her to feel like it was a place that if she wanted to talk to me about it, she could, and if she wanted to show me any of her scars or any of her cuts, she could do that too." p. 296* *"I think my emotional reactions were different because I had a different relationship with her by then so my emotional reactions were more understanding. I was concerned about suicidal risk, but in a less panicked sort of way. I felt more confident in my relationship with her, I felt I was able to trust her to disclose and be honest so, rather than try and hide things from me, that she had in the beginning of our relationship. So I really felt better, because I felt a better connection with her, my concern was less panicked." p. 296*

	Author theme: Work with NSSI stress and challenge trainees at many levels *Example quote: "'Oh what do I do? I've never dealt with this before.' You know, and 'What's going on with this girl that she is doing this?' And so I think a lot of the emotions I felt were related to my status as a beginner counselor as opposed to the act itself, I was just basically afraid that I wasn't prepared for this, that I wasn't experienced enough to work with her." p. 298* *"So I did a suicidal assessment and then I consulted with my supervisor and asked him to do the same thing, just to make sure I was, perceiving the right things. Once I felt that she was convincing me ''No, I'm not suicidal, it's not what I want'' it was okay, ''She wants me to keep this a secret now, so do I disclose and risk our bond? Do I keep it a secret because she has the right to confidentiality even though she's only thirteen?'' So I had a lot of different ethical things to deal with and I had to work out the ethical things in my mind." p. 298* Author theme: Experience provides new but incomplete learning *Example quote: "I think I'd probably be more directive with her, I'd be less nice (laughs). I found I treated her very nicely and I think at the expense of getting into detailed analysis. I feel I would push things a bit more with her, I would challenge her more. Yeah, I'd confront her more. I don't know, maybe I would try working more on techniques on how to avoid cutting when she was feeling the urge. Something we didn't do a lot of . . . like cognitive strategies, thought stopping or something like that." p. 299* *"Just overly focusing on getting rid of the symptom I don't think that's necessarily useful, because they have a lot of shame and just focusing on the symptom might actually bring about more symptoms. I remember the beginning of my relationship with this client, she was very clear: ''I don't want to talk about this stuff because it makes me worse.'' So, I think that making it more interpersonal, might be necessary, obviously a symptom reduction is a good idea, but I think it has to come once a good bond is established and once there's an interpersonal communication going on." p. 299*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias as the author's do not fully describe the ethical*

Section	Question	Answer
		considerations taken into account beyond including a "statement of ethics approval" (p. 292) within the participants' consent form.)
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included specialist staff. Study not conducted in the UK.)*

Dunkley, 2014

Bibliographic Reference	Dunkley C; Transmit and receive: what factors inhibit or facilitate the communication of emotional pain between suicidal patients and mental health professionals?; 2014; 274

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Mixed: community (mental health community treatment teams; an assessment and brief intervention team; an assertive outreach team); inpatient (psychiatric inpatient units; a psychiatric intensive care unit; a mother and baby mental health inpatient unit); outpatient (psychological therapies services).
Data collection and analysis	Focus groups were held with mental healthcare staff using a brief inventory as a prompt sheet, as well as a second printed sheet containing a list of items based on DeCoster's (1997) research into the reactions of general practitioners when confronted with emotional communication from their patients. This was introduced towards the end of the focus groups to prompt further discussion. Individual interviews lasting from 45 minutes to 1.5 hours were held with patients who had self-harmed using an interview schedule, and contact details given to participants to provide further comments after the interview as needed. All groups and interviews were digitally recorded. Data from patients and staff members were combined and analysed using iterative, inductive thematic analysis with a critical realist approach, whereby fragments of transcripts were coded into categories, which then merged into overarching themes.

Recruitment strategy	All participants were recruited from the same NHS Trust. Staff participants were recruited via in-house communication, using criterion-based purposeful sampling. Patient participants were recruited primarily through staff members involved in the focus groups via snowball sampling, plus posters encouraging potential participants to self-refer. Authors chose not to alter the recruitment method to seek male patient participants proactively.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Staff participants had to: • be qualified or a trainee in nursing, social work, psychology, psychiatry or occupational therapy • currently be working with adults at risk of suicide within the NHS Trust hosting the research. Patient participants had to: • be current patients of Adult Mental Health Services who identified themselves as having direct, lived experience of emotional pain via the Emotional Pain Brief Screening Inventory, a self-report measure designed specifically for the study • have a history of at least 1 medically serious suicide attempt plus current suicidal ideation. 'Medically serious' was defined as an incident in which the person has expressed intent to die and engaged in self-injury requiring hospitalisation for physical treatment for a period of at least 24 hours (not including patients discharged directly from the A&E unit) • be willing to be audiotaped or otherwise willing to submit another form of material that could be coded.
Exclusion criteria	There were no exclusion criteria for staff participants who met inclusion criteria. Patient participants were excluded if they: • were under the age of 18 years • were not currently active cases under mental health services.

Sample size	N = 35 patients and staff members (n = 26 staff members; n = 9 patients (10 patient participants were recruited, but 1 withdrew before the formal interview was held)).
Participant characteristics	**Staff participants:** **Mean age (SD):** Not reported. A variety of ages was represented. **Sex (female/ male):** Not reported. The groups of nurses and psychologists were all female and the other groups were mixed gender groups. **Role**: Occupational therapists: 6 Community mental health nurses: 5 Clinical social workers: 5 Psychologists: 5 Psychiatrists: 5 **Setting:** Clinical groups represented were: Community: 7 (Mental health community treatment teams: 5; assessment and brief intervention team: 1; assertive outreach team: 1) Inpatient: 4 (psychiatric inpatient units: 2; psychiatric intensive care unit: 1; mother and baby mental health inpatient unit: 1)

	Outpatient: 2 (psychological therapies services) **Range of years in post/ experience:** Not reported. A variety of years of experience was represented. **Client group (adults, children/ CYP):** Adults. **Patient participants:** **Mean age (range):** Not reported (27-58 years) **Sex (female/male):** 9/ 0 **Ethnicity:** Not reported **Co-morbidity:** Diagnoses were not mutually exclusive: Depression: 8 Anxiety: 7 Severe physical health or disability problem: 6

	Personality disorder: 5 Schizophrenia: 2 Anorexia Nervosa: 2 Obsessive Compulsive Disorder: 2 Phobia: 2 **Duration of self-harm:** Not reported **Suicide attempts:** At least 1 medically serious suicide attempt: 9
Results	Author theme: Unspoken and Unheard *Example quote: “I think there's two kind of people, as well, you've got the people who will call you up and say about their emotional pain but you have the other kind of people who doesn't contact you about their emotional pain, and they're the ones I feel more sometimes concerned about because they find it very difficult to express their emotions and they're kind of…a lot...that...quite often much more risky than the ones that do call up.” Social worker' p. 96* *“but it doesn't feel enough to just say, "I'm hurting, in emotional pain," It’s like it doesn't have any impact, it doesn't lead to people doing increased contact or showing that they're concerned or anything. It's like if you actually can say you're in emotional pain, well, they think, well, you're in control, you're thinking logically, you've said this and all the rest of it, so we don't need to bother with you.” p. 105*

	"Just make it as if it's something that's ok to talk about, that it's not so awful because I think people sometimes people can think that that this is...the thoughts they're having are so awful that they can't possibly express them or put them onto somebody else..or talk..or do that" Social Worker' p. 107 *"I think sometimes it's poor questioning I suppose having been a Samaritan I'm used…I'm used to sort of..er..using open questions rather than closed questions to find out how someone is really feeling and giving enough time for that and being comfortable with silence as well which I think is another thing that people often aren't comfortable with,, erm.. It's more frustrating to come out of an appointment feeling that I haven't been heard than to have an appointment at all because it just adds to the sense of not being heard and understood which then can further increase the emotional pain and make the situation harder" p. 107* *"that you feel like that if you're going to say something you'll open the floodgates and you won't be able to stop crying, you'll...you feel like you'll look bad in front of whoever you're with...erm... And that's something else...it's... I've noticed at times, if I've been really emotionally in pain and I am so genuinely upset and I can't stop crying, whoever you're seeing doesn't give you enough time to actually compose yourself before leaving the building and I've walked out of the building through the waiting room with people, absolutely sobbing my eyes out, and then having to go out and get in the car and drive home." pp. 112-113* *"I think…erm…one thing that we haven't really talked about is medication and things like being under the Mental Health Act, and symptoms. I think all of those contribute massively to emotional pain. I've got one client who's on a CTO (Community Treatment Order) at the moment, he hates it and his levels of distress are just awful, and there's part of me that thinks actually he'd probably be safer if he wasn't on a CTO. It's not really helping us manage things (OT2 interjects 'yeah') very well, And the whole medication battle (OT1 mmm) as well." p. 115*

	Author theme: Spoken and Unheard *Example quote: "I think there are times when I would choose not to get them to talk about emotional pain, if I didn't feel equipped, or it wasn't the right situation to do it…erm…if that makes any sense". OT 1* *"If something's going on for you sometimes (others murmur agreement) you feel you're not necessarily in the right place to really… one – hear it, and two – maybe actually react in the way that will be helpful." OT2* *"Mmm yeah, I think that's quite realistic, you know, you meet somebody in the street, you wouldn't necessarily start opening all their personal issues up, it's about time and place and appropriateness." OT3' p. 121* *"I don't know..I really can't remember what it was about now but when she changed the subject I just thought 'oh, I can't bring that up again..um I must be in the wrong and I shouldn't have brought it up.'" p. 122* *"and I certainly know there's another girl in the group who feels the same as I do, and she was here the other day and she said, "Oh, I'm gonna say I only had one attempt at self-harm this week cos that will keep Jake happy". That's so wrong! Why are we driven to lie to keep (the group leaders) happy? And I think it's because they don't give us the time to be us, to be honest, to be truthful, because they have their little boxes to tick in because that reflects on how their behaviour is and how they're seen by management" pp. 122-123* *"(She) tells me that I need to use my skills, but then I'm like, "but they haven't worked" and I just don't know what else she expects me to do when she doesn't give me any new things to do, apart from just keep going on about breathing. And I just can't see how that's gonna be beneficial 'cos you have to breathe to be alive (laughs) so I just can't see...just don't really get much of a response" p. 125* *"Like they'll ask you something, the person I see, and she's asked me that last week, and then I tell her the answer and she's writing it down like it's all NEWS to her, and you're thinking (indignant tone) - d'you know what I mean? What? I've told*

	you that last week! But then you think, well I can't expect them to remember when they're seeing hundreds of people. So it makes you feel like you're nobody, like you're just somebody like a robot." p. 126 *"I think with the paperwork thing...I think.. I'd..was it would agree sort of almost… it's almost cathartic I find it actually to write down maybe an assessment and sort of formulate it and organise…" OT' p. 127* *"But the reality is, particularly in the NHS that they never ever stick to their promises or what they say" p. 128* *"And if you do bring them into hospital you know, are you going to make the emotional pain worse? Because what may happen is that at the moment they're being protected but they now see themselves as a failure in a different way. Now they've failed because they've been admitted to hospital, they're now part of the 'mad' people…" Psychiatrist' p. 130* *"We need to be able to manage those emotions, not to have them or to … somehow inappropriately express them." Nurse' p. 131* Author theme: Spoken and also heard *Example quote: "They listen well and they're not judgemental and they don't give up on me" p. 148* *"my care-coordinator knows quite a bit about me so she would know I would enjoy a particular type of film and she would say to me 'go and put the film on and phone me back afterwards and tell me how you're feeling' " p. 135*

	“I didn't want to go to (mental health team base) I think I put it off for several years because of the connection with work. So I paid for counselling with a local charity. And the difference between somebody who's trained and somebody who is trained but, I don't want to sound ungrateful but is a do-gooder… erm…” p. 138 *“from the patient's point of view like I say you don't want to be honest and say, "well yeah I might do it again when I get home" Or, "I feel at the moment I won't do it but I am a bit scared that I might…you know it might all come over me again and then I might do it" I think if you'd just come out of hospital and it came over you I think I'd feel more that I could ring up then, because I'd be able to say, "look," you know, "a couple of days ago I was in hospital but I'm trying to get some help so it doesn't get this bad" p. 139* *“Oh my God she's crying! Oh! And it was it sort of, y'know the emotion, you know, showing emotion and not being the "I've-got-the- certificate-I-know-more-than-you" It's better hand-in-hand…” p. 144* *“What it all boils down to and understanding that they are in pain and that...you know maybe they need to talk about it maybe they need to just cry for ten, fifteen minutes, I suppose. Because when I find I'm in deep emotional pain I can't actually cry at home or... You know, when I'm on my own, I... I can't, no matter how hard I try, I can't cry on my own, but yet if I'm with somebody you know, I suppose it's a lot easier to cry. I think the time needs to be given.” pp. 145-146* Author theme: Unspoken but still heard *Example quote: “Almost like kind of a comforting, they're kind of leaning forward and... yeah, they look as if they're in pain. They might be wincing, so those kind of things, they might be holding themselves in some way. So those would be kind of some of the signs for me even without anybody saying something” p. 151*

	"It would also be about allowing other forms of communication, for me sometimes it's much easier for me to write down how I'm actually feeling than to verbally say it." p. 153 *"I've got a client who actually communicates his emotional pain really well and doesn't like to talk about it but he writes poetry. So each week I turn up and…and I don't need to ask even, when he's ready in the session he'll just spontaneously pull a poem out and read it to me, telling me about his week. And sometimes then he wants to talk about it afterwards, other times he doesn't but that's his way of telling me this is how it is. And he also plays a lot of music as well, which to start off with I just thought he was just telling me, "I like this CD" or whatever, but now I've realised actually it communicates how he's feeling quite a lot… so I've learned quite a lot about him over the time just with music and his poetry." p. 153* *"We often get comments from people who know the clients well - in their social circumstances- that they are expressing distress in different ways, so it's actually feedback from other people around them as well; (e.g.) 'normally this person is quite a happy person', (or) 'this person is a bit moody but doesn't get this distressed'" OT' p. 154* *"People that I believe have met me on that deeper level, I know, they're the people that I have imaginary conversations with, like I can pour my heart out to them, and I almost know what they're going to say back, things like that, and they prevent you - because you feel cared about, you feel that you matter, you feel that somebody knows how hard it is and just to have got through to the next day was an achievement, instead of getting through to you the next day because it's their job and it was on their timetable to phone you at such-and-such a time but they don't know why." p. 168*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Section	Question	Answer
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Staff participants are people working on psychiatric wards with people at risk of suicide; it is unclear if this included people with suicidal ideation. All patient participants had self-harmed. Study was part conducted in non-specialist settings but included specialist staff and patients providing data regarding skills for specialist staff)*

Dunkley, 2018

Bibliographic Reference	Dunkley, Christine; Borthwick, Alan; Bartlett, Ruth; Dunkley, Laura; Palmer, Stephen; Gleeson, Stefan; Kingdon, David; Hearing the Suicidal Patient's Emotional Pain; Crisis; 2018; vol. 39; 267-274

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	See Dunkley 2014
Data collection and analysis	See Dunkley 2014
Recruitment strategy	See Dunkley 2014
Study dates	See Dunkley 2014
Sources of funding	See Dunkley 2014
Inclusion criteria	See Dunkley 2014
Exclusion criteria	See Dunkley 2014
Sample size	See Dunkley 2014

Participant characteristics	See Dunkley 2014
Results	Author theme: Unspoken Communication – Alienated and Wordless *Example quote: “When over the many years when you do try […] and communicate […] it’s not heard or the right questions aren’t asked. […] I haven’t used [the out-of-hours service] for years purely because if I rang […] it was because I was in desperate need of help […] and to phone up, wait for the phone call to come back and actually often not actually be asked how I’m feeling, but instead, ‘well, ring your care coordinator, ring your doctor in the morning’ is actually worse than having no help at all.” (patient)' p. 270* Author theme: Spoken But Unheard – Misaligned *Example quote: “If everybody who came to you saying, ‘I’ve got suicidal thoughts and I’m going to,’ y’know, ‘take all my medication’… and you said, ‘... you obviously need to go into hospital’ then […] the hospitals would be full, so there’s a point where […] you have to use some sort of professional judgment and not necessarily connect an actual suicide attempt with an expression of emotional pain.” (social worker)’ p. 270* *“… The concerns about opening a can of worms… I don’t necessarily buy into that [...] I think even if you haven’t got a lot of time sometimes just acknowledging actually how distressing that is for people can be helpful. […] I think it’s a bit of a myth that we have to wrap things up because actually clients don’t wrap things up and it’s going round in their head the whole time, so I think it can be quite validating if we notice something.” (nurse)' p. 271* Author theme: Spoken and Unheard/Heard: Depersonalized Versus Individualized *Example quote: “You’re thinking […] What? I’ve told you that last week! But then you think, well I can’t expect them to remember when they’re seeing hundreds of people. So it makes you feel like you’re nobody, like you’re just somebody like a robot.” (patient)' p. 271*

	“There was [sic], like, 15 of us [in a therapy group], and she’d remember something, like she’d say, ‘oh –(whatever your name is)– you said last week…’ […] And I’d think, God that’s really amazing! […] and it made you think she’s listening, and you felt like… comfortable, that you could engage with her.” (patient)' p. 271 *“… like the answers they give you generally are out of books, […] and I think, well! […] What’s that all about? They haven’t actually got any answers apart from what they’re taught to tell you. […] they just reel off these things to everybody instead of proper talking to you.” (patient)' p. 271*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes

Section	Question	Answer
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(Please see Dunkley 2014.)*
Overall risk of bias and relevance	Relevance	Relevant *(Please see Dunkley 2014.)*

Hagen, 2017a

Bibliographic Reference	Hagen, Julia; Hjelmeland, Heidi; Knizek, Birthe Loa; Relational Principles in the Care of Suicidal Inpatients: Experiences of Therapists and Mental Health Nurses; Issues in mental health nursing; 2017; vol. 38; 99-106

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Norway
Setting	Inpatient – psychiatric wards (acute ward, crisis unit, general psychiatric ward, rehabilitation ward, unit for psychosis, or another specialized ward)
Data collection and analysis	Semi-structured individual interviews lasting from 48 minutes to 1 hour 22 minutes were held using an interview guide, and field notes taken. Interviews were recorded and transcribed verbatim. Data were analysed using inductive principles from systematic text condensation, and then data were read through theoretical perspectives.
Recruitment strategy	Potential participants with experience of providing treatment and care for suicidal patients were approached by the units' management, and then authors contacted potential participants by email.
Study dates	2013

Sources of funding	Not reported.
Inclusion criteria	Participants had to: • Have experience providing treatment and care for suicidal patients
Exclusion criteria	Not reported.
Sample size	N = 16 mental health professionals
Participant characteristics	**Mean age (range):** Not reported (28-60 years) **Sex (female/ male):** 10/ 6 **Role**: Psychiatrists: 4 Psychologists: 4 Mental health nurses: 8 **Setting:** Psychiatric wards: Acute ward or crisis unit: 11 Other (general psychiatric ward, rehabilitation ward, unit for psychosis, or another specialized ward): 5

	Range of years in post/ experience: 2-30 years **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Connection and care *Example quote: "…to get a relationship. It keeps people alive. That is not enough, you have to be able to assign a correct diagnosis and implement effective treatment for the underlying disorder. But the relationship makes them believe, I think, that you will and can help them. And then they give themselves the time it takes for the other [treatment] to work." p. 101* *"For there are two, actually in Norway there are two camps in the suicidology. And there are those who see suicide risk and suicide almost as its own matter. And where it should very much be intervened on that. And then there is the second group to which I belong, […]who view suicide as a negative event belonging to serious mental disorders. As a result, the best suicide preventive effort is to quickly get to correct diagnosis and initiate correct treatment for all." p. 101* *"…and then I stood in that relationship… –yes, what shall we say– […] alone, more or less. Well, there was another contact put in, but he related mostly to me who he knew best [….] The day after he took his life. So it is difficult to be in it … It … And then in many ways it is also good to get a good relationship, but you get—there is much to be in, because you get so close to the person that it is you he is taking it out on." pp.101-102* *"…if there are too many admissions in here, then I am little afraid that we quickly may become both mom, sister, aunt, friend, etc. etc. And what is then left of the motivation to go out into the world and find it, I think. So to be warm and empathetic on the one side, but not becoming everything for the patient on the other side, that's an art, as I see it." p. 102*

	Author theme: Duty and control *Example quote: "It is to ask [about suicidal thoughts]. Take them seriously. Then one must always make a good assessment based of the knowledge one has, and based of the – everything from next of kin, collateral information, to—to colleague information, to staff information—or, that is, from personnel in the ward. Then one has to make a psychiatrically good suicide assessment of the patient, I think." p. 102* *"But it is clear that I am concerned of covering my back and having done a proper job. That I am concerned of. But I am also very concerned that I have recorded this properly. Because – because the day it happens, it is that what matters—what's in the medical records. In terms of what reprimand I get from those who are required to reprimand …. So it [national guidelines for the prevention of suicide] affects me – of course, it does. And that – but I am, as I said, not sure that what we do, as we are required to do according to the guidelines..is—yes, that there is really much to be gained. Don't know." p. 102* *"And today, unfortunately we have that bullshit, the computer and the technology, right, as if it is more important to write down and tell the boss that…or who. And then, what shall I say, even if people call and say they are suicidal, we have forms and computers and such things and need to write. It is not for the patient's sake. It is for my sake. That my boss…if the patient takes his own life at home while on the emergency phone. Then they cannot denounce me, and I've done my job. But I think that the most important is to sit down and talk to the person and be…provide closeness. That is the most important." p. 103* *"… you should be careful not to have too much interventions for patients with suicide risk, take over too much responsibility. That's unfortunate. The last thing I've heard is that at the acute ward, it can be like you have to check on the patient so often that you have no time to get a relationship with him. Because you have to tick off a checklist every fifteen minutes to those who are really threatened. How good is that for the patient? And.. yes, if one can do it [suicide] in less than fifteen minutes then one perhaps can make it anyway. So that is a measure that perhaps does not feel quite right." p. 103*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(Please see Hagen 2017b.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Please see Hagen 2017b.)*

Hagen, 2017b

Bibliographic Reference	Hagen, Julia; Knizek, Birthe Loa; Hjelmeland, Heidi; Mental Health Nurses' Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor; Archives of psychiatric nursing; 2017; vol. 31; 31-37

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Norway
Setting	Healthcare - inpatient (psychiatric wards)
Data collection and analysis	Please see Hagen 2017a.
Recruitment strategy	Please see Hagen 2017a.
Study dates	Please see Hagen 2017a.
Sources of funding	Please see Hagen 2017a.
Inclusion criteria	Please see Hagen 2017a.
Exclusion criteria	Please see Hagen 2017a.
Sample size	N = 8 mental health nurses
Participant characteristics	**Mean age (range):** 43-60 years **Sex (female/ male):** 7/ 1 **Role**:

	Mental health nurses: 8 **Setting:** Psychiatric wards, including: Acute ward: 5 Acute/ crisis unit: 1 Specialised ward: 1 Rehabilitation ward: 1 **Range of years in post/ experience:** 5-25 years **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Alertness to Suicidal Cues *Example quote: "We have saved many people, we managed to, so in the moment we should be there, we were there. We managed to save them. (…)… gut-feeling is very important then. And then, so it has happened that, you have supervision of a patient every 15 minutes, but that does not mean that 15 minutes is 15 minutes, you can die within 15 minutes, right? (…) But you check on the patient once, and then your gut-feeling tells you that, oh, no, you [the patient] are lying calm and smiling. But, then the gut-feeling tells you to come back in one minute and surprise her.(…) And then, then you're right, that has happened, that I have experienced. You come, you go out and close the door and then look back, oh, what is she doing (…) is about to strangle herself or hang herself". pp. 32-33*

	"…if the patient does not take his own life, we have – we do have more self-harm when we have a lot of temporary staff in the ward in the summer. We do. We also have more like acting out, we notice that too. (…) they do not pick up the signals before the turmoil starts, right". p. 33 Author theme: Relieving Psychological Pain and Inspiring Hope *Example quote: "…to try to open some hatches to let in some light, so to speak, I am very engaged in then, when it comes to conversations. Because, if everything is revolving around the sad, terrible, and…then I think we are like taping black bags on the windows, making it even more black. I am a little concerned about trying to open some hatches and then getting in some more light". p. 33* Author theme: Regulation of Emotions and Emotional Expressions *Example quote: "Yes, it is about being the calm and confident one. (…)We represent, or in my opinion should represent, when someone in a deep crisis is admitted, and then someone in the surroundings has to stay calm and steady. And appear like confident then. (…) You must be aware of it so that the patient's crisis does not color [affect] you so much that you are at a loss, but that you're able to be there and endure hearing that someone says 'yes, I want to die. I don't want to live'". p. 34* *"…you manage to be professional to the patient, but you struggle a lot, you know, you have to – as a professional on the outside, and then you're being torn inside". p. 34* Author theme: Balancing Emotional Involvement and Professional Distance

	Example quote: "One has to have oneself – one must be…clarified oneself, one must know what – what feelings are mine and what feelings are the patient's now, in this. And what am I going to carry now for the patient, and what is it that the patient should get back to carry himself". p. 34 *"…if one has been in that kind of pressure with several patients [engaging in suicidal acts/self-harm] over several weeks, and that that one somehow feels that now I need a break, if it could be possible that I work with another kind of issue now, then I prefer that for a few days to kind of collect myself a little again". p. 34*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are people working on psychiatric wards with people who have suicidal behaviour; as this includes suicidal ideation, participants are not required to have worked with people who have previously self-harmed. Study not conducted in the UK.)*

Hagen, 2018

Bibliographic Reference	Hagen, Julia; Knizek, Birthe Loa; Hjelmeland, Heidi; Former suicidal inpatients' experiences of treatment and care in psychiatric wards in Norway; International journal of qualitative studies on health and well-being; 2018; vol. 13; 1461514

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Norway
Setting	Inpatient - psychiatric wards

Data collection and analysis	In-depth, individual semi-structured interviews lasting 31 to 114 minutes were held, using an interview schedule to guide the interview if necessary. Interviews were recorded and transcribed verbatim. Data were analysed using interpretative phenomenological analysis.
Recruitment strategy	Participants were recruited through nurses in selected acute psychiatric wards and therapists in selected psychiatric outpatient units who informed potential participants of the study. Nurses in acute psychiatric wards then provided participants with an information letter with instructions to contact the author after they had been discharged, while therapists in psychiatric outpatient units then asked participants if the author could contact them by phone.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be former patients over 18 years old who had been admitted to an adult psychiatric ward because of suicide attempt or severe suicidal thoughts during the last 12 months
Exclusion criteria	Not reported.
Sample size	N = 5 former psychiatric inpatients
Participant characteristics	**Mean age (range):** Not reported (33-54 years) **Sex (female/male):** 4/ 1 **Ethnicity:** Not reported **Co-morbidity:** Not reported

	Duration of self-harm: Not reported **Suicide attempts:** Admitted to acute ward because of a suicide attempt: 3 Admitted to acute ward because they were close to attempting suicide: 2
Results	Author theme: Seeking a sense of companionship to feel safe to share their suffering and suicidality *Example quote: “it feels very safe to have NN [the therapist], because he has . . . knows me and my whole situation [. . .] Yes, so that is very safe then. So, I feel like I can say anything to him then” p. 5* Author theme: Seeking individualized treatment and care to feel recognized as a valuable person *Example quote: “She [the nurse] just came up to me and, ‘Yes, I see you are tired now, and it’s all right. Just be tired’, and I thought that was so good. And it was she who found me with [the means to attempt suicide] that night. [She] sat down and instead of in a way, it was someone I felt in a way . . . accused me a bit sometimes, not accused but sort of like, ‘it is foolishness to engage in such things’, while she was a little more like, ’yes I understand you are in pain, or I can’t really understand how you are doing, but it will get better, I am sure you can make it’. And at the same time somehow, yeah, just was a comforting fellow human being”. p. 5* *“. . . I said I had a very bad night and that I was worried in a way before I was going to bed. And then [the nurse] said ‘yes, it goes up and down for all of us in life, you know’. And then I tried to communicate that ‘I am really having a hard time now’, and then she said, ‘yes, but you have to think like [a Norwegian singer-songwriter], be an optimist’. And I interpreted it more like yes, ‘pull yourself together’. And then I just finished politely and smiled and said ‘thanks for the conversation’ and went to bed, that is, I went and sat down in the living room after I had taken medicine until I became so tired that I was sure to get to sleep when I went”. pp. 5-6*

	"they also told me that 'it [suicidal thoughts] is something we do not want to talk about too often because it may give you ideas. If you are not there, we shall not induce those thoughts in you', but perhaps it would have helped me to try to talk about it sometimes'" p. 6 *"I really got very good information [. . .] about depression, about the first step of taking medicines was also a big step for me. And maybe accepting that I was ill. Taking the first pill was enormously difficult. [. . .] Because it really affected me to accept that. And reading the brochure where it is explained very much as a disease. I did not feel ill. I just felt sad, that I did not want to live anymore. That is something completely different from being ill in the head. So, accepting that is terribly difficult". p. 6* *"the only thing I really doubt a little, that has actually to do with the medication. [. . .] That there is really no evidence that it helps. So why do they offer that as the only solution? In addition to—or, maybe it is a bit overrated then. They could have been a little more honest about that". p. 6*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants were people who had been admitted to an adult psychiatric ward because of suicide attempt or severe suicidal thoughts. 2/5 participants reported they had been close to attempting suicide but it is unclear whether these participants had self-harmed. Study not conducted in the UK.)*

Hom, 2020a

Bibliographic Reference	Hom, M. A.; Bauer, B. W.; Stanley, I. H.; Boffa, J. W.; Stage, D. L.; Capron, D. W.; Schmidt, N. B.; Joiner, T. E.; Suicide attempt survivors' recommendations for improving mental health treatment for attempt survivors; Psychological services; 2020

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	USA
Setting	Community (home/ residential)
Data collection and analysis	Participants completed a brief web-based self-report survey assessing sociodemographic characteristics and history of psychiatric diagnoses, which included an open-ended response question 'How can healthcare professionals improve treatment experiences for suicide attempt survivors?' Data were extracted into a Microsoft Excel worksheet and an initial list of themes was created and reviewed. The finalised coding scheme was then used to code all of the written responses independently.
Recruitment strategy	Participants were recruited via social media and email listservs focused on suicide prevention and attempt survivorship. Only people who provided responses to the item assessing recommendations for improving mental health treatment were included.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be aged 18 years or older • have reported a lifetime suicide attempt history on a self-report adaptation of the Self-Injurious Thoughts and Behaviors Interview-Short Form • be fluent in English • correctly answer five multiple-choice questions based on the form to demonstrate comprehension of study procedures • provide reCAPTCHA verification to rule out survey robots

	• answer the final question of the survey assessing recommendations for improving mental health treatment
Exclusion criteria	Not reported.
Sample size	N = 329 suicide attempt survivors
Participant characteristics	**Mean age (SD):** 35.07 (12.18) years **Gender:** Female: 268 Male: 33 Transgender, non-binary: 12 Transgender female: 0 Transgender male: 7 Other: 8 Did not state: 1 **Race:** White/ Caucasian: 283 Asian/Pacific Islander: 14

	Black/African American: 6 Native American or Alaska Native: 5 Other: 21 **Co-morbidity*:** Mean number of psychiatric diagnoses per person: 4.61 (2.09) Anxiety disorder: 239 Bipolar disorder: 106 Borderline personality disorder: 81 Depressive disorder: 273 Eating disorder: 59 Post-traumatic stress disorder (PTSD): 159 Schizophrenia: 8 Substance use disorder: 42 Other: 66 None: 16 *Categories are not mutually exclusive

	Duration of self-harm: Not reported **Suicide attempts:** Mean number of suicide attempts per person (SD): 3.47 (4.89) Single attempt: 96 Multiple attempts: 232 Missing: 1
Results	Author theme: Provider interactions *Example quote: “[shame], ‘tough love,’ and pity aren’t effective responses to someone who’s just attempted to end their life.” p. 4* *“Take time to listen and make sure you’re not jumping to conclusions.” p. 6* *“[Be] compassionate and understanding [about] what can lead to a person attempting suicide . . .” p. 6* *“[Do not] push too hard too fast on ‘getting better.’” p. 6* *“Listen to their experiences and trust they know how they feel and what they need to stay well.” p. 6*

	“. . . I need a place I know I can speak freely without being afraid someone is going to act to take away my power and choices.” p. 6 *“We don’t want the doctor to worry about covering his own ass more than he cares about seeing us get better.” p. 6* Author theme: Intake and treatment planning *Example quote: “Medication is only one part of the solution. We need therapy as well. We need coping mechanisms.” p. 5* *“Take time to get to know us and understand our past traumas besides the suicide attempt.” p. 5* *“Avoid immediately resorting to diagnosing survivors with specific mental illnesses . . . focus on the triggers and symptoms instead of the possible diagnosis.” p. 7* *“Be more open to discussing suicidal ideation and bring it up in sessions rather than waiting for the patient to bring it up.” p. 5* Author theme: Treatment delivery

	Example quote: "Treatment should aim to challenge unhealthy thoughts and develop healthy coping strategies." p. 8 *"More trans-friendly [resources] . . ."; "More culturally competent, client-centered, anti-oppressive practice . . ."; "Educate [yourself] on genocidal [government] policies that have caused intergenerational traumas . . ."; ". . . [handle] LGBTQ rejection trauma." p. 8* Author theme: Structural issues *Example quote: "Get training! Learn how to ask about ideation in a sensitive manner." p. 9* *"Doctors, general physicians, mental health intake and counselors and emergency room staff need to be more educated on signs and symptoms so . . . detection of suicidal ideation is spotted early and treated before a suicide attempt is made." p. 9*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(There was potential for bias to be introduced during the recruitment strategy, as participants had to self-identify as having attempted suicide as well as other diagnostic factors in order to be included. The authors acknowledged that a single open-ended question on a survey as the only method of data collection limited the amount of nuance available in responses, although this method did ensure anonymity and may have encouraged more honesty in responses. Additionally, minimal information was given regarding ethical considerations.)*
Overall risk of bias and relevance	Relevance	Relevant *(Participants all self-identified as having attempted suicide. Study was conducted in a*

Section	Question	Answer
		non-specialist setting but included patients providing data regarding skills for specialist and non-specialist staff. Study not conducted in the UK.)

Hom, 2020b

Bibliographic Reference	Hom, Melanie A.; Albury, Evan A.; Gomez, Marielle M.; Christensen, Kirsten; Stanley, Ian H.; Stage, Dese'Rae L.; Joiner, Thomas E.; Suicide attempt survivors' experiences with mental health care services: A mixed methods study; Professional Psychology: Research and Practice; 2020; vol. 51; 172-183

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	USA
Setting	Community
Data collection and analysis	Authors analysed transcripts from unstructured interviews lasting between 120-150 minutes, held during the Live Through This project. Interviews were recorded and transcribed.
Recruitment strategy	Potential participants had to submit their contact information through the project website. The project creator then contacted potential participants to confirm eligibility.
Study dates	2011-2017
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be aged 18 years or older • be willing to use their full name and likeness • be willing to sign a model release • be willing to have their voice recorded • personally identify as a suicide attempt survivor

	• have at least 1 year elapsed since their most recent attempt
Exclusion criteria	Not reported.
Sample size	N = 96 suicide attempt survivors
Participant characteristics	**Mean age (SD):** 35.05 (11.43) years **Gender:** Female: 64 Male: 31 Gender non-conforming: 1 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** At least 1 suicide attempt: 96

Results	Author theme: Positive factors: Provider-related factors *Example quote: “They set me up with . . . a therapist here in town who’s just fantastic. She is the best therapist I’ve ever had. She kicks you in your ass when you need it. I’m the type who [wants someone to] just tell it like it is . . .” p. 176* *“Really, that’s all I wanted–to talk to someone, to have someone listen to what I was saying, and just reaffirm, ‘You’re not crazy.’ The guy I saw was great . . . He was the first person I had spoken to who listened and didn’t try to get me to take a bunch of vitamins.” p. 176* *“[The psychologist] and I talked about suicide a lot, and she brought it out in the open so it wasn’t so scary.” p. 176* *“My own experience with being diagnosed was largely positive because it gave me a sense of credibility. It’s maybe not the best way to put it, but it said, ‘This is a real thing. Here is a set of words you can use to easily describe your situation to somebody.’” p. 176* Author theme: Positive factors: Treatment-related factors *Example quote: “I’m [taking medication] for my sanity . . . It’s not like, ‘You’re doing well now, you don’t need your medication.’ It’s actually like, ‘I’m doing well now because I have my medication.’” p. 176* *“I never thought that the therapy helped me at all, because it was just talking about how I was feeling and all of that, whereas with DBT, it was actual skills you could use.” p. 176*

	“We talked about things, in therapy, that bothered me growing up that probably contributed to my depression . . . I did have a lot of anger that I turned inward. We talked about that in therapy, and that helped.” p. 177 *“Medication worked for me, but you have to be your own advocate because you go to most psychiatrists and they’re just pill dispensers . . . With my psychiatrist, we talk and we discuss and we work it out together.” p. 177* Author theme: Negative factors: Provider-related factors *Example quote: “My psychologist scared me. I didn’t like talking to him.” p. 178* *“I went to a new psychiatrist for the first time recently . . . She did the intake questionnaire and clearly did not understand suicide or cutting. Those are issues relevant to me.” p. 178* *“Nobody asked me my thoughts. Nobody asked me my opinion. Nobody asked me what was or wasn’t working.” p. 178* *“. . . it would have been nice to be treated like I actually knew what I was talking about. A lot of times I was just brushed off and they would talk to my mom instead of me . . .” p. 178* *“More often than not, people have this experience: they reveal to a clinician that they are suicidal, and a cloud comes over the person’s eyes where the cognition starts to happen. [They start to think], ‘Okay, what is my boss gonna say? I wonder what the protocol is,’ and so on. That’s a problem because that shuts down the therapeutic connection . . .” p. 178*

	Author theme: Negative factors: Treatment-related factors *Example quote: "Then they had me on so many drugs. They overmedicated me. I'm not against medication helping someone through mental health concerns or whatever, but when you're overmedicating someone . . . I had a toxic reaction." p. 179*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No
Data collection	Was the data collected in a way that addressed the research issue?	No
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	No
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Serious concerns about bias arising through the recruitment, data collection and ethics processes due to data being collected for a separate advocacy project. The authors assessed that the chosen method of data collection and recruitment strategy to be potentially inappropriate to provide the desired information.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist and non-specialist staff. Study not conducted in the UK.)*

Idenfors, 2015

Bibliographic Reference	Idenfors, H.; Kullgren, G.; Renberg, E. S.; Professional care after deliberate self-harm: A qualitative study of young people's experiences; Patient Preference and Adherence; 2015; vol. 9; 199-207

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Sweden
Setting	Mixed (ED, psychiatric emergency services, child and adolescent psychiatry clinic, and a psychiatric inpatient ward)
Data collection and analysis	Individual structured interviews using open-ended questions and lasting between 22 to 41 minutes were held 6 months after the person's first healthcare contact for deliberate self-harm. Interviews were recorded and transcribed. Data were analysed into meaning units (words or phrases related to each other), which were then condensed and assigned a code. The codes were refined into categories, continuously checked against the original interview texts. Common themes were constructed from the categories by two of the researchers in collaboration.
Recruitment strategy	Medical staff at the recruitment sites (ED, psychiatric emergency services, child and adolescent psychiatry clinic, and a psychiatric ward) in a single catchment area identified eligible patients for potential inclusion.
Study dates	2009-2011
Sources of funding	Not reported.
Inclusion criteria	Patients had to: • be aged 16–24 years • have deliberately self-harmed (DSH) according to ICD-10 criteria X60-X84 • have no previous contact with health services due to DSH.
Exclusion criteria	Not reported.
Sample size	N=9 were interviewed (n = 10 were initially interviewed but 1 declined participation in the follow-up interview)
Participant characteristics	**Mean age (range):** 20 (17-24) years **Sex (female/male):** 5/ 4 **Ethnicity:** Not reported

	Co-morbidity: Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported.
Results	Author theme: Having trust in the care of the professionals *Example quote: "Of course I understand how they look at it – they don't want me to overdose again, so [...] Then it felt like they took you more seriously instead of other doctors who just pumped you full of drugs." p. 202* *"Have they forgotten me, like, why is nothing happening and like all the worry which wasn't exactly good which meant more emergency visits at the mobile team." p. 202*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Insufficient information provided regarding ethical considerations, plus insufficient data provided to support themes.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was part conducted in non-specialist settings but included patients providing data regarding skills for specialist and non-specialist staff. Study not conducted in the UK.)*

Karman, 2015

Bibliographic Reference	Karman, Pieter; Kool, Nienke; Gamel, Claudia; van Meijel, Berno; From judgment to understanding: mental health nurses' perceptions of changed professional behaviors following positively changed attitudes toward self-harm; Archives of psychiatric nursing; 2015; vol. 29; 401-6

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	The Netherlands
Setting	Healthcare - inpatient and outpatient mental health facilities
Data collection and analysis	Semi-structured interviews using open-ended questions were held using an interview guide that was informed by the emerging conceptual model, and lasted between 40 to 60 minutes. Interviews were digitally recorded and transcribed verbatim. Data were analysed using a systematic constant comparison approach consistent with grounded theory methods.
Recruitment strategy	Potential participants were recruited from a sample of professionals enrolled in a self-harm training program. Participants were contacted by email with information regarding the study, and then contacted by telephone by the lead author.
Study dates	Not reported.
Sources of funding	Authors did not receive funding for this study.
Inclusion criteria	Participants had to: • be a mental health nurse • participate in a specific self-harm training program 10-14 months before the start of the study • have a positive attitude change of at least 4 points between the pre- and post-test measurements on the Attitudes towards Deliberate Self-harm Questionnaire (ADSHQ)
Exclusion criteria	Not reported.
Sample size	N = 11 mental health nurses
Participant characteristics	**Mean age (range):** 41.6 (26-57) years

	Sex (female/ male): 9/ 2 **Role**: Mental health nurses: 11 **Setting:** Clinical groups represented were: Inpatient healthcare facilities: 6 Outpatient healthcare facilities: 5 **Mean number of years in post/ experience (range):** 17.2 (4-32) years **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Behavioural changes *Example quote: "The idea is that you take a person more seriously and that you encourage people to show more of themselves, because the other approach (i.e. using restrictive methods) just led patients to resist and to distance themselves from us." p. 403*

	"Well, before I was like: we need to get rid of this [i.e., self-harming behavior]. And now I just realize, well, so this is what you need right now." p. 404 *"I do not think we are here just to please patients. To me, that is not a way to provide good treatment." p. 404* Author theme: Influence of the Training Program on Nurses' Attitudes Towards Self-Harm *Example quote: "I saw it as a negative way of attention seeking. If you can't get it in a positive way, then you try it in a negative way. And now you see that it is just inability to cope. And I think that's the biggest change." p. 403* Author theme: Conditions for behavioural change Example quote: N/A

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Authors did not justify their study design and there are minor concerns around ethical issues, although the authors justified this as being because no patients participated. Additionally, authors recruited nurses who took part in a voluntary training program as opposed to a compulsory program, which may have biased findings to be overly positive.)*
Overall risk of bias and relevance	Relevance	Relevant *(The study did not specify whether participants were required to have worked with people who have previously self-harmed, although some mental health nurses declined to*

Section	Question	Answer
		participate due to their lack of experience with patients who self-harm, implying included participants did have this experience. Study not conducted in the UK.)

Kelada, 2017

Bibliographic Reference	Kelada, Lauren; Hasking, Penelope; Melvin, Glenn A.; School response to self-injury: Concerns of mental health staff and parents; School psychology quarterly : the official journal of the Division of School Psychology, American Psychological Association; 2017; vol. 32; 173-187

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	Education - state and private schools
Data collection and analysis	Parent participants were mailed questionnaires with open-ended questions regarding their experiences with mental health staff at their child's school. Staff participants took part in semi-structured interviews lasting an average of 30 minutes, of which 4 were conducted face-to-face, and 15 were conducted via the phone. Interviews were audio recorded and transcribed verbatim. Both the written responses and audio transcripts of interviews were thematically analysed by the authors using the qualitative data management program NVivo Version 10, and an independent researcher assessed interrater reliability.
Recruitment strategy	Parent participants were recruited as part of a larger study on adolescent non-suicidal self-injury (NSSI). Staff participants were recruited either from state and private schools or as part of a bigger study on adolescent NSSI.
Study dates	Not reported.
Sources of funding	Not reported.

Inclusion criteria	Participants had to: • Be school mental health staff • OR be parents of high-school students who had self-harmed, who had interacted with school mental health staff regarding their child's self-harming behaviour
Exclusion criteria	Potential participants were excluded if: • They were parents who had not had any contact with school mental health staff regarding their child's self-harm
Sample size	N = 29 (n= 10 parents of adolescents who had self-harmed; n = 19 school mental health staff)
Participant characteristics	**Staff participants:** **Mean age (SD):** Not reported **Sex (female/ male):** 14/ 5 **Role**: Wellbeing/ welfare coordinators: 12 School counsellors: 4 School psychologists: 3 **Setting:** School types represented were:

	State schools: 15 Private schools: 4 **Mean years in post/ experience (SD):** 12.53 (9.05) years **Client group (adults, children/ CYP):** Children **Parent participants:** **Mean age (SD):** 45.20 (3.52) years **Sex (female/male):** 10/ 0 **Relationship to person who has self-harmed:** Mother: 10
Results	Author theme: Future sector-wide policy *Example quote: "I'm fortunate in that I'm quite experienced in this role and have sought further education, but . . . there are student welfare officers who come in with minimal qualifications and those poor workers are dealing with self-harmers . . . there's a lot of people out there who are working with people who are self-harming in schools who are not given the skills or*

	the "how-to's" and . . . is just overwhelmed by it. So I think we need to resource our school staff better, or welfare or counseling school staff better" [S7]' p. 179 *"I think it's really unfair to leave me in a potentially legally awkward situation—not just me, me and the school, but I take a lot of that stress on. . . . I had to work through a policy for the school and do my own research on it, when it's just becoming such a huge issue. Give me a checklist that we have to do. It's ridiculous . . . do not tell me what to say to a kid, but tell me what . . . to do in this situation, and what's going to keep—I know it sounds cold—but what's going to keep the school legally safe . . . it's been like we're floundering and do not have that much support with exactly what to do about the problem" [S3]' p. 179* *"I'd like there to be some clear written guideline about do we notify a parent immediately. Just a clear procedure, a step-by-step procedure, you know, whether it be notify parents or not, whether it be follow-up and make sure they're referred out, do you know what I mean? I'd really like to see some clear procedure written down in that policy. . . . It would certainly take a lot of the legal pressure off us" [S6]' p. 179* *"Policies are usually not what I find—are not really specific, you know, they're fairly broad and general . . . you need some specifics in there sometimes. . . . They're fairly broad and, kind of, you have to go "well that's a bit obscure, I do not really—you know, that could be taken either way, really" [S11]' p. 179* Author theme: Support for school mental health staff *Example quote: "I think it would be really good for principals to be educated because the principal, like, they carry the can for whatever happens in the school and they often—I feel they often do not understand about self-harm, that they think "oh my goodness it's self-harm they're gonna kill themselves tonight." So to have education for principals as an inoculation—not if it happens, but for all principals, that when it does happen—this is what your response needs to be and understand that it's not necessary going to end in a—it's unlikely to end in a suicide attempt" [S2]' p. 181*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias due to researcher reflexivity not being considered.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included specialist staff, and parents/ carers providing data regarding skills for specialist staff. Study not conducted in the UK.)*

Kool, 2009

Bibliographic Reference	Kool, Nienke; van Meijel, Berno; Bosman, Maartje; Behavioral change in patients with severe self-injurious behavior: a patient's perspective; Archives of psychiatric nursing; 2009; vol. 23; 25-31

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	The Netherlands
Setting	Healthcare - inpatient/ outpatient (psychiatric intensive treatment centre with an inpatient and an outpatient clinic)
Data collection and analysis	Individual semi-structured interviews were held. Interviews were audio recorded and transcribed verbatim. Data were analysed using a grounded theory approach in WINMAX qualitative text analysis software.
Recruitment strategy	Treatment providers at the psychiatric intensive treatment centre referred patients to the study.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • have a history of severe self-harm on a long-term basis ('severe' defined as harm inflicted several times a week and/or necessitating medical treatment) • no longer or only rarely self-harm during the study period • have sufficient command of the Dutch language

	• have adequate insight to reflect on their own experiences and behaviour.
Exclusion criteria	Participants were excluded if they: • had comorbid psychotic symptoms.
Sample size	N = 12 women with a history of self-harm
Participant characteristics	**Mean age (range):** 39 (26-60) years **Sex (female/male):** 12/ 0 **Ethnicity:** Not reported **Co-morbidity:** None: 12 (not reported in the data but participants were excluded if they had comorbid psychotic symptoms) **Mean duration of self-harm (range):** 22 (6-46) years **Suicide attempts:** Not reported.
Results	Author theme: Limit setting and connecting

	Example quote: "Safety means that I know nothing horrible will happen, there will be no fighting when I say something to you. Whatever I say I can safely say. There will be no punishment, no consequences. I am not turned down for what I am." p. 28 Author theme: Self-esteem *Example quote: "The carers told me they did not disapprove of me as a person, but because of what I did. For me this meant there was nothing wrong with my character, my personality. When I came out of isolation, they saw me as me and I could just start again with a clean slate." p. 28* Author theme: Negative factors *Example quote: "The nurse said: 'Come, let me bandage your wounds' and then she comforted me. Then I thought, if I cut myself next time, I will get her attention again." p. 30*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Minor concerns regarding lack of justification for research design and no discussion of data saturation. Moderate concerns due lack of information regarding ethical considerations, including whether adequate information about the study was given to participants, whether the potential effects of the study on participants were considered, and whether ethics approval was sought.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Lahoz, 2020

Bibliographic Reference	Lahoz, Titia; Winslov, Jan-Henrik; Christiansen, Rikke; Krogh, Soren; Knudsen, Per Bjerregaard; Wang, August G.; Erlangsen, Annette; Nielsen, Klaus; The treatment in the Danish suicide prevention clinics: a clinician perspective; Nordic journal of psychiatry; 2020; vol. 74; 533-540

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Denmark
Setting	Suicide prevention clinics
Data collection and analysis	Semi-structured interviews were held, lasting about an hour. Interviews were recorded and transcribed verbatim, with quotes translated from Danish to English. Authenticity was preserved during translation by prioritising closeness to the text and choice of words over lingual fluency. Data were analysed using phenomenological condensation of meaning.
Recruitment strategy	Participants were recruited from Danish suicide prevention clinics using a purposive sampling strategy, where participants entered the study of their own accord. 2 clinicians were recruited from each of the 5 regions in Denmark.
Study dates	Not reported.
Sources of funding	This study was funded by the authors alone.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N = 10 volunteer clinicians
Participant characteristics	**Mean age (range):** Not reported (age groups ranged from 30-39 to 60-69 years) **Sex (female/ male):** 7/ 3

	Role: Psychologist: 6 Mental health nurse: 2 Psychiatrist: 1 Clinical social worker: 1 **Setting:** Suicide prevention clinics **Mean years in post/ experience (SD):** Years of experience: 20.2 (10.87) Years of experience in the field: 11.1 (9.44) **Client group (adults, children/ CYP):** Not reported
Results	Author theme: Meaningful vs. formal treatment approach *Example quote: "We cannot spend time on diagnostic interviews…, we need to intervene even though we are uncertain of the underlying problems" p. 536* Author theme: Patient- vs. therapist-oriented treatment

	Example quote: "The main thing is to get an alliance with the patient… What they start talking about I follow…and if they do not say much I address the current situation about how they are feeling…" p. 536 *"… some will say, the fact that I have suicidal thoughts or have had a suicide attempt…is caused by the problems I have…, so I would like to talk about my problems, and that is obviously understandable…then you have a task in explaining to them, that we would like…to make sure, that you keep yourself alive, while we talk about the problems and that, in my opinion, I think we can negotiate, even if there are some, that can be somewhat annoyed, that the focus is on the suicide problem…" p. 536* Author theme: Direct vs. indirect treatment *Example quote: "…as you know yourself, what would you be able to do if you experience this way again?…everything counts aside from self-harming… e.g. Write a letter" p. 536*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes

Section	Question	Answer
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns regarding lack of justification for the research design and inadequate discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are people working on suicide prevention wards with people who have suicidal behaviour; as this includes suicidal ideation, therefore participants are not required to have worked with people who have previously self-harmed. Study not conducted in the UK.)*

Lees, 2014

Bibliographic Reference	Lees, David; Procter, Nicholas; Fassett, Denise; Therapeutic engagement between consumers in suicidal crisis and mental health nurses; International journal of mental health nursing; 2014; vol. 23; 306-15

Study Characteristics

Study type	General qualitative inquiry This study reported the qualitative findings only from a larger mixed-methods study.
Country/ies where study was carried out	Australia
Setting	Community and inpatient settings within a public mental health service
Data collection and analysis	The first part of the study included a survey of mental health nurses (n = 87) in order to identify key issues, contextual data, and as a way to invite nurses to the interview stage. In-depth semi-structured interviews were then held with a subsection of the surveyed nurses. In-depth semi-structured interviews were also held with people who had recovered from recent suicidal crises during which they had received mental health nursing care. Data were analysed using constant comparative and classical content analysis. Themes were developed iteratively using both survey and interview data, though survey data were contained to 'descriptive statistics' in order to prioritise data from the interviews.
Recruitment strategy	Staff participants were recruited via email and personal invitation from the author. Patient participants were recruited via their current mental health services community case managers.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Staff participants who were interviewed were mental health nurses who had recent experiences of nursing care with consumers in suicidal crisis. Patient participants were people who had recovered from recent suicidal crises during which they had received mental health nursing care.
Exclusion criteria	Not reported.
Sample size	N = 96 nurses and people who had suicidal crises (n=87 mental health nurses were surveyed and of these, n=11 went on to complete the interview stage; n = 9 people who had recovered from recent suicidal crises during which they had received mental health nursing care)
Participant characteristics	**Staff participants (data reported for those who were interviewed only):** **Mean age (SD):** 48 (not reported) years

	Sex (female/ male): 6/ 5 **Role**: Mental health nurses: 11 **Setting:** Adult hospital inpatient mental health services: 7 Adult community mental health services: 4 **Mean years in post/ experience (SD):** 12 (not reported) years **Client group (adults, children/ CYP):** Adults **Patient participants:** **Mean age (SD):** 41 (not reported) years **Sex (female/male)**: 6/ 3

	Co-morbidity: Not reported **Ethnicity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported.
Results	Author theme: Consumer service needs *Example quote: "It's about engaging with that client . . . I can't see that there's any other reason . . . other than you're custodial and you sit there and observe and I don't see that as particularly therapeutic." (RN4)' p. 309* *"There was no one I was able to tell the story of why I was suicidal. Like they go to a lot of trouble to make sure you're properly medicated . . . but no one's really interested in hearing the story of why you did it or why you're in that sort of shape." p. 309* Author theme: Prominent interventions *Example quote: "I had lots of things going on, and I didn't think a pill would fix that. . . . They thought that it was just the depression that was clouding my thoughts, but it wasn't that simple, and I needed to talk about that." p. 310*

	Author theme: Nature of therapeutic engagement *Example quote: "By discussing it as much as possible, you sort out in your own head what you were thinking . . . to get better, you need to discuss it" p. 310* *"Sometimes, if they wait for you to bring it up, you may not bring it up, especially if you're planning it" p. 310* *"You try not to get emotionally involved, but you have to get involved to talk to them." (RN8)' p. 310* *"There was one nurse who was good. He was genuine. There were some nurses that you feel like they're just doing their job sort of thing . . . but I felt that he really cared (long pause). . . . Him caring . . . it showed me that I'm worth something (voice breaking) . . . that I'm worth being alive." p. 311* *"I had no family support, no friends, no one to talk to, and I find it really hard to trust people with what I say . . . I could really trust some of those nurses." p. 311* Author theme: Consumer service needs *Example quote: 'Additionally, it was commonly asserted that the education and training received had given nurses "little preparation for dealing positively with people in suicidal crisis" (RN5), and that additional workplace training would enhance their practice with regards to the care of suicidal consumers.'*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Can't tell

Section	Question	Answer
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Serious concerns regarding recruitment strategy and author reflexivity: authors primarily recruited nurse participants through personal connections which may have biased the data to be overly positive if particular nurses were selected for inclusion; authors acknowledged nurses were reluctant to approach patients to recruit them for the study due to concerns around exacerbating suicidality. This may have biased the data if patients with a higher risk of suicide were not included, or if nurses only approached patients for inclusion if they had positive experiences. Authors did have a ‘consumer–participant support person’ (p. 308) present during interviews with patient participants, but no other information regarding author reflexivity, especially regarding the nurse participants, is given. Additionally, minor concerns around lack of justification for data collection method, and lack of information regarding saturation of data, form of data, whether the researcher examined their own role during data analysis, and credibility of findings.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are people who had recently experienced suicidal crises and nurses who cared for people in suicidal crises. The authors do not define suicidal crisis beyond its association with 'risk of suicide' and therefore may include suicidal ideation, meaning patient participants were not required to have self-harmed, and staff participants were not required to have worked with people who had self-harmed. Study not conducted in the UK.)*

Lindgren, 2004

Bibliographic Reference	Lindgren, B. M.; Wilstrand, C.; Glue, F.; Olofsson, B.; Struggling for hopefulness: a qualitative study of Swedish women who self-harm; Journal of Psychiatric & Mental Health Nursing (Wiley-Blackwell); 2004; vol. 11; 284-291

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Sweden
Setting	Inpatient & outpatient psychiatric care
Data collection and analysis	Individual structured interviews including 4 open-ended questions, ranging from 40 to 50 min, were recorded and transcribed verbatim. 2 researchers read & re-read the transcripts before dividing them into meaning units (relevant words/phrases). These meaning units were then refined and grouped according to the 4 interview questions, and classified as positive or negative. Through further abstractions, two themes were formulated each with five sub-themes. During the analysis, the first and second authors compared and contrasted the categories, codes, sub-themes, and themes with the original text until consensus was reached.
Recruitment strategy	Psychiatric and social service personnel in a community mental health service and a university psychiatric clinic in northern Sweden informed patients about the purpose and criteria of this study and requested their participation.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • Be adult men or women with a history of self-harm as defined in Favazza's classification of 'superficial or moderate self-injury that is episodic or repetitive' • have a history of inpatient or outpatient care with a current discharge status • be fluent in the Swedish language • voluntarily consent to participate in an interview.
Exclusion criteria	Not reported.
Sample size	N=9 people with a history of self-harm
Participant characteristics	**Mean age (range):** 25 (19-35) years **Sex (female/male):** 9/ 0

	Ethnicity: Not reported **Co-morbidity:** Co-morbidities were self-reported: Borderline personality disorder: 5 Anxiety syndrome: 1 Depression: 1 Declined to report: 2 **Duration of self-harm:** Not reported **Suicide attempts:** Not reported.
Results	Author theme: Expecting to be confirmed while being confirmed fosters hopefulness *Example quote: "I think they have been so good and I know that’s not the way for every patient, but they managed to look behind all my symptoms and see ME so to say, the person who was deep inside and that was what made me stronger" p. 287* *"Yes, it feels as if, I don’t know, some kind of my own responsibility, to try to resist. It may be less of “Poor little you! Carry you around and protect you from everything” and more of ‘We take it seriously, but you still have to take your own responsibility’." p. 287*

	"It was as if I felt that, now it is me who is here, and now it is me who is going to talk about the things that I feel are bothersome. Even if it is not easy for me, I feel that now it's me and I'm going to say what I think and reflect upon and feel and want, and then she (nurse) will try to help me." p. 287 *"Understanding . . . But then, understanding is not the same thing as supporting everything you say" p. 288* *"I've not been able to hold any limits nor to focus on anything. I have followed every impulse and I needed help to set the outside limits and they (staff) have been very good at that. They have been self-confident when helping me to set the limits that I'm not able to set myself" p. 288* Author theme: Expecting to be confirmed while not being confirmed stifles hopefulness *Example quote: "Well, because sometimes I've experienced that the staff treats . . . I felt treated more like a, I don't know what, like a kind of human being or barely a human being at all." p. 288* *"Staff said to me "You are mentally ill which means you are paranoid. You imagine things that are not real" so, you get misunderstood no matter what you say" p. 288* *"The worst thing that can happen is when people just disappear because someone else has decided that you shouldn't have contact with this person. This has happened more than once." p. 289*

	"The staff seems to believe it's dangerous to talk about it, if you do, it'll come back as lots of germs who will infect people or so. It's so taboo and you should put it in a little box and then it doesn't exist" p. 289

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns around lack of justification for recruitment strategy and no mention of data saturation.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Littlewood, 2019

Bibliographic Reference	Littlewood, Donna L.; Quinlivan, Leah; Graney, Jane; Appleby, Louis; Turnbull, Pauline; Webb, Roger T.; Kapur, Navneet; Learning from clinicians' views of good quality practice in mental healthcare services in the context of suicide prevention: a qualitative study; BMC psychiatry; 2019; vol. 19; 346

Study Characteristics

Study type	General qualitative inquiry The authors conducted an analysis of qualitative data collected as part of NCISH, a UK-wide consecutive case series study of all deaths by suicide among people in contact with mental healthcare services.
Country/ies where study was carried out	UK
Setting	Independent and National Health Service (NHS) mental health providers (including inpatient units, crisis and home treatment teams, community mental health teams, psychological services).
Data collection and analysis	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) questionnaires which collected data on individuals who had died by suicide and included the question 'Can you give examples of good practice in your service that others might adopt?' were sent to the consultant psychiatrists responsible for the care of patients who had died by suicide and typically completed by the senior clinician(s) who was part of the patients care team. Data were analysed using a hybrid approach to thematic analysis, whereby data were coded deductively and inductively and themes were then developed by grouping codes.
Recruitment strategy	Participants were consultant physicians across the UK who had been involved in the care of a person who had died by suicide. These clinicians were sent NCISH questionnaires as part of a UK-wide consecutive case series study of all deaths by suicide among people in contact with mental healthcare services.
Study dates	Data were available for questionnaire returns made in relation to patient’s death by suicide that occurred from 1st January 2011 to 31st December 2016.

Sources of funding	NCISH is funded by the Healthcare Quality Improvement Partnership (HQIP). The lead author who led the analysis and preparation of the manuscript was funded by the National Institute for Health Research (NIHR) Greater Manchester Patient Safety Translational Research Centre (grant number PSTRC-20160-03).
Inclusion criteria	In this study, qualitative data were collected from the questionnaires of clinicians responsible for the care of people who: • were aged 18 years or older • had died by suicide • were in contact with specialist mental healthcare services during the 12 month period before their death • died in England • were not in prison when they died
Exclusion criteria	Not reported.
Sample size	N = 2331 clinicians
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role**: Consultant psychiatrists: 232 Service managers: 131 Mental health practitioners: 63 Doctors: 47 Psychologists: 37

	Other: 16 Not specified: 1804 **Setting:** Of the 62 mental health providers that submitted responses: NHS mental health service providers: 57 (2286/ 2331 (98%) responses) Independent providers: 5 (45/ 2331 (2%) responses) **Range of years in post/ experience:** Not reported **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Patient safety and the importance of good practice in mental healthcare services *Example quote: "Use of collaboratively created crisis plans to support out of hours care" p. 4* *"We include regular 'learning lessons' feedback where care can be improved and where care has gone well in our clinical improvement and business meetings" p. 4* Author theme: Develop strong relationships with patients and family/carers

	Example quote: "His care co-ordinator knew him very well, had regular contact, there were clear efforts to try and have frequent contact with him" p. 4 Author theme: Provide timely access to tailored and appropriate care *Example quote: "Patient's wishes were taken into consideration" p. 4* Author theme: Facilitates seamless transitions *Example quote: "Discharge/transfer of care plans to be communicated with GP and the relevant services" p. 5* Author theme: Establish a sufficiently skilled, resourced and supported staff team *Example quote: "Increased emphasis on training and education in suicide prevention" p. 5*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	No
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Moderate concerns of risk of bias due to the research design and recruitment strategy. The questionnaire was part of a broader enquiry sent to clinicians following a patient suicide; this context may have introduced bias in responses and limited the scope of the data to suicide prevention rather than good quality practice. Furthermore, the research design made the iterative exploration of emergent themes and seeking further explanation not possible, increasing risk of bias from the researcher's interpretation. There was no explanation given regarding the possible participants who were sent questionnaires but did not provide an answer to the qualitative question.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are clinicians who had cared for people who had died by suicide and were not required to have worked with people who had previously self-harmed.)*

Long, 2010

Bibliographic Reference	Long, M.; Jenkins, M.; Counsellors' perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm; Counselling and Psychotherapy Research; 2010; vol. 10; 192-200

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	UK
Setting	Voluntary and private counselling sectors
Data collection and analysis	Semi-structured interviews lasting about 45 minutes were held using an interview guide that was adjusted to incorporate themes as data were collected. Data were transcribed and analysed using grounded theory methodology until theoretical saturation was obtained.
Recruitment strategy	Emails were sent to members of the Northern Ireland Forum for Counsellors inviting potential participants to contact the author by email or telephone. The counsellors who responded recommended colleagues, and a snowball sampling technique was then employed.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants were counsellors currently in practice.
Exclusion criteria	Not reported.
Sample size	N = 8 counsellors

Participant characteristics	**Mean age (SD):** 43.75 (14.39) years **Sex (female/ male):** 7/1 **Role**: Counsellor: 8 **Setting:** Voluntary sector: 6 Voluntary sector and private practice: 1 Not reported: 1 **Mean (SD) of years in post/ experience:** 9.13 (6.6) **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: The role of the therapeutic relationship for clients who self-harm *Example quote: "I think also to know that there's someone there who isn't rushing you, because defence mechanisms are there for a reason." p. 196*

	"Most of the wounds of self-harm go very deep . . . when you get to the core of the self-harm it's terrifying . . . terrifying for the person even going there." p. 196 *"That you don't judge them or moralise . . . To be there for the client, to welcome the client into the therapeutic space." p. 196* *"The clients are the experts on their own lives." p. 196* *"You've [the counsellor] been given this great privilege to be told about this and you should never take that for granted." p. 197* *"The therapeutic dance, the sensitivity, the gentleness that has to go on between the two people . . . it has to be held in some way, very, very gently." p. 197* *"The person has to some extent been rejected at many times in their lives and they don't need another professional person to do that." p. 197* *"It's not easy, when you're working with someone who's covered in marks, and if that's going to mess you up through transference then you're not the person to be in that room . . . It's about recognising your limitations." p. 197*

	Author theme: Counsellors' skills and qualities for working with self-harm *Example quote: "I think it's quite difficult for them to make the initial connection, really to be brave enough, so it's about . . . letting that person know there is immediate support and that it's going to continue." p. 197* *"Being there. Being a presence for them. Listening to them. Not judging. Accepting." p. 197* *"Is that to protect the counsellor rather than the client . . . if we ask this person to do this then we're taking away the very act that helps them to continue living . . . so to deny them that opportunity might be to deny them of the one thing they have to help them at that particular time." p. 198* *"Empathy with their pain and trying if you like, to have the transference, picking up their pain, picking up their pain where it's felt in the counsellor's body, how do I feel when that client's communicating with me." p. 198* *"It's finding ways of helping people to selfharm that are less dangerous. So for example with a client who was very bad with drugs and wasn't ready to deal with coming off drugs, in therapy we looked at certain things, for example safer injecting, avoiding drug cocktails, things that would keep him safe . . . hopefully if he finds in time that he is ready to deal with the drugs then he will come back, he knows I will be there." pp. 198-199* *"It's different for every person, but endings are something that I like the client to decide when they feel they want to not when I tell them to." p. 198*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Can't tell

Section	Question	Answer
Research value	How valuable is the research?	The research has some value
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Some concerns about insufficient information provided regarding data analysis, credibility of findings, and the value of the research. Minor concerns due to lack of discussion around researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Highly relevant *(Authors did not specify that participants had to have worked with people who had self-harmed, however authors specifically collected data regarding the participants' experiences of working with people who had self-harmed, suggesting all participants had this experience.)*

McGough, 2021

Bibliographic Reference	McGough, S.; Wynaden, D.; Ngune, I.; Janerka, C.; Hasking, P.; Rees, C.; Mental health nurses' perspectives of people who self-harm; International journal of mental health nursing; 2021; vol. 30; 62-71

Study Characteristics

Study type	General qualitative inquiry This study reported the qualitative findings only from a larger mixed-methods study.
Country/ies where study was carried out	Australia
Setting	Healthcare (setting not reported).
Data collection and analysis	Semi-structured interviews using an interview guide were held via telephone, lasting an average of 35 minutes. Interviews were digitally recorded and transcribed verbatim. Data were analysed using inductive content analysis to identify categories from the data.

Recruitment strategy	An initial quantitative online survey was sent to emergency and mental health nurses via an email from their respective professional colleges. Of the mental health nurses who completed the survey, those who agreed to be interviewed were included in this study using a convenience sampling approach.
Study dates	Not reported.
Sources of funding	This study was not funded.
Inclusion criteria	Participants were mental health nurses who had experience working with people who self-harm.
Exclusion criteria	Not reported.
Sample size	N = 14 mental health nurses
Participant characteristics	**Mean age (SD):** 43.21 (9.85) years **Sex (female/ male):** 9/ 5 **Role**: Mental health nurse (registered nurse): 13 Mental health nurse (enrolled nurse): 1 **Setting:** Not reported. **Years in post/ experience:** More than 10 years: 5

	6-10 years: 4 1-5 years: 5 **Client group (adults, children/ CYP):** Adults: 9 All age groups: 4 Adolescents: 1
Results	Author theme: Level of comfort to care for people who self-harm *Example quote: "I would say [I am] quite comfortable. . .[it developed] just through time basically, just experience working within the field, and probably also, mainly even more so from [watching] colleagues . . . for me a few nurses early on in my career that I guess helped me to see self-harm differently." p. 65* Author theme: Nursing role *Example quote: "It's managing their actual self-harm wounds if there are any, and then . . . trying to figure out why they are using that as an outlet for their emotions or a way of coping with distress. . . . and then how else we can help them to cope with that distress and those sorts of feelings other than harming themselves." p. 65* Author theme: Barriers and facilitators to providing care

	Example quote: "I think being open and non-judgemental in your approach, validating how they are feeling, what's going on for them. . . and helping them figure out alternatives . . .[You need] a really open mind and that kind of constant positive regard . . . a lot of it is your attitude and therapeutic relationship is absolutely everything." p. 66 Author theme: Education and training *Example quote: "What would be useful is . . . getting the perspective of the consumers, someone who has self-harmed to be able to talk about it. . . because in that way it becomes more real. . ..I found [it] helpful to see the perspective and with mitigating risks from the consumers perspective." p. 66* *"People who present with significant self-harm really, really challenge that core belief about themselves [nurses] and their profession and if you can contain that distress you go a long way to providing a supportive environment [for staff] . . . we don't want them being hijacked by their anxiety or fear." p. 66* Author theme: Appropriateness of current pathways to care and how the healthcare system supports people with self-harm *Example quote: "I think probably the care plan needs to be more comprehensive . . .[and] cooperating . . . trying to get the consumer to a space where they can start thinking more objectively about their experiences and then getting them to actually start thinking about what they could actually implement in term of strategies that are not causing permanent damage." p. 67*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes

Section	Question	Answer
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant *(Participants were specialist staff but the setting was not reported so may have been non-specialist. Study not conducted in the UK.)*

Mughal, 2021

Bibliographic Reference	Mughal F; Dikomitis L; Babatunde O; Chew-Graham CA; Experiences of general practice care for self-harm: a qualitative study of young people's perspectives.; The British journal of general practice : the journal of the Royal College of General Practitioners; 2021

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	Healthcare - primary care
Data collection and analysis	Participants had individual semi-structured Interviews with the same investigator, which were recorded and transcribed. Interview data were analysed using reflexive thematic analysis applying principles of constant comparison, compatible with a critical realist stance. Analysis was flexible and recursive, moving between stages. All transcripts were independently coded by at least two authors. Codes were compared across transcripts, sorted into wider categories, and recorded in an analysis table to support the generation of candidate themes. Higher-level recurring themes were agreed upon by all the investigators. Data collection stopped when data saturation was felt to be reached
Recruitment strategy	Participants were recruited from the community, Twitter, and self-harm third-sector organisations. The recruitment poster was displayed around some universities in the North of England and the Midlands, local council libraries, and sixth-form colleges. A Twitter recruitment message was written with the patient advisory group and posted on the lead author's personal account. Eight national self-harm third-sector organisations were contacted by email to ask if they would share the recruitment poster within their organisations. All participants were offered a £10 Amazon voucher on completion of interview.
Study dates	2019
Sources of funding	This research was funded by the Scientific Foundation Board of the Royal College of General Practitioners (Grant reference SFB 2018-29). The investigators were also supported by: a National Institute for Health Research (NIHR) In-Practice Fellowship 2017-20 (ref: IPF-2017-11-002), a NIHR School for Primary Care Research GP Career Progression Fellowship, a NIHR Doctoral Fellowship (NIHR300957), a Senior Fellowship by the Higher Education Academy, and the West Midlands NIHR Applied Research Collaboration.
Inclusion criteria	Young people aged 16-25 years, regardless of type of self-harm were eligible to participate.

Exclusion criteria	Not reported
Sample size	N=13
Participant characteristics	**Mean age (range):** 22 (19-25 years) **Sex (female/ transgender male):** 12/ 1 **Ethnicity:** (Self-identified): White British: 7 White American: 1 Asian British: 1 Mixed: 3 Did not disclose: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported

Results	Author theme: NHS services *Example quote: "I think the first one was erm, there was a CBT experiment afterwards, these are in like a year break of each other but erm, the CBT person, they wanted to do it over the phone which I found more difficult to begin with and then they were half an hour late for the appointment on the phone so I found that like 'okay, you're not going to turn up to a phone appointment on time then I don't think that this would work" p. 8* *"The first time I spoke to someone about it, it was honestly the most useless […] first of all they just told me I was being attention seeking [CAMHS counsellor] so I just kind of, yeah, […] it took me a while to look for help again […] she wasn't really listening to what I was saying and as she was just finishing the sentences for me." p. 8*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist and non-specialist staff. Very little data provided regarding specialist staff.)*

O'Donovan, 2007

Bibliographic Reference	O'Donovan, A.; Pragmatism rules: The intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals; Journal of Psychiatric and Mental Health Nursing; 2007; vol. 14; 64-71

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Ireland
Setting	Acute psychiatric inpatient units

Data collection and analysis	In-depth semi-structured interviews were held using an interview schedule. Data were analysed using content analysis and theme analysis, whereby categories were developed from the raw data, connected and evolved into themes.
Recruitment strategy	Participants were recruited from 2 acute psychiatric inpatient units through convenience sampling.
Study dates	Not reported.
Sources of funding	Not reported.
Inclusion criteria	Participants were psychiatric nurses working with non-suicidal self-harming people.
Exclusion criteria	Not reported.
Sample size	N = 8 psychiatric nurses
Participant characteristics	**Mean age (range):** Not reported (25-55 years) **Sex (female/ male):** 6/ 2 **Role**: Psychiatric nurses: 8 **Setting:** Acute psychiatric inpatient units **Range of years in post/ experience:** 6 months - 15 years **Client group (adults, children/ CYP):** Not reported.

Results	Author theme: Physical safety and prevention of self-harm *Example quote: "it depends on what the person is voicing to you really, you can't take everything off everyone, whatever the person discloses to you, you react to that." p. 67* Author theme: Intervention strategies *Example quote: "you can only try help somebody try figure out why, what is the reason for them self-harming, what is going on for them in their lives, what experiences they had in the past and also trying to look at what has brought on this episode of self-harm, what has made things get that bad that they felt they needed to self-harm." p. 68*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Can't tell
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	No
Research value	How valuable is the research?	The research has some value
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Moderate concerns regarding lack of justification for using qualitative methodology (the aim of the study was to discover what practices psychiatric nurses used when working with people who had self-harmed) or for the research design, and a lack of information regarding the recruitment process, data collection, data analysis, author reflexivity, and ethical considerations. The authors state that six themes emerged from the findings, however only 2 are presented with no justification for the missing data: 'For the purpose of this paper, the focus will be on the prevention and intervention strategies psychiatric nurses engaged in when working with non-suicidal self-harming individuals.' (p. 67). Additionally, the authors state the value of the study is limited, as it does not provide any new insight into the best approach to working with people who self-harm.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK. Authors did not specify that participants had to have worked with people who had self-harmed, however authors specifically collected data regarding the participants' experiences of working with people who had self-harmed, suggesting all participants had this experience.)*

Omerov, 2020

Bibliographic Reference	Omerov, P.; Kneck, Å; Karlsson, L.; Cronqvist, A.; Bullington, J.; To Identify and Support Youths Who Struggle with Living—Nurses' Suicide Prevention in Psychiatric Outpatient Care; Issues in Mental Health Nursing; 2020; vol. 41; 574-583

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Sweden
Setting	Psychiatric outpatient care.
Data collection and analysis	Participants were interviewed individually with the same 3 open-ended questions. Interviews were recorded and transcribed. Data analysis involved reading the transcriptions several times to get an understanding of the interviews as well as of the material. Marking and grouping relevant quotes of text with similar content and context. These quotes were refined in to sub-categories, categories and main categories. A retrospective interpretation was done by further analysing the data and themes were generated.
Recruitment strategy	People meeting the inclusion criteria were suggested by central organizations who establish strategies and guidelines for suicide-prevention in Sweden
Study dates	2015
Sources of funding	The authors received no financial compensation. No grants were received for this study or to cover the costs to publish in open access.
Inclusion criteria	Participants had to be involved in suicide-prevention by teaching or supporting healthcare professionals in mental healthcare, to have long experience of working with suicide-prevention with youths or young adults, and be recognized as an expert by organizations who establish strategies and guidelines for suicide-prevention in Sweden.
Exclusion criteria	Not reported
Sample size	N=6 psychiatric nurses
Participant characteristics	**Mean age (SD):** Not reported

	Sex (female/ male): 4/ 2 **Role:** Qualified nurse with psychiatric training: 1 General medical doctor with psychiatric training: 1 Psychiatrists: 2 Child psychiatrist: 1 Allied health professionals (including clinical psychologists, clinical social workers and occupational therapists): 1 **Setting:** Psychiatric outpatient care **Mean years in post/ experience (SD):** At least 10 years of clinical experience: 6 **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Engagement necessary but demanding

	Example quote: "It has become a mantra for me that you have to work to push oneself over the threshold, to dare seeing, to dare hearing, to dare asking and to dare talking." p. 576 *"With this way of thinking …it is my responsibility that this human being is alive then it gets too heavy and I get scared. So you need to handle your own fear." p. 577* Author theme: Acknowledgement of warnings signs *Example quote: "the most important is that you have the courage to be open, for it may be there, always be open for this that there may be a risk for suicide and it that it doesn't need to look like what I had in mind." p. 577* Author theme: Supportive relationship *Example quote: "I am glad that you came here. And we will do everything to help you. Because now I understand that this is really serious. What you tell me worries me." p. 578* *"When this has happened earlier [started to drink, have nightmares, eat fast-food] you started to think about suicide, is it the same way now? Is this something we need to be aware of? I often talk about us not you, or now you need to, but let's work together. What can we learn about this, I am also a part of this." p. 578* *"when they start hearing that, just to be seen as fellow human being, then it starts awakening hope and one starts to see oneself a little through the assessors' eyes, the nurses' eyes, that the other person sees the youth as a human being with possibilities, with a lot of problems, but it is not a problem to have problems it is fully compatible with life and possibilities." p. 579*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	No
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Yes

Section	Question	Answer
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Moderate concerns of risk of bias due to the lack of a clear statement of the research aims, meaning it was unclear whether the research design was appropriate. There was limited use of participant quotations to illustrate themes and it was unclear whether data analysis was rigorous. The recruitment strategy was not well described. There was a lack of discussion regarding researcher reflexivity and on ethics of the research.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Participants are newly qualified doctors working with people who have suicidal behaviour; as this includes suicidal ideation, participants are not required to have worked with people who have previously self-harmed. Study not conducted in the UK.)*

Rissanen, 2012

Bibliographic Reference	Rissanen, Marja-Liisa; Kylma, Jari; Laukkanen, Eila; Helping self-mutilating adolescents: descriptions of Finnish nurses; Issues in mental health nursing; 2012; vol. 33; 251-62

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Finland
Setting	Healthcare - university hospital adolescent psychiatry departments
Data collection and analysis	The data were collected using focus group interviews, individual interviews, and written descriptions. The transcriptions were coded for meaningful words and phrases. These codes were grouped into categories and subcategories. During the analysis, the researchers discussed the process and categories that emerged, agreeing any changes.
Recruitment strategy	Nurses from the Department of Adolescent Psychiatry of one of the five University Hospitals in Finland were invited to participate. The head nurses of four wards were informed about this study and were sent advertisements about the study

	with a request to give a copy of it to each nurse on their wards. The study was also advertised in three magazines targeted at health care professionals - inviting health care professionals to send written descriptions of help for adolescents who self-mutilate anonymously.
Study dates	April to May 2005
Sources of funding	Not reported.
Inclusion criteria	Participants had to be qualified nurses (registered or practical nurses) with experience caring for self-mutilating adolescents.
Exclusion criteria	Not reported.
Sample size	N=9 psychiatric nurses (n=5 focus groups; n=2 individual interviews; n=2 written descriptions)
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role:** Qualified nurses: 9 **Setting:** Inpatient adolescent mental-health wards **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Adolescents
Results	Author theme: Helpers

	Example quote: "Especially when parents are unable to help, then the role of school personnel as helpers is very significant . . . I mean interfering in it . . . and also supporting adolescents and finding ways to cope with everyday problems or violence at home and so on. Taking care of others." p. 255 *"It [self-mutilation] is not easy for teachers to discuss, when it is not even so easy for health care professionals . . . but discussion of it is important." p. 255* Author theme: Helping and caring *Example quote: "Making contact on the personal level is significant; I think, of course, work experience is influential, too." p. 256* *"It is important to talk about it in the caring community. Hiding will not help. Discussing together makes self-mutilation visible and it will help us." p. 256* *"It is typical that she feels guilty about what she has done [self-mutilation], and so you must be very sensitive in what you say. That's because she might feel guiltier and think that she is bad, and this might cause extra traumatisation." p. 257* *"Accepting this kind behaviour is forbidden, but understanding . . . and then finding a shared understanding, and then continuing forward . . ." p. 257*

	"It is not the talking . . . an adolescent is wordless . . . you must use other means to find understanding . . . for example by drawing." p. 256 *"You know, "holding," being there, often without words." p. 257* *"It should be a stock-in-trade to ask about it [self-cutting] when meeting an adolescent who has mood disorders, I mean, even if there were no references to it. It should be asked every time, irrespective of the gender, but for some reason it does not come to mind." p. 259*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research has some value
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Authors did not justify their use of focus groups or written descriptions, which can limit discussion of a sensitive topic, and did not discuss saturation of data. Researcher reflexivity was also not considered. Additionally, the authors did not discuss the findings in relation to current practice, or ways in which the research can be used.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Rowe, 2017

Bibliographic Reference	Rowe, Joanne; Jaye, Chrystal; Caring for self-harming patients in general practice; Journal of primary health care; 2017; vol. 9; 279-285

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	New Zealand
Setting	Community
Data collection and analysis	Each participant was interviewed once, using a semi-structured interview guide. Interviews were transcribed and thematic analysis was done by coding the text according to the questions in the interview guide, allowing for new insights. These codes were then grouped into categories. Regular meetings between the investigators ensured agreement on the final themes that emerged from the data.
Recruitment strategy	Participants were recruited primarily through advertising in a free regional newspaper. Other recruitment details not reported.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Age > 16 years, at least 2 years since the person had last self harmed
Exclusion criteria	None reported
Sample size	N=12
Participant characteristics	**Mean age (range):** not reported (19-70) years **Sex (female/male):** 9/ 3 **Ethnicity:** New Zealand European: 11 Māori: 1

	Co-morbidity: Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported
Results	Author theme: 'Seeing of me' *Example quote: "They did a lot of talking and they never listened, especially my psychiatrist… I can remember many instances where I'd say, 'I feel like this', and she'd go, 'no, no, no you don't, you feel like this'. And completely flip it around because that didn't fit in with her little 15 min slot for me." p. 282* *"I think it's because it's a different relationship you have with your counsellor than what you have with, say your psychiatrist. You get a lot closer and…. if you want to do the work you have to learn how to trust them. From there you build an amazing relationship. For me, [my counsellor] knows 99% of my life. She's here every week, she cares, yeah." p. 282* *"Nurses don't tell you how horrible it was to have to put a femoral line in a girl who had just taken some sort of overdose of 'XYZ'. You know, like you don't get that feedback, because that's not the way that the system works." p. 282* Author theme: Relationship-centred care *Example quote: "It's just making you talk, and think, and challenge. She [counsellor] challenges very subtly. It's professional, but there is much more of a… yeah, I was going to say caring, nurturing, and caring. There is concern there." p. 282*

Critical appraisal

Section	**Question**	**Answer**
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Lack of discussion regarding researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included patients*

Section	Question	Answer
		providing data regarding skills for specialist and non-specialist staff. Study not conducted in the UK.)

Simoes, 2020

Bibliographic Reference	Simoes, R. M. P.; Dos Santos, J. C. P.; Martinho, M. J. C. M.; Adolescents with Suicidal Behaviours: a qualitative study about the assessment of Inpatient Service and Transition to Community; Journal of psychiatric and mental health nursing; 2020

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Portugal
Setting	Healthcare (inpatient service rooms or outpatient consultation offices).
Data collection and analysis	Semi-structured interviews were held, lasting an average of 45 minutes. Interviews were recorded and transcribed. Data were analysed using content analysis without a category chart, whereby content was studied to identify categories, which were then grouped for analysis.
Recruitment strategy	Participants were recruited via convenience sampling.
Study dates	May 2018 to May 2019.
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be aged between 10 and 19 years old • have suicidal behaviour (defined as an intentional act of self-harm, including attempted suicide, suicidal ideation and self-harming behaviour)

	• have been admitted to a child psychiatric unit regardless of the clinical diagnosis and clinically discharged afterwards • have a favourable medical opinion • provide written and signed free and informed consent to participate in the study (if older than14) • provide written and signed free and informed consent from their parents and/ or legal guardians to participate in the study.
Exclusion criteria	Not reported.
Sample size	N = 33 adolescents with suicidal behaviour
Participant characteristics	**Mean age (SD):** 15.91 (1.18) years **Sex (female/male)**: 24/ 9 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:**

	At least 1 suicide attempt: 31 Not reported: 2.
Results	Author theme: Most important aspects of hospitalization *Example quote: "(E3) locking a person in the bedroom is not therapy at all" p. 6* *"(E3) listening more to the youngsters and not changing medication without discussing it with the patient" p. 6* Author theme: Suggestions for service improvement *Example quote: "(E11) we should be listened to, even though it may seem like something simple, it isn't always like that," p. 6* *"(E16) teaching me how to deal with the same issues in the future" p. 6* *"(E20) helping us find better goals," p. 6* *"(E5) we do not all like the same things… they should do more activities with just me," p. 6*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Can't tell

Section	Question	Answer
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns regarding lack of information regarding the recruitment strategy, and slightly unclear descriptions of themes at times.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in non-specialist settings but participants provided data regarding their experiences in specialist settings, with specialist staff. Study not conducted in the UK. 2 participants (6.1%) had not attempted suicide, however the study did not detail whether these participants had self-harmed with non-suicidal intent.)*

Storey, 2005

Bibliographic Reference	Storey, P.; Hurry, J.; Jowitt, S.; Owens, D.; House, A.; Supporting young people who repeatedly self-harm; Journal of The Royal Society for the Promotion of Health; 2005; vol. 125; 71-75

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting	EDs
Data collection and analysis	Interviews were held with participants. No other information is given.
Recruitment strategy	Participants were recruited at four A&E clinics, two in the south-west of England and two in the north of England after attending following an episode of self-harm. Patients were informed about the study by the A&E clinic, either at the time of their presentation or by letter shortly after, and asked if they would agree to be approached by the research team.
Study dates	Not reported

Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=38 (n=74 were interviewed but only data from those who said they had self-harmed before they were 16 years old during their interview were reported)
Participant characteristics	**Mean age (range):** Not reported (16-22) years **Sex (female/male)**: Not reported **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Mean age of index episode for women: 14 years Mean age of index episode for men: 15 years Self-harm history: Participants with index self-harm episode between the ages of 13 and 16 years: 34

	Participants with index self-harm episode at the age of 12 years or younger: 4 **Suicide attempts:** Not reported
Results	Author theme: Experiences of services *Example quote: "See someone, then it stops. See another person. You need someone continuously or it's not going to work." p. 73* *"I felt that they were just sat there, just 'my job, I get paid for it'." p. 73* *"I never had a problem with my past and he kept dragging it up… I'd go to talk about [current problem] and then he'd stop me. And he'd go, 'Yes, blah blah, very interesting. Now let's talk about your childhood, and like about your dad. You seem to have hostility towards him.' And I'm like, I'm trying to talk to you about the problem that's bugging me, not about that. And like, he just wouldn't listen. And it got to me so much that every time I just walked out of the office, I'd just cry. So I won't go back." p. 73*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell
Findings	Is there a clear statement of findings?	Can't tell
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Concerns regarding data collection and analysis as no information is provided in relation to these processes. Few quotes are provided to support themes. Insufficient discussion regarding researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Highly relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist and non-specialist staff.)*

Talseth, 2001

Bibliographic Reference	Talseth, A. G.; Jacobsson, L.; Norberg, A.; The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians; Journal of advanced nursing; 2001; vol. 34; 96-106

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Norway
Setting	Psychiatric inpatient hospital
Data collection and analysis	Narrative interviews were held in the meeting room in the ward when patients' primary health nurses were not present, and lasted between 30 and 60 minutes. Interviews were tape-recorded and transcribed verbatim. Data were analysed using phenomenological-hermeneutic method.
Recruitment strategy	Chief physicians or senior nurses of a psychiatric hospital sent names of potential participants who had all been hospitalised for more than 1 week to the authors. The chief physician informed the patient verbally and in writing about the project, and the author then contacted each patient's primary health nurse to make an appointment with the nurse and the patient to provide information about the study and give participants the opportunity to join.
Study dates	Not reported.
Sources of funding	The authors received financial support from the Psychiatric Research Centre for Finnmark and Troms-PFFT, Norway.
Inclusion criteria	Participants had to: • have expressed thoughts of, a wish to, or have attempted suicide.
Exclusion criteria	Not reported.
Sample size	N = 19 psychiatric inpatients
Participant characteristics	**Mean age (SD):** Not reported

	Sex (female/ male): 9/ 10 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Attempted suicide: 11.
Results	Author theme: Trusting each other *Example quote: "When we talked about my situation before I was admitted, she drew conclusions (summed up) about what I had said and she said it out loud. She gave me a summing-up out aloud many times. You get the feeling the person trusts you." p. 101* *"First I feel calm and I feel that the person sitting at the other side of the table doesn't want to hurt me. I am usually very sceptical and on guard but here I didn't have that sensation. Here it was easy, I could be myself. It makes you feel at ease in relation to the person you're talking to, and that's good." p. 101*

	Author theme: Respecting patients' integrity *Example quote: "My mother had phoned and wanted to be present at a discussion. The physician approached me and asked me very thoroughly whether that would be all right for me. He consults me and no decisions are taken above my head." p. 101* Author theme: Listening to patients with prejudice *Example quote: "When he listens he asks questions on the basis of what I have said. That shows me that he has understood what I have been saying. He asks thoughtful questions: he lets me think and answers me. I understand him and he takes me seriously." p. 101* *"He doesn't understand because he's so busy talking himself. He has already formed an opinion in his head on how everything has been, how everything is and how everything will be. However much I try to tell him, he is deaf to what I say. He can't be bothered to open himself up to other possibilities." p. 102* *"There was no talk about the attempted suicide. That disappointed me, something that was missing for me to feel that the conversations were complete. That I could feel slightly warm feelings, there could have been a slightly warmer atmosphere between us when we were talking. That was why I was there, because of the attempted suicide. It was forgotten about." p. 102* Author theme: Mistrusting each other *Example quote: "I didn't feel that I could entirely trust her to keep the information to herself, even though I emphasized several times that it was to be between the physician and me. She indicated that she understood this and took me seriously. I had lost a little of my confidence in her, she proved not to be entirely loyal towards me." p. 102*

	Author theme: Not respecting patients' integrity *Example quote: "In a way I became a little expectant. I was afraid of saying too much. I was afraid that she would start deciding and perhaps taking decisions I did not agree with. Control my life." p. 102*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes

Section	Question	Answer
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Partially relevant *(11 participants had attempted suicide but it is unclear if the other 8 participants had engaged in self-harm without suicidal intent, or if they had suicidal ideation but had not self-harmed. Study not conducted in the UK.)*

Te Maro, 2019

Bibliographic Reference	Te Maro, Ben; Cuthbert, Sasha; Sofo, Mia; Tasker, Kahn; Bowden, Linda; Donkin, Liesje; Hetrick, Sarah E.; Understanding the Experience and Needs of School Counsellors When Working with Young People Who Engage in Self-Harm; International journal of environmental research and public health; 2019; vol. 16

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	New Zealand
Setting	Education: secondary schools
Data collection and analysis	Participants had semi-structured interviews lasting between 45–80 min. Interviews were recorded and transcribed verbatim. The transcripts were analysed thematically. This involved identifying, analysing, and categorizing a pattern of themes within and across interviews. Initial codes were generated based on initial ideas that are relevant and consistent across

	participants. These codes were then organized into meaningful groups, which were refined to form overarching themes. Some of the interviews were coded by 2 researchers to ensure consistency.
Recruitment strategy	Purposive sampling was used to ensure representation from state, state integrated, and private schools, at all levels of socioeconomic status, and geographical locations across the Auckland region. Emails were sent to the researchers' existing network of contacts with a request to contact the researchers by email or phone if participants were interested in participating.
Study dates	Not reported but likely 2018 or later
Sources of funding	This study received no external funding.
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=28 school pastoral care providers
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** 21/7 **Role:** Trained counsellors*: 26 Chaplin: 1 Social worker: 1 *Only data from this group of participants were extracted.

	Setting: Education - secondary schools **Mean years in post/ experience (SD):** 9.9 (9.05) **Client group (adults, children/ CYP):** Children (12 - 18 years)
Results	Author theme: Discrepancy — Differences in the Way That Self-Harm is Managed *Example quote: "I wouldn't say we got any specific training in self-harm : : : . A lot of my training has come through external training from my [previous job]" p. 7* *"Meet with all the new staff at the start of every year and explain what we do here and the services we have" p. 7* *"So, every young person gets exactly the same questions I think that's really important. Can I say while this is being recorded it would be so good if nationwide everybody did the same assessment" p. 8* *"Confidentiality breaching that has to happen at times inevitably puts your relationship is at risk. Our relationship stays more protected if the nurse does the informing of family as an accompli without negotiating with the student" p. 9*

	"Collegiality between the nurses and the other counsellor is absolutely essential" […] "Teachers had noticed things but hadn't feed it back to us"' p. 10 *"Yeah, trust us, we're the professionals, we're the trained psychologists : : : um : : : and we've made an assessment and this person isn't at risk. Whereas we're the ones that have had lots and lots of in depth conversations with them" p. 10* *"I will hold something before I take it to senior management because they'll always be "let's call whanau" and sometimes that actually makes a situation bigger : : : I don't think there needs to be immediate family involvement" p. 11* Author theme: Need for Guidelines *Example quote: "We realized that that wasn't really any process for how to deal with it at our school. So, I went online to see what I could track down : : : the ones for managing traumatic events for schools are like the encyclopedia Britannica. You know it's too long, too complicated : : : you've got to have it simple so you can use it" p. 11* *"[guidelines] would be really useful because then it becomes a bottom line and then the school can adjust to their school needs" p. 12*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Section	Question	Answer
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias due to a lack of discussion around justification of the research design and the recruitment process (unclear whether the participants are representative of the population).)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a non-specialist setting but included specialist staff. Study not conducted in the UK.)*

Vatne, 2016

Bibliographic Reference	Vatne, May; Naden, Dagfinn; Crucial resources to strengthen the desire to live: Experiences of suicidal patients; Nursing ethics; 2016; vol. 23; 294-307

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Norway
Setting	Acute psychiatric units
Data collection and analysis	Semi-structured interviews lasting between 90-110 minutes were held using an interview guide. After repeated listening to recordings of the interviews, they were transcribed verbatim and tentative themes noted. These were reviewed and checked against the interviews, with verbatim statements selected to support each theme.
Recruitment strategy	Participants were invited to participate by psychology specialists at two emergency psychiatric units and one crisis resolution team.
Study dates	Not reported.
Sources of funding	The study received no specific grant funding.
Inclusion criteria	Participants had to: • have serious suicidality • be non-psychotic • be able to verbalize experiences • have access to a therapist at least 2 weeks after the interview.
Exclusion criteria	Not reported.
Sample size	N=10 patients at adult psychiatric units
Participant characteristics	**Mean age (range):** Not reported (21-52 years)

	Sex (female/male): 6/ 4 **Ethnicity:** Not reported **Co-morbidity:** Not reported (all were non-psychotic) **Duration of self-harm:** Not reported **Suicide attempts:** One attempt: 8 More than 1 attempt: 2
Results	Author theme: Someone who cares *Example quote: "Even though everything is chaos, there is someone who knows about me . . . But I have to feel that they will safeguard what I say, not use it against me, but use it to help me. So there are fewer layers of protection; the layers are thinner, it is easier to bear . . ." p. 302* *"That is one of the reasons why I feel very secure when I am discharged; I know who they are and they know who I am" p. 302*

	'"But, "as he said, "that in itself does not prevent a person from carrying out a suicide."' p. 302

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns regarding lack of discussion of data saturation.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Wadman, 2018

Bibliographic Reference	Wadman, R.; Armstrong, M.; Clarke, D.; Harroe, C.; Majumder, P.; Sayal, K.; Vostanis, P.; Townsend, E.; Experience of Self-Harm and Its Treatment in Looked-After Young People: An Interpretative Phenomenological Analysis; Archives of suicide research : official journal of the International Academy for Suicide Research; 2018; vol. 22; 365-379

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	UK
Setting	Foster care or residential homes for looked after children and young people.
Data collection and analysis	Participants had individual semi-structured interviews. The interviews were recorded, transcribed, and subjected to interpretive phenomenological analysis. The analysis steps were: 1) familiarization with material through reading and re-reading of the transcript; 2) noting first impressions of the account; 3) exploratory and largely descriptive comments reflecting initial understanding of the content; 4) conceptual/ interpretative comments, identifying themes that captured the essential qualities of the account; and 5) organizing themes (for the group as a whole) into a meaningful hierarchy for the account(s) using clusters, super- and subordinate levels.
Recruitment strategy	Participants were recruited in the community (via a self-harm support organization and wider advertising), through Child and Adolescent Mental Health Services (CAMHS), and via social care.
Study dates	March 2014 and April 2015
Sources of funding	Funded by the Department of Health Policy Research Programme (The “Listen-up!” project: Understanding and helping looked-after young people who self-harm, 023/0164).
Inclusion criteria	Young people with experience of living in foster care or residential homes (11 to 21 years) who had self-harmed in the previous 6 months.

Exclusion criteria	Not reported.
Sample size	N=24
Participant characteristics	**Mean age (range):** 16 (14-21) years **Sex (female/male):** 20/ 4 **Ethnicity:** Not reported **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported
Results	Author theme: Experience of Clinical Services *Example quote: "… although the lady I was talking to was, she was nice, but she was just incredibly patronizing. And it made me feel a bit like a child, it's like I'm 18 years old, not eight" p. 372*

	"… she doesn't listen to what I say … I don't know, she twists things I say to … I don't know how to explain it, but it's like nothing seems important to her that I say" p. 372 *"And I feel it sometimes when they're there, they don't really interact with you, they just sit there with their notebook. They don't look at you, just sit there with the notebook and pen" p. 372* *"They haven't done anything. And I don't know what to expect, because they haven't, I can't see any changes. I don't think when I'm doing something 'oh, what would CAMHS say?'" p. 373* *"And she went out of her way to make me feel comfortable, and I never felt like I was talking to a professional, she'd always make me feel like she was, like she was really, she was so good." p. 373* *"We actually do, like, activities, so I can express how I feel sometimes, which I find a bit easier. And there's things that I can fiddle with, things that I can do while I'm there. And she, she doesn't sit there and stare at you like "I know how you feel," she's just realistic. So, I find it quite easy talking to her, and she said, she always said to me, "I understand if here and not say a word, I don't mind."" p. 373*

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Section	Question	Answer
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Yes
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant *(Study was conducted in a non-specialist setting but included patients providing data regarding skills for specialist and non-specialist staff.)*

Wilstrand, 2007

Bibliographic Reference	Wilstrand, C.; Lindgren, B. M.; Gilje, F.; Olofsson, B.; Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm; Journal of psychiatric and mental health nursing; 2007; vol. 14; 72-8

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Sweden
Setting	Acute psychiatric inpatient wards.
Data collection and analysis	Narrative interviews lasting between 40 to 50 minutes were held. Interviews were audiotaped and transcribed verbatim. Data were analysed using qualitative content analysis, whereby texts were divided into meaning units, which were then condensed, sorted into categories, and abstracted into themes.
Recruitment strategy	Participants were recruited using purposive sampling. Potential participants were given written and verbal information about the study by head nurses at 4 acute psychiatric wards.
Study dates	Spring 2002
Sources of funding	Not reported.
Inclusion criteria	Participants had to: • be employed at an inpatient psychiatric ward as a registered nurse • have experienced caring for self-harm patients • be willing to narrate their experience in an interview.
Exclusion criteria	Nurses who had participated in dialectical behavioural therapy (DBT) education or training were excluded.
Sample size	N = 6 psychiatric nurses
Participant characteristics	**Mean age (range):** 40 (27-53) years

	Sex (female/ male): 3/ 3 **Role**: Specialist psychiatric nurses: 4 Generalist nurses: 2 **Setting:** Acute psychiatric inpatient wards **Mean (range) of years in post/ experience:** 9.4 (1-18) **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Being burdened with feelings *Example quote: "She [patient] was lying under the blanket and used a razorblade to cut herself on the arm, despite being on close observation. You see, under the blanket you can do much . . . Cut yourself with a razor, one can see, if you are not under the blanket. And you do not lift up the blanket – that is a question of integrity." p. 75* Author theme: Balancing professional boundaries *Example quote: "To be clear about rules from the beginning and the whole staff has to be informed and supportive so that we work on the same script." p. 75*

	"I can feel cold in a way . . . Emotionally you have to cut off some part otherwise it can be very, very hard. In an acute situation you have to act first." p. 75

Critical appraisal

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Can't tell
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	No
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes

Section	Question	Answer
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Minor concerns of risk of bias due to lack of adequate justification of the research design and lack of consideration of researcher reflexivity beyond "our backgrounds influenced the interpretive process" (p. 76).)*
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Appendix E Forest plots

Forest plots for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F GRADE-CERQual tables

GRADE CERQual tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Table 6: Summary of evidence (GRADE CERQual): 1 Expertise

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 1.1: Formal training for/ experience working with people who have self-harmed					
19 (Awenat 2017, Behrman 2019, Berger 2014, Christianson 2008, De Stefano 2012, Dunkley 2014, Hagen 2017b, Hom 2020b, Karman 2015, Kelada 2017, Lees 2014, Lindgren 2004, Littlewood 2019, Long 2010, McGough 2021, Rissanen 2012, Te Maro 2019, Vatne 2016, Wilstrand 2007)	9 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using structured interviews; 1 study using narrative interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 1 study using focus groups; 2 studies using questionnaires and semi-structured interviews; 1 study using open-ended	Both staff and patient participants said that specialist staff needed to have had both formal training on how to work with people who have self-harmed, as well as experience working with people who have self-harmed. Staff members with experience working with people who have self-harmed said it gave them the skills to work with these patients in a very rooted and stable way. Some staff reported a lack of confidence that was rooted in inexperience despite having specialised in mental health care, which led to them not knowing what to do or say to patients who had self-harmed. Specialist staff also wanted up-to-date training that was fit for purpose in specific areas such as assessment, risk assessment, identifying dual diagnoses, and positive risk taking. Some staff spoke more generally about needing additional education regarding how to care for people who have self-harmed, and mental health nurses who had received this type of education felt they learned valuable information from it. School mental health staff felt that experience with students who have self-harmed gave them confidence in treating self-harm, however for those who were inexperienced, policies needed to be in place for staff to follow to account for this lack of experience. These participants said that sector-wide guidelines or policies could factor as training for school counsellors and would ensure consistency of care across schools, however they emphasised that these needed to be in plain language, adaptable to each school's needs, and provide explicit instructions. In particular, specialist staff in schools wanted training regarding questions to ask students to assess risk of self-harm. School mental health staff felt that non-specialist school staff should also receive education about self-harm so they could be more equipped with the skills to manage self-harm when it occurred in schools. Patient participants felt they could tell when specialist staff lacked experience and confidence, and felt these staff members were unequipped to help them.	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(15 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
	questionnaires; 1 study using questionnaires	Patient participants also felt more confident confiding in staff they saw as being well trained and professional. They reported that they needed care from staff who had specific training in relevant areas, like suicide, cutting and identifying dual diagnoses. Some patient participants appreciated a balance where the staff member clearly had professional competence but could still interact with the patient in a friendly manner. Parents also felt as though specialist staff need to be able to identify dual diagnoses that include marijuana, alcohol, and opiate use and abuse among adolescents. *'However, although all participants are specialized in mental health nursing, one of them stated that she does not feel educated or confident enough to talk with patients about suicide, and another informant stated that there should be much more focus on caring for suicidal persons in the education.'* (Hagen 2017b) *"I went to a new psychiatrist for the first time recently . . . She did the intake questionnaire and clearly did not understand suicide or cutting. Those are issues relevant to me." p. 178* (Hom 2020b) *'Residents, parents, and community mental health professionals noted the importance of identifying dual diagnoses that includes marijuana, alcohol, and opiate use and abuse among adolescents. Information is needed on how these mood-altering substances interact with prescription medications and the hazards that illegal drug use can create for patients.'* (Behrman 2019)		*necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	
Sub-theme 1.2: Ability to recognise and treat the underlying causes of self-harm					
16 (Behrman 2019, Berg 2020, Craigen 2009, Dunkley 2014, Hagen 2017a, Hagen 2018, Hom 2020a, Hom 2020b, Karman 2015, Lahoz 2020, Lees	6 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using structured interviews; 1 study using narrative	Participants felt it was important that staff had the ability to diagnose and treat comorbidities or other underlying causes rather than simply trying to prevent self-harm. Some staff felt that it was helpful to look for and treat an underlying diagnosis such as anxiety, but most participants spoke more broadly about potential triggers/ causes for self-harm that weren't necessarily linked to diagnoses. Specialist staff said, for example, that it was important for non-specialist staff to be able to differentiate between ordinary adolescent development and mental illness in young people, in order to lower the stigma of mental health services. Some staff disagreed that finding the individual underlying cause of self-harm was important, instead saying that formal treatment approaches were more useful than addressing potential issues that	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Very low
			Relevance	Moderate concerns: Most evidence is from a substantially	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
2014, Lindgren 2004, O'Donovan 2007, Rissanen 2012, Storey 2005, Talseth 2001)	interviews; 1 study using interviews; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 1 study using focus groups; 1 study using a survey and semi-structured interviews; 1 study using surveys	might be meaningful to the patient. These participants felt there was an urgency to begin treatment even without awareness of underlying factors or potential diagnoses. Most patient participants felt that it was therapeutic when staff attempted to understand the potential causes/ reasons for their self-harm, including relevant social, physical and environmental factors. There was some disagreement among patient participants regarding how staff should respond to this, however: some wanted staff to be able to provide coping mechanisms or solutions for their problems, while others wanted time to sit with their emotional pain after talking about their personal lives without necessarily being offered a solution. Some participants were wary of specialist staff who hyper-focused on an aspect of their life which the patient considered to be irrelevant to their concerns, and wanted psychiatrists in particular to take cues from the patient about potential causes for self-harm, rather than making assumptions. Diagnosis was a more contentious issue among patient participants, who disagreed about its utility. Some expressed it was unhelpful when staff focused entirely on diagnosing and treating a comorbidity, especially when the treatment included medication. Some participants felt clinicians' eagerness to diagnose them led to them being misdiagnosed, or that the focus on an underlying diagnosis was prioritised over taking other factors and the patient's perspective into account. They felt that once a clinician had made up their mind as to what the patient's issues were, they were not open to other possibilities. Some patients also felt there was stigma attached to some diagnoses, and that some staff used a diagnosis as an excuse not to therapeutically engage with them. Young people who had self-harmed additionally felt that staff were sometimes unable to distinguish between normal mood swings associated with their age, and mental illness. However, others appreciated having a diagnosis as a way to understand and validate their own feelings. These participants felt it was empowering to have the vocabulary to describe their experiences and that it helped them seek appropriate treatment. Parents of people who had self-harmed felt that sometimes specialist staff were too quick to diagnose the patient without adequately exploring the patient's concerns. *"you can only try help somebody try figure out why, what is the reason for them self-harming, what is going on for them in their lives, what experiences they had in the past and also trying to look at what has brought on this*		different context to the review question *(12 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	Moderate concerns: Most evidence is contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	

Study information		**Description of theme or finding**	**CERQual assessment of the evidence**		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		episode of self-harm, what has made things get that bad that they felt they needed to self-harm." p. 68 (O'Donovan 2007) *"We cannot spend time on diagnostic interviews…, we need to intervene even though we are uncertain of the underlying problems" p. 536* (Lahoz 2020) *"The underlying issues are really the key to the behaviour. Instead of just putting a Band-aid on the issue, if you could treat the actual thing that is causing it, that is better." p. 85* (Craigen 2009) *"It takes a doctor (psychiatrist) five minutes to give me a diagnosis and put me on a med" p. 878* (Behrman 2019) *"My own experience with being diagnosed was largely positive because it gave me a sense of credibility. It's maybe not the best way to put it, but it said, 'This is a real thing. Here is a set of words you can use to easily describe your situation to somebody.'" p. 176* (Hom 2020b) *'Adolescents, parents, and community members all reported a common concern that mental illness diagnoses are made too quickly and followed by prescribing medications without exploring other possible treatment options.'* (Behrman 2019)			
Sub-theme 1.3: Understanding of techniques to manage self-harm					
14 (Alonzo 2017, Craigen 2009, De Stefano 2012, Dunkley 2014, Hom 2020a, Hom 2020b, Karman 2015, Lahoz 2020, Littlewood 2019, Long 2010, McGough 2021, Rissanen 2012, Simoes	8 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using focus groups, interviews and written descriptions; 1 study using focus groups and interviews;	Specialist staff said that one of the most important aspects of their role was knowing techniques to prevent or reduce self-harm and suicidality (including suicide contracts, safety plans, harm minimisation techniques, and preparation for discharge), and their appropriateness for each patient. Some staff, for example, were very opposed to using self-harm contracts as they felt this had the effect of taking away a coping technique that the patient might still need. Some staff mentioned it was important to have the ability to switch between 'direct' treatment (where the focus was on providing techniques to prevent self-harm) when perceived self-harm or suicide risk was highest, and 'indirect' treatment (where the focus was on underlying issues related to self-harm) when risk was perceived as low. Staff therefore felt that it was important to supplement an interpersonal or therapeutic alliance strategy with symptom reduction techniques, and that one without the other was not as effective. Staff reported that interpersonal strategies allowed them to get a	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(10*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
2020, Wadman 2017)	1 study using focus groups; 2 studies using questionnaires	better understanding of the patient, which then enabled them to work collaboratively with the patient. They said this was especially important, for example, when drafting safety plans. Mental health nurses felt it was important to understand that they needed to help the patient manage self-harm by themselves by teaching the patient stress-reduction techniques, rather than simply pressuring the patient to stop self-harming. Mental health nurses also felt it was important for school staff to have the skills to help adolescents who self-harm to find alternative coping techniques. Patient participants acknowledged that staff having the skills to help patients develop coping mechanisms was useful, including psychotherapy and preparation for discharge. Some participants felt that being taught specific coping skills was more helpful than just talking about their feelings; however, some suggested counsellors should know how to engage clients in learning new coping skills before stripping them of their old ones, expressing that suicide/ self-harm contracts were not useful for this reason. These participants wanted to feel a sense that their interactions with specialist staff had actually helped them in a more tangible way, in order to justify their time spent with services. Additionally, there was disagreement regarding how helpful alternative coping behaviours were. Some found them helpful and felt that staff encouragement to think of alternative behaviours allowed them to be more involved in their own care, while those who were taught more simplistic coping techniques felt they were only temporary solutions that did not help stop self-harm in the long-term. Some patient participants said that it was unhelpful when staff were not open to patient input regarding their own care, for example not seeking feedback, or continuing with techniques even when the patient had expressed they weren't working. They wanted their individual expertise on their own situation to be acknowledged and incorporated into their treatment (see theme 'Collaborating to provide personalised care'). This indicated the need for staff to have the skills to explore multiple different management techniques. *"It's managing their actual self-harm wounds if there are any, and then . . . trying to figure out why they are using that as an outlet for their emotions or a way of coping with distress. . . . and then how else we can help them to cope with that distress and those sorts of feelings other than harming themselves." p. 65* (McGough 2021) *"Treatment should aim to challenge unhealthy thoughts and develop healthy coping strategies." p. 8* (Hom 2020a)		*studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		"There were periods where I managed to assuage the need to self-injure by picking up another healthy or acceptable behaviour, at the urging of a counselor … if that makes sense. It didn't really last too long because they were terribly simplistic behaviours that were sort of short-term answers." p. 84 (Craigen 2009)			
Sub-theme 1.4: Collaborating to provide personalised care					
10 (Berg 2020, Dunkley 2014/ Dunkley 2018, Hagen 2018, Lahoz 2020, Littlewood 2019, McGough 2021, Omerov 2020, Simoes 2020, Talseth 2001, Vatne 2016)	5 studies using semi-structured interviews; 1 study using interviews with open-ended questions; 1 study using narrative interviews; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using questionnaires	Some staff participants mentioned a therapist-oriented approach, whereby care is dictated by the formal requirements of a particular treatment, potentially at the expense of problems that the patient feels are relevant. These staff felt that focusing on formal techniques could have the benefit of preventing suicide in the short-term. However, most staff felt that providing patient-oriented care that focused on the patient's individual needs and goals was a more important skill, and that care should be tailored to the patient with that patient's active involvement in decision-making. These participants said that patients should be treated as experts on themselves and interacted with as such, especially when developing coping strategies. Overall, most staff agreed that even if formal approaches were used for treatment, personalising care to address specific concerns of the patient was an important skill. Patients reported receiving standardised care was unhelpful and felt impersonal. They felt staff care provision should go beyond what they were taught in order to be individual to the person, and that staff should have the skill to provide care without relying on depersonalised statements or solutions, which patients reported as dismissive even if well-meaning. Patient participants also wanted to be involved in decision-making regarding their own care, and felt that when they were given the opportunity to collaborate with the specialist staff, they gained additional understanding of their own problems in life. Participants also said that personalised care included pacing any treatment appropriately for the individual. As an example of making care more personalised, two participants felt that at least one session of treatment should be held in the person's home environment to enable patients to maintain a sense of individuality. *'Patient- vs. therapist-oriented approach refers to whether the therapist follows a manual, or other formal requirements rather than what seems important to the patient. […] Most clinicians used a patient-oriented approach*	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Low
			Relevance	Serious concerns: All evidence is from a substantially different context to the review question *(7 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with people with suicidal behaviour which did not necessarily include self-harm)*	

Study information		**Description of theme or finding**	**CERQual assessment of the evidence**		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		of meeting acute needs, providing empathy, and working towards a joint understanding of the individual history of suicidality […] "The main thing is to get an alliance with the patient… What they start talking about I follow…and if they do not say much I address the current situation about how they are feeling…"' (Lahoz 2020) *"… like the answers they give you generally are out of books, […] and I think, well! […] What's that all about? They haven't actually got any answers apart from what they're taught to tell you. […] they just reel off these things to everybody instead of proper talking to you." (patient)' p. 271* (Dunkley 2018)	Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	
Sub-theme 1.5: Ability to prescribe medication appropriately					
9 (Behrman 2019, Borrill 2005, Dunkley 2014, Hagen 2018, Hom 2020a, Hom 2020b, Idenfors 2015, Lees 2014, Simoes 2020)	3 studies using semi-structured interviews; 1 study using structured interviews; 1 study using unstructured interviews; 1 study using focus groups and interviews; 1 study using focus groups; 1 study using surveys and semi-structured interviews; 1 study using surveys	Both staff and patient participants felt that specialist staff needed to be more aware of the limitations of prescribing medication for people who have self-harmed. Staff participants recognised that sometimes prescribing medication to suicidal patients increased their levels of distress, causing the opposite effect to the one intended by prescribing. Most patient participants expressed they wanted professionals to be less reliant on prescribing medicines for people who have self-harmed, especially without concurrent therapeutic treatment. Patients were also concerned when specialist staff prescribed them with medication for a comorbidity when they did not think they had one. Some participants felt as though some staff did not have an understanding of the risks of overmedicating people, potentially resulting in harmful adverse effects. Others echoed this and said it made them feel as though they were being experimented on. On the other hand, one participant who was in prison reported that her psychiatrist stopped prescribing her medication prematurely, which precipitated repeat self-harm. This shows the positive impact she felt her medication had on preventing repeat self-harm. Other patients valued clinicians' ability to prescribe because they felt their medication was a primary cause for their mental health improving, but still agreed that the decision to go on medication should come after thorough assessment and a collaborative agreement with the patient, and should happen alongside some form of therapeutic treatment. Parent participants felt as though some specialist staff prescribed medication prematurely, without adequately exploring other treatment options first.	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(7 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		"I think…erm…one thing that we haven't really talked about is medication and things like being under the Mental Health Act, and symptoms. I think all of those contribute massively to emotional pain. I've got one client who's on a CTO (Community Treatment Order) at the moment, he hates it and his levels of distress are just awful, and there's part of me that thinks actually he'd probably be safer if he wasn't on a CTO. It's not really helping us manage things (OT2 interjects 'yeah') very well, And the whole medication battle (OT1 mmm) as well." p. 115 (Dunkley 2014) *"the only thing I really doubt a little, that has actually to do with the medication. [. . .] That there is really no evidence that it helps. So why do they offer that as the only solution? In addition to—or, maybe it is a bit overrated then. They could have been a little more honest about that". p. 6* (Hagen 2018) *"two weeks before I came in I saw a psychiatrist who said I didn't need medication anymore and stopped giving it to me.. since then (self-harm) got really bad" p. 61* (Borrill 2005) *'Parents who had a child in the mental health system and community health professionals noted the importance of "understanding medications, their side effects, and adhering to prescriptions."' p. 879* (Behrman 2019)		*did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Findings were based on 9 studies with a large sample size but understanding of the theme would benefit from richer data from staff participants	
Sub-theme 1.6: Sharing expertise with colleagues					
9 (Behrman 2019, Berg 2020, Christianson 2008, Hagen 2017a, Karman 2015, Littlewood 2019, Long 2010, McGough 2021, Te Maro 2019)	6 studies using semi-structures interviews; 1 study using semi-structured focus groups and interviews; 1 study using focus groups; 1 study using questionnaires	Most staff participants felt that sharing knowledge and experiences regarding self-harm with colleagues allowed them to challenge misconceptions, develop their understanding of self-harm, and increase their knowledge base. These participants felt that having sessions where they shared their expertise, gave feedback, and provided examples of good practice allowed them to improve care without formal training. Sharing knowledge regarding the patient and their care plan between different care teams was also seen as important. School specialist staff said they wanted non-specialist staff (such as teachers) to communicate with them if they noticed concerning behaviour from students, and wanted specialist staff in external agencies to trust their judgment regarding patients. Staff participants expressed that effective communication and good patient note taking were vital skills that facilitated the patients' transitions between services, and that without these, patients could fall through the safety net. However, one staff participant felt that	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(5 studies not*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		working in a team made it difficult to improve or change behaviours, as this required them to go against established techniques. Parents of people who had self-harmed said that staff in different health care teams needed to communicate more effectively with each other regarding the patient's care, and that a lack of communication between teams negatively affected that person's recovery. *'[…] one participant indicated that working in a team had inhibited her ability to change her behavior in the past. Team members had a different approach to self-harm (i.e. more neutral and less empathic) than she did and this made her feel insecure. Later when she worked independently in community mental health care she was able to change her behavior more easily and according to her own insights and beliefs.'* (Karman 2015) *"We always talk with the patient together when assessing suicide. Then, we are two persons who can calibrate each other's experience afterwards, to talk about it and assess the risk together" (female nurse, 1.5 years of experience, short-term stabilisation ward).' p. 5* (Berg 2020) *"they (providers) don't talk to each other." p. 876* (Behrman 2019)		*conducted in the UK, studies included staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	

Table 7: Summary of evidence (GRADE CERQual): 2 Engagement with the patient

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
Sub-theme 2.1: Creating an open line of communication					
25 (Alonzo 2017, Awenat 2017, Behrman 2019, Berg 2020, Borrill 2005,	13 studies using semi-structured interviews; 1 study using unstructured	Staff participants felt that a large part of care was actively listening to the patients' concerns, needs, and wants in order to tailor any treatment more effectively, but also as a therapeutic method in and of itself. This involved letting the patient talk without questioning or interrupting them. Staff also said it was important to take every patient's concerns seriously – even if they	Methodological limitations	Minor concerns about methodological limitations as per CASP	Moderate

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
Craigen 2009, De Stefano 2012, Dunkley 2014/ Dunkley 2018, Hagen 2018, Hom 2020a, Hom 2020b, Karman 2015, Kool 2009, Lees 2014, Lindgren 2004, Long 2010, Mughal 2021, Omerov 2020, Rissanen 2012, Rowe 2017, Simoes 2020, Storey 2005, Talseth 2001, Vatne 2016, Wadman 2017)	interviews; 1 study using structured interviews; 1 study using narrative interviews; 1 study using interviews with open-ended questions; 1 study using interviews; 2 studies using focus groups; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 1 study using surveys; 1 study using surveys and semi-structured interviews	seemed minor – and let patients know their message had been heard (for example, through repeating information back to the patient) to help them feel validated. This skill required staff to be able to balance confirmation of a patient's suffering with the importance of not diminishing the patient's experiences. Staff said that having an open line of communication facilitated the patient's engagement with treatment. They felt that uncertainty around knowing what to say could prevent them from communicating with the patient at all or at least in a meaningful way. However, some staff said that even when they felt this, it was important to push through their discomfort and initiate conversation with the patient, as the patient may only be willing to communicate openly for a limited time. Some specialist staff members mentioned the importance of speaking to young people who had self-harmed alone without their parents present, as their experience was that young people were less likely to be fully honest about their concerns and self-harm when parents were there to hear as well. Others suggested chatting about daily activities to open up the conversation and make the patient feel comfortable before talking about topics that are more sensitive. Some participants also mentioned the technique 'holding', where the staff member was there to hear the patient but did not necessarily respond with words. Staff also noted that they needed to be able to recognise warning signs and use them as indications that they needed to listen more intensively. Some participants felt that filling out risk assessment scales during appointments with the patient created a barrier between the patient and caregiver and closed off lines of communication. Patient participants said that they valued when staff actively listened and communicated understanding, and that this allowed them to open up and be honest about their experiences. They felt that staff misinterpreting what they were saying or '[putting] words in your mouth' was unhelpful, as was staff rushing them, dismissing or not understanding their concerns, or providing what they felt was an inappropriate response to their levels of distress. Some participants reported that expressing their distress sometimes had the unintended effect of diminishing its significance because it reassured non-specialist staff that the patient's ability to express their emotions meant they were in control of them. Some participants also said they needed staff to ask the right questions and provide an invitation to speak in order to reassure them that it was okay to voice their distress. Patient participants did not find it helpful when staff discouraged them from openly talking about their self-harm/ suicidality, as they felt this closed off communication (see theme 'Sensitively broaching the subject of self-harm'). However, some expressed that it was reassuring when staff clarified communication would not be forced, and that		qualitative checklist	
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(17 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		patients did not have to talk on days where communication was more difficult for them. Some participants reported that out-of-hours services that signposted them to other services when they wanted to talk to someone also closed off potential lines of communication, and put them off seeking help during future crises. Some patients felt that they could communicate better through writing rather than talking, and that allowing this type of communication enabled them to be open with staff - some staff participants agreed that alternative, creative techniques such as journaling, activities, drawing or painting allowed patients to explore and process their feelings in another way. Other patient participants felt that receiving psychological therapies over the phone was inappropriate, and that communication needed to happen in person. There was a conflict between patient and staff participants regarding note-taking - patient participants felt that this was an indication that the professional was not actively listening to them, while staff expressed they did this to help them remember personal details, which then allowed them to demonstrate they had listened to the patient later. *“I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to ‘when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?’ I try to make a natural transition and create some trust during the conversation so the patient feels it’s safe to open up and talk about things along the way” (1 year of experience, locked wards).' p. 4* (Berg 2020) *“I think with the paperwork thing...I think.. I’d..was it would agree sort of almost… it’s almost cathartic I find it actually to write down maybe an assessment and sort of formulate it and organise…” OT' p. 127* (Dunkley 2014) *"When he listens he asks questions on the basis of what I have said. That shows me that he has understood what I have been saying. He asks thoughtful questions: he lets me think and answers me. I understand him and he takes me seriously." p. 101* (Talseth 2001)			

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
		"Like they'll ask you something, the person I see, and she's asked me that last week, and then I tell her the answer and she's writing it down like it's all NEWS to her, and you're thinking (indignant tone) - d'you know what I mean? What? I've told you that last week! But then you think, well I can't expect them to remember when they're seeing hundreds of people. So it makes you feel like you're nobody, like you're just somebody like a robot." p. 126 (Dunley 2014)			
Sub-theme 2.2: Fostering a therapeutic relationship					
23 (Alonzo 2017, Berg 2020, Craigen 2009, De Stefano 2012, Dunkley 2014/ Dunkley 2018, Hagen 2017a, Hagen 2018, Hom 2020a, Hom 2020b, Kool 2009, Lahoz 2020, Lees 2014, Lindgren 2004, Littlewood 2019, Long 2010, McGough 2021, O'Donovan 2007, Omerov 2020, Rissanen 2012, Rowe 2017, Storey 2005, Talseth 2001, Wilstrand 2007)	10 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using structured interviews; 2 studies using narrative interviews; 1 study using interviews with open-ended questions; 1 study using interviews; 1 study using focus groups; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 2	Most staff participants said it was vital to create a personal connection with the patient, by being empathetic and focusing on the patient's feelings. Staff reported that building a relationship was vital to ensuring that patients engaged with their care and said that it helped manage suicidality in its own right, especially as many patients who had self-harmed had experienced negative reactions to them in the past or experienced hurt in past relationships. They felt that such a relationship could be therapeutic in nature when staff expressed that they wanted to understand and help the patient, as it let the patient feel taken care of. Staff also said that expressing hope for recovery and a belief that change is possible for the patient could enable patients to share in that hope and therefore foster recovery. Some participants pointed out that it was important to achieve balance regarding their connection with the patient, so that the patient did not become overly reliant on them and therefore reduce their independence and their motivation to stop self-harming - this was particularly important to staff in inpatient settings, who managed the day-to-day care of patients. Staff participants also expressed that ending the therapeutic relationship was an important skill, which required staff to listen to the needs of the patient and prepare the patient for continuing without the patient-caregiver relationship. Patient participants agreed that they wanted staff to be empathetic and compassionate, and to see the patient as an individual beyond just being defined by their self-harm, demonstrated, for example, by remembering details about the patient's life or having a shared connection. Male patient participants specifically mentioned that a therapeutic relationship had to be built on a sense of mutual respect. Both staff and patient participants said that knowing the patient as an individual as well as their details and preferences enabled staff to respond to their distress in a more helpful manner. Establishing a connection also helped to minimise the patient's sense of isolation, distress, and objectification when preventative measures such as observation or detention were taken by staff. Some participants said that having such a connection prevented them from harming themselves because	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(17 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
	studies using questionnaires; 1 study using surveys and semi-structured interviews	it increased their self-esteem, and they felt that someone cared about them. Participants said they felt uncared about or as though they were a burden when staff demonstrated a lack of understanding, forgot details they had told them, or focused solely on operational aspects such as the next appointment, 'box-ticking', or only whether the patient had self-harmed rather than their overall wellbeing. Young people also said that being patronised by staff, even if the intention of the staff member was to be kind, hampered the creation of a connection between patient and caregiver. Patients said that distance between the caregiver and the patient contributed to feelings of alienation and loneliness, whereas they felt comfortable and willing to engage if there was a connection with the staff. However, some patient participants warned of the potential dangers of therapeutic relationships, including the fact that receiving sympathy and care from clinicians could motivate them to self-harm again in order to receive positive attention. Some patients also said that having an empathetic relationship with a clinician could result in a feeling of disconnection when that relationship was terminated, and others felt abandoned when sessions abruptly ended with no adequate explanation. *"I think a personal connection is really key in any therapist/ patient relationship." pp. 82-83* (Craigen 2009) *"…if there are too many admissions in here, then I am little afraid that we quickly may become both mom, sister, aunt, friend, etc. etc. And what is then left of the motivation to go out into the world and find it, I think. So to be warm and empathetic on the one side, but not becoming everything for the patient on the other side, that's an art, as I see it." p. 102* (Hagen 2017a) *"People that I believe have met me on that deeper level, I know, they're the people that I have imaginary conversations with, like I can pour my heart out to them, and I almost know what they're going to say back, things like that, and they prevent you - because you feel cared about, you feel that you matter, you feel that somebody knows how hard it is and just to have got through to the next day was an achievement, instead of getting through to you the next day because it's their job and it was on their timetable to phone you at such-and-such a time but they don't know why." p. 168* (Dunkley 2014) *"The nurse said: 'Come, let me bandage your wounds' and then she comforted me. Then I thought, if I cut myself next time, I will get her attention again." p. 30* (Kool 2009)	Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 2.3: Building mutual trust					
19 (Alonzo 2017, Berg 2020, De Stefano 2012, Dunkley 2014/ Dunkley 2018, Hagen 2017a, Hagen 2018, Hom 2020a, Hom 2020b, Idenfors 2015, Kool 2009, Lees 2014, Lindgren 2004, Long 2010, Mughal 2021, Omerov 2020, Rowe 2017, Storey 2005, Talseth 2001, Vatne 2016)	8 studies using semi-structured interviews; 2 studies using structured interviews; 1 study using unstructured interviews; 1 study using narrative interviews; 1 study using interviews with open-ended questions; 1 study using interviews; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups; 1 study using surveys; 1 study using surveys and semi-structured interviews	Staff reported that self-harm could be a difficult or scary topic for patients to talk about and that building trust established a feeling of safety, thereby allowing patients to be honest about their feelings and their self-harm. They felt that establishing trust required time and a safe space, meaning that rushing patients or making them feel unsafe was counterintuitive to building trust. Staff participants agreed with patient participants that maintaining confidentiality was also an important factor in building trust, and that staff should trust that patients were the experts on their own experiences. However, clinical social workers reported that having the ability to tell when a threat of self-harm was 'genuine' was an important skill that helped them to prioritise patients who needed more resource-intensive care. This showed that not all staff participants felt they could trust their patients in return. Patient participants said that having trust in specialist staff and the healthcare system was vital to recovery. This included trusting that if patients sought help, they would receive it. Patient participants reported that trust was linked to a feeling of safety, and a sense that the patient would not be punished for certain behaviour or for being honest about their behaviour and their feelings. This safety allowed them the freedom to express emotion. Trust could be built through active listening (see theme 'Creating an open line of communication'), responding non-judgmentally (see theme 'Being non-judgmental') and through building an interpersonal connection (see theme 'fostering a therapeutic relationship'). Patient participants also wanted staff to be honest with them about both the positive and negative aspects of care. Patients said trust could be broken if their concerns were dismissed or belittled, care was withheld or promised but not provided, or there was personal mistrust between the clinician and the patient, for example because the clinician had been judgmental towards the patient. One participant gave the example of a specialist staff member being late to an appointment, which signalled that they could not trust the clinician and dissuaded them from engaging with services. Once trust was broken, patients generally expressed unwillingness to engage with or even to seek care. Patients felt as much as they should be able to trust staff, similarly, staff should also trust patients when they spoke about their own experiences, feelings, and needs - patients wanted to be believed. However, some patients felt that they were driven to lie to mental health professionals, whether this meant exaggerating emotional pain or hiding it, in order to keep the professionals happy, to continue accessing treatment, or to avoid punishment. These participants felt they were not given the opportunity to be truthful because the truth could lead to withdrawal of	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(13 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	Minor concerns: Some evidence is contradictory without a credible explanation for differences	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		services, negative comments, or forceful care (such as hospitalisation) without consent. *"I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to 'when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?' I try to make a natural transition and create some trust during the conversation so the patient feels it's safe to open up and talk about things along the way" (1 year of experience, locked wards).' p. 4* (Berg 2020) *"If everybody who came to you saying, 'I've got suicidal thoughts and I'm going to,' y'know, 'take all my medication'… and you said, '... you obviously need to go into hospital' then […] the hospitals would be full, so there's a point where […] you have to use some sort of professional judgment and not necessarily connect an actual suicide attempt with an expression of emotional pain." (social worker)' p. 270* (Dunkley 2018) *"When we talked about my situation before I was admitted, she drew conclusions (summed up) about what I had said and she said it out loud. She gave me a summing-up out aloud many times. You get the feeling the person trusts you." p. 101* (Talseth 2001) *"I had no family support, no friends, no one to talk to, and I find it really hard to trust people with what I say . . . I could really trust some of those nurses." p. 311* (Lees 2014)	Adequacy	No or very minor concerns	
Sub-theme 2.4: Mutual understanding of goals					
12 (Alonzo 2017, De Stefano 2012, Hagen 2017b, Hom 2020a, Hom 2020b, Karman 2015, Lindgren 2004, Long 2010, Omerov 2020, Simoes	6 studies using semi-structured interviews; 1 study using structured interviews; 1 study using unstructured interviews; 1 study using	Staff reported it was important to express hope and set goals that encouraged the patient to be more oriented towards thinking about life and their future. They felt it was important that there was a joint understanding of these goals so the patient could be supported with their own problem-solving capabilities, and share in the hope of recovery. However, some staff said that the ability to be directive with patients was important, and that pushing or challenging patients assisted with symptom reduction.	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
2020, Storey 2005, Vatne 2016)	interviews with open-ended questions; 1 study using interviews; 1 study using focus groups; 1 study using surveys	Patient participants agreed that collaboratively working towards goals was important, and that this included involving patients in their own care planning (see theme 'Collaborating to provide personalised care'). They expressed that it was necessary for staff to recognise each patient's individual ability and therefore be patient with them, allowing patients to grow at their own pace. However, others said they appreciated when their therapist challenged them and '[told] it like it is'. *'After the training, there was also an increased focus on the normal and healthy aspects of the patient's functioning. Participants realized that the only way to deal effectively with the patient's problems and the related self-harming behavior was to work together with the patient and set goals that reflected the patient's experiences, problems and behaviors.'* (Karman 2015) *"[Do not] push too hard too fast on 'getting better.'" p. 6* (Hom 2020a) *"They set me up with . . . a therapist here in town who's just fantastic. She is the best therapist I've ever had. She kicks you in your ass when you need it. I'm the type who [wants someone to] just tell it like it is . . ." p. 176* (Hom 2020b)		a substantially different context to the review question *(10 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Findings were based on 12 studies with a large sample size but understanding of the theme would benefit from more quoted data from all participants	
Sub-theme 2.5: Ability to read non-verbal cues					
7 (Alonzo 2017, Berg 2020, Craigen 2009,	2 studies using semi-structured interviews; 1	Staff reported that various non-verbal cues such as crying, long silences, certain postures and movements, avoiding eye contact, contradictions in presentation, mood shifts, and facial expressions could be indicators that the	Methodological limitations	Minor concerns about methodological	Very low

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Dunkley 2014, Hagen 2017b, Hom 2020a, Rissanen 2012)	study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 1 study using focus groups; 1 study using surveys	patient is in distress. Some staff had experiences with patients who expressed their feelings through non-verbal means such as asking the clinician to listen to certain music. Staff and patients reported that it was important that staff were attentive and could read and interpret these cues to be able to accurately tell how the patient is feeling as a factor of risk assessment. Some staff reported the reason this skill was critical was that the patients who were most at risk of self-harm were usually those who struggled to express their emotional pain. Staff also reported having a 'gut feeling' - having experience with/ knowing the patient enabled people to read non-verbal cues more easily that may flag risk. Staff participants reported this as fallible though, and said the bigger picture needed to be taken into account as well. Patients reported staff sometimes believed they were getting better based on what the patients said when the opposite was true, indicating these professionals were not attentive enough to notice these cues. *"I think it's complex… their posture in the room, are they verbal, are they nonverbal, are they withholding, are they checking us out? I mean, you can tell sometimes, when a client has something to say, and they're not sure they're going to give you that information." p. 161* (Alonzo 2017) *"I had one [counselor] convinced that I was fine… it was great, except that I was getting worse." p. 86* (Craigen 2019)		limitations as per CASP qualitative checklist	
			Relevance	Serious concerns: All evidence is from a substantially different context to the review question *(5 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Findings from patient participants were based on only 1 study with a small sample size, and theme understanding of	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
				the theme would benefit from more evidence from all participants	

Table 8: Summary of evidence (GRADE CERQual): 3 Sensitivity

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
Sub-theme 3.1: Being non-judgmental					
19 (Alonzo 2017, Behrman 2019, Berg 2020, Berger 2014, Borrill 2005, Craigen 2009, De Stefano 2012, Dunkley 2014, Hagen 2017b, Hom 2020a, Hom 2020b, Karman 2015, Kool 2009, Lindgren 2004, Long 2010, McGough 2021, Mughal 2021, Rissanen 2012, Rowe 2017)	10 studies using semi-structured interviews; 1 study using structured interviews; 1 study using unstructured interviews; 1 study using semi-structured focus groups and interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 2 studies using focus groups; 1 study using surveys; 1	Having compassion for people who had self-harmed, even when the staff could not personally understand their actions, was seen as an important skill, whereas having a negative mind-set towards a patient who had self-harmed (such as seeing the behaviour as selfish or irresponsible) was seen by staff participants as blocking the care process. However, staff felt it was more important to behave positively towards patients and not *express* negative attitudes or opinions towards their self-harm – even if they secretly maintained judgmental attitudes – than it was not having those negative opinions at all. Some staff participants felt that they could still provide quality care while feeling shock, panic, fear, or anger, but acknowledged that it was important to be skilled at hiding these feelings so as not to further distress the patient. Mental health nurses felt an important part of their training was learning not to perceive self-harm as manipulative or negatively attention-seeking, leading them to be less accusatory towards patients. Some staff who mentioned this theme felt that positive regard should be unconditional, while a minority felt that prioritising pleasing patients was not a part of their role. Patient participants agreed that feeling as though staff were not judging them contributed to feelings of acceptance and safety. They agreed that it was hurtful when staff expressed fear or discomfort when they disclosed their self-harm or suicidality, and felt targeted when staff expressed stigmatising, accusatory or negative views. This could have the effect of legitimising patient participants' already negative perceptions of themselves. Male patient participants often expressed that they expected to be judged for their mental health concerns, and therefore encountering mental health professionals who did not fulfil these expectations provided a significant therapeutic benefit.	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(14 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
	study using open-ended questionnaires	Patient participants in prison said they appreciated being able to express themselves however they wanted to without being judged by specialist staff. Some patient participants also mentioned the need to retain dignity and a sense of mutual respect during interactions with clinicians. *"I think being open and non-judgemental in your approach, validating how they are feeling, what's going on for them. . . and helping them figure out alternatives . . .[You need] a really open mind and that kind of constant positive regard . . . a lot of it is your attitude and therapeutic relationship is absolutely everything." p. 66* (McGough 2021) *"The counsellor listens to me - I can express anger by swearing and she doesn't mind ... she doesn't judge you, she's there to listen to you" p. 65* (Borrill 2015)		*behaviour which did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	
Sub-theme 3.2: Sensitively approaching the subject of self-harm					
15 (Awenat 2017, Berg 2020, Borrill 2005, De Stefano 2012, Dunkley 2014/ Dunkley 2018, Hagen 2018, Hom 2020a, Hom 2020b, Karman 2015, Lees 2014, Lindgren 2004, Long 2010, Omerov 2020, Rissanen 2012, Talseth 2001)	6 studies using semi-structured interviews; 1 study using structured interviews; 1 study using unstructured interviews; 1 study using narrative interviews; 1 study using interviews with open-ended questions; 1 study using semi-structured focus groups and interviews; 1 study using	While most staff participant agreed that addressing emotional pain was important, some felt that it was inappropriate to broach the subject if the situation was wrong, if they felt unequipped to broach sensitive subjects, or if they did not have the time. Some staff received feedback from patients that they did not want to talk about self-harm; these staff felt it was important to take cues from the patient as to when it was appropriate to talk about self-harm and that this was sometimes only possible once a therapeutic connection had been made. Most staff agreed that it was important to respect patients' boundaries when broaching the subject of their self-harm, and said an approach must be tailored to the individual depending on whether they felt it was more appropriate to be direct or cautious. However, while most staff who mentioned this theme agreed that the subjects of self-harm and suicidality should be approached at the appropriate time, others felt it was important to discuss sensitive subjects regardless of whether the situation felt appropriate. For example, some participants felt that self-harm should always be questioned when scars are noticed or when talking to an adolescent with mood disorders. These staff felt that being risk-averse by avoiding talking about self-harm or suicidality was a barrier to effective care, to the detriment of the patient, and that it was important to discuss the issue rather than avoid it, even if this just meant acknowledging the patient's distress. Other specialist staff said that it was important to maintain communication about sensitive topics even if patients responded with aggression, despair, or threats of suicide, because this signalled to the patient that they could talk about these subjects	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(10 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
	focus groups and interviews; 1 study using focus groups, interviews and written descriptions;1 study using surveys and semi-structured interviews; 1 study using surveys	freely. Some psychiatric nurses who worked in schools additionally felt it was important for non-specialist school staff to discuss self-harm with adolescents because they thought this helped to reduce its incidence. They said this should include approaching students to ask about self-harm marks. Some staff suggested that a useful way to approach sensitive subjects without distressing the patient was to reassure them that they were allowed to discuss these topics and to try to reduce some of the stigma attached to expressing their emotional pain. Patient participants also expressed that they wanted to talk about their self-harm or suicidality and felt that it was unhelpful when staff were reluctant to broach the subject due to concerns about the patient's emotional capacity. These participants considered this hesitancy to be linked to stigma around self-harm which had the effect of dissuading communication, whereas openly talking about self-harm was seen as de-stigmatising and allowed it to be seen as less 'scary'. Additionally, some patient participants contradicted the opinions of the staff and said that they found it more intimidating when they were left to bring up the topic of self-harm themselves, and instead wanted the professionals to do so. They felt that being left to bring up self-harm or suicidality themselves gave them the opportunity to avoid mentioning it at all, which was dangerous as patients said they were more likely to avoid discussing self-harm if they were planning to self-harm or attempt suicide. Other patients felt that talking about their feelings of suicidality could result in intensifying their emotional distress. For example, one participant who was in prison and had a history of sexual abuse said that discussing sensitive subjects related to their self-harm brought back memories of trauma and caused them further distress. Some participants felt that being encouraged to talk about self-harm and then not being given adequate time to compose themselves before an appointment ends was inappropriate, and discouraged them from talking about self-harm in the future. They wanted professionals to be able to recognise when patients needed time to be able to sit and experience the feelings which emerged from talking about the emotional pain linked to their self-harm, without being rushed or interrupted. *"Just overly focusing on getting rid of the symptom I don't think that's necessarily useful, because they have a lot of shame and just focusing on the symptom might actually bring about more symptoms. I remember the beginning of my relationship with this client, she was very clear: "I don't want to talk about this stuff because it makes me worse." So, I think that making it more interpersonal, might be necessary, obviously a symptom reduction is a*		*staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	Minor concerns: Some evidence is contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		good idea, but I think it has to come once a good bond is established and once there's an interpersonal communication going on." p. 299 (de Stefano 2012) *"… The concerns about opening a can of worms… I don't necessarily buy into that [...] I think even if you haven't got a lot of time sometimes just acknowledging actually how distressing that is for people can be helpful. […] I think it's a bit of a myth that we have to wrap things up because actually clients don't wrap things up and it's going round in their head the whole time, so I think it can be quite validating if we notice something." (nurse)' p. 271* (Dunkley 2018) *"they also told me that 'it [suicidal thoughts] is something we do not want to talk about too often because it may give you ideas. If you are not there, we shall not induce those thoughts in you', but perhaps it would have helped me to try to talk about it sometimes"' p. 6* (Hagen 2018) *"that you feel like that if you're going to say something you'll open the floodgates and you won't be able to stop crying, you'll...you feel like you'll look bad in front of whoever you're with...erm... And that's something else...it's... I've noticed at times, if I've been really emotionally in pain and I am so genuinely upset and I can't stop crying, whoever you're seeing doesn't give you enough time to actually compose yourself before leaving the building and I've walked out of the building through the waiting room with people, absolutely sobbing my eyes out, and then having to go out and get in the car and drive home." pp. 112-113* (Dunkley 2014)			
Sub-theme 3.3: Ability to balance autonomy and safety					
14 (Berg 2020, De Stefano 2012, Dunkley 2014, Hagen 2017a, Hom 2020a, Karman 2015, Kool 2009, Lindgren 2004, O'Donovan 2007, Simoes 2020, Talseth 2001, Te Maro 2019, Vatne	8 studies using semi-structured interviews; 1 study using structured interviews; 2 studies using narrative interviews; 1 study using semi-structured	Staff said that most decision-making involved consideration of how they would uphold the patient's autonomy while maintaining their physical safety. This skill is aided by the understanding of various concepts, including: when it is appropriate to disclose/ break confidentiality; when to make the decision to take a patient to hospital versus when other techniques can help discourage suicidality instead; when making decisions against a patient's will (such as using restraint or observation) is necessary. For specialist school staff, the question of autonomy mostly involved making decisions regarding the breaking of confidentiality. There was variation among these participants regarding when they thought it was appropriate to break confidentiality, though they acknowledged doing so usually damaged their therapeutic relationship with the patient. Inpatient psychiatric nurses mentioned a large part of this skill was making an environment physically safe, by deciding how restrictive to be with	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Very low
			Relevance	Serious concerns: All evidence is from a substantially different context to the review	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
2016, Wilstrand 2007)	focus groups and interviews; 1 study using focus groups and interviews; 1 study using surveys	measures like removing potentially harmful objects. When making these decisions, psychiatric nurses said it was important to take cues from the patient as to how restrictive they needed to be, which included assessing which patients were distressed/ acutely suicidal (which referred to people who were currently at high risk of self-harming/ attempting suicide). For patients who were acutely distressed/ suicidal, staff felt it was more important to prioritise physically protecting the patient at the risk of a loss of autonomy, whereas they felt it was more important to prioritise autonomy over physical protection for patients who were chronically distressed/ suicidal (which referred to people who struggled with suicidal ideation but were not currently at high risk of suicide). Some staff felt that being either under- *or* over-protective was harmful, while others felt that making decisions about a patient's care that kept them safe against their will could damage the relationship between the caregiver and the patient and ultimately harm the patient's wellbeing in the long-term. These participants said that being overly risk-averse was unhelpful, and that instead, having the courage to take positive risks benefited the patient in the long-term. Mental health nurses reported that training helped them understand the fact that there needed to be a balance between using restrictive measures to forcefully prevent the patient hurting themselves, and allowing patients the opportunity to manage self-harm by themselves. These participants felt that being overly restrictive actually encouraged patients to resist the nurses further and participate in more dangerous behaviour. Some staff felt that regardless of this, it was their job to keep people from hurting themselves and that was their ultimate priority above all else. Some patients argued that risk-averse behaviours like forced isolation could not be considered therapy, and were unhelpful. Most patient participants appreciated when they were invited to take responsibility for their own actions and were allowed autonomy, as they felt this contributed to a feeling of being valued. They said that being allowed to participate in their own care encouraged them to take their care seriously and helped them learn how to continue to resist self-harm in daily life. In addition, some patients agreed with staff that positive risk-taking (such as having the potential to be discharged from hospital regardless of risk) allowed them to be more honest about their feelings and about potential future self-harm, rather than feeling like they had to lie about their capacity to manage self-harm in order to be granted more autonomy. Positive risk-taking also allowed patients to feel like they could seek help during moments of crisis because there was no threat to their autonomy as a result. On the other hand, some patients appreciated when mental health professionals set and imposed 'limits' by means of establishing consequences		question *(11 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	Minor concerns: Some evidence is contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
		for self-harming behaviour, because these patients did not feel capable of setting limits for themselves. *"I feel damned if I do and damned if I don't. Society criticises us (specialised mental health care) for using too many physical constraints and calls for more autonomy (for the patient), but at the same time, we are made accountable for the suicides and are told that we should have done more to prevent them. They (members of society) don't truly comprehend the complexity of this task" (10 years of experience, locked ward).' p. 6* (Berg 2020) *"The idea is that you take a person more seriously and that you encourage people to show more of themselves, because the other approach (i.e. using restrictive methods) just led patients to resist and to distance themselves from us." p. 403* (Karman 2015) *"Yes, it feels as if, I don't know, some kind of my own responsibility, to try to resist. It may be less of "Poor little you! Carry you around and protect you from everything" and more of 'We take it seriously, but you still have to take your own responsibility'." p. 287* (Lindgren 2004) *"I've not been able to hold any limits nor to focus on anything. I have followed every impulse and I needed help to set the outside limits and they (staff) have been very good at that. They have been self-confident when helping me to set the limits that I'm not able to set myself" p. 288* (Lindgren 2004)			
Sub-theme 3.4: Cultural sensitivity					
3 (Behrman 2019, Craigen 2009, Hom 2020a)	1 study using semi-structured interviews; 1 study using focus groups; 1 study using surveys	Some staff participants said it was important to be aware of the patient's background and how it might affect or influence self-harm for that patient. These staff said that cultural competency was an important skill, and noted that specialist and non-specialist staff needed to be more sensitive to cultural differences when caring for patients who have self-harmed. Patient participants reported that therapy or counselling that forced religious views on them were unhelpful. They also wanted care that was culturally competent and took into account how their background might influence their treatment and experiences relating to self-harm.	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Very low
			Relevance	Serious concerns: All evidence is from a substantially different context to the review	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
		"Doctors need to realize that treating the adolescent who has two parents, secure home and income, and a good school, are very different from the kid who comes from a broken home, has limited resources, and a struggling school system." p. 877 (Behrman 2019) *"More trans-friendly [resources] . . ."; "More culturally competent, client-centered, anti-oppressive practice . . ."; "Educate [yourself] on genocidal [government] policies that have caused intergenerational traumas . . ."; ". . . [handle] LGBTQ rejection trauma." p. 8* (Hom 2020a)		question *(3 studies not conducted in the UK, studies included staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm, and/ or parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Findings were based on 3 studies with a large sample size but understanding of the theme would benefit from richer data from staff participants.	

Table 9: Summary of evidence (GRADE CERQual): 4 Self-preservation

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 4.1: Maintaining emotional distance					
8 (Christianson 2008, De Stefano 2012, Dunkley 2014, Hagen 2017b, Lees 2014, Long 2010, Rissanen 2012, Wilstrand 2007)	4 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using focus groups and interviews; 1 study using focus groups, interviews and written descriptions; 1 study using surveys and semi-structured interviews	Although specialist staff acknowledged it was important to form strong bonds with patients, they felt that having a good relationship with the person meant their own mental health was more strongly affected. Some participants felt it was important to recognise the limits of their roles as professionals in order to minimise their own distress after adverse events, while others felt they had to shut off their feelings entirely in order to cope. Other staff participants disagreed and said that having an interpersonal focus instead allowed them to manage their own emotionality better when engaging with the patient. Some staff and patient participants also felt that co-bearing emotional pain with the patient was a useful facet of care, which consisted of the clinician demonstrating emotion and expressing how they were affected by the patient's words and actions. This indicated that maintaining emotional distance between the patient and the staff member could damage the quality of the care. Some patient participants did not expect mental health professionals to be emotionally affected by the patient's communication of distress as they assumed staff saw this as just a facet of their job, and some found that evidence of this helped them share the emotional load and feel cared about. *"I can feel cold in a way . . . Emotionally you have to cut off some part otherwise it can be very, very hard. In an acute situation you have to act first." p. 75* (Wilstrand 2007) *"Empathy with their pain and trying if you like, to have the transference, picking up their pain, picking up their pain where it's felt in the counsellor's body, how do I feel when that client's communicating with me." p. 198* (Long 2010) *"Oh my God she's crying! Oh! And it was it sort of, y'know the emotion, you know, showing emotion and not being the "I've-got-the- certificate-I-know-more-than-you" It's better hand-in-hand…" p. 144* (Dunkley 2014)	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Low
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(6 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed, or staff working with and/ or people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	Moderate concerns: Most evidence is contradictory without a	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
				credible explanation for differences	
			Adequacy	No or very minor concerns	
Sub-theme 4.2: Being 'strong'					
5 (Christianson 2008, Dunkley 2014, Hagen 2017b, McGough 2021, Omerov 2020)	3 studies using semi-structured interviews; 1 study using interviews with open-ended questions; 1 study using focus groups and interviews	Staff participants said that working with patients who had self-harmed or were suicidal could be distressing for the staff members, especially when they felt responsible for preventing repeat self-harm. As a result, staff said they needed to be able to control their own fear and negative emotions in order to preserve their own mental health and so as not to distress the patient more. They acknowledged that sometimes this was more about pretending to be calm and confident rather than actually feeling as such, though others felt they did have to be mentally strong as well. Some mentioned that it was not just necessary to be mentally strong for themselves or the patients, but for other members of staff. These participants said that containing distress was key to creating a positive atmosphere, which then helped other colleagues not to be overwhelmed by negative emotions. *"Yes, it is about being the calm and confident one. (…)We represent, or in my opinion should represent, when someone in a deep crisis is admitted, and then someone in the surroundings has to stay calm and steady. And appear like confident then. (…) You must be aware of it so that the patient's crisis does not color [affect] you so much that you are at a loss, but that you're able to be there and endure hearing that someone says 'yes, I want to die. I don't want to live'". p. 34* (Hagen 2017b)	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	Low
			Relevance	Serious concerns: All evidence is from a substantially different context to the review question *(4 studies not conducted in the UK, studies included staff for whom it was unclear if they had worked with people who had self-harmed)*	
			Coherence	No or very minor concerns	
			Adequacy	No or very minor concerns	
Sub-theme 4.3: Recognising personal limitations					
2 (Hagen 2017b, Long 2010)	2 studies using semi-	Some staff participants said that being able to recognise when they were at emotional capacity or could no longer provide adequate care because their	Methodological limitations	Minor concerns about methodological limitations as	Low

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
	structured interviews	ability was stretched was an important skill. They said this included reacting appropriately to this realisation, for example by taking appropriate breaks. *"…if one has been in that kind of pressure with several patients [engaging in suicidal acts/self-harm] over several weeks, and that that one somehow feels that now I need a break, if it could be possible that I work with another kind of issue now, then I prefer that for a few days to kind of collect myself a little again". p. 34* (Hagen 2017b)		per CASP qualitative checklist	
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(1 study not conducted in the UK, study included staff for whom it was unclear if they had worked with people who had self-harmed)*	
			Coherence	No or very minor concerns	
			Adequacy	Moderate concerns: Findings were based only based on 2 studies with a small sample size and understanding of theme would benefit from richer data	
Sub-theme 4.4: Awareness of legal responsibilities					
5 (Hagen 2017a, Hom 2020a, Hom 2020b,	2 studies using semi-structured interviews; 1 study using	Staff participants felt it was important to be aware of their legal responsibilities and which procedures they were legally required to do when caring for people who had self-harmed. School mental health staff in particular felt they were in a legally tenuous position without sector-wide policies regarding their duty of care, and wanted to know what their legal responsibilities were, especially	Methodological limitations	Minor concerns about methodological limitations as per CASP	Moderate

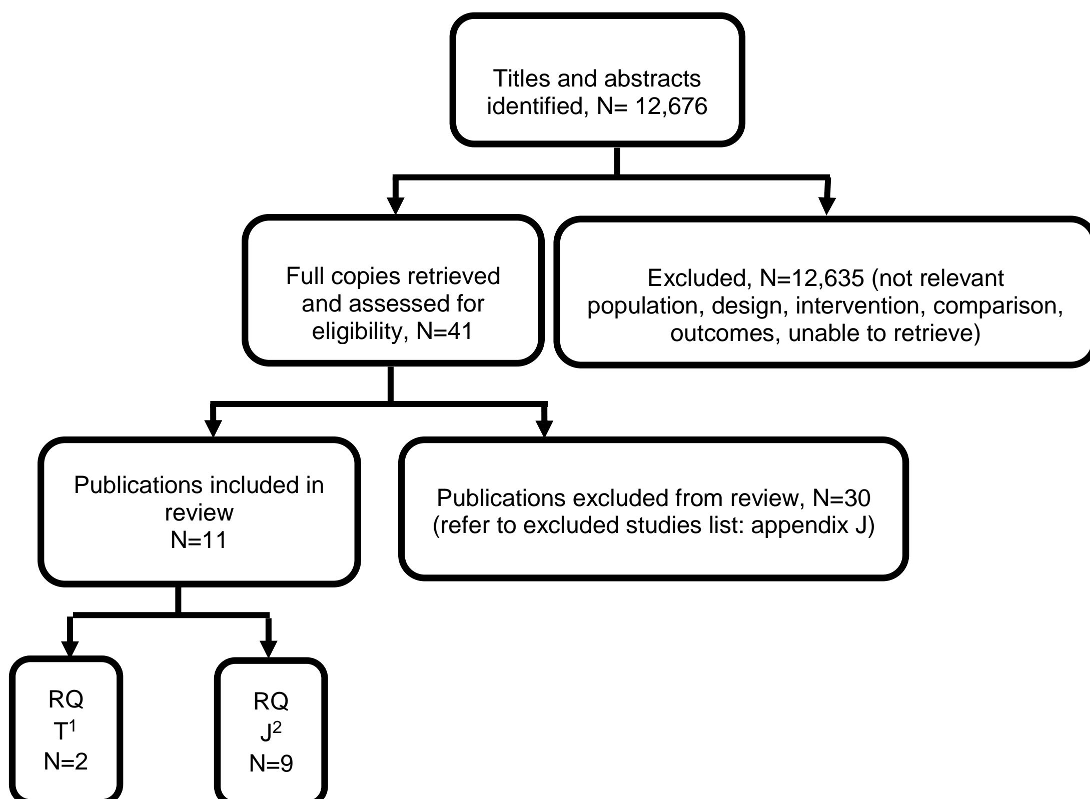
Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
Kelada 2017, Te Maro 2019)	unstructured interviews; 1 study using questionnaires and semi-structured interviews; 1 study using surveys	concerning parental disclosure. Staff felt this was important to protect themselves legally in case of adverse events, but some had mixed feelings regarding how helpful these procedures were for the patients themselves. Some felt they were helpful to recognise when they had done what they were supposed to. Others felt they were only following the procedures to avoid being reprimanded regardless of patient need, and some even expressed frustration that they were encouraged to prioritise their own interests over the wellbeing of the patient. Some patient participants said they could tell when staff were overly concerned about following formal processes and said that they did not want staff to prioritise their own legal protection over the patient's care, because it negatively affected their ability to connect with the staff member. *"I think it's really unfair to leave me in a potentially legally awkward situation—not just me, me and the school, but I take a lot of that stress on. . . . I had to work through a policy for the school and do my own research on it, when it's just becoming such a huge issue. Give me a checklist that we have to do. It's ridiculous . . . do not tell me what to say to a kid, but tell me what . . . to do in this situation, and what's going to keep—I know it sounds cold—but what's going to keep the school legally safe . . . it's been like we're floundering and do not have that much support with exactly what to do about the problem" [S3]' p. 179* (Kelada 2017) *"And today, unfortunately we have that bullshit, the computer and the technology, right, as if it is more important to write down and tell the boss that…or who. And then, what shall I say, even if people call and say they are suicidal, we have forms and computers and such things and need to write. It is not for the patient's sake. It is for my sake. That my boss…if the patient takes his own life at home while on the emergency phone. Then they cannot denounce me, and I've done my job.But I think that the most important is to sit down and talk to the person and be…provide closeness. That is the most important." p. 103* (Hagen 2017a) *"We don't want the doctor to worry about covering his own ass more than he cares about seeing us get better." p. 6* (Hom 2020a)		qualitative checklist	
			Relevance	Moderate concerns: All evidence is from a different context to the review question *(5 studies not conducted in the UK, study included staff for whom it was unclear if they had worked with people who had self-harmed)*	
			Coherence	Minor concerns: Some evidence is ambiguous or contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	

Appendix G Economic evidence study selection

Study selection for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

A global health economics search was undertaken for all areas covered in the guideline. Figure 3 shows the flow diagram of the selection process for economic evaluations of interventions and strategies associated with the care of people who have self-harmed.

Figure 3: Flow diagram of economic article selection for global health economic search



Abbreviations: RQ: Research question
Notes:
1 What are the most effective models of care for people who have self-harmed?
2 What psychological and psychosocial interventions (including safety plans and electronic health-based interventions) are effective for people who have self-harmed?

Appendix H Economic evidence tables

Economic evidence tables for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

No evidence was identified which was applicable to this review question.

Appendix I Economic model

Economic model for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Excluded qualitative studies

Please note that the current search was undertaken with the search for review questions Q (What are the views and preferences of staff in specialist mental health settings about what supervision is required for staff in specialist mental health settings who assess and treat people who have self-harmed?), R (What are the views and preferences of staff in non-specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist mental health settings who assess and treat people who have self-harmed?), and S (What are the views and preferences of staff in non-specialist mental health settings about what supervision is required for staff in non-specialist mental health settings who assess and treat people who have self-harmed?), and the list of excluded studies below only lists the 77 studies that were excluded for all reviews in contrast to the 93 excluded studies specified in the PRISMA diagram. This is because routing used in EPPI-Reviewer to separate the results of review questions P-S (for which a combined search was performed) resulted in EPPI-Reviewer being unable to generate the excluded studies list in the usual format, with the excluded studies for review questions P-S separated. Please see the PRISMA diagram for details of the (93-77=) 16 studies not listed in the excluded studies tables below, which are studies that met the inclusion criteria for review questions Q, R and/ or S.

Table 10: Excluded studies and reasons for their exclusion

Study	Code [Reason]
Balcombe, Lucille; Phillips, Louise; Jones, Julia (2011) ENGAGEMENT WITH YOUNG PEOPLE WHO SELF-HARM. Mental Health Practice 15: 14-18	- No direct qualitative data on phenomena of interest
Barekatain, M., Aminoroaia, M., Samimi, S. M. A. et al. (2013) Educational needs assessment for psychiatry residents to prevent suicide: A qualitative approach. International Journal of Preventive Medicine 4: 1200-1205	- Country not in PICO
Berg, Siv Hilde; Rortveit, Kristine; Aase, Karina (2017) Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. BMC health services research 17: 73	- Systematic review - included studies checked for relevance
Berger, E.; Hasking, P.; Reupert, A. (2014) "We're Working in the Dark Here": Education Needs of Teachers and School Staff Regarding	- No direct qualitative data on phenomena of interest

Study	Code [Reason]
Student Self-Injury. School Mental Health 6: 201-212	
Berger, Emily; Hasking, Penelope; Martin, Graham (2013) 'Listen to them': Adolescents' views on helping young people who self-injure. Journal of adolescence 36: 935-45	- Population not in PICO *Only 10% (N=263) of participants had self-harmed*
Best, R. (2005) An educational response to deliberate self-harm: Training, support and school-agency links. Journal of Social Work Practice 19: 275-287	- Population not in PICO *Participants are non-specialist staff who do not normally assess as treat people who have self-harmed*
Brown, J. and Beail, N. (2009) Self-harm among people with intellectual disabilities living in secure service provision: a qualitative exploration. Journal of Applied Research in Intellectual Disabilities 22: 503-513	- Population not in PICO *Study defined self-harm as inclusive of repetitive stereotypical self-injurious behaviour such as head-banging. The study included people who had intellectual disabilities who had self-harmed but did not specify how many of the participants' method of self-harm was repetitive stereotypical self-injurious behaviour*
Davis, Taijah (2020) Applied suicide intervention skills training program (ASIST): An evaluation of school counselor preparedness for immediate suicide intervention. Dissertation Abstracts International Section A: Humanities and Social Sciences 81: No-Specified	- Full text not provided *Only part of text provided in PDF, the rest not available*
De Silva, Eve; Bowerman, Lisa; Zimitat, Craig (2015) A suicide awareness and intervention program for health professional students. Education for health (Abingdon, England) 28: 201-4	- No direct qualitative data on phenomena of interest
Duperouzel, H. and Fish, R. (2008) Why couldn't I stop her? Self injury: The views of staff and clients in a medium secure unit. British Journal of Learning Disabilities 36: 59-65	- Study conducted pre-2000 *Paper includes 2 studies - 1 (Fish 2000) conducted pre-2000; the other study is not referenced*
Eckerström, Joachim, Flyckt, Lena, Carlborg, Andreas et al. (2020) Brief admission for patients with emotional instability and self-harm: A qualitative analysis of patients' experiences during crisis. International Journal of Mental Health Nursing 29: 962-971	- No direct qualitative data on phenomena of interest *Themes explored patients perspectives of a specific intervention (brief admission)*

Study	Code [Reason]
El-Den, Sarira, O'Reilly, Claire L., Murphy, Andrea L. et al. (2019) A systematic review of healthcare professionals' knowledge, attitudes and confidence in relation to suicide. Research in Social & Administrative Pharmacy 15: e8-e9	- Conference abstract
Elzinga, Elke, de Kruif, Anja J. T. C. M., de Beurs, Derek P. et al. (2020) Engaging primary care professionals in suicide prevention: A qualitative study. PloS one 15: e0242540	- No direct qualitative data on phenomena of interest *Primary healthcare professionals provided feedback on a specific suicide prevention training course; they did not discuss required skills*
Ferguson, M. S., Reis, J. A., Rabbetts, L. et al. (2018) The effectiveness of suicide prevention education programs for nurses: A Systematic Review. Crisis 39: 96-109	- Systematic review - included studies checked for relevance
Fish, R. M. (2000) Working with people who harm themselves in a forensic learning disability service: experiences of direct care staff. Journal of Learning Disabilities (14690047) 4: 193-207	- Study conducted pre-2000
Fisher, G. and Foster, C. (2016) Examining the needs of paediatric nurses caring for children and young people presenting with self-harm/suicidal behaviour on general paediatric wards: Findings from a small-scale study. Child Care in Practice: 1-14	- No direct qualitative data on phenomena of interest
Fox, C. (2011) Working with clients who engage in self-harming behaviour: experiences of a group of counsellors. British Journal of Guidance & Counselling 39: 41-51	- No direct qualitative data on phenomena of interest
Gelkopf, Marc, Roffe, Ziva, Behrbalk, Pnina et al. (2009) Attitudes, opinions, behaviors, and emotions of the nursing staff toward patient restraint. Issues in mental health nursing 30: 758-63	- Country not in PICO
Granek, L., Nakash, O., Shapira, S. et al. (2020) Oncologists, oncology nurses and oncology social workers experiences with suicide: impact on patient care. Journal of Psychosocial Oncology 38: 543-556	- Country not in PICO
Gryglewicz, K., Monahan, M. M., Chen, J. I. et al. (2020) Examining the effects of role play	- Quantitative study

Study	Code [Reason]
practice in enhancing clinical skills to assess and manage suicide risk. Journal of Mental Health 29: 549-557	
James, M. and Warner, S. (2005) Coping with their lives - women, learning disabilities, self-harm and the secure unit: A Q-methodological study. British Journal of Learning Disabilities 33: 120-127	- No direct qualitative data on phenomena of interest
Jordan, Joanne, McKenna, Hugh, Keeney, Sinead et al. (2012) Providing meaningful care: learning from the experiences of suicidal young men. Qualitative health research 22: 1207-19	- Population not in PICO *Study included men who had experienced suicidal ideation but did not specify whether any participants had self-harmed*
Keogh, Brian; Doyle, Louise; Morrissey, Jean (2007) Suicidal behaviour. A study of emergency nurses' educational needs when caring for this patient group. Emergency nurse : the journal of the RCN Accident and Emergency Nursing Association 15: 30-5	- Literature review
Leavey, Gerard, Mallon, Sharon, Rondon-Sulbaran, Janeet et al. (2017) The failure of suicide prevention in primary care: family and GP perspectives - a qualitative study. BMC psychiatry 17: 369	- No direct qualitative data on phenomena of interest
Lee, Frances (2016) Self-harm training in secondary schools: An educational psychology intervention using interpretative phenomenological analysis. Educational and Child Psychology 33: 105-116	- Population not in PICO
Leung, M., Chow, C. B., Ip, P. K. P. et al. (2019) Self-harm attempters' perception of community services and its implication on service provision. International Journal of Nursing Sciences 6: 50-57	- No direct qualitative data on phenomena of interest
Lindeman, M. A.; Kuipers, P.; Grant, L. (2015) Front-line worker perspectives on indigenous youth suicide in Central Australia: Contributors and prevention strategies. International Journal of Emergency Mental Health 17: 191-196	- No direct qualitative data on phenomena of interest
Lindgren, B. M., I, O. Ster, Astrom, S. et al. (2011) 'They don't understand . . . you cut yourself in order to live.' Interpretative repertoires jointly constructing interactions	- No direct qualitative data on phenomena of interest

Study	Code [Reason]
between adult women who self-harm and professional caregivers. International Journal of Qualitative Studies on Health and Well-being 6: 7254	
Long, Maggie; Manktelow, Roger; Tracey, Anne (2016) "Knowing that I'm not alone": client perspectives on counselling for self-injury. Journal of mental health (Abingdon, England) 25: 41-6	- No direct qualitative data on phenomena of interest
Lukaschek, K.; Erazo, N.; Ladwig, K. H. (2016) Police deployment after railway suicide: A qualitative content analysis of 127 narrative reports. Nervenheilkunde 35: 329-335	- Study not in english
Maple, M.; McKay, K.; Sanford, R. (2019) The attempt was my own! suicide attempt survivors respond to an Australian community-based suicide exposure survey. International Journal of Environmental Research and Public Health 16: 4549	- No direct qualitative data on phenomena of interest
Maple, Myfanwy, McKay, Kathy, Hess, Nicole C. L. et al. (2019) Providing support following exposure to suicide: A mixed method study. Health & social care in the community 27: 965-972	- Population not in PICO *Participants are people providing support to people bereaved by suicide*
Martin, Catherine and Chapman, Rose (2014) A mixed method study to determine the attitude of Australian emergency health professionals towards patients who present with deliberate self-poisoning. International emergency nursing 22: 98-104	- No direct qualitative data on phenomena of interest
Marzano, Lisa; Ciclitira, Karen; Adler, Joanna (2012) The impact of prison staff responses on self-harming behaviours: prisoners' perspectives. The British journal of clinical psychology 51: 4-18	- No direct qualitative data on phenomena of interest
Mason, Karen; Geist, Monica; Clark, Mollie (2019) A Developmental Model of Clergy Engagement With Suicide: A Qualitative Study. Omega 79: 347-363	- Population not in PICO
McAllister, Margaret, Moyle, Wendy, Billett, Stephen et al. (2009) 'I can actually talk to them now': qualitative results of an educational intervention for emergency nurses caring for	- No direct qualitative data on phenomena of interest

Study	Code [Reason]
clients who self-injure. Journal of clinical nursing 18: 2838-45	
McGrath, Ryan L., Parnell, Tracey, Verdon, Sarah et al. (2020) Trust, conversations and the 'middle space': A qualitative exploration of the experiences of physiotherapists with clients with suicidal thoughts and behaviours. PloS one 15: e0238884	- Population not in PICO
Michail, Maria and Tait, Lynda (2016) Exploring general practitioners' views and experiences on suicide risk assessment and management of young people in primary care: a qualitative study in the UK. BMJ open 6: e009654	- No direct qualitative data on phenomena of interest
Montross Thomas, Lori P., Palinkas, Lawrence A., Meier, Emily A. et al. (2014) Yearning to be heard: what veterans teach us about suicide risk and effective interventions. Crisis 35: 161-7	- No direct qualitative data on phenomena of interest
Moseley, R. L., Gregory, N. J., Smith, P. et al. (2019) A 'choice', an 'addiction', a way 'out of the lost': exploring self-injury in autistic people without intellectual disability. Molecular autism 10: 18	- No direct qualitative data on phenomena of interest
Mughal, F., Troya, M. I., Dikomitis, L. et al. (2020) Role of the GP in the management of patients with self-harm behaviour: A systematic review. Cancer Prevention Research 13: E364-E373	- No direct qualitative data on phenomena of interest
Newman, C. F. (2005) Reducing the risk of suicide in patients with bipolar disorder: Interventions and safeguards. Cognitive and Behavioral Practice 12: 76-88	- Literature review
Ngune, I., Hasking, P., McGough, S. et al. (2020) Perceptions of knowledge, attitude and skills about non-suicidal self-injury: A survey of emergency and mental health nurses. International journal of mental health nursing	- Quantitative study
O'Connor, Sophie and Glover, Lesley (2017) Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis. Psychology and psychotherapy 90: 480-501	- No direct qualitative data on phenomena of interest

Study	Code [Reason]
O'Donovan, A. and Gijbels, H. (2006) Understanding Psychiatric Nursing Care with Nonsuicidal Self-Harming Patients in Acute Psychiatric Admission Units: The Views of Psychiatric Nurses. Archives of Psychiatric Nursing 20: 186-192	- Full text not provided
Perry, Amanda E., Waterman, Mitch G., House, Allan O. et al. (2019) Implementation of a problem-solving training initiative to reduce self-harm in prisons: a qualitative perspective of prison staff, field researchers and prisoners at risk of self-harm. Health & justice 7: 14	- No direct qualitative data on phenomena of interest
Pierret, A. C. S., Anderson, J. K., Ford, T. J. et al. (2020) Review: Education and training interventions, and support tools for school staff to adequately respond to young people who disclose self-harm - a systematic literature review of effectiveness, feasibility and acceptability. Child and Adolescent Mental Health	- No direct qualitative data on phenomena of interest
Popadiuk, Natalee; Young, Richard A.; Valach, Ladislav (2008) Clinician perspectives on the therapeutic use of the self-confrontation procedure with suicidal clients. Journal of Mental Health Counseling 30: 14-30	- No direct qualitative data on phenomena of interest *Study lacks direct qualitative data on either skills or supervision*
Rebair, Annessa and Hulatt, Ian (2017) Identifying nurses' needs in relation to suicide awareness and prevention. Nursing standard (Royal College of Nursing (Great Britain) : 1987) 31: 44-51	- Full text not provided
Reeves, A. and Mintz, R. (2001) Counsellors' experiences of working with suicidal clients: An exploratory study. Counselling and Psychotherapy Research 1: 172-176	- Population not in PICO
Reichardt, Jane (2016) Exploring school experiences of young people who have self-harmed: How can schools help?. Educational and Child Psychology 33: 28-39	- Full text not provided
Rippon, Daniel; Reid, Keith; Kay, Gail (2018) Views on restrictive practices on young people in psychiatric wards. Nursing Times 114: 4-4	- No direct qualitative data on phenomena of interest

Study	Code [Reason]
Ross, Victoria; Kolves, Kairi; De Leo, Diego (2017) Teachers' Perspectives on Preventing Suicide in Children and Adolescents in Schools: A Qualitative Study. Archives of suicide research : official journal of the International Academy for Suicide Research 21: 519-530	- Population not in PICO
Rossetti, Jeanette, Jones-Bendel, Trish, Portell, Pauline et al. (2012) Changing attitudes about self-injury prevention management: lessons learned. Journal of psychosocial nursing and mental health services 50: 42-6	- Literature review
Russell-Broaddus, C. A. (2004) The suicidal patient's experience of nursing care in the emergency room. msn: N.PAG p-N.PAG p	- Full text unavailable
Scheckel, Martha M. and Nelson, Kimberly A. (2014) An interpretive study of nursing students' experiences of caring for suicidal persons. Journal of professional nursing : official journal of the American Association of Colleges of Nursing 30: 426-35	- Population not in PICO
Shamsaei, Farshid; Yaghmaei, Safura; Haghighi, Mohammad (2020) Exploring the lived experiences of the suicide attempt survivors: a phenomenological approach. International Journal of Qualitative Studies on Health & Well-Being 15: 1-11	- Country not in PICO
Sharpe, T. L., Jacobson Frey, J., Osteen, P. J. et al. (2014) Perspectives and Appropriateness of Suicide Prevention Gatekeeper Training for MSW Students. Social Work in Mental Health 12: 117-131	- Population not in PICO
Shilubane, Hilda N., Bos, Arjan Er, Ruiter, Robert Ac et al. (2015) High school suicide in South Africa: teachers' knowledge, views and training needs. BMC public health 15: 245	- No direct qualitative data on phenomena of interest
Shtivelband, Annette; Aloise-Young, Patricia A.; Chen, Peter Y. (2015) Sustaining the Effects of Gatekeeper Suicide Prevention Training. Crisis 36: 102-109	- No direct qualitative data on phenomena of interest
Sousa, Marta, Goncalves, Rui Abrunhosa, Cruz, Ana Rita et al. (2019) Prison officers' attitudes	- Quantitative study

Study	Code [Reason]
towards self-harm in prisoners. International journal of law and psychiatry 66: 101490	
Stallman, Helen M. (2020) Online needs-based and strengths-focused suicide prevention training: Evaluation of Care · Collaborate · Connect. Australian Psychologist 55: 220-229	- No direct qualitative data on phenomena of interest
Stanley, Nicky, Mallon, Sharon, Bell, Jo et al. (2010) Suicidal students' use of and attitudes to primary care support services. Primary Health Care Research and Development 11: 315-325	- No direct qualitative data on phenomena of interest
Sun, Fan-Ko, Long, Ann, Boore, Jennifer et al. (2006) Patients and nurses' perceptions of ward environmental factors and support systems in the care of suicidal patients. Journal of clinical nursing 15: 83-92	- Country not in PICO
Sun, Fan-Ko, Long, Ann, Chiang, Chun-Ying et al. (2019) A theory to guide nursing students caring for patients with suicidal tendencies on psychiatric clinical practicum. Nurse education in practice 38: 157-163	- Country not in PICO
Sun, Fan-Ko, Long, Ann, Chiang, Chun-Ying et al. (2020) The psychological processes voiced by nursing students when caring for suicidal patients during their psychiatric clinical practicum: A qualitative study. Journal of clinical nursing 29: 525-534	- Country not in PICO
Sweeney, F.; Clarbour, J.; Oliver, A. (2018) Prison officers' experiences of working with adult male offenders who engage in suicide-related behaviour. Journal of Forensic Psychiatry and Psychology 29: 467-482	- No direct qualitative data on phenomena of interest
Talseth, Anne-Grethe and Gilje, Fredricka L. (2011) Nurses' responses to suicide and suicidal patients: a critical interpretive synthesis. Journal of clinical nursing 20: 1651-67	- Systematic review - included studies checked for relevance
Taylor, B. (2003) Exploring the perspectives of men who self-harm. Learning in Health & Social Care 2: 83-91	- No direct qualitative data on phenomena of interest
Taylor, Tatiana L., Hawton, Keith, Fortune, Sarah et al. (2009) Attitudes towards clinical	- Systematic review - included studies checked for relevance

Study	Code [Reason]
services among people who self-harm: systematic review. The British journal of psychiatry : the journal of mental science 194: 104-10	
Vandewalle, J., Deproost, E., Goossens, P. et al. (2020) The working alliance with people experiencing suicidal ideation: A qualitative study of nurses' perspectives. Journal of advanced nursing 76: 3069-3081	- Population not in PICO
Vatne, May and Naden, Dagfinn (2018) Experiences that inspire hope: Perspectives of suicidal patients. Nursing ethics 25: 444-457	- No direct qualitative data on phenomena of interest
Vedana, Kelly Graziani Giacchero, Magrini, Daniel Fernando, Miasso, Adriana Inocenti et al. (2017) Emergency Nursing Experiences in Assisting People With Suicidal Behavior: A Grounded Theory Study. Archives of psychiatric nursing 31: 345-351	- No direct qualitative data on phenomena of interest
Vrale, G. B. and Steen, E. (2005) The dynamics between structure and flexibility in constant observation of psychiatric inpatients with suicidal ideation. Journal of psychiatric and mental health nursing 12: 513-8	- Population not in PICO
Warrender, D. (2015) Staff nurse perceptions of the impact of mentalization-based therapy skills training when working with borderline personality disorder in acute mental health: a qualitative study. Journal of psychiatric and mental health nursing 22: 623-33	- No direct qualitative data on phenomena of interest *Qualitative data are feedback on training for a specific psychosocial intervention (Mentalisation-Based Therapy)*
Wheatley, Malcolm and Austin-Payne, Hannah (2009) Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting. Behavioural and cognitive psychotherapy 37: 293-309	- Quantitative study
Whisenhunt, J. L., Chang, C. Y., Flowers, L. R. et al. (2014) Working with clients who self-injure: A grounded theory approach. Journal of Counseling and Development 92: 387-397	- No direct qualitative data on phenomena of interest

Excluded economic studies

Table 11: Excluded studies from the guideline economic review

Study	Reason for Exclusion
Adrian, M., Lyon, A. R., Nicodimos, S., Pullmann, M. D., McCauley, E., Enhanced "Train and Hope" for Scalable, Cost-Effective Professional Development in Youth Suicide Prevention, Crisis, 39, 235-246, 2018	Not relevant to any of the review questions in the guideline - this study examined the impact of an educational training ongoing intervention, and the effect of the post-training reminder system, on mental health practitioners' knowledge, attitudes, and behaviour surrounding suicide assessment and intervention. As well, this study was not a full health economic evaluation
Borschmann R, Barrett B, Hellier JM, et al. Joint crisis plans for people with borderline personality disorder: feasibility and outcomes in a randomised controlled trial. Br J Psychiatry. 2013;202(5):357-364.	Not relevant to any of the review questions in the guideline - this study examined the feasibility of recruiting and retaining adults with borderline personality disorder to a pilot randomised controlled trial investigating the potential efficacy and cost-effectiveness of using a joint crisis plan
Bustamante Madsen, L., Eddleston, M., Schultz Hansen, K., Konradsen, F., Quality Assessment of Economic Evaluations of Suicide and Self-Harm Interventions, Crisis, 39, 82-95, 2018	Study design - this review of health economics studies has been excluded for this guideline, but its references have been hand-searched for any relevant health economic study
Byford, S., Barrett, B., Aglan, A., Harrington, V., Burroughs, H., Kerfoot, M., Harrington, R. C., Lifetime and current costs of supporting young adults who deliberately poisoned themselves in childhood and adolescence, Journal of Mental Health, 18, 297-306, 2009	Study design – no comparative cost analysis
Byford, S., Leese, M., Knapp, M., Seivewright, H., Cameron, S., Jones, V., Davidson, K., Tyrer, P., Comparison of alternative methods of collection of service use data for the economic evaluation health care interventions, Health Economics, 16, 531-536, 2007	Study design – no comparative cost analysis
Byford, Sarah, Barber, Julie A., Harrington, Richard, Barber, Baruch Beautrais Blough Brent Brodie Byford Carlson Chernoff Collett Fergusson Garland Goldberg Harman Harrington Hawton Huber Kazdin Kazdin Kerfoot Kerfoot Kerfoot Knapp Lindsey McCullagh Miller Netten Reynolds Sadowski Shaffer Simms Wu, Factors that influence the cost of deliberate self-poisoning in children and adolescents, Journal of Mental Health Policy and Economics, 4, 113-121, 2001	Study design – no comparative cost analysis
Denchev, P., Pearson, J. L., Allen, M. H., Claassen, C. A., Currier, G. W., Zatzick, D. F., Schoenbaum, M., Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients, Psychiatric Services, 69, 23-31, 2018	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of outpatient interventions (Postcards, Telephone outreach, Cognitive Behaviour Therapy) to reduce suicide risk among patients presenting to general hospital emergency departments
Dunlap, L. J., Orme, S., Zarkin, G. A., Arias, S. A., Miller, I. W., Camargo, C. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., Manton, A. P., Clark, R., Boudreaux, E. D., Screening and Intervention for Suicide Prevention: A Cost-	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of suicide screening followed by an intervention to identify suicidal individuals and prevent recurring self-harm

Study	Reason for Exclusion
Effectiveness Analysis of the ED-SAFE Interventions, Psychiatric services (Washington, D.C.), appips201800445, 2019	
Fernando, S. M., Reardon, P. M., Ball, I. M., van Katwyk, S., Thavorn, K., Tanuseputro, P., Rosenberg, E., Kyeremanteng, K., Outcomes and Costs of Patients Admitted to the Intensive Care Unit Due to Accidental or Intentional Poisoning, Journal of Intensive Care Medicine, 35, 386-393, 2020	Study design – no comparative cost analysis
Flood, C., Bowers, L., Parkin, D., Estimating the costs of conflict and containment on adult acute inpatient psychiatric wards, Nursing economic$, 26, 325-330, 324, 2008	Study design – no comparative cost analysis
Fortune, Z., Barrett, B., Armstrong, D., Coid, J., Crawford, M., Mudd, D., Rose, D., Slade, M., Spence, R., Tyrer, P., Moran, P., Clinical and economic outcomes from the UK pilot psychiatric services for personality-disordered offenders, International Review of Psychiatry, 23, 61-9, 2011	Not relevant to any of the review questions in the guideline
George, S., Javed, M., Hemington-Gorse, S., Wilson-Jones, N., Epidemiology and financial implications of self-inflicted burns, Burns, 42, 196-201, 2016	Study design – no comparative cost analysis
Gunnell, D., Shepherd, M., Evans, M., Are recent increases in deliberate self-harm associated with changes in socio-economic conditions? An ecological analysis of patterns of deliberate self-harm in Bristol 1972-3 and 1995-6, Psychological medicine, 30, 1197-1203, 2000	Study design - cost-of-illness study
Kapur, N., House, A., Dodgson, K., Chris, M., Marshall, S., Tomenson, B., Creed, F., Management and costs of deliberate self-poisoning in the general hospital: A multi-centre study, Journal of Mental Health, 11, 223-230, 2002	Study design – no comparative cost analysis
Kapur, N., House, A., May, C., Creed, F., Service provision and outcome for deliberate self-poisoning in adults - Results from a six centre descriptive study, Social Psychiatry and Psychiatric Epidemiology, 38, 390-395, 2003	Study design – no comparative cost analysis
Kinchin, I., Russell, A. M. T., Byrnes, J., McCalman, J., Doran, C. M., Hunter, E., The cost of hospitalisation for youth self-harm: differences across age groups, sex, Indigenous and non-Indigenous populations, Social Psychiatry and Psychiatric Epidemiology, 55, 425-434, 2020	Study design – no comparative cost analysis
O'Leary, F. M., Lo, M. C. I., Schreuder, F. B., "Cuts are costly": A review of deliberate self-harm admissions to a district general hospital plastic surgery department over a 12-month period, Journal of Plastic, Reconstructive and Aesthetic Surgery, 67, e109-e110, 2014	Study design – no comparative cost analysis

Study	Reason for Exclusion
Olfson, M., Gameroff, M. J., Marcus, S. C., Greenberg, T., Shaffer, D., National trends in hospitalization of youth with intentional self-inflicted injuries, American Journal of Psychiatry, 162, 1328-1335, 2005	Study design – no comparative cost analysis
Ostertag, L., Golay, P., Dorogi, Y., Brovelli, S., Cromec, I., Edan, A., Barbe, R., Saillant, S., Michaud, L., Self-harm in French-speaking Switzerland: A socio-economic analysis (7316), Swiss Archives of Neurology, Psychiatry and Psychotherapy, 70 (Supplement 8), 48S, 2019	Conference abstract
Ougrin, D., Corrigall, R., Poole, J., Zundel, T., Sarhane, M., Slater, V., Stahl, D., Reavey, P., Byford, S., Heslin, M., Ivens, J., Crommelin, M., Abdulla, Z., Hayes, D., Middleton, K., Nnadi, B., Taylor, E., Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: a randomised controlled trial, The Lancet Psychiatry, 5, 477-485, 2018	Not self-harm. In addition, the interventions evaluated in this economic analysis (a supported discharge service provided by an intensive community treatment team compared to usual care) were not relevant to any review questions
Palmer, S., Davidson, K., Tyrer, P., Gumley, A., Tata, P., Norrie, J., Murray, H., Seivewright, H., The cost-effectiveness of cognitive behavior therapy for borderline personality disorder: results from the BOSCOT trial, Journal of Personality Disorders, 20, 466-481, 2006	Not self-harm
Quinlivan L, Steeg S, Elvidge J, et al. Risk assessment scales to predict risk of hospital treated repeat self-harm: A cost-effectiveness modelling analysis. J Affect Disord. 2019;249:208-215.	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of of risk assessment scales versus clinical assessment for adults attending an emergency department following self-harm
Richardson JS, Mark TL, McKeon R. The return on investment of postdischarge follow-up calls for suicidal ideation or deliberate self-harm. Psychiatr Serv. 2014;65(8):1012-1019.	Not enough data reporting on cost-effectiveness findings
Smits, M. L., Feenstra, D. J., Eeren, H. V., Bales, D. L., Laurenssen, E. M. P., Blankers, M., Soons, M. B. J., Dekker, J. J. M., Lucas, Z., Verheul, R., Luyten, P., Day hospital versus intensive out-patient mentalisation-based treatment for borderline personality disorder: Multicentre randomised clinical trial, British Journal of Psychiatry, 216, 79-84, 2020	Not self-harm
Tsiachristas, A., Geulayov, G., Casey, D., Ness, J., Waters, K., Clements, C., Kapur, N., McDaid, D., Brand, F., Hawton, K., Incidence and general hospital costs of self-harm across England: estimates based on the multicentre study of self-harm, Epidemiology & Psychiatric Science, 29, e108, 2020	Study design – no comparative cost analysis
Tsiachristas, A., McDaid, D., Casey, D., Brand, F., Leal, J., Park, A. L., Geulayov, G., Hawton, K., General hospital costs in England of medical and psychiatric care for patients who self-harm:	Study design – no comparative cost analysis

Study	Reason for Exclusion
a retrospective analysis, The Lancet Psychiatry, 4, 759-767, 2017	
Tubeuf, S., Saloniki, E. C., Cottrell, D., Parental Health Spillover in Cost-Effectiveness Analysis: Evidence from Self-Harming Adolescents in England, PharmacoEconomics, 37, 513-530, 2019	This study is not a separate study from one already included in the guideline for topic 5.2 (Cottrel 2018). This secondary analysis presents alternative parental health spillover quantification methods in the context of a randomised controlled trial comparing family therapy with treatment as usual as an intervention for self-harming adolescents of (Cottrel 2018), and discusses the practical limitations of those methods
Tyrer, P., Thompson, S., Schmidt, U., Jones, V., Knapp, M., Davidson, K., Catalan, J., Airlie, J., Baxter, S., Byford, S., Byrne, G., Cameron, S., Caplan, R., Cooper, S., Ferguson, B., Freeman, C., Frost, S., Godley, J., Greenshields, J., Henderson, J., Holden, N., Keech, P., Kim, L., Logan, K., Manley, C., MacLeod, A., Murphy, R., Patience, L., Ramsay, L., De Munroz, S., Scott, J., Seivewright, H., Sivakumar, K., Tata, P., Thornton, S., Ukoumunne, O. C., Wessely, S., Randomized controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: The POPMACT study, Psychological medicine, 33, 969-976, 2003	Study design - no economic evaluation
Van Roijen, L. H., Sinnaeve, R., Bouwmans, C., Van Den Bosch, L., Cost-effectiveness and Cost-utility of Shortterm Inpatient Dialectical Behavior Therapy for Chronically Parasuicidal BPD (Young) Adults, Journal of Mental Health Policy and Economics, 18, S19-S20, 2015	Conference abstract
van Spijker, B. A., Majo, M. C., Smit, F., van Straten, A., Kerkhof, A. J., Reducing suicidal ideation: cost-effectiveness analysis of a randomized controlled trial of unguided web-based self-help, Journal of medical Internet research, 14, e141, 2012	Not self-harm

Appendix K Research recommendations – full details

Research recommendations for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

No research recommendations were made for this review question.

Appendix L Qualitative quotes

Qualitative quotes for review question: What are the views and preferences of staff in specialist mental health settings, people who have self-harmed and their family members/carers about what skills are required for staff in specialist mental health settings who assess and treat people who have self-harmed?

Table 12: Theme 1: Expertise

Study	Evidence
Sub-theme 1.1: Formal training for/ experience working with people who have self-harmed	
Awenat 2017	"I haven't had any specific training with [suicidal patients] because that would be my role to kind of, ehm, do that." (AHP: 09)' p. 105
Behrman 2019	'Residents, parents, and community mental health professionals noted the importance of identifying dual diagnoses that includes marijuana, alcohol, and opiate use and abuse among adolescents. Information is needed on how these mood-altering substances interact with prescription medications and the hazards that illegal drug use can create for patients.' P. 879
Berger 2014	"It is important to get as much information as possible, particularly being in a remote area with very few accessible resources" (Mental health worker)' p. 31
Christianson 2008	"What I see happening now is the training programs are shorter. They seem to have much less practicum time, they're putting people in schools to do practicums where they're basically throwing them into school to do the job and having a fellow counsellor kind of oversee them, but not the same kind of intense focus on the counselling process." p. 213
De Stefano 2012	"'Oh what do I do? I've never dealt with this before.' You know, and 'What's going on with this girl that she is doing this?' And so I think a lot of the emotions I felt were related to my status as a beginner counselor as opposed to the act itself, I was just basically afraid that I wasn't prepared for this, that I wasn't experienced enough to work with her." p. 298
Dunkley 2014	"I didn't want to go to (mental health team base) I think I put it off for several years because of the connection with work. So I paid for counselling with a local charity. And the difference between somebody who's trained and somebody who is trained but, I don't want to sound ungrateful but is a do-gooder… erm…" p. 138
Hagen 2017b	"…if the patient does not take his own life, we have – we do have more self-harm when we have a lot of temporary staff in the ward in the summer. We do. We also have more like acting out, we notice that too. (…) they do not pick up the signals before the turmoil starts, right". p. 33
Hagen 2017b	'However, although all participants are specialized in mental health nursing, one of them stated that she does not feel educated or confident enough to talk with patients about suicide, and another informant stated that there should be much more focus on caring for suicidal persons in the education.' p. 33
Hom 2020b	"I went to a new psychiatrist for the first time recently . . . She did the intake questionnaire and clearly did not understand suicide or cutting. Those are issues relevant to me." p. 178
Karman 2015	'She explained this by the fact that she had had many years of working experience on a ward where severe self-harm was a frequent phenomenon. Because of this working experience, the participant felt that she had a very rooted and stable way of working with patients who self-harm.' p. 404

Study	Evidence
Kelada 2017	"I'm fortunate in that I'm quite experienced in this role and have sought further education, but . . . there are student welfare officers who come in with minimal qualifications and those poor workers are dealing with self-harmers . . . there's a lot of people out there who are working with people who are self-harming in schools who are not given the skills or the "how-to's" and . . . is just overwhelmed by it. So I think we need to resource our school staff better, or welfare or counseling school staff better" [S7]' p. 179
Kelada 2017	"Policies are usually not what I find—are not really specific, you know, they're fairly broad and general . . . you need some specifics in there sometimes. . . . They're fairly broad and, kind of, you have to go "well that's a bit obscure, I do not really—you know, that could be taken either way, really" [S11]' p. 179
Kelada 2017	"I think it would be really good for principals to be educated because the principal, like, they carry the can for whatever happens in the school and they often—I feel they often do not understand about self-harm, that they think "oh my goodness it's self-harm they're gonna kill themselves tonight." So to have education for principals as an inoculation—not if it happens, but for all principals, that when it does happen—this is what your response needs to be and understand that it's not necessary going to end in a—it's unlikely to end in a suicide attempt" [S2]' p. 181
Lees 2014	'Of particular concern was the finding that many nurses did not have the best possible attitude, education, training, or support to optimally meet the challenges and opportunities at hand, and more fully realize therapeutic engagement. […] Additionally, it was commonly asserted that the education and training received had given nurses 'little preparation for dealing positively with people in suicidal crisis' (RN5), and that additional workplace training would enhance their practice with regards to the care of suicidal consumers.' p. 311
Lindgren 2004	'The results reveal that participants think and expect staff to have understanding about selfharm that involves a certain kind of competence, being 'sure' of their selves, knowledgeable about what they are doing, ability to see the need for help and then take the participant seriously.' p. 288
Littlewood 2019	"Increased emphasis on training and education in suicide prevention" p. 5
Long 2010	'The skills and qualities required for maintaining the therapeutic relationship were seen as personal, professional and ethical. Skills included: […] having practical awareness and experience of self-harm; continuing professional development; mirroring best professional practice' p. 198
McGough 2021	"I would say [I am] quite comfortable. . .[it developed] just through time basically, just experience working within the field, and probably also, mainly even more so from [watching] colleagues . . . for me a few nurses early on in my career that I guess helped me to see self-harm differently." p. 65
Rissanen 2012	"Making contact on the personal level is significant; I think, of course, work experience is influential, too." p. 256
Te Maro 2019	"I wouldn't say we got any specific training in self-harm … A lot of my training has come through external training from my [previous job]" p. 7
Te Maro 2019	"Meet with all the new staff at the start of every year and explain what we do here and the services we have" p. 7
Te Maro 2019	'The participant responses revealed a desire for some consistency and guidance about what and how to ask across participants […] "So, every young person gets exactly the same questions I think that's really important. Can I say while this is being recorded it would be so good if nationwide everybody did the same assessment"' p. 8

Study	Evidence
Te Maro 2019	"We realized that that wasn't really any process for how to deal with it at our school. So, I went online to see what I could track down … the ones for managing traumatic events for schools are like the encyclopedia Britannica. You know it's too long, too complicated … you've got to have it simple so you can use it" p. 11
Te Maro 2019	"[guidelines] would be really useful because then it becomes a bottom line and then the school can adjust to their school needs" p. 12
Vatne 2006	'They emphasized the importance of being met by professionals who listened, showed respect, gave them the feeling of being equally valuable persons, got involved, possessed professional knowledge and signalled hope and the belief that we will be able to tackle this together.' p. 302
Wilstrand 2007	'This sub-theme focused on the need for staff education as well as physical, financial and staff resources. Participants imagined what it would be like if nurses who understood self-harm patients provided care in small units, without mixing patients, with adequate finances, trained staff and sufficient time.' p. 75
Sub-theme 1.2: Ability to recognise and treat the underlying causes of self-harm	
Behrman 2019	'Adolescents, parents, and community members all reported a common concern that mental illness diagnoses are made too quickly and followed by prescribing medications without exploring other possible treatment options. […] "It takes a doctor (psychiatrist) five minutes to give me a diagnosis and put me on a med"' p. 878
Behrman 2019	'Community mental health professionals also reported the need for pediatricians to discern the distinctions between ordinary adolescent development and mental illness to lower the stigma of mental health services […] "I'm pretty normal; it was so embarrassing. I hate that if you have some kind of issue, you're labeled mentally ill."' p. 878
Berg 2020	'"I work with the individual patients' underlying feelings about suicidality… Through gaining insight, the patients find other ways to express their emotions" (male psychologist with specialisation, 15 years of experience, open rehabilitation ward).' p. 6
Craigen 2009	"The underlying issues are really the key to the behaviour. Instead of just putting a Band-aid on the issue, if you could treat the actual thing that is causing it, that is better." p. 85
Dunkley 2014	"if I was sitting talking to somebody from (the mental health team) and explaining every single thing that's ever happened that's made me the way I am, and how I deal or don't deal with things, and then at the end of it they didn't give me an answer, cos I'd be expecting an answer, then I'd be really frustrated and think, well you don't even, like, understand." p. 147
Hagen 2017a	"For there are two, actually in Norway there are two camps in the suicidology. And there are those who see suicide risk and suicide almost as its own matter. And where it should very much be intervened on that. And then there is the second group to which I belong, […] who view suicide as a negative event belonging to serious mental disorders. As a result, the best suicide preventive effort is to quickly get to correct diagnosis and initiate correct treatment for all." p. 101
Hagen 2018	"I really got very good information [...] about depression, about the first step of taking medicines was also a big step for me. And maybe accepting that I was ill. Taking the first pill was enormously difficult. [...] Because it really affected me to accept that. And reading the brochure where it is explained very much as a disease. I did not feel ill. I just felt sad, that I did not want to live anymore. That is

Study	Evidence
	something completely different from being ill in the head. So, accepting that is terribly difficult” p. 6
Hom 2020a	“Take time to get to know us and understand our past traumas besides the suicide attempt.” p. 5
Hom 2020a	“Avoid immediately resorting to diagnosing survivors with specific mental illnesses . . . focus on the triggers and symptoms instead of the possible diagnosis.” p. 7
Hom 2020b	“My own experience with being diagnosed was largely positive because it gave me a sense of credibility. It’s maybe not the best way to put it, but it said, ‘This is a real thing. Here is a set of words you can use to easily describe your situation to somebody.’” p. 176
Hom 2020b	“We talked about things, in therapy, that bothered me growing up that probably contributed to my depression . . . I did have a lot of anger that I turned inward. We talked about that in therapy, and that helped.” p. 177
Karman 2015	‘The goal of participants became to explore the nature and background of the self-harming behavior in order to treat self-harm more effectively. Self-harm was validated as a coping mechanism […] "Well, before I was like: we need to get rid of this [i.e., self-harming behavior]. And now I just realize, well, so this is what you need right now."’ p. 404
Lahoz 2020	"We cannot spend time on diagnostic interviews…, we need to intervene even though we are uncertain of the underlying problems" p. 536
Lees 2014	"There was no one I was able to tell the story of why I was suicidal. Like they go to a lot of trouble to make sure you’re properly medicated . . . but no one’s really interested in hearing the story of why you did it or why you’re in that sort of shape." p. 309
Lees 2014	‘For example, there was indication that the diagnostic label of ‘borderline personality disorder’ was overused by some nurses, was seen to have inherently negative connotations, and sometimes used as a reason for the nurses not to attempt interpersonal engagement with the consumer.’ p. 311
Lindgren 2004	‘The results show that participants experience being understood when staff: try to explore the reasons for self-harm actions; ask how they feel; talk openly with them about what they did and why they did it; and consider healthy ways to express themselves. [...] Understanding is more than knowing about self-harm, it also includes knowing the individual’s personal reasons and feelings related to self-harm. […]"Understanding ... But then, understanding is not the same thing as supporting everything you say"’ p. 288
O'Donovan 2007	"you can only try help somebody try figure out why, what is the reason for them self-harming, what is going on for them in their lives, what experiences they had in the past and also trying to look at what has brought on this episode of self-harm, what has made things get that bad that they felt they needed to self-harm." p. 68
Rissanen 2012	“Accepting this kind behaviour is forbidden, but understanding ... and then finding a shared understanding, and then continuing forward...” p. 257
Storey 2005	“I never had a problem with my past and he kept dragging it up… I’d go to talk about [current problem] and then he’d stop me. And he’d go, ‘Yes, blah blah, very interesting. Now let’s talk about your childhood, and like about your dad. You seem to have hostility towards him.’ And I’m like, I’m trying to talk to you about the problem that’s bugging me, not about that. And like, he just wouldn’t listen. And it got to me so much that every time I just walked out of the office, I’d just cry. So I won’t go back.” p. 73

Study	Evidence
Talseth 2001	"He doesn't understand because he's so busy talking himself. He has already formed an opinion in his head on how everything has been, how everything is and how everything will be. However much I try to tell him, he is deaf to what I say. He can't be bothered to open himself up to other possibilities." p. 102
Sub-theme 1.3: Understanding of techniques to manage self-harm	
Alonzo 2017	"I may not be able to give an aspirin today, to cure your voices or cure your depression, but I'm giving you a bit of hope, I'm giving you that nurturing... that many of our consumers, many people don't have... why is it important to do that? Because people don't have a voice, they don't have the forum or environment where it's okay to speak up." p. 164
Craigen 2009	"There were periods where I managed to assuage the need to self-injure by picking up another healthy or acceptable behaviour, at the urging of a counselor … if that makes sense. It didn't really last too long because they were terribly simplistic behaviours that were sort of short-term answers." p. 84
Craigen 2009	"You can't strip someone of their old clothes until you have a new set available." p.85
De Stefano 2012	"I think I'd probably be more directive with her, I'd be less nice (laughs). I found I treated her very nicely and I think at the expense of getting into detailed analysis. I feel I would push things a bit more with her, I would challenge her more. Yeah, I'd confront her more. I don't know, maybe I would try working more on techniques on how to avoid cutting when she was feeling the urge. Something we didn't do a lot of . . . like cognitive strategies, thought stopping or something like that." p. 299
Dunkley 2014	"(She) tells me that I need to use my skills, but then I'm like, "but they haven't worked" and I just don't know what else she expects me to do when she doesn't give me any new things to do, apart from just keep going on about breathing. And I just can't see how that's gonna be beneficial 'cos you have to breathe to be alive (laughs) so I just can't see...just don't really get much of a response" p. 125
Hom 2020a	"Treatment should aim to challenge unhealthy thoughts and develop healthy coping strategies." p. 8
Hom 2020b	"I never thought that the therapy helped me at all, because it was just talking about how I was feeling and all of that, whereas with DBT, it was actual skills you could use." p. 176
Hom 2020b	"Nobody asked me my thoughts. Nobody asked me my opinion. Nobody asked me what was or wasn't working." p. 178
Karman 2015	"The idea is that you take a person more seriously and that you encourage people to show more of themselves, because the other approach (i.e. using restrictive methods) just led patients to resist and to distance themselves from us." p. 403
Lahoz 2020	'The direct approach implied gathering information about risk factors, suicide intention, restricting access to lethal means, and creating a safety plan […] If suicide risk was perceived as elevated, clinicians would opt for a direct approach and if risk was perceived as low, they would switch to an indirect approach […] "…as you know yourself, what would you be able to do if you experience this way again?…everything counts aside from self-harming… e.g. Write a letter"' p. 536
Littlewood 2019	"Use of collaboratively created crisis plans to support out of hours care" p. 4
Long 2010	'Two counsellors related their views on using counselling contracts that ask clients not to self-harm while undergoing therapy. Both counsellors were strongly

Study	Evidence
	opposed to the notion of such contracts […] "Is that to protect the counsellor rather than the client ... if we ask this person to do this then we're taking away the very act that helps them to continue living ... so to deny them that opportunity might be to deny them of the one thing they have to help them at that particular time."' p. 198
Long 2010	'"Five of the counsellors recommended the use of creative techniques for clients during the therapeutic relationship, such as journaling or painting. These allow clients to determine their own progress and process their feelings about the therapy." p. 198
Long 2010	"It's finding ways of helping people to selfharm that are less dangerous. So for example with a client who was very bad with drugs and wasn't ready to deal with coming off drugs, in therapy we looked at certain things, for example safer injecting, avoiding drug cocktails, things that would keep him safe ... hopefully if he finds in time that he is ready to deal with the drugs then he will come back, he knows I will be there." pp. 198-199
McGough 2021	"It's managing their actual self-harm wounds if there are any, and then ... trying to figure out why they are using that as an outlet for their emotions or a way of coping with distress. ... and then how else we can help them to cope with that distress and those sorts of feelings other than harming themselves." p. 65
Rissanen 2012	"Especially when parents are unable to help, then the role of school personnel as helpers is very significant ... I mean interfering in it ... and also supporting adolescents and finding ways to cope with everyday problems or violence at home and so on. Taking care of others." p. 255
Simoes 2020	"(E16) teaching me how to deal with the same issues in the future" p. 6
Wadman 2017	"They haven't done anything. And I don't know what to expect, because they haven't, I can't see any changes. I don't think when I'm doing something 'oh, what would CAMHS say?'" p. 373
Sub-theme 1.4: Collaborating to provide personalised care	
Berg 2020	'HCPs considered suicidal patients to be a heterogeneous group: they believed there was no such thing as a typical "suicidal patient". Safe clinical practice for these patients was therefore dependent on HCPs' diverse approaches to the individual patients.' p. 6
Dunkley 2014	"You have to listen to what the person is saying and take the treatment at the rate that individual can take it, and I just think that's so important, everybody is an individual" p. 134
Dunkley 2014	"I think one of the main points is if you're ever treating anybody even just once, just once in the whole of their treatment, say they've got 20 sessions, one of those sessions go to where they live and see what they are in their own home environment." p. 136
Dunkley 2018	"… like the answers they give you generally are out of books, […] and I think, well! […] What's that all about? They haven't actually got any answers apart from what they're taught to tell you. […] they just reel off these things to everybody instead of proper talking to you." (patient)' p. 271
Hagen 2018	'Individualized treatment and care involved encountering mental health workers who took them seriously and who treated them with respect, who was sensitive and recognized their suicidality and needs, and who made them feel like valuable fellow human beings. […] "She [the nurse] just came up to me and, 'Yes, I see you are tired now, and it's all right. Just be tired', and I thought that was so good. And it was she who found me with [the means to attempt suicide] that night. [She] sat down and instead of in a way, it was someone I felt in a way . . . accused me a bit sometimes, not accused but sort of like, 'it is foolishness to

Study	Evidence
	engage in such things', while she was a little more like, 'yes I understand you are in pain, or I can't really understand how you are doing, but it will get better, I am sure you can make it'. And at the same time somehow, yeah, just was a comforting fellow human being"' p. 5
Lahoz 2020	'Patient- vs. therapist-oriented approach refers to whether the therapist follows a manual, or other formal requirements rather than what seems important to the patient. […] Most clinicians used a patient-oriented approach of meeting acute needs, providing empathy, and working towards a joint understanding of the individual history of suicidality […] "The main thing is to get an alliance with the patient… What they start talking about I follow…and if they do not say much I address the current situation about how they are feeling…"' p. 536
Lahoz 2020	"… some will say, the fact that I have suicidal thoughts or have had a suicide attempt…is caused by the problems I have…, so I would like to talk about my problems, and that is obviously understandable…then you have a task in explaining to them, that we would like…to make sure, that you keep yourself alive, while we talk about the problems and that, in my opinion, I think we can negotiate, even if there are some, that can be somewhat annoyed, that the focus is on the suicide problem…" p. 536
Littlewood 2019	'This theme centred around providing timely access to tailored support and treatment including: […] Tailored needs-based care with active patient involvement in developing person-centred care plans and decision making in relation to their care. […] "Patient's wishes were taken into consideration"' p. 4
McGough 2021	"What would be useful is . . . getting the perspective of the consumers, someone who has self-harmed to be able to talk about it. . . because in that way it becomes more real. . ..I found [it] helpful to see the perspective and with mitigating risks from the consumers perspective." p. 66
McGough 2021	"I think probably the care plan needs to be more comprehensive . . .[and] cooperating . . . trying to get the consumer to a space where they can start thinking more objectively about their experiences and then getting them to actually start thinking about what they could actually implement in term of strategies that are not causing permanent damage." p. 67
Omerov 2020	"When this has happened earlier [started to drink, have nightmares, eat fast-food] you started to think about suicide, is it the same way now? Is this something we need to be aware of? I often talk about us not you, or now you need to, but let's work together. What can we learn about this, I am also a part of this." p. 578
Simoes 2020	"(E5) we do not all like the same things… they should do more activities with just me," p. 6
Talseth 2001	"My mother had phoned and wanted to be present at a discussion. The physician approached me and asked me very thoroughly whether that would be all right for me. He consults me and no decisions are taken above my head." p. 101
Vatne 2006	'Being met by available professional who adapted their help to the needs of the interviewee was cited as a meaningful resource […] "That is one of the reasons why I feel very secure when I am discharged; I know who they are and they know who I am"' p. 302
Sub-theme 1.5: Ability to prescribe medication appropriately	
Behrman 2019	'Adolescents, parents, and community members all reported a common concern that mental illness diagnoses are made too quickly and followed by prescribing medications without exploring other possible treatment options. […] "It takes a

Study	Evidence
	doctor (psychiatrist) five minutes to give me a diagnosis and put me on a med"' p. 878
Behrman 2019	'Parents who had a child in the mental health system and community health professionals noted the importance of "understanding medications, their side effects, and adhering to prescriptions."' p. 879
Borrill 2005	"two weeks before I came in I saw a psychiatrist who said I didn't need medication any more and stopped giving it to me.. since then (self-harm) got really bad" p. 61
Dunkley 2014	"I think…erm…one thing that we haven't really talked about is medication and things like being under the Mental Health Act, and symptoms. I think all of those contribute massively to emotional pain. I've got one client who's on a CTO (Community Treatment Order) at the moment, he hates it and his levels of distress are just awful, and there's part of me that thinks actually he'd probably be safer if he wasn't on a CTO. It's not really helping us manage things (OT2 interjects 'yeah') very well, And the whole medication battle (OT1 mmm) as well." p. 115
Hagen 2018	"the only thing I really doubt a little, that has actually to do with the medication. [. . .] That there is really no evidence that it helps. So why do they offer that as the only solution? In addition to—or, maybe it is a bit overrated then. They could have been a little more honest about that". p. 6
Hom 2020a	"Medication is only one part of the solution. We need therapy as well. We need coping mechanisms." p. 5
Hom 2020b	"I'm [taking medication] for my sanity ... It's not like, 'You're doing well now, you don't need your medication.' It's actually like, 'I'm doing well now because I have my medication.'" p. 176
Hom 2020b	"Medication worked for me, but you have to be your own advocate because you go to most psychiatrists and they're just pill dispensers ... With my psychiatrist, we talk and we discuss and we work it out together." p. 177
Hom 2020b	"Then they had me on so many drugs. They overmedicated me. I'm not against medication helping someone through mental health concerns or whatever, but when you're overmedicating someone ... I had a toxic reaction." p. 179
Idenfors 2015	"Of course I understand how they look at it – they don't want me to overdose again, so [...] Then it felt like they took you more seriously instead of other doctors who just pumped you full of drugs." p. 202
Lees 2014	"I had lots of things going on, and I didn't think a pill would fix that. ... They thought that it was just the depression that was clouding my thoughts, but it wasn't that simple, and I needed to talk about that." p. 310
Simoes 2020	"(E3) listening more to the youngsters and not changing medication without discussing it with the patient" p. 6
Sub-theme 1.6: Sharing expertise with colleagues	
Behrman 2019	"they (providers) don't talk to each other." p. 876
Behrman 2019	"The mental health care system is so out of whack, there are so many holes in the safety net." p. 876
Berg 2020	'"We always talk with the patient together when assessing suicide. Then, we are two persons who can calibrate each other's experience afterwards, to talk about it and assess the risk together" (female nurse, 1.5 years of experience, short-term stabilisation ward).' p. 5
Christianson 2008	"I think it's important information for other people to have, that these are some of the things that can happen, that you don't have control of the situation when the

Study	Evidence
	student's not with you. I think it's important that we share those experiences with others." p. 216
Hagen 2017a	"It is to ask [about suicidal thoughts]. Take them seriously. Then one must always make a good assessment based of the knowledge one has, and based of the – everything from next of kin, collateral information, to—to colleague information, to staff information—or, that is, from personnel in the ward. Then one has to make a psychiatrically good suicide assessment of the patient, I think." p. 102
Karman 2015	'The ability to openly discuss experiences concerning self-harm with direct colleagues during the training was found to be essential in changing professional behavior. In contrast, one participant indicated that working in a team had inhibited her ability to change her behavior in the past.' p. 404
Littlewood 2019	"We include regular 'learning lessons' feedback where care can be improved and where care has gone well in our clinical improvement and business meetings" p. 4
Littlewood 2019	'This theme highlighted the importance of effective communication practice that facilitates seamless transitions between, and discharge from services. Practices included: Care planning should include and be communicated with the relevant care team and other health and social care providers, particularly the patient's GP. Patient notes should be up-to-date and accessible to all staff teams involved in providing care. […] "Discharge/transfer of care plans to be communicated with GP and the relevant services"' p. 5
Long 2010	'Qualities included were: welcoming the client; being there on time; ongoing trust; acceptance and understanding; awareness of own issues cultivated through personal therapy and supervision; self-care; respect for clients and respect for self; keeping the relationship fresh; being prepared for 'bit-by-bit progress'; peer supervision and open communication with colleagues.' p. 198
McGough 2021	"I would say [I am] quite comfortable... [it developed] just through time basically, just experience working within the field, and probably also, mainly even more so from [watching] colleagues ... for me a few nurses early on in my career that I guess helped me to see self-harm differently." p. 65
Te Maro 2019	'"Collegiality between the nurses and the other counsellor is absolutely essential" […] "Teachers had noticed things but hadn't feed it back to us"' p. 10
Te Maro 2019	"Yeah, trust us, we're the professionals, we're the trained psychologists … um … and we've made an assessment and this person isn't at risk. Whereas we're the ones that have had lots and lots of in depth conversations with them" p. 10

Table 13: Theme 2: Engagement with the patient

Study	Evidence
Sub-theme 2.1: Creating an open line of communication	
Alonzo 2017	"The whole issue of engagement brings up your own sense of competency in terms of, "Do I have the skills to engage this client?… Can I really help this person?... What am I bringing to the table in terms of competency?"... I think those issues play a part in the engagement process." p. 161
Awenat 2017	'"I don't think it erm it negatively impacts on a patient… in fact, erm being more open and bringing that, you know, bring those words into the conversation makes it real and makes it easier for the parient to talk about it." (Psychiatrist: 11)' p. 105
Behrman 2019	"Kids won't be honest with the pediatrician if the parents are sitting there," p. 876

Study	Evidence
Berg 2020	'"I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to 'when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?' I try to make a natural transition and create some trust during the conversation so the patient feels it's safe to open up and talk about things along the way" (1 year of experience, locked wards).' p. 4
Borrill 2005	"The counsellor listens to me - I can express anger by swearing and she doesn't mind ... she doesn't judge you, she's there to listen to you" p. 65
Craigen 2009	"[My counselor] was just a really good listener and I think that was very beneficial." p. 82
De Stefano 2012	"I really wanted to make sure that I was making her feel okay about talking to me about it. I knew that other people have probably had a reaction of fear towards her, and I really wanted to make sure that even though she wasn't a hundred percent comfortable talking to me about it, I really wanted her to feel like it was a place that if she wanted to talk to me about it, she could, and if she wanted to show me any of her scars or any of her cuts, she could do that too." p. 296
Dunkley 2014	"but it doesn't feel enough to just say, "I'm hurting, in emotional pain," It's like it doesn't have any impact, it doesn't lead to people doing increased contact or showing that they're concerned or anything. It's like if you actually can say you're in emotional pain, well, they think, well, you're in control, you're thinking logically, you've said this and all the rest of it, so we don't need to bother with you." p. 105
Dunkley 2014	"Just make it as if it's something that's ok to talk about, that it's not so awful because I think people sometimes people can think that that this is...the thoughts they're having are so awful that they can't possibly express them or put them onto somebody else… or talk… or do that" Social Worker' p. 107
Dunkley 2014	"I think sometimes it's poor questioning I suppose having been a Samaritan I'm used… I'm used to sort of… er… using open questions rather than closed questions to find out how someone is really feeling and giving enough time for that and being comfortable with silence as well which I think is another thing that people often aren't comfortable with, erm… It's more frustrating to come out of an appointment feeling that I haven't been heard than to have an appointment at all because it just adds to the sense of not being heard and understood which then can further increase the emotional pain and make the situation harder" p. 107
Dunkley 2014	"I don't know... I really can't remember what it was about now but when she changed the subject I just thought 'oh, I can't bring that up again… um I must be in the wrong and I shouldn't have brought it up.'" p. 122
Dunkley 2014	"Like they'll ask you something, the person I see, and she's asked me that last week, and then I tell her the answer and she's writing it down like it's all NEWS to her, and you're thinking (indignant tone) - d'you know what I mean? What? I've told you that last week! But then you think, well I can't expect them to remember when they're seeing hundreds of people. So it makes you feel like you're nobody, like you're just somebody like a robot." p. 126
Dunkley 2014	"I think with the paperwork thing... I think… I'd… was it would agree sort of almost… it's almost cathartic I find it actually to write down maybe an assessment and sort of formulate it and organise…" OT' p. 127
Dunkley 2014	"Certainly just articulating that you've heard, you've received the message, and that you've been listening. That you've understood what they've said to you." Psychologist' p. 135

Study	Evidence
Dunkley 2014	“It would also be about allowing other forms of communication, for me sometimes it's much easier for me to write down how I'm actually feeling than to verbally say it.” p. 153
Dunkley 2018	“When over the many years when you do try […] and communicate […] it’s not heard or the right questions aren’t asked. […] I haven’t used [the out-of-hours service] for years purely because if I rang […] it was because I was in desperate need of help […] and to phone up, wait for the phone call to come back and actually often not actually be asked how I’m feeling, but instead, ‘well, ring your care coordinator, ring your doctor in the morning’ is actually worse than having no help at all.” (patient)' p. 270
Hagen 2018	“... I said I had a very bad night and that I was worried in a way before I was going to bed. And then [the nurse] said ‘yes, it goes up and down for all of us in life, you know’. And then I tried to communicate that ‘I am really having a hard time now’, and then she said, ‘yes, but you have to think like [a Norwegian singer-songwriter], be an optimist’. And I interpreted it more like yes, ‘pull yourself together’. And then I just finished politely and smiled and said ‘thanks for the conversation’ and went to bed, that is, I went and sat down in the living room after I had taken medicine until I became so tired that I was sure to get to sleep when I went” pp. 5-6
Hom 2020a	“Take time to listen and make sure you’re not jumping to conclusions.” p. 6
Hom 2020b	“Really, that’s all I wanted–to talk to someone, to have someone listen to what I was saying, and just reaffirm, ‘You’re not crazy.’ The guy I saw was great ... He was the first person I had spoken to who listened and didn’t try to get me to take a bunch of vitamins.” p. 176
Karman 2015	‘Some participants said they avoided talking about the behaviour with patients. [...] After the training, nine participants said they responded with increased understanding of the patient's situation. Self-harm was more openly discussed in both group and individual therapy. […] "Well, before I was like: we need to get rid of this [i.e., self-harming behavior]. And now I just realize, well, so this is what you need right now."’ p. 404
Kool 2009	‘Respondents indicated that they felt connected when they were listened to and had the feeling they were being taken seriously.’ p. 28
Lees 2014	"By discussing it as much as possible, you sort out in your own head what you were thinking . . . to get better, you need to discuss it" p. 310
Lindgren 2004	‘The results show that participants experience being understood when staff: try to explore the reasons for self-harm actions; ask how they feel; talk openly with them about what they did and why they did it; and consider healthy ways to express themselves. [...] Understanding is more than knowing about self-harm, it also includes knowing the individual’s personal reasons and feelings related to self-harm. […] "Understanding ... But then, understanding is not the same thing as supporting everything you say"’ p. 288
Lindgren 2004	"Staff said to me “You are mentally ill which means you are paranoid. You imagine things that are not real” so, you get misunderstood no matter what you say" p. 288
Long 2010	"You’ve [the counsellor] been given this great privilege to be told about this and you should never take that for granted." p. 197
Long 2010	"I think it’s quite difficult for them to make the initial connection, really to be brave enough, so it’s about . . . letting that person know there is immediate support and that it’s going to continue." p. 197

Study	Evidence
Mughal 2021	"I think the first one was erm, there was a CBT experiment afterwards, these are in like a year break of each other but erm, the CBT person, they wanted to do it over the phone which I found more difficult to begin with and then they were half an hour late for the appointment on the phone so I found that like 'okay, you're not going to turn up to a phone appointment on time then I don't think that this would work'" p. 8
Omerov 2020	"It has become a mantra for me that you have to work to push oneself over the threshold, to dare seeing, to dare hearing, to dare asking and to dare talking." p. 576
Omerov 2020	"the most important is that you have the courage to be open, for it may be there, always be open for this that there may be a risk for suicide and it that it doesn't need to look like what I had in mind." p. 577
Omerov 2020	'The respondents described that it was important that the youth was able to speak without being questioned or interrupted by giving them advice and reassuring comments. However, at the same time, the need for confirming the patient's hardship and suffering was emphasized as well the importance of using words for re-assurance. [...] But some respondents also cautioned that one should not diminish the youth's problem by normalizing the difficulties.' p. 578
Omerov 2020	'One respondent acknowledged the possibility for nurses working with the patients' own story in their encounters, but found this to be difficult in the psychiatric outpatient setting, where using scales for suicide- risk assessment was obligatory. The respondent experienced that using the scales damaged the rapport and told how she sometimes finished the scales after her meetings with the patient.' p. 578
Rissanen 2012	"You know, "holding," being there, often without words." p. 257
Rowe 2017	"They did a lot of talking and they never listened, especially my psychiatrist… I can remember many instances where I'd say, 'I feel like this', and she'd go, 'no, no, no you don't, you feel like this'. And completely flip it around because that didn't fit in with her little 15 min slot for me." p. 282
Simoes 2020	"(E11) we should be listened to, even though it may seem like something simple, it isn't always like that," p. 6
Storey 2005	'Another young woman gained little from her sessions feeling that her counsellor failed to listen or to hear what she was trying to say […] "I felt that they were just sat there, just 'my job, I get paid for it'."' p. 73
Talseth 2001	"When he listens he asks questions on the basis of what I have said. That shows me that he has understood what I have been saying. He asks thoughtful questions: he lets me think and answers me. I understand him and he takes me seriously." p. 101
Vatne 2006	'They emphasized the importance of being met by professionals who listened, showed respect, gave them the feeling of being equally valuable persons, got involved, possessed professional knowledge and signalled hope and the belief that we will be able to tackle this together. […] "Even though everything is chaos, there is someone who knows about me ... But I have to feel that they will safeguard what I say, not use it against me, but use it to help me. So there are fewer layers of protection; the layers are thinner, it is easier to bear ..."' p. 302
Wadman 2017	"… she doesn't listen to what I say … I don't know, she twists things I say to … I don't know how to explain it, but it's like nothing seems important to her that I say" p. 372

Study	Evidence
Wadman 2017	“And I feel it sometimes when they’re there, they don’t really interact with you, they just sit there with their notebook. They don’t look at you, just sit there with the notebook and pen” p. 372
Wadman 2017	“We actually do, like, activities, so I can express how I feel sometimes, which I find a bit easier. And there’s things that I can fiddle with, things that I can do while I’m there. And she, she doesn’t sit there and stare at you like “I know how you feel,” she’s just realistic. So, I find it quite easy talking to her, and she said, she always said to me, “I understand if here and not say a word, I don’t mind.”" p. 373
Sub-theme 2.2: Fostering a therapeutic relationship	
Alonzo 2017	"Just having that warmth and that realness, you know, a personal touch, means a lot and just helps them to keep coming." p. 164
Berg 2020	'“I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to ‘when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?’ I try to make a natural transition and create some trust during the conversation so the patient feels it’s safe to open up and talk about things along the way” (1 year of experience, locked wards).' p. 4
Craigen 2009	"I think a personal connection is really key in any therapist/ patient relationship." pp. 82-83
De Stefano 2012	"I really wanted to make sure that I was making her feel okay about talking to me about it. I knew that other people have probably had a reaction of fear towards her, and I really wanted to make sure that even though she wasn’t a hundred percent comfortable talking to me about it, I really wanted her to feel like it was a place that if she wanted to talk to me about it, she could, and if she wanted to show me any of her scars or any of her cuts, she could do that too." p. 296
Dunkley 2014	“my care-coordinator knows quite a bit about me so she would know I would enjoy a particular type of film and she would say to me ‘go and put the film on and phone me back afterwards and tell me how you're feeling’" p. 135
Dunkley 2014	“People that I believe have met me on that deeper level, I know, they’re the people that I have imaginary conversations with, like I can pour my heart out to them, and I almost know what they're going to say back, things like that, and they prevent you - because you feel cared about, you feel that you matter, you feel that somebody knows how hard it is and just to have got through to the next day was an achievement, instead of getting through to you the next day because it's their job and it was on their timetable to phone you at such-and-such a time but they don't know why.” p. 168
Dunkley 2018	“You’re thinking […] What? I’ve told you that last week! But then you think, well I can’t expect them to remember when they’re seeing hundreds of people. So it makes you feel like you’re nobody, like you’re just somebody like a robot.” (patient)' p. 271
Dunkley 2018	“There was [sic], like, 15 of us [in a therapy group], and she’d remember something, like she’d say, ‘oh –(whatever your name is)– you said last week…’ […] And I’d think, God that’s really amazing! […] and it made you think she’s listening, and you felt like… comfortable, that you could engage with her.” (patient)' p. 271
Hagen 2017a	"…to get a relationship. It keeps people alive. That is not enough, you have to be able to assign a correct diagnosis and implement effective treatment for the underlying disorder. But the relationship makes them believe, I think, that you

Study	Evidence
	will and can help them. And then they give themselves the time it takes for the other [treatment] to work." p. 101
Hagen 2017a	"…if there are too many admissions in here, then I am little afraid that we quickly may become both mom, sister, aunt, friend, etc. etc. And what is then left of the motivation to go out into the world and find it, I think. So to be warm and empathetic on the one side, but not becoming everything for the patient on the other side, that's an art, as I see it." p. 102
Hagen 2018	"it feels very safe to have NN [the therapist], because he has . . . knows me and my whole situation [. . .] Yes, so that is very safe then. So, I feel like I can say anything to him then" p. 5
Hom 2020a	"[Be] compassionate and understanding [about] what can lead to a person attempting suicide ..." p. 6
Hom 2020b	'One theme that commonly emerged among those reporting positive treatment experiences was strong therapeutic alliance; individuals reported positive experiences when a provider was empathetic, felt trustworthy, and appropriately challenged them.' p. 176
Kool 2009	"The carers told me they did not disapprove of me as a person, but because of what I did. For me this meant there was nothing wrong with my character, my personality. When I came out of isolation, they saw me as me and I could just start again with a clean slate." p. 28
Kool 2009	"The nurse said: 'Come, let me bandage your wounds' and then she comforted me. Then I thought, if I cut myself next time, I will get her attention again." p. 30
Lahoz 2020	"The main thing is to get an alliance with the patient… What they start talking about I follow…and if they do not say much I address the current situation about how they are feeling…" p. 536
Lees 2014	"It's about engaging with that client ... I can't see that there's any other reason ... other than you're custodial and you sit there and observe and I don't see that as particularly therapeutic." (RN4)' p. 309
Lees 2014	"There was one nurse who was good. He was genuine. There were some nurses that you feel like they're just doing their job sort of thing ... but I felt that he really cared (long pause). ... Him caring ... it showed me that I'm worth something (voice breaking) ... that I'm worth being alive." p. 311
Lindgren 2004	"I think they have been so good and I know that's not the way for every patient, but they managed to look behind all my symptoms and see ME so to say, the person who was deep inside and that was what made me stronger" p. 287
Lindgren 2004	"The worst thing that can happen is when people just disappear because someone else has decided that you shouldn't have contact with this person. This has happened more then once." p. 289
Littlewood 2019	"His care co-ordinator knew him very well, had regular contact, there were clear efforts to try and have frequent contact with him" p. 4
Long 2010	"The person has to some extent been rejected at many times in their lives and they don't need another professional person to do that." p. 197
Long 2010	"It's different for every person, but endings are something that I like the client to decide when they feel they want to not when I tell them to." p. 198
McGough 2021	"I think being open and non-judgemental in your approach, validating how they are feeling, what's going on for them... and helping them figure out alternatives ... [You need] a really open mind and that kind of constant positive regard ... a lot of it is your attitude and therapeutic relationship is absolutely everything." p. 66

Study	Evidence
O'Donovan 2007	‘Therapeutic interaction with service users who self-harm was seen by the participants as an important component of the role of the psychiatric nurse. It was used to inform the nurse on the potential for further self-harm, to assess mood and to inform future care.’ p. 68
Omerov 2020	"I am glad that you came here. And we will do everything to help you. Because now I understand that this is really serious. What you tell me worries me." p. 578
Omerov 2020	"when they start hearing that, just to be seen as fellow human being, then it starts awakening hope and one starts to see oneself a little through the assessors’ eyes, the nurses’ eyes, that the other person sees the youth as a human being with possibilities, with a lot of problems, but it is not a problem to have problems it is fully compatible with life and possibilities." p. 579
Rissanen 2012	“Making contact on the personal level is significant; I think, of course, work experience is influential, too.” p. 256
Rowe 2017	"It’s just making you talk, and think, and challenge. She [counsellor] challenges very subtly. It’s professional, but there is much more of a… yeah, I was going to say caring, nurturing, and caring. There is concern there." p. 282
Storey 2005	‘During that time, she had one support worker for about 18 months with whom she had established a positive rapport and with whom she had been able to discuss her problems. However, the sessions had stopped abruptly with no adequate explanation that she could recall and she had felt let down by the sudden termination of this support. […] “See someone, then it stops. See another person. You need someone continuously or it’s not going to work.”’ p. 73
Talseth 2001	"First I feel calm and I feel that the person sitting at the other side of the table doesn't want to hurt me. I am usually very sceptical and on guard but here I didn't have that sensation. Here it was easy, I could be myself. It makes you feel at ease in relation to the person you're talking to, and that's good." p. 101
Wadman 2017	"… although the lady I was talking to was, she was nice, but she was just incredibly patronizing. And it made me feel a bit like a child, it’s like I’m 18 years old, not eight” p. 372
Wadman 2017	“And she went out of her way to make me feel comfortable, and I never felt like I was talking to a professional, she’d always make me feel like she was, like she was really, she was so good.” p. 373
Wilstrand 2007	"To be clear about rules from the beginning and the whole staff has to be informed and supportive so that we work on the same script." p. 75
Sub-theme 2.3: Building mutual trust	
Alonzo 2017	‘Clinicians in our focus groups defined treatment engagement as a multilayered phenomenon that includes: […] (f) the client’s trust in the clinician.’ p. 161
Berg 2020	‘“I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to ‘when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?’ I try to make a natural transition and create some trust during the conversation so the patient feels it’s safe to open up and talk about things along the way” (1 year of experience, locked wards).' p. 4
De Stefano 2012	"I think my emotional reactions were different because I had a different relationship with her by then so my emotional reactions were more understanding. I was concerned about suicidal risk, but in a less panicked sort of way. I felt more confident in my relationship with her, I felt I was able to trust her to disclose and be honest so, rather than try and hide things from me, that she

Study	Evidence
	had in the beginning of our relationship. So I really felt better, because I felt a better connection with her, my concern was less panicked." p. 296
Dunkley 2014	“and I certainly know there's another girl in the group who feels the same as I do, and she was here the other day and she said, "Oh, I'm gonna say I only had one attempt at self-harm this week cos that will keep Jake happy". That's so wrong! Why are we driven to lie to keep (the group leaders) happy? And I think it's because they don't give us the time to be us, to be honest, to be truthful, because they have their little boxes to tick in because that reflects on how their behaviour is and how they're seen by management” pp. 122-123
Dunkley 2014	“But the reality is, particularly in the NHS that they never ever stick to their promises or what they say” p. 128
Dunkley 2018	‘“If everybody who came to you saying, ‘I’ve got suicidal thoughts and I’m going to,’ y’know, ‘take all my medication’… and you said, ‘... you obviously need to go into hospital’ then […] the hospitals would be full, so there’s a point where […] you have to use some sort of professional judgment and not necessarily connect an actual suicide attempt with an expression of emotional pain.” (social worker)’ p. 270
Hagen 2017a	‘The therapists’ relational focus is reflected in how they talked about establishing a trusting and collaborative treatment alliance with the potentially suicidal patient’ p. 101
Hagen 2018	‘The participants pointed to not being able to talk confidentially with just anyone. It seemed as if ‘good chemistry’ or a good connection involved a sense of companionship with the mental health worker, which involves closeness and trust. […] “it feels very safe to have NN [the therapist], because he has . . . knows me and my whole situation [...] Yes, so that is very safe then. So, I feel like I can say anything to him then”’ p. 5
Hom 2020a	“Listen to their experiences and trust they know how they feel and what they need to stay well.” p. 6
Hom 2020b	‘Therapeutic alliance issue: Could not trust provider; lack of empathy/understanding from provider: “My psychologist scared me. I didn’t like talking to him.”’ p. 178
Hom 2020b	‘Poor collaboration: Provider not open to input; did not trust individual’s own expertise: “... it would have been nice to be treated like I actually knew what I was talking about. A lot of times I was just brushed off and they would talk to my mom instead of me...”’ p. 178
Idenfors 2015	‘Participants reported that promises made to them about the effects of medication and waiting times were not fulfilled. This led to mistrust, worry, and a fear of being forgotten. There was a request for more openness on these issues. […] "Have they forgotten me, like, why is nothing happening and like all the worry which wasn’t exactly good which meant more emergency visits at the mobile team."’ p. 202
Kool 2009	"Safety means that I know nothing horrible will happen, there will be no fighting when I say something to you. Whatever I say I can safely say. There will be no punishment, no consequences. I am not turned down for what I am." p. 28
Lees 2014	"I had no family support, no friends, no one to talk to, and I find it really hard to trust people with what I say . . . I could really trust some of those nurses." p. 311
Lindgren 2004	‘Being believed was conveyed by a sense of being worthwhile. This involved trusting that staff would help them through their struggle. […] "It was as if I felt that, now it is me who is here, and now it is me who is going to talk about the things that I feel are bothersome. Even if it is not easy for me, I feel that now it’s

Study	Evidence
	me and I'm going to say what I think and reflect upon and feel and want, and then she (nurse) will try to help me."' p. 287
Long 2010	'The counsellors acknowledged the need for time, in that clients will need time to establish trust in the therapist and in the therapeutic process. […] "I think also to know that there's someone there who isn't rushing you, because defence mechanisms are there for a reason."' p. 196
Long 2010	'With regard to confidentiality, the counsellors recognised that the relationship must be a safe, neutral and confidential space for clients. […] "Most of the wounds of self-harm go very deep . . . when you get to the core of the self-harm it's terrifying . . . terrifying for the person even going there."' p. 196
Long 2010	'The counsellors spoke of equality as important in the counselling relationship. […] "The clients are the experts on their own lives."' p. 196
Mughal 2021	"I think the first one was erm, there was a CBT experiment afterwards, these are in like a year break of each other but erm, the CBT person, they wanted to do it over the phone which I found more difficult to begin with and then they were half an hour late for the appointment on the phone so I found that like 'okay, you're not going to turn up to a phone appointment on time then I don't think that this would work" p. 8
Omerov 2020	'Confirmation was recommended in order to make the youth feel safe and taken care of. […] "I am glad that you came here. And we will do everything to help you. Because now I understand that this is really serious. What you tell me worries me."' p. 578
Rowe 2017	"Nurses don't tell you how horrible it was to have to put a femoral line in a girl who had just taken some sort of overdose of 'XYZ'. You know, like you don't get that feedback, because that's not the way that the system works." p. 282
Storey 2005	'The consultation as described by that young woman and many more interviewees demonstrates a failure in the process of therapy; explanations, the establishment of trust and negotiation of the aims of therapy have not been established successfully before embarking upon assessment and treatment.' p. 73
Talseth 2001	"When we talked about my situation before I was admitted, she drew conclusions (summed up) about what I had said and she said it out loud. She gave me a summing-up out aloud many times. You get the feeling the person trusts you." p. 101
Talseth 2001	"I didn't feel that I could entirely trust her to keep the information to herself, even though I emphasized several times that it was to be between the physician and me. She indicated that she understood this and took me seriously. I had lost a little of my confidence in her, she proved not to be entirely loyal towards me." p. 102
Vatne 2006	"Even though everything is chaos, there is someone who knows about me . . . But I have to feel that they will safeguard what I say, not use it against me, but use it to help me. So there are fewer layers of protection; the layers are thinner, it is easier to bear . . ." p. 302
Sub-theme 2.4: Mutual understanding of goals	
Alonzo 2017	'Several of the mental health nurses' descriptions of interactions with suicidal patients were about relieving their psychological pain and inspiring hope. This process seems to involve gaining a joint understanding of the patient's life situation and suicidality, and then, helping the patient to be more oriented toward life and the future.' p. 161

Study	Evidence
De Stefano 2012	"I think I'd probably be more directive with her, I'd be less nice (laughs). I found I treated her very nicely and I think at the expense of getting into detailed analysis. I feel I would push things a bit more with her, I would challenge her more. Yeah, I'd confront her more. I don't know, maybe I would try working more on techniques on how to avoid cutting when she was feeling the urge. Something we didn't do a lot of . . . like cognitive strategies, thought stopping or something like that." p. 299
Hagen 2017b	"…to try to open some hatches to let in some light, so to speak, I am very engaged in then, when it comes to conversations. Because, if everything is revolving around the sad, terrible, and…then I think we are like taping black bags on the windows, making it even more black. I am a little concerned about trying to open some hatches and then getting in some more light". p. 33
Hom 2020a	'On this point, participants suggested that providers strive to collaborate with their patients by taking into account attempt survivors' own goals and preferences as well as jointly problem-solving treatment setbacks. […] "[Do not] push too hard too fast on 'getting better.'"' p. 6
Hom 2020b	"They set me up with ... a therapist here in town who's just fantastic. She is the best therapist I've ever had. She kicks you in your ass when you need it. I'm the type who [wants someone to] just tell it like it is ..." p. 176
Karman 2015	'After the training, there was also an increased focus on the normal and healthy aspects of the patient's functioning. Participants realized that the only way to deal effectively with the patient's problems and the related self-harming behavior was to work together with the patient and set goals that reflected the patient's experiences, problems and behaviors.' p. 404
Lindgren 2004	"Yes, it feels as if, I don't know, some kind of my own responsibility, to try to resist. It may be less of "Poor little you! Carry you around and protect you from everything" and more of 'We take it seriously, but you still have to take your own responsibility'." p. 287
Long 2010	'Qualities included were: welcoming the client; being there on time; ongoing trust; acceptance and understanding; awareness of own issues cultivated through personal therapy and supervision; self-care; respect for clients and respect for self; keeping the relationship fresh; being prepared for 'bit-by-bit progress'; peer supervision and open communication with colleagues.' p. 198
Omerov 2020	'One respondent emphasized that the nurse needs to support the patient's own problem-solving. […] "When this has happened earlier [started to drink, have nightmares, eat fast-food] you started to think about suicide, is it the same way now? Is this something we need to be aware of? I often talk about us not you, or now you need to, but let's work together. What can we learn about this, I am also a part of this."' p. 578
Simoes 2020	"helping us find better goals" p. 6
Storey 2005	'The consultation as described by that young woman and many more interviewees demonstrates a failure in the process of therapy; explanations, the establishment of trust and negotiation of the aims of therapy have not been established successfully before embarking upon assessment and treatment.' p. 73
Vatne 2006	'They emphasized the importance of being met by professionals who listened, showed respect, gave them the feeling of being equally valuable persons, got involved, possessed professional knowledge and signalled hope and the belief that we will be able to tackle this together. In addition, examples of guidance and tips needed to cope with daily life and situations that continually taxed one's feelings of worth and self-confidence were deemed important. Getting help to

Study	Evidence
	establish a type of structure in daily life was seen as important, particularly during the first few days after an attempted suicide.' p. 302
Sub-theme 2.5: Ability to read non-verbal cues	
Alonzo 2017	"I think it's complex… their posture in the room, are they verbal, are they nonverbal, are they withholding, are they checking us out? I mean, you can tell sometimes, when a client has something to say, and they're not sure they're going to give you that information." p. 161
Berg 2020	'The experience of a "gut feeling" varied across situations and was related to a) a lack of contact and connection (e.g., lack of eye contact, withdrawal, lack of communication about suicidal ideations, poor mental state and/or lack of trust); b) a mismatch between a patient's observed behaviour and his or her spoken words (e.g., saying she felt fine while showing signs of withdrawal and stress); and c) an unpredictable or sudden change in behaviour (e.g., acting drugged, agitated, or withdrawn or exhibiting sudden contempt or happiness) […] "It's often a gut feeling you get, and that is what makes it difficult. You should be able to document this in a suicide risk assessment. But it is, in a way, what happens in a meeting with the patient, their spoken and unspoken words, their background, their history, everything, in a way, the overall picture" (1 year of experience, locked wards).' pp. 4-5
Craigen 2009	"I had one [counselor] convinced that I was fine… it was great, except that I was getting worse." p. 86
Dunkley 2014	"I think there's two kind of people, as well, you've got the people who will call you up and say about their emotional pain but you have the other kind of people who doesn't contact you about their emotional pain, and they're the ones I feel more sometimes concerned about because they find it very difficult to express their emotions and they're kind of…a lot...that...quite often much more risky than the ones that do call up." Social worker' p. 96
Dunkley 2014	"Almost like kind of a comforting, they're kind of leaning forward and... yeah, they look as if they're in pain. They might be wincing, so those kind of things, they might be holding themselves in some way. So those would be kind of some of the signs for me even without anybody saying something" p. 151
Dunkley 2014	"I've got a client who actually communicates his emotional pain really well and doesn't like to talk about it but he writes poetry. So each week I turn up and…and I don't need to ask even, when he's ready in the session he'll just spontaneously pull a poem out and read it to me, telling me about his week. And sometimes then he wants to talk about it afterwards, other times he doesn't but that's his way of telling me this is how it is. And he also plays a lot of music as well, which to start off with I just thought he was just telling me, "I like this CD" or whatever, but now I've realised actually it communicates how he's feeling quite a lot… so I've learned quite a lot about him over the time just with music and his poetry." p. 153
Hagen 2017b	'It appears that they very much rely on intuitive knowledge, although they acknowledge that they sometimes may be wrong. [...] "We have saved many people, we managed to, so in the moment we should be there, we were there. We managed to save them. (…)… gut-feeling is very important then. And then, so it has happened that, you have supervision of a patient every 15 minutes, but that does not mean that 15 minutes is 15 minutes, you can die within 15 minutes, right? (…) But you check on the patient once, and then your gut-feeling tells you that, oh, no, you [the patient] are lying calm and smiling. But, then the gut-feeling tells you to come back in one minute and surprise her.(…) And then, then you're right, that has happened, that I have experienced. You come, you go

Study	Evidence
	out and close the door and then look back, oh, what is she doing (…) is about to strangle herself or hang herself".' pp. 32-33
Hom 2020a	"Doctors, general physicians, mental health intake and counselors and emergency room staff need to be more educated on signs and symptoms so ... detection of suicidal ideation is spotted early and treated before a suicide attempt is made." p. 9
Rissanen 2012	"It is not the talking . . . an adolescent is wordless . . . you must use other means to find understanding . . . for example by drawing." p. 256

Table 14: Theme 3: Sensitivity

Study	Evidence
Sub-theme 3.1: Being non-judgmental	
Alonzo 2017	"You need to approach clients with a lack of judgment and take some time in the engagement process, in understanding and thinking about the (client's) issues. You have to be careful about how you ask questions; you can't be like a robot. If you take the time to engage with the client and you feel that engagement as the social worker, the client will be more likely to want to come to treatment with you." p. 164
Behrman 2019	'Adolescents expected to be treated with respect and listened to rather than have impersonal and disrespectful interactions with health care providers. This theme was overwhelmingly and consistently reported by all five groups.' p. 877
Berg 2020	'HCPs ensured that employing checklists and forms did not compromise the therapeutic relationship. Thus, they completed the checklist and the form for suicide risk assessments after talking with the patient. As patients opened up about their emotions, HCPs affirmed their feelings and approached them with non-judgemental and exploratory attitudes, providing hope and signalling that they were able to and had time to listen. ' p. 4
Berger 2014	"The first student was hard to comprehend why and to not respond negatively towards the action they had inflicted, but I have gained more advice and experience in my responses to students and feel more confident in responding appropriately" (Mental health worker)' p. 29
Berger 2014	"Some staff are still hard to convince not to make a big deal in front of students in regard to self-harm concerns. Some people still believe it is just an attention seeking device!!" (Mental health worker)' p. 30
Borrill 2005	"The counsellor listens to me - I can express anger by swearing and she doesn't mind ... she doesn't judge you, she's there to listen to you" p. 65
Craigen 2009	"I think the bottom line is try not to alienate them further. Because there is already the knowledge that what you are doing is very bizarre and not normal, and you need to be careful of inadvertently stigmatizing them further." p. 87
De Stefano 2012	"I really wanted to make sure that I was making her feel okay about talking to me about it. I knew that other people have probably had a reaction of fear towards her, and I really wanted to make sure that even though she wasn't a hundred percent comfortable talking to me about it, I really wanted her to feel like it was a place that if she wanted to talk to me about it, she could, and if she wanted to show me any of her scars or any of her cuts, she could do that too." p. 296
Dunkley 2014	"They listen well and they're not judgemental and they don't give up on me" p. 148

Study	Evidence
Hagen 2017b	"…you manage to be professional to the patient, but you struggle a lot, you know, you have to – as a professional on the outside, and then you're being torn inside". p. 34
Hom 2020a	"[shame], 'tough love,' and pity aren't effective responses to someone who's just attempted to end their life." p. 4
Hom 2020b	"The message I got when I left the hospital, by the time I was leaving, was that I was being selfish for not going home, I was being selfish for trying to kill myself. Everything I was feeling, someone else was interpreting as me being selfish." p. 178
Karman 2015	"I saw it as a negative way of attention seeking. If you can't get it in a positive way, then you try it in a negative way. And now you see that it is just inability to cope. And I think that's the biggest change." p. 403
Karman 2015	"I do not think we are here just to please patients. To me, that is not a way to provide good treatment." p. 404
Kool 2009	'Patients felt that they could feel emotions without being judged. […] "Safety means that I know nothing horrible will happen, there will be no fighting when I say something to you. Whatever I say I can safely say. There will be no punishment, no consequences. I am not turned down for what I am."' p. 28
Lindgren 2004	"Well, because sometimes I've experienced that the staff treats . . . I felt treated more like a, I don't know what, like a kind of human being or barely a human being at all." p. 288
Long 2010	"That you don't judge them or moralise . . . To be there for the client, to welcome the client into the therapeutic space." p. 196
Long 2010	'Therapist qualities identified were empathy, trust, unconditional positive regard, acceptance, allowing time, creating a safe environment, not judging the client or their behaviour and allowing the client to determine the pace and content of therapy. […] "Being there. Being a presence for them. Listening to them. Not judging. Accepting."' p. 197
McGough 2021	"I think being open and non-judgemental in your approach, validating how they are feeling, what's going on for them. . . and helping them figure out alternatives . . .[You need] a really open mind and that kind of constant positive regard . . . a lot of it is your attitude and therapeutic relationship is absolutely everything." p. 66
Mughal 2021	"The first time I spoke to someone about it, it was honestly the most useless […] first of all they just told me I was being attention seeking [CAMHS counsellor] so I just kind of, yeah, […] it took me a while to look for help again […] she wasn't really listening to what I was saying and as she was just finishing the sentences for me." p. 8
Rissanen 2012	"It is typical that she feels guilty about what she has done [self-mutilation], and so you must be very sensitive in what you say. That's because she might feel guiltier and think that she is bad, and this might cause extra traumatisation." p. 257
Rowe 2017	'While listening was important, so was the need for non-judgmental, compassionate professionalism. […] "I think it's because it's a different relationship you have with your counsellor than what you have with, say your psychiatrist. You get a lot closer and…. if you want to do the work you have to learn how to trust them. From there you build an amazing relationship. For me, [my counsellor] knows 99% of my life. She's here every week, she cares, yeah."' p. 282
Sub-theme 3.2: Sensitively approaching the subject of self-harm	

Study	Evidence
Awenat 2017	'"Should I ask? Shouldn't I ask? What kind of question should I ask? What kind of question shouldn't I ask?" (AHP:08)' p. 105
Berg 2020	'"I start off easy and ask why they are here, and the more the patient talks about their challenges, the more you can go into the things he talks about, and then in a way, it leads to a natural transition to 'when you have this struggle that you describe, have you ever had thoughts that it would have been easier to die or thoughts of taking your own life?' I try to make a natural transition and create some trust during the conversation so the patient feels it's safe to open up and talk about things along the way" (1 year of experience, locked wards).' p. 4
Berg 2020	'"If there is a chronic suicidal patient, one should not talk about suicidality all the time. Therefore, I don't want to ask if the patient has thoughts of suicide before I let that patient out unless the patient says very clearly that he or she has suicidal plans. If I see that the patient struggles, I would ask the patient, 'Do you think it is okay for you to go out now?', and then you will get some gut feeling about this. It has been difficult at times to risk locking out patients, especially at night and on weekends, when you are alone there. However, there is an assessment the therapist has done, and we have to stick to the plan, especially with emotionally unstable patients with chronic suicidality. You have to give them responsibility back, and it is challenging" (female mental health nurse, 4 years of experience, locked acute ward).' p. 7
Borrill 2005	"'..it didn't help ... sitting talking about it and then going back to my cell.. it started off nightmares, flashbacks, all over again" p. 65
De Stefano 2012	"I think I'd probably be more directive with her, I'd be less nice (laughs). I found I treated her very nicely and I think at the expense of getting into detailed analysis. I feel I would push things a bit more with her, I would challenge her more. Yeah, I'd confront her more. I don't know, maybe I would try working more on techniques on how to avoid cutting when she was feeling the urge. Something we didn't do a lot of . . . like cognitive strategies, thought stopping or something like that." p. 299
De Stefano 2012	"Just overly focusing on getting rid of the symptom I don't think that's necessarily useful, because they have a lot of shame and just focusing on the symptom might actually bring about more symptoms. I remember the beginning of my relationship with this client, she was very clear: "I don't want to talk about this stuff because it makes me worse." So, I think that making it more interpersonal, might be necessary, obviously a symptom reduction is a good idea, but I think it has to come once a good bond is established and once there's an interpersonal communication going on." p. 299
Dunkley 2014	"that you feel like that if you're going to say something you'll open the floodgates and you won't be able to stop crying, you'll...you feel like you'll look bad in front of whoever you're with...erm... And that's something else...it's... I've noticed at times, if I've been really emotionally in pain and I am so genuinely upset and I can't stop crying, whoever you're seeing doesn't give you enough time to actually compose yourself before leaving the building and I've walked out of the building through the waiting room with people, absolutely sobbing my eyes out, and then having to go out and get in the car and drive home." pp. 112-113
Dunkley 2014	'"I think there are times when I would choose not to get them to talk about emotional pain, if I didn't feel equipped, or it wasn't the right situation to do it…erm…if that makes any sense". OT 1 "If something's going on for you sometimes (others murmur agreement) you feel you're not necessarily in the right place to really… one – hear it, and two – maybe actually react in the way that will be helpful." OT2 "Mmm yeah, I think that's quite realistic, you know, you

Study	Evidence
	meet somebody in the street, you wouldn't necessarily start opening all their personal issues up, it's about time and place and appropriateness." OT3' p. 121
Dunkley 2014	"What it all boils down to and understanding that they are in pain and that...you know maybe they need to talk about it maybe they need to just cry for ten, fifteen minutes, I suppose. Because when I find I'm in deep emotional pain I can't actually cry at home or... You know, when I'm on my own, I... I can't, no matter how hard I try, I can't cry on my own, but yet if I'm with somebody you know, I suppose it's a lot easier to cry. I think the time needs to be given." pp. 145-146
Dunkley 2018	"… The concerns about opening a can of worms… I don't necessarily buy into that [...] I think even if you haven't got a lot of time sometimes just acknowledging actually how distressing that is for people can be helpful. […] I think it's a bit of a myth that we have to wrap things up because actually clients don't wrap things up and it's going round in their head the whole time, so I think it can be quite validating if we notice something." (nurse)' p. 271
Hagen 2018	"they also told me that 'it [suicidal thoughts] is something we do not want to talk about too often because it may give you ideas. If you are not there, we shall not induce those thoughts in you', but perhaps it would have helped me to try to talk about it sometimes" p. 6
Hom 2020a	"Be more open to discussing suicidal ideation and bring it up in sessions rather than waiting for the patient to bring it up." p. 5
Hom 2020a	"Get training! Learn how to ask about ideation in a sensitive manner." p. 9
Hom 2020b	"[The psychologist] and I talked about suicide a lot, and she brought it out in the open so it wasn't so scary." p. 176
Karman 2015	'This also meant that, when patients were not ready to talk about their self-harming behavior openly, the participants would not address it until patients were ready. Thus patients' boundaries were respected more.' p. 404
Lees 2014	"Sometimes, if they wait for you to bring it up, you may not bring it up, especially if you're planning it" p. 310
Lindgren 2004	"The staff seems to believe it's dangerous to talk about it, if you do, it'll come back as lots of germs who will infect people or so. It's so taboo and you should put it in a little box and then it doesn't exist" p. 289
Long 2010	"The therapeutic dance, the sensitivity, the gentleness that has to go on between the two people . . . it has to be held in some way, very, very gently." p. 197
Omerov 2020	"It has become a mantra for me that you have to work to push oneself over the threshold, to dare seeing, to dare hearing, to dare asking and to dare talking." p. 576
Omerov 2020	"the most important is that you have the courage to be open, for it may be there, always be open for this that there may be a risk for suicide and it that it doesn't need to look like what I had in mind." p. 577
Rissanen 2012	"It [self-mutilation] is not easy for teachers to discuss, when it is not even so easy for health care professionals . . . but discussion of it is important." p. 255
Rissanen 2012	"It is important to talk about it in the caring community. Hiding will not help. Discussing together makes self-mutilation visible and it will help us." p. 256
Rissanen 2012	"Every time I see marks of any kind on the hands I ask about them. I never leave out asking what these marks are about. Never. And the discussion might begin from that." p. 259
Rissanen 2012	"It should be a stock-in-trade to ask about it [self-cutting] when meeting an adolescent who has mood disorders, I mean, even if there were no references to

Study	Evidence
	it. It should be asked every time, irrespective of the gender, but for some reason it does not come to mind." p. 259
Talseth 2001	"There was no talk about the attempted suicide. That disappointed me, something that was missing for me to feel that the conversations were complete. That I could feel slightly warm feelings, there could have been a slightly warmer atmosphere between us when we were talking. That was why I was there, because of the attempted suicide. It was forgotten about." p. 102
Sub-theme 3.3: Ability to balance autonomy and safety	
Berg 2020	"I feel damned if I do and damned if I don't. Society criticises us (specialised mental health care) for using too many physical constraints and calls for more autonomy (for the patient), but at the same time, we are made accountable for the suicides and are told that we should have done more to prevent them. They (members of society) don't truly comprehend the complexity of this task" (10 years of experience, locked ward).' p. 6
Berg 2020	'For participants with acute suicidal behaviour, the greatest fear among HCPs was the under-protection of the patient (e.g., access to lethal means when hospitalised in an open ward), particularly during psychotic phases. In these cases, HCPs prioritised physically preventing the patient from attempting suicide, with the risk of over-protection (e.g., loss of autonomy). HCPs perceived both under-protecting and overprotecting (e.g., constant observation for a long period) patients with chronic suicidal behaviour to be harmful. Therefore, the HCPs constantly assessed patients' suicidality and made daily trade-offs. They had to decide whether to empower the patient to take responsibility for his/her own safety, despite the risk of suicide attempts, or to increase protection for a brief period at the risk of worsening the suicide risk and reducing the patient's sense of independence.' p. 7
De Stefano 2012	"So I did a suicidal assessment and then I consulted with my supervisor and asked him to do the same thing, just to make sure I was, perceiving the right things. Once I felt that she was convincing me ''No, I'm not suicidal, it's not what I want'' it was okay, ''She wants me to keep this a secret now, so do I disclose and risk our bond? Do I keep it a secret because she has the right to confidentiality even though she's only thirteen?'' So I had a lot of different ethical things to deal with and I had to work out the ethical things in my mind." p. 298
Dunkley 2014	'"And if you do bring them into hospital you know, are you going to make the emotional pain worse? Because what may happen is that at the moment they're being protected but they now see themselves as a failure in a different way. Now they've failed because they've been admitted to hospital, they're now part of the 'mad' people…" Psychiatrist' p. 130
Dunkley 2014	"from the patient's point of view like I say you don't want to be honest and say, "well yeah I might do it again when I get home" Or, "I feel at the moment I won't do it but I am a bit scared that I might…you know it might all come over me again and then I might do it" I think if you'd just come out of hospital and it came over you I think I'd feel more that I could ring up then, because I'd be able to say, "look," you know, "a couple of days ago I was in hospital but I'm trying to get some help so it doesn't get this bad"" p. 139
Hagen 2017a	"… you should be careful not to have too much interventions for patients with suicide risk, take over too much responsibility. That's unfortunate. The last thing I've heard is that at the acute ward, it can be like you have to check on the patient so often that you have no time to get a relationship with him. Because you have to tick off a checklist every fifteen minutes to those who are really threatened. How good is that for the patient? And.. yes, if one can do it [suicide]

Study	Evidence
	in less than fifteen minutes then one perhaps can make it anyway. So that is a measure that perhaps does not feel quite right." p. 103
Hom 2020a	". . . I need a place I know I can speak freely without being afraid someone is going to act to take away my power and choices." p. 6
Karman 2015	"The idea is that you take a person more seriously and that you encourage people to show more of themselves, because the other approach (i.e. using restrictive methods) just led patients to resist and to distance themselves from us." p. 403
Kool 2009	'In the treatment setting for inpatients, limits were imposed by putting patients in isolation, sometimes at the patient's own request, sometimes on the initiative of staff. Another way of limit setting consisted of patients being referred back to their previous therapist if the many treatment interventions failed to stop the self-injuries. Several respondents indicated that, because they could not set any limits themselves, it was important for them that limits were imposed by others.' p. 28
Lindgren 2004	"Yes, it feels as if, I don't know, some kind of my own responsibility, to try to resist. It may be less of "Poor little you! Carry you around and protect you from everything" and more of 'We take it seriously, but you still have to take your own responsibility'." p. 287
Lindgren 2004	"I've not been able to hold any limits nor to focus on anything. I have followed every impulse and I needed help to set the outside limits and they (staff) have been very good at that. They have been self-confident when helping me to set the limits that I'm not able to set myself" p. 288
O'Donovan 2007	"it depends on what the person is voicing to you really, you can't take everything off everyone, whatever the person discloses to you, you react to that." p. 67
Simoes 2020	"(E3) locking a person in the bedroom is not therapy at all" p. 6
Talseth 2001	"In a way I became a little expectant. I was afraid of saying too much. I was afraid that she would start deciding and perhaps taking decisions I did not agree with. Control my life." p. 102
Te Maro 2019	"Confidentiality breaching that has to happen at times inevitably puts your relationship is at risk. Our relationship stays more protected if the nurse does the informing of family as an accompli without negotiating with the student" p. 9
Vatne 2006	'Getting help without being committed to the hospital was perceived as being shown confidence and being given responsibility for their own lives. Still others considered the hospital admission as important for staying alive. One interviewee who was committed to an emergency ward described how the psychologist, family doctor and psychiatric health workers at the municipal level cooperated to make life more secure for him and easier to live […] "But," as he said, "that in itself does not prevent a person from carrying out a suicide."' p. 302
Wilstrand 2007	"She [patient] was lying under the blanket and used a razorblade to cut herself on the arm, despite being on close observation. You see, under the blanket you can do much . . . Cut yourself with a razor, one can see, if you are not under the blanket. And you do not lift up the blanket – that is a question of integrity." p. 75
Sub-theme 3.4: Cultural sensitivity	
Behrman 2019	'The community mental health professionals were the only respondents who noted the importance of cultural competency when communicating with adolescents and their parents […] Mental health providers pointed out a lack of cultural sensitivity on the part of pediatricians, especially when serving minority populations. […] "Doctors need to realize that treating the adolescent who has two parents, secure home and income, and a good school, are very different

Study	Evidence
	from the kid who comes from a broken home, has limited resources, and a struggling school system."' p. 877
Craigen 2009	"I didn't really appreciate the handing out of the scripture verses to tell me that I am loved no matter which way I am and I have to accept myself for who I am." p. 83
Hom 2020a	"More trans-friendly [resources] ..."; "More culturally competent, client-centered, anti-oppressive practice ..."; "Educate [yourself] on genocidal [government] policies that have caused intergenerational traumas ..."; "... [handle] LGBTQ rejection trauma." p. 8

Table 15: Theme 4: Self-preservation

Study	Evidence
Sub-theme 4.1: Maintaining emotional distance	
Christianson 2008	"Again, I think that eventually I had to understand that there is no control in a lot of those situations and in that whole process that I had to take ownership of myself and let everything else go I think was important. That ceremony that I had in my backyard where I took all of [her] letters and basically said prayers and burnt them up, that really helped me understand and work through that." p. 216
De Stefano 2012	"I think my emotional reactions were different because I had a different relationship with her by then so my emotional reactions were more understanding. I was concerned about suicidal risk, but in a less panicked sort of way. I felt more confident in my relationship with her, I felt I was able to trust her to disclose and be honest so, rather than try and hide things from me, that she had in the beginning of our relationship. So I really felt better, because I felt a better connection with her, my concern was less panicked." p. 296
Dunkley 2014	"Oh my God she's crying! Oh! And it was it sort of, y'know the emotion, you know, showing emotion and not being the "I've-got-the- certificate-I-know-more-than-you" It's better hand-in-hand…" p. 144
Hagen 2017b	"One has to have oneself – one must be…clarified oneself, one must know what – what feelings are mine and what feelings are the patient's now, in this. And what am I going to carry now for the patient, and what is it that the patient should get back to carry himself". p. 34
Lees 2014	'"You try not to get emotionally involved, but you have to get involved to talk to them." (RN8)' p. 310
Long 2010	"Empathy with their pain and trying if you like, to have the transference, picking up their pain, picking up their pain where it's felt in the counsellor's body, how do I feel when that client's communicating with me." p. 198
Rissanen 2012	"You know, "holding," being there, often without words." p. 257
Wilstrand 2007	"I can feel cold in a way . . . Emotionally you have to cut off some part otherwise it can be very, very hard. In an acute situation you have to act first." p. 75
Sub-theme 4.2: Being 'strong'	
Christianson 2008	"I had to be strong for everybody else right? I had to be strong for the students and I had to put my grieving aside so I could do that." p. 215
Dunkley 2014	"We need to be able to manage those emotions, not to have them or to … somehow inappropriately express them." Nurse' p. 131
Hagen 2017b	'The mental health nurses seem to try to control their emotions and be confident and calm, or at least to appear as such, in acute and difficult situations […] "Yes, it is about being the calm and confident one. (…) We represent, or in my opinion

Study	Evidence
	should represent, when someone in a deep crisis is admitted, and then someone in the surroundings has to stay calm and steady. And appear like confident then. (…) You must be aware of it so that the patient's crisis does not color [affect] you so much that you are at a loss, but that you're able to be there and endure hearing that someone says 'yes, I want to die. I don't want to live'".' p. 34
McGough 2021	"People who present with significant self-harm really, really challenge that core belief about themselves [nurses] and their profession and if you can contain that distress you go a long way to providing a supportive environment [for staff] ... we don't want them being hijacked by their anxiety or fear." p. 66
Omerov 2020	"With this way of thinking …it is my responsibility that this human being is alive then it gets too heavy and I get scared. So you need to handle your own fear." p. 577
Sub-theme 4.3: Recognising personal limitations	
Hagen 2017b	"…if one has been in that kind of pressure with several patients [engaging in suicidal acts/self-harm] over several weeks, and that that one somehow feels that now I need a break, if it could be possible that I work with another kind of issue now, then I prefer that for a few days to kind of collect myself a little again". p. 34
Long 2010	"It's not easy, when you're working with someone who's covered in marks, and if that's going to mess you up through transference then you're not the person to be in that room . . . It's about recognising your limitations." p. 197
Sub-theme 4.4: Awareness of legal responsibilities	
Hagen 2017a	"But it is clear that I am concerned of covering my back and having done a proper job. That I am concerned of. But I am also very concerned that I have recorded this properly. Because – because the day it happens, it is that what matters—what's in the medical records. In terms of what reprimand I get from those who are required to reprimand …. So it [national guidelines for the prevention of suicide] affects me – of course, it does. And that – but I am, as I said, not sure that what we do, as we are required to do according to the guidelines… is—yes, that there is really much to be gained. Don't know." p. 102
Hagen 2017a	"And today, unfortunately we have that bullshit, the computer and the technology, right, as if it is more important to write down and tell the boss that…or who. And then, what shall I say, even if people call and say they are suicidal, we have forms and computers and such things and need to write. It is not for the patient's sake. It is for my sake. That my boss…if the patient takes his own life at home while on the emergency phone. Then they cannot denounce me, and I've done my job. But I think that the most important is to sit down and talk to the person and be…provide closeness. That is the most important." p. 103
Hom 2020a	"We don't want the doctor to worry about covering his own ass more than he cares about seeing us get better." p. 6
Hom 2020b	"More often than not, people have this experience: they reveal to a clinician that they are suicidal, and a cloud comes over the person's eyes where the cognition starts to happen. [They start to think], 'Okay, what is my boss gonna say? I wonder what the protocol is,' and so on. That's a problem because that shuts down the therapeutic connection ..." p. 178
Kelada 2017	"I think it's really unfair to leave me in a potentially legally awkward situation—not just me, me and the school, but I take a lot of that stress on. ... I had to work through a policy for the school and do my own research on it, when it's just becoming such a huge issue. Give me a checklist that we have to do. It's ridiculous ... do not tell me what to say to a kid, but tell me what ... to do in this

Study	Evidence
	situation, and what's going to keep—I know it sounds cold—but what's going to keep the school legally safe ... it's been like we're floundering and do not have that much support with exactly what to do about the problem" [S3]' p. 179
Kelada 2017	"I'd like there to be some clear written guideline about do we notify a parent immediately. Just a clear procedure, a step-by-step procedure, you know, whether it be notify parents or not, whether it be follow-up and make sure they're referred out, do you know what I mean? I'd really like to see some clear procedure written down in that policy. ... It would certainly take a lot of the legal pressure off us" [S6]' p. 179
Te Maro 2019	'There was considerable variability in the threshold that was required for providing information to the family/whanau across schools. Some schools had policies about this and gave clear guidance, whilst others did not. […] "I will hold something before I take it to senior management because they'll always be "let's call whanau" and sometimes that actually makes a situation bigger … I don't think there needs to be immediate family involvement"' p. 11