National Institute for Health and Care Excellence

Draft for consultation

Self-harm: assessment, management and preventing recurrence

[R] Evidence review for skills required by staff in non-specialist settings

NICE guideline number tbc

Evidence reviews underpinning recommendations 10.5-6, 1.13.1, 1.13.2 and 1.13.4 in the NICE guideline

January 2022

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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Skills required by staff in non-specialist settings

Review question

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

Introduction

Non-specialist staff are likely to have less experience working with people who have self-harmed and to have less access to appropriate training. Therefore, the objective of this review is to identify the views and preferences of non-specialist staff, people who have self-harmed and their family members/carers about what skills are required for non-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 the Population, Phenomenon of interest and Context (PPC) characteristics of this review.

Table 1: Summary of the protocol (PPC table)

Population	Inclusion: • Staff in non-specialist settings that assess and/or treat people who have self-harmed • People who have self-harmed and been assessed and/or treated in non-specialist 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 non-specialist 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 non-specialist inpatient, outpatient and community settings in which management of people who have self-harmed is provided, including: • Primary, secondary and tertiary healthcare settings (including pre-hospital care, accident and emergency departments, community pharmacies, inpatient care, and transitions between departments and services) • Home, residential and community settings, such as supported accommodation • Supported care settings • Education and childcare settings • Criminal justice system Immigration removal centres.

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 6 mixed-methods studies (Bailey 2019, Cullen 2019, Doyle 2007, Fox 2015, Hom 2020a, Hom 2020b) and 16 qualitative studies in 18 articles (Awenat 2017, Behrman 2019, Borrill 2005, Chapman 2014, Gorton 2019, Hoifodt 2006, Hoifodt 2007, Idenfors 2015, Jelinek 2013, Mughal 2021, Ngune 2020, Rees 2017, Rees 2018, Rowe 2017, Storey 2005, Vatne 2016, Wadman 2018, Wand 2019) were included for this review. Two articles reported results from the same study (Hoifodt 2006, Hoifodt 2007); another 2 articles reported results from overlapping populations from the same study (Rees 2017, Rees 2018).

The included studies are summarised in Table 2.

The studies were carried out in the following countries: UK (Awenat 2017, Bailey 2019, Borrill 2005, Fox 2015, Gorton 2019, Mughal 2021, Rees 2017, Rees 2018, Storey 2005, Wadman 2018); Australia (Chapman 2014, Jelinek 2013, Ngune 2020, Wand 2019); Ireland (Doyle 2007); New Zealand (Rowe 2017); Norway (Hoifodt 2006, Hoifodt 2007, Vatne 2016); Sweden (Idenfors 2015); USA (Behrman 2019, Cullen 2019, Hom 2020a, Hom 2020b).

Studies exploring the views and preferences of non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 specialist staff

work in non-specialist settings, and it would be inappropriate to suggest they should have the same skillset as non-specialist staff. Therefore, this review summarised evidence regarding skills required by non-specialist staff, while another review was conducted to summarise evidence regarding skills required by specialist mental health staff (see Evidence Report P). 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 non-specialist settings, the following were represented in the included studies:

- healthcare:
  - primary care: Bailey 2019, Fox 2015, Mughal 2021
  - tertiary general hospitals: Doyle 2007, Wand 2019
  - emergency departments (EDs): Chapman 2014, Cullen 2019, Jelinek 2013, Ngune 2020, Storey 2005
- 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
  - ambulance service: Rees 2017, Rees 2018
  - pharmacies: Gorton 2019
- prison: Borrill 2005

The following specialist settings were represented in the included studies:

- healthcare (inpatient mental health clinics): Awenat 2017, Vatne 2016

Three studies represented mixed settings:

- mixed non-specialist:
  - primary and secondary care: Hoifodt 2007
- mixed specialist and non-specialist:
  - primary care and in the community: Behrman 2019
  - emergency department, psychiatric emergency services, child and adolescent psychiatry clinic, and a psychiatric inpatient ward: Idenfors 2015

The studies included people in the following population groups:

- non-specialist staff who worked with people who have self-harmed: Chapman 2014, Cullen 2019, Fox 2015, Gorton 2019, Ngune 2020, Rees 2017, Rees 2018
- non-specialist staff who worked with suicidal patients, including those with suicidal ideation: Awenat 2017, Doyle 2007, Hoifodt 2006, Hoifodt 2007, Jelinek 2013
- people who have self-harmed: Borrill 2005, Hom 2020a, Hom 2020b, Idenfors 2015, Mughal 2021, Rowe 2017, Storey 2005, Vatne 2016, Wadman 2018
- family members/ carers of people who have self-harmed: Wand 2019
- mixed populations:
  - people who have self-harmed and non-specialist staff who worked with them: Bailey 2019
  - people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-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 non-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
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, 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
Bailey 2019 **Aim of the study:** to explore with young	N=45 (n=30 healthcare staff; n=15 young people)	**Study dates:** Not reported	• Type and pattern of self-harm influences consultation experience

Study and aim of the study	Population	Methods	Author themes
people, GPs and PNs why young people present with self-harm to primary care and whether young people, GPs and PNs can take steps to have more helpful consultations about self-harm in GP surgeries **Country:** UK	**Staff participants:** **Mean age (SD):** Not reported **Sex (female/ male):** 22/ 8 **Role:** Practice nurses: 16 GPs: 14 **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** young people **People who have self-harmed:** **Mean age (range):** Not reported (16-25 years) **Sex (female/male):** 7/ 8 **Ethnicity:** White: 14 Mixed race: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported	**Data collection and analysis:** Separate focus groups were held for staff and for young people. Narrative data were analysed by the lead researcher using inductive thematic analysis.	• Young people often have several reasons for their self-harm, so young people and clinicians are concerned about the disclosure of the behaviour • Interventions for self-harm and potential for use of self-help materials in general practitioners surgeries
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.	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:**	**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	• Broken mental health care system • Importance of communication • Stigma associated with mental health care • Early detection • Lack of knowledge of recovery resources

Study and aim of the study	Population	Methods	Author themes
Country: USA	**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 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 stated that patients were 'equally mixed male and female'. **Ethnicity:** Caucasian: 10 African-American: 1 **Co-morbidity:** Not reported	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.	

Study and aim of the study	Population	Methods	Author themes
	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.		
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.	• Mental health problems • Post-Incident Experiences • What Makes a Difference?
Chapman 2014 **Aim of the study:** To explore staff perceptions about caring for patients who present to the emergency department following	N=169 qualitative survey responses from ED staff **Mean age (range):** Not reported (27 to 55 years) **Sex (female/ male):** Not reported. Authors	**Study dates:** Not reported **Data collection and analysis:** Qualitative data were collected using an anonymous self-administered questionnaire.	• Depends on the patient and the situation • Treat everyone the same • Skilled and confident to manage these patients

Study and aim of the study	Population	Methods	Author themes
deliberate self-poisoning. **Country:** Australia	reported participants were mainly female **Role:** Emergency department doctors and nurses: 169 (authors reported participants were mainly nurses) **Setting:** Emergency department **Mean years in post/ experience (SD):** Not reported. **Client group (adults, children/ CYP):** Not reported.	Data from the open-ended questions were transcribed and the key words or phrases were underlined and significant meanings listed, aggregated and categorised. All the categories were then compared with each other to identify recurring themes.	
Cullen 2019 **Aim of the study:** To understand emergency department nursing leadership perspectives on how to improve the quality of emergency care for deliberate self-harm patients. **Country:** USA	N=476 hospitals sent a survey response **Mean age (SD):** Not reported. **Sex (female/ male):** Not reported. **Role:** Emergency department nursing directors or managers: 381 Social workers: 15 Others (or not reported): 80 **Setting:** Emergency department **Mean years in post/ experience (SD):** Not reported. **Client group (adults, children/ CYP):** Not reported.	**Study dates:** May 2017 to January 2018 **Data collection and analysis:** Participants were sent copies of a survey, which included an open-ended question. All responses were read to gain familiarity with the data, then coded into notable concepts separately, and then discussed together. Codes were condensed into five unique themes. Inter-coder reliability was assessed during the coding process and discrepancies were resolved with team discussions until consensus was achieved.	• Access to mental health care and staff within the hospital • Access to mental health care in the community
Doyle 2007 **Aim of the study:** To describe the experiences and	N=42 questionnaire responses from ED nurses	**Study dates:** Not reported **Data collection and analysis:** Data were	• Emergency department nurses' role

Study and aim of the study	Population	Methods	Author themes
challenges that nurses encounter when caring for patients who present to the ED with suicidal behaviour. **Country:** Ireland	**Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role:** Qualified nurses: 42 **Setting:** Emergency department **Mean years in post/ experience (SD):** 8.4 years (SD not reported) **Client group (adults, children/ CYP)**: Not reported.	collected using a questionnaire with quantitative and qualitative open-ended questions. Qualitative data were analysed using a thematic analysis approach.	• Challenges when caring for suicidal patients
Fox 2015 **Aim of the study:** To explore GPs' capabilities, motivations and opportunities for discussing self-harm and to identify barriers to and enablers for proactively discussing self-harm with young people. **Country:** UK	N=28 GPs (n=28 completed the survey; of those n=10 were also interviewed) **Mean age (range):** Not reported (20 to 60 years) **Sex (female/ male):** 21/ 7 **Role:** GP: 28 **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Not reported.	**Study dates:** Not reported **Data collection and analysis:** Participants completed an online survey, which included both quantitative and open-ended qualitative questions. Some participants were also interviewed by telephone. The survey and interview results were combined. Qualitative data were analysed by one researcher using inductive thematic analysis, which involved coding, followed by the identification and clustering of themes and production of a descriptive summary.	• GPs' skills, knowledge and perceptions about young people and self-harm • Identifying, talking to and supporting young people who self-harm
Gorton 2019 **Aim of the study:** To explore the current and potential role of community pharmacy teams in self-harm and suicide prevention.	N=25 pharmacy staff **Mean age (range):** Not reported (18 to >65 years) **Sex (female/ male):** 18/ 7	**Study dates:** Not reported (likely 2017 or later) **Data collection and analysis:** Semi-structured, face-to-face interviews were	• Relationship with patient • Pharmacy environment • Training • Facilitated referral pathway

Study and aim of the study	Population	Methods	Author themes
Country: UK	**Role:** Dispensing/ pharmacy assistants: 10 Pharmacists: 8 Pharmacy technicians, pre-registration pharmacists or delivery drivers: 7 **Setting:** Community pharmacies **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Not reported.	transcribed and analysed using an inductive analysis approach.	• Restricting access to means
Hoifodt 2006 See Hoifodt 2007	See Hoifodt 2006	See Hoifodt 2006	• Striving for relatedness • Intervening competently • Being emotionally involved
Hoifodt 2007 **Aim of the study:** To explore the meaning of newly educated physicians' lived experiences in treating patients at risk of committing suicide **Country:** Norway	N=13 newly graduated doctors **Mean age (SD):** Not reported. Authors reported participants were around 30 years. **Sex (female/male):** 6/7 **Role:** Newly qualified doctors: 13 **Setting:** Primary care: 9 Secondary care (non-psychiatric): 4 **Mean years in post/ experience (SD):** Not reported. All participants had completed their graduate internship during the last 6	**Study dates:** January to June 2002 **Data collection and analysis:** Individual narrative interviews were conducted with clarifying questions. Analysis involved transcribing the interviews, reading these several times, and dividing the text into meaning units, which were simplified and organised into themes. Finally, the original texts were considered as a whole alongside the themes and research questions.	• Preparing for practice • Participating in the professional community

Study and aim of the study	Population	Methods	Author themes
	months prior to the interview. **Client group (adults, children/ CYP):** Not reported.		
Hom 2020a **Aim of the study:** To identify and synthesize suicide attempt survivors' recommendations for how to enhance mental health treatment experiences for attempt survivors. **Country:** USA	N=329 suicide attempt survivors **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	**Study dates:** Not reported **Data collection and analysis:** Participants 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.	• Provider interactions • Intake and treatment planning • Structural issues •

Study and aim of the study	Population	Methods	Author themes
	*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		
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: 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	**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	• Am I really in good hands? • Making yourself better

Study and aim of the study	Population	Methods	Author themes
	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.	codes were refined into categories and continuously checked against the original interview texts. Common themes were constructed from the categories.	
Jelinek 2013 **Aim of the study:** To better understand ED staff knowledge and levels of confidence in treating people with mental health related problems using qualitative methods. **Country:** Australia	N=36 ED staff **Mean age (SD):** Not reported **Sex (female/ male):** Not reported **Role:** ED nurses: 16 ED doctors - ED directors: 5 ED doctors - ED staff specialists: 8 ED doctors - registrars: 7 **Setting:** Emergency department **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Not reported.	**Study dates:** Not reported **Data collection and analysis:** Interview questions were emailed in advance to participants before semi-structured interviews were held via telephone. The transcribed data were analysed for themes using methods outline in Ritchie 2003.	• Perceived knowledge gaps • Confidence
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	**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,	• Help-seeking avenues • Barriers to seeking help from general practice • Facilitators to accessing care

Study and aim of the study	Population	Methods	Author themes
	Asian British: 1 Mixed: 3 Did not disclose: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported	compatible with a critical realist stance.	
Ngune 2020 **Aim of the study:** To explore emergency nurses' experiences of working with patients who self-harm. **Country:** Australia	N=18 ED nurses **Mean age (SD):** 46.06 (11.49) **Female/ male:** 14/4 **Role:** Qualified nurses: 18 **Setting:** Emergency department **Mean years in post/ experience (SD):** More than 10 years: 10 6 to 10 years: 3 1 to 5 years: 1 **Client group (adults, children/ CYP):** Adults: 8 All age groups: 10	**Study dates:** November 2018 to January 2019 **Data collection and analysis:** Semi-structured interviews were conducted using an interview guide. Data were analysed using inductive content analysis and thematic framework analysis.	• Nurses' level of comfort to work with people who self-harm • Nursing role • Facilitators and barriers • Education and training
Rees 2017 **Aim of the study:** To explore paramedics' perceptions and experiences of caring for people who self-harm, to inform education and policy. **Country:** UK	N=11 paramedics **Mean age (SD):** Not reported **Sex (female/ male):** 4/ 7 **Role:** Paramedic: 11 **Setting:** Community (ambulance service)	**Study dates:** 2014 to 2016 **Data collection and analysis:** Individual semi-structured interviews were held, recorded and transcribed. Researchers also noted context and emotion during the interviews. Data were analysed using a grounded theory approach.	• Professional, legal and ethical tensions • Relationships with police and coercion

Study and aim of the study	Population	Methods	Author themes
	Range of years in post/ experience: 2-40 years **Client group (adults, children/ CYP):** Not reported.		
Rees 2018 See Rees 2017.	N=11 paramedics **Mean age (SD):** Not reported **Sex (female/ male):** 3/ 8 **Role:** Paramedic: 11 **Setting:** Community (ambulance service) **Range of years in post/ experience:** 1-38 years **Client group (adults, children/ CYP):** Not reported.	See Rees 2017.	• Context • Judgements and values • Isolation and system failure • Managing Risk • Competence at the boundary of mental and physical health needs
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'

Study and aim of the study	Population	Methods	Author themes
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
Vatne 2016 **Aim of the study:** To develop a deeper understanding of suicidal patients in the aftermath of suicidal attempts. **Country:** Norway	N=10 people who had attempted suicide **Mean age (range):** Not reported (21-52 years) **Sex (female/ male):** 6/ 4	**Study dates:** Not reported **Data collection and analysis:** Participants were interviewed using a semi-structured guide 2 weeks after a suicide attempt and in a place of their choice.	• Someone who cares

Study and aim of the study	Population	Methods	Author themes
	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	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.	• Not wanting to talk
Wand 2019 **Aim of the study:** To examine the insights of carers to better understand self-harm in their older relatives. **Country:** Australia	N=32 carers of 30 older people who had self-harmed. **Mean age (SD):** Not reported. **Sex (female/ male):** 17/15 **Relationship to person who has self-harmed:** Adult child: 24 Spouse: 5 Sibling: 1	**Study dates:** Not reported **Data collection and analysis:** Individual interviews with open-ended questions were held with carers within a month of the self-harm episode. Each interview was transcribed and coded into themes and subthemes using an iterative, grounded theory approach.	• Barriers to seeking help prior to self-harm • Potential solutions • Perceptions of clinical care

Study and aim of the study	Population	Methods	Author themes
	Grandchild: 1 Friend: 1		

CYP: children and young people; DSH: deliberate self-harm; ED: emergency department; GP: general practitioner; N: Number; PN: practice nurse; SD: standard deviation; UK: United Kingdom; USA: United States of America

See the full evidence tables in appendix D.

Summary of the evidence

The required skills identified in the included studies fell under 4 main themes – self-harm prevention, knowledge, engagement with the patient, and communication style. A total of 14 subthemes were associated with the 4 main themes, and these are all illustrated in Figure 1 and summarised in Table 3. The following subgroups were represented in the evidence: non-specialist staff who worked with people who have self-harmed; non-specialist staff who worked with suicidal patients; people who have self-harmed; people with suicidal ideation or attempt; family members/ carers of people who had died by suicide or were receiving mental health care. Family members/ carers of people who had self-harmed were not clearly represented amongst the studies identified, because it was not clear whether the included participants were family members/ carers or people who had self-harmed. They were also only represented in mixed populations.

Figure 1: Theme chart

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. Self-harm prevention			
1.1 Ability to accurately assess risk of self-harm	Moderate	11	**Population group:** non-specialist staff who worked with people who have self-harmed (5); non-specialist staff who worked with suicidal patients (3); people who have self-harmed (3); family members/ carers of people who have self-harmed (0); mixed populations (0)

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
	1.2 Preventing further self-harm during care	High	6	**Population group:** non-specialist staff who worked with people who have self-harmed (2); non-specialist staff who worked with suicidal patients (2); people who have self-harmed (1); family members/ carers of people who have self-harmed (1); mixed populations (0)
	1.3 Ensuring continuity of care paths	Low	11	**Population group:** non-specialist staff who worked with people who have self-harmed (3); non-specialist staff who worked with suicidal patients (3); people who have self-harmed (3); family members/ carers of people who have self-harmed (0); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	1.4 Ability to provide medication appropriately	Low	12	**Population group:** non-specialist staff who worked with people who have self-harmed (2); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (6); family members/ carers of people who have self-harmed (1); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	1.5 Ability to recommend coping techniques	Moderate	7	**Population group:** non-specialist staff who worked with people who have self-harmed (2); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (3); family members/ carers of people who have self-harmed (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 non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
2.	**Knowledge**			
	2.1 Formal training on working with people who have self-harmed	Moderate	11	**Population group:** non-specialist staff who worked with people who have self-harmed (6); non-specialist staff who worked with suicidal patients (3); people

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				who have self-harmed (1); family members/ carers of people who have self-harmed (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 non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	2.2 Ability to recognise the underlying causes of self-harm	Low	8	**Population group:** non-specialist staff who worked with people who have self-harmed (3); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (3); family members/ carers of people who have self-harmed (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 non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	2.3 Knowledge of formal processes	Moderate	6	**Population group:** non-specialist staff who worked with people who have self-harmed (4); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (1); family members/ carers of people who have self-harmed (0); mixed populations (0)
	2.4 Sharing information with colleagues	High	8	**Population group:** non-specialist staff who worked with people who have self-harmed (3); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (3); family members/ carers of people who have self-harmed (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 non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
3. Engagement with the patient				
	3.1 Creating an open line of communication	High	18	**Population group:** non-specialist staff who worked with people who have self-harmed (5); non-specialist staff who worked with suicidal patients (3); people who have self-harmed (7); family members/ carers of people who have self-harmed (1); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				with suicidal patients, including those with suicidal ideation: 1)
	3.2 Making time for the patient	Low	5	**Population group:** non-specialist staff who worked with people who have self-harmed (2); non-specialist staff who worked with suicidal patients (0); people who have self-harmed (1); family members/ carers of people who have self-harmed (0); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	3.3 Being collaborative	Low	4	**Population group:** non-specialist staff who worked with people who have self-harmed (0); non-specialist staff who worked with suicidal patients (0); people who have self-harmed (3); family members/ carers of people who have self-harmed (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 non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
4. Communication style				
	4.1 Evasive versus caring	Low	7	**Population group:** non-specialist staff who worked with people who have self-harmed (2); non-specialist staff who worked with suicidal patients (1); people who have self-harmed (2); family members/ carers of people who have self-harmed (0); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)
	4.2 Positive attitude	Low	15	**Population group:** non-specialist staff who worked with people who have self-harmed (5); non-specialist staff who worked with suicidal patients (2); people who have self-harmed (6); family members/ carers of people who have self-harmed (0); mixed populations (people who had self-harmed and non-specialist staff who had worked with them: 1; people with suicidal ideation or attempt, family

Themes and subthemes		Quality	No. of studies	Study populations, including those specified as sub-groups in the protocol (number of studies)
				members/ carers of people who had died by suicide or were receiving mental health care, and non-specialist staff who worked with suicidal patients, including those with suicidal ideation: 1)

See appendix F for full GRADE tables.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this 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 non-specialist 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 non-specialist staff may work in specialist settings. As a result, the views of people who have self-harmed, non-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 non-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 low to high 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: non-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 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 non-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 P), 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 in the specialist staff review were similar to those identified in the non-specialist staff review, with some differences between themes relating to the level of detail or specific needs of more specialist staff. As a result, the committee's discussion of the evidence for both this review and the specialist staff skills review has been summarised in Evidence Review P. Please refer to the Benefits and harms section of Evidence Review P for information regarding how the evidence found in this review informed recommendations.

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 costs implications resulting from training staff in non-specialist 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, 1.13.2 and 1.13.4. Other evidence supporting these recommendations can be found in the evidence reviews on skills in specialist settings (evidence report P) and supporting people to be safe (evidence report N).

References – included studies

Qualitative

Study
Awenat, Yvonne, Peters, Sarah, Shaw-Nunez, Emma et al. (2017) Staff experiences and perceptions of working with in-patients who are suicidal: qualitative analysis. The British journal of psychiatry : the journal of mental science 211: 103-108
Bailey, Di, Kemp, Linda, Wright, Nicola et al. (2019) Talk About Self-Harm (TASH): participatory action research with young people, GPs and practice nurses to explore how the experiences of young people who self-harm could be improved in GP surgeries. Family practice 36: 621-626
Behrman, G. U., Secrest, S., Ballew, P. et al. (2019) Improving pediatricians' knowledge and skills in suicide prevention: Opportunities for social work. Qualitative Social Work 18: 868-885
Borrill, Jo, Snow, Louisa, Medlicott, Diana et al. (2005) Learning from 'Near Misses': Interviews with Women who Survived an Incident of Severe Self-Harm in Prison. Howard Journal of Criminal Justice 44: 57-69
Chapman, Rose and Martin, Catherine (2014) Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: a qualitative perspective. International emergency nursing 22: 140-5
Cullen, Sara Wiesel, Diana, Amaya, Olfson, Mark et al. (2019) If You Could Change 1 Thing to Improve the Quality of Emergency Care for Deliberate Self-harm Patients, What Would It Be? A National Survey of Nursing Leadership. Journal of emergency nursing 45: 661-669
Doyle, Louise; Keogh, Brian; Morrissey, Jean (2007) Caring for patients with suicidal behaviour: an exploratory study. British journal of nursing (Mark Allen Publishing) 16: 1218-22
Fox, Fiona; Stallard, Paul; Cooney, Geraldine (2015) GPs role identifying young people who self-harm: a mixed methods study. Family practice 32: 415-9
Gorton, Hayley C., Littlewood, Donna, Lotfallah, Christine et al. (2019) Current and potential contributions of community pharmacy teams to self-harm and suicide prevention: A qualitative interview study. PloS one 14: e0222132
Hoifodt, T. S. and Talseth, A. G. (2006) Dealing with suicidal patients - A challenging task: A qualitative study of young physicians' experiences. BMC Medical Education 6: 44
Hoifodt, T. S.; Talseth, A. G.; Olstad, R. (2007) A qualitative study of the learning processes in young physicians treating suicidal patients: From insecurity to personal pattern knowledge and self-confidence. BMC Medical Education 7: 21
Hom, M. A., Bauer, B. W., Stanley, I. H. et al. (2020) Suicide attempt survivors' recommendations for improving mental health treatment for attempt survivors. Psychological services
Hom, Melanie A., Albury, Evan A., Gomez, Marielle M. et al. (2020) Suicide attempt survivors' experiences with mental health care services: A mixed methods study. Professional Psychology: Research and Practice 51: 172-183
Idenfors, H.; Kullgren, G.; Renberg, E. S. (2015) Professional care after deliberate self-harm: A qualitative study of young people's experiences. Patient Preference and Adherence 9: 199-207

Study
Jelinek, G. A., Weiland, T. J., Mackinlay, C. et al. (2013) Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: Findings from a national qualitative study. International Journal of Emergency Medicine 6: 2
Mughal F, Dikomitis L, Babatunde O et al. (2021) 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
Ngune, I., Wynaden, D., McGough, S. et al. (2020) Emergency nurses' experience of providing care to patients who self-harm. Australasian emergency care
Rees, N., Rapport, F., Snooks, H. et al. (2017) How do emergency ambulance paramedics view the care they provide to people who self harm?: Ways and means. International journal of law and psychiatry 50: 61-67
Rees, Nigel, Porter, Alison, Rapport, Frances et al. (2018) Paramedics' perceptions of the care they provide to people who self-harm: A qualitative study using evolved grounded theory methodology. PloS one 13: e0205813
Rowe, Joanne and Jaye, Chrystal (2017) Caring for self-harming patients in general practice. Journal of primary health care 9: 279-285
Storey, P., Hurry, J., Jowitt, S. et al. (2005) Supporting young people who repeatedly self-harm. Journal of The Royal Society for the Promotion of Health 125: 71-75
Vatne, May and Naden, Dagfinn (2016) Crucial resources to strengthen the desire to live: Experiences of suicidal patients. Nursing ethics 23: 294-307
Wadman, R., Armstrong, M., Clarke, D. et al. (2018) 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 22: 365-379
Wand, Anne Pamela Frances, Peisah, Carmelle, Draper, Brian et al. (2019) Carer insights into self-harm in the very old: A qualitative study. International journal of geriatric psychiatry 34: 594-600

Economic

No studies were identified that met the inclusion criteria.

Appendices

Appendix A Review protocols

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

Table 4: Review protocol

Field	Content
PROSPERO registration number	CRD42021220483
Review title	Skills required for staff in non-specialist settings who assess and treat people who have self-harmed
Review question	What are the views and preferences of staff in non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist settings who assess and treat people who have self-harmed?
Objective	To identify the views and preferences of staff in non-specialist settings, people who have self-harmed and their family members/carers about the skills that are required for staff in non-specialist 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 non-specialist settings that assess and/or treat people who have self-harmed • People who have self-harmed and been assessed and/or treated in non-specialist 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 non-specialist inpatient, outpatient and community settings in which management of people who have self-harmed is provided, including: • Primary, secondary and tertiary healthcare settings (including pre-hospital care, accident and emergency departments, community pharmacies, inpatient care, and transitions between departments and services) • Home, residential and community settings, such as supported accommodation • Supported care settings • Education and childcare settings • Criminal justice system • Immigration removal centres. •
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.

Field	Content
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.
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 non-specialist 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 ☐ ☐

Field	Content
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
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=220483
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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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

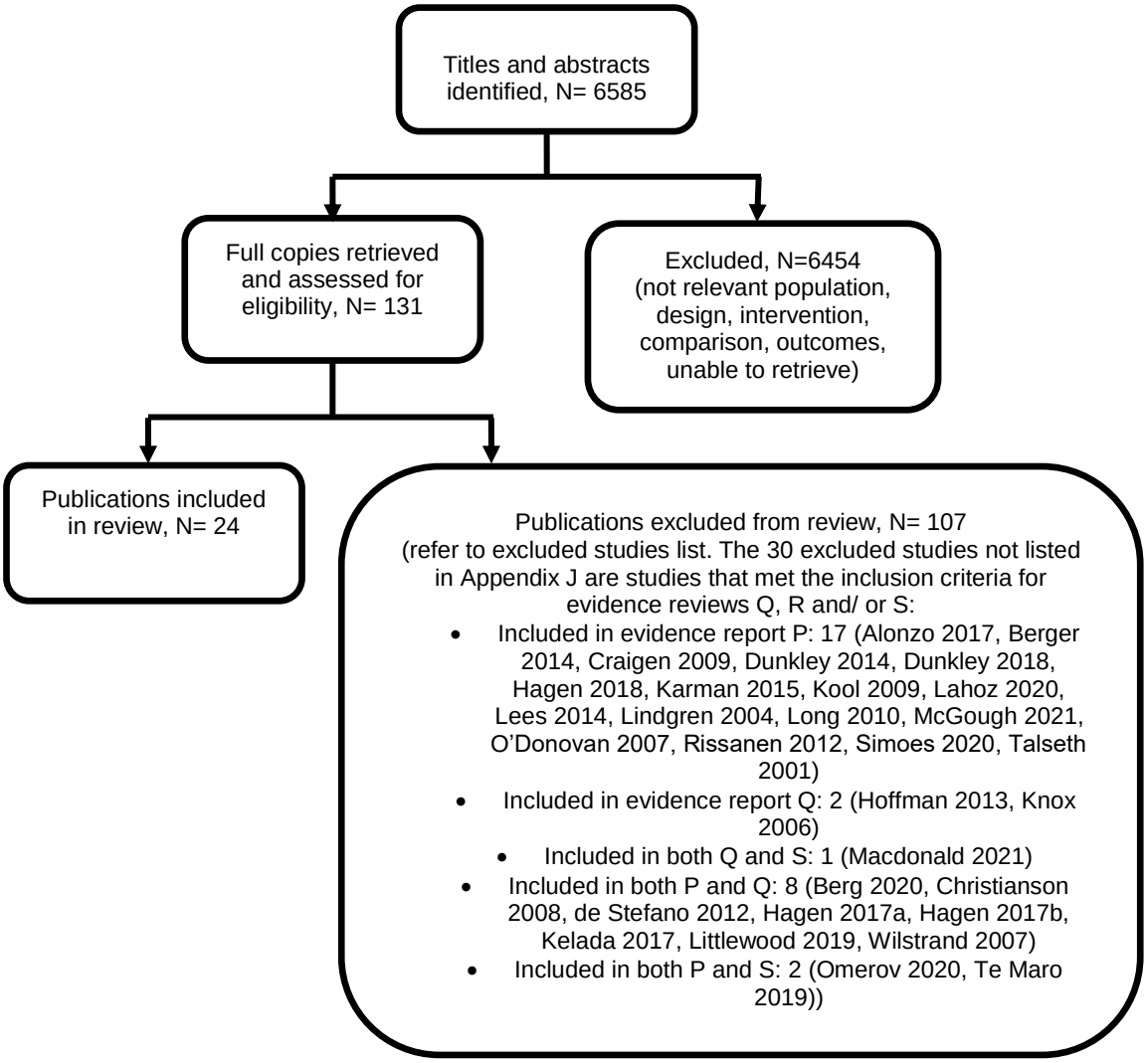
#	Searches
1	MeSH descriptor: poisoning IN NHSEED, HTA
2	MeSH descriptor: self-injurious behavior EXPLODE ALL TREES IN NHSEED, HTA
3	MeSH descriptor: self mutilation IN NHSEED, HTA
4	MeSH descriptor: suicide IN NHSEED, HTA
5	MeSH descriptor: suicidal ideation IN NHSEED, HTA
6	MeSH descriptor: suicide, 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: What are the views and preferences of staff in non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist settings who assess and treat people who have self-harmed?

Table 5: Evidence tables

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
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.
Results	Author theme: Talking About Suicide *Example quote: '"Everyone was like "you can't say words like that!" and I was like "well I can say words like that", because we're people and we're professional services. So I think, learning how to say those words, you know, "if you want to kill yourself, or if you're attempting suicide", sometimes being stark about it is actually beneficial because I think... it's putting a situation into reality." (Nurse assistant/ support worker: 02)' p. 105* *'"So usually during the course of conversation if someone says "I'm suicidal, I'm gonna die, I'm gonna do this" and then you kinda like… talk about something else… then say "oh, you're going on holiday next year?", "you're doing something over the summer?"" (Nurse: 05)' p. 105* *"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*

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.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Partially relevant *(Study was conducted in a specialist setting but included non-specialist staff. 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.)*

Bailey, 2019

Bibliographic Reference	Bailey, Di; Kemp, Linda; Wright, Nicola; Mutale, Gabriella; Talk About Self-Harm (TASH): participatory action research with young people, GPs and practice nurses to explore how the experiences of young people who self-harm could be improved in GP surgeries; Family practice; 2019; vol. 36; 621-626

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	UK
Setting	Healthcare - primary care
Data collection and analysis	Separate focus groups were held for staff and for young people. Narrative data were analysed by the lead researcher using inductive thematic analysis, which involved coding and the identification and clustering of themes. A second researcher analysed the transcripts separately, to arrive at a consensus about overarching themes and subcategories.
Recruitment strategy	Three multi-doctor GP surgeries were purposefully selected to take part in the study: GPs and practice nurses were invited to take part in focus groups. Young people with experience of self-harm were recruited through a snowball sampling approach beginning with the introduction of the project to young people’s organizations: these young people then approached other people they knew to take part.
Study dates	Not reported
Sources of funding	NHS Nottingham City Clinical Commissioning Group (CCG/NTU/01/RCF/13–14).
Inclusion criteria	Not reported

Exclusion criteria	Not reported
Sample size	N=45 (n=30 healthcare staff; n=15 young people)
Participant characteristics	**Staff:** **Mean age (SD):** Not reported **Sex (female/ male)**: 22/ 8 **Role:** Practice nurses: 16 GPs: 14 **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP)**: young people **People who have self-harmed:**

	Mean age (range): Not reported (16-25 years) **Sex (female/male)**: 7/ 8 **Ethnicity:** White: 14 Mixed race: 1 **Co-morbidity:** Not reported **Duration of self-harm:** Not reported **Suicide attempts:** Not reported
Results	Author theme: Type and pattern of self-harm influences consultation experience *Example quote: "it's what you do say if they say something that's serious. I would get a doctor" [FG6]' p. 624*

	One young person suggested that their GP did not "really want to pay us much attention", while another in the same focus group said: "When I try to see my doctor they always refer, just send me to a nurse instead of the actual GP which is annoying because he is my GP and he is supposed to be able to see me" [FG8].' p. 624 *"I would say that my doctor's better than the mental health services…I'll see my doctor and it's like she'll talk to me about everything" [FG9].' p. 624* *"Mental health disorders often come in a 10 minute consultation* *and it often takes 20 minutes. When you are at 15 minutes* *perhaps we might not have made time for that question but I think now many of us do" p. 624* Author theme: Young people often have several reasons for their self-harm, so young people and clinicians are concerned about the disclosure of the behaviour *Example quote: "I think they [clinicians] can be thinking like…what problems can you have 'cause you're, what, fifteen or something but no one knows what is happening at home" [FG8]' p. 625* *"I was scared to talk to the doctor….I just didn't feel confident enough" [FG9].' p. 625* *"asking a young person about their self-harm, do you risk making it worse?" [FG7].' p. 625* *"Just sort of reassure you that it's gonna be ok" p. 625*

	Author theme: Interventions for self-harm and potential for use of self-help materials in general practitioners surgeries *Example quote: "You might want to look at this [referring to self-harm]. This is part of your depression or your anxiety but look you're on the first couple of rungs and there's a whole ladder beyond here" [FG3].' p. 625* *"there should be like a set procedure to be honest, like, step one, if…that doesn't work…two, three, four, then, last resort, it's on medication" [FG9].' p. 625* *"Ten minute slot it's quite short and then the doctor feels rushed" [FG9].' p. 625* *"I'd say like obviously get them out and look at them with the young person together" [FG9].' p. 625*

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?	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 has some value
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Some concerns regarding the lack of justification for the data collection method, lack of discussion of data saturation, and limited information regarding data analysis and researcher reflexivity. Serious concerns regarding the lack of information provided about ethical considerations, considering data were collected from participants through focus groups. Limited discussion regarding the value of the research.)*
Overall risk of bias and relevance	Relevance	Highly relevant

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: participation were that 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 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 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 Author theme: Importance of communication *Example quote: "I think they (pediatricians) left out a really important thing. And every single one of them left it out. And it's that you're going to mess up. So, preparing us for downs and for relapses is really important." p. 876* *"someone has to care for you and tell you they want you to succeed and that you're going to grow out of this." p. 876* *"Stigma of mental illness persists even among physicians, we are either too quick to prescribe Rx or refer out with no follow up." p. 876* *"He (pediatrician) didn't help, like he really didn't show me any ways to cope with problems." p. 876* *"I (adolescent) was never talked to, like, they never asked me, 'Oh how do you feel about taking medications?' Instead, 'no, you're going to take this medicine.' If I knew what was going on it would've probably been easier." p. 877* Author theme: Stigma associated with mental health care *Example quote: "It takes a doctor (psychiatrist) five minutes to give me a diagnosis and put me on a med" p. 878*

	"They don't even listen to you," p. 877 *"We are lacking early detection skills and education on depression, anxiety, and dual diagnosis" p. 877* Author theme: Early detection *Example quote: "they are missing it; not asking the right questions, the gravity of the issue was lost." p. 878* Author theme: Lack of knowledge of recovery resources *Example quote: "feeling inadequate in making diagnoses along with sufficient knowledge of medications that are efficacious and considered best practices." p. 878*

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?	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. 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: Mental health problems *Example quote: ". . . yesterday they left me until night time before they gave me a dose.... and that's when I burnt myself ... cause the largactil's to make me calmer, and when you don't have it your whole mind just flips and turns, you don't know what you're doing'." p. 61* Author theme: Post-Incident Experiences *Example quote: "I would like them to have sat down and talked to me - it looked like I'd been punished for being angry" p. 63*

	"I knew the officers would come and check on me but ... I thought I had at least 15 minutes. But I didn't - I think he (the SPC) knew something was wrong. (SPC) told an officer to keep an eye on me and five minutes later he came back. If he hadn't come I wouldn't be here" p. 64 *"If they see you smiling they think you're all right.. but I'm just trying to be strong for my friend" p. 64* Author theme: What Makes a Difference? *Example quote: "they don't get at the root of the problem -just say she's upset and it's her way" p. 64* *"They said if you need to talk please open up - they were brilliant. Their kindness made a difference" p. 64* *"The senior officer said if I get suicidal again, talk to an officer. But the officers seemed so busy they didn't want to know" p. 64* *"I feel like a ball being passed from one to another" p. 64* *"You can't expect someone to stop self-harming just because you're talking to them. A lot of issues are not going to be dealt with overnight just by having a chat" p. 64*

	"I've been let down so much in the past I can't ask for help.. staff talk to me but I can't talk, I can't even cry ... there's never been anyone in my life, anyone, who hasn't let me down" 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
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.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Chapman, 2014

Bibliographic Reference	Chapman, Rose; Martin, Catherine; Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: a qualitative perspective; International emergency nursing; 2014; vol. 22; 140-5

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	Emergency department
Data collection and analysis	Qualitative data were collected using an anonymous self-administered questionnaire. Data from the open-ended questions were transcribed and the key words or phrases were underlined and significant meanings listed, aggregated and categorised. All the categories were then compared with each other to identify recurring themes.
Recruitment strategy	The survey was distributed to all doctors and nurses working within three Emergency Departments (EDs) in one hospital network (n = 410) to investigate their attitude towards patients who present to the ED with deliberate self-poisoning.
Study dates	Not reported
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=169 provided qualitative data.

Participant characteristics	Demographics reported in Martin & Chapman (2014) **Mean age (range):** Not reported (27 to 55 years) **Sex (female/ male):** Emergency department doctors and nurses: 169 (authors reported participants were mainly nurses) **Role:** Emergency department doctors and nurses: numbers not reported but mainly nurses **Setting**: Emergency department **Mean years in post/ experience (SD):** Not reported. **Client group (adults, children/ CYP)**: Not reported.
Results	Author theme: Depends on the patient and the situation

	Example quote: ". . .In the ED the focus of care is on the emergency not the mental health/counselling. I feel as if I 1) don't have time to explore MH [mental health] issues, 2) aren't encouraged to explore MH issues, 3) don't feel as though the department is the right place to explore this. The emergency room is designated to deal with emergencies. . . ." p. 143 Author theme: Treat everyone the same *Example quote: ". . .Anyone has the right to be treated with respect and dignity whatever their presenting problem. . ." p. 143* Author theme: Skilled and confident to manage these patients *Example quote: ". . .it makes me feel useful when caring for patient with DSP. . . . maybe it would make a difference or changes patient view by active listening, talking with them, being supportive . . ." p. 143* *". . .training in how to deal with each type (adolescent, psychiatric past, drug issues, first presentation) would be ideal. . ." p. 143*

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?	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 *(Insufficient discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study not conducted in the UK.)*

Cullen, 2019

Bibliographic Reference	Cullen, Sara Wiesel; Diana, Amaya; Olfson, Mark; Marcus, Steven C.; If You Could Change 1 Thing to Improve the Quality of Emergency Care for Deliberate Self-harm Patients, What Would It Be? A National Survey of Nursing Leadership; Journal of emergency nursing; 2019; vol. 45; 661-669

Study Characteristics

Study type	Mixed-methods

Country/ies where study was carried out	USA
Setting	Emergency department
Data collection and analysis	Participants were sent copies of a survey, which included an open-ended question: “Given the existing resources, if you could change one thing to improve the quality of emergency care for your deliberate self-harm patients, what would it be?” All responses were read to gain familiarity with the data, then coded into notable concepts separately, and then discussed together. Codes were condensed into five unique themes. Inter-coder reliability was assessed during the coding process and discrepancies were resolved with team discussions until consensus was achieved. The frequency with which each theme was mentioned was examined alone and then across strata of hospital characteristics, including admission volume, urban/rural and teaching status.
Recruitment strategy	Hospitals with ≥5 self-harm visits in 2012 were identified from Medicaid claims. From this list, the investigators selected a nationally representative sample of 665 hospitals and sent them the survey via mail and/or email. The study team initiated a coordinated recruitment strategy of key leadership staff (nurse directors or managers) at each Emergency Department (ED). Respondents were paid $100 (unless it was against hospital rules). Only one response per hospital was included.
Study dates	May 2017 to January 2018
Sources of funding	Not reported.
Inclusion criteria	Not reported - but see recruitment strategy.
Exclusion criteria	Not reported.
Sample size	N=476 hospitals
Participant characteristics	**Mean age (SD):** Not reported. **Sex (female/ male):** Not reported. **Role:** Emergency department nursing directors or managers: 381

	Social workers: 15 Others (or not reported): 80 **Setting:** Emergency department **Mean years in post/ experience (SD):** Not reported. **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Access to mental health care and staff within the hospital *Example quote: "educate nurses on identifying patients at risk and establishing a therapeutic rapport" p. 5* *"clear accreditation guidelines on what is required for interval assessment and documentation on self-harm patients, …guidance and training…if an ED provider is to ever be 'releasing' a involuntary psych hold patient before the expiration of that hold. Also if an ED stay awaiting an inpatient bed extends over the 24 hour time frame, is there required expectations of the ED provider" p. 5* Author theme: Access to mental health care in the community

	Example quote: "Immediate referral to an OP facility with followup by a case worker/case manager… I feel we do excellent emergent care and work diligently to get patients referred to an appropriate location, but then they are no longer followed by anyone…,until they return to the ED and the cycle begins again." 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?	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?	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 *(Insufficient discussion of researcher reflexivity and ethical considerations.)*

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

Doyle, 2007

Bibliographic Reference	Doyle, Louise; Keogh, Brian; Morrissey, Jean; Caring for patients with suicidal behaviour: an exploratory study; British journal of nursing (Mark Allen Publishing); 2007; vol. 16; 1218-22

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	Ireland
Setting	Two teaching hospitals (tertiary care)
Data collection and analysis	Data was collected using a 15-item questionnaire The first part was quantitative and the rest used open-ended questions to capture feelings and thoughts when caring for people with suicidal behaviour. Qualitative data were analysed using a thematic analysis approach.
Recruitment strategy	Questionnaires were sent to each nurse working in the emergency department of 2 teaching hospitals. Due to a poor response a second round of questionnaires were sent out.
Study dates	Not reported.
Sources of funding	Not reported
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=42 questionnaire responses from ED nurses
Participant characteristics	**Mean age (SD)**: Not reported

	Sex (female/ male): not reported **Role:** Qualified nurses: 42 **Setting:** emergency department **Mean years in post/ experience (SD):** 8.4 years (SD not reported) **Client group (adults, children/ CYP)**: Not reported.
Results	Author theme: Emergency department nurses' role Example quote: N/A Author theme: Challenges when caring for suicidal patients 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?	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?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	No
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 *(Insufficient discussion of researcher reflexivity and ethical considerations. No data provided to support themes.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Fox, 2015

Bibliographic Reference	Fox, Fiona; Stallard, Paul; Cooney, Geraldine; GPs role identifying young people who self-harm: a mixed methods study; Family practice; 2015; vol. 32; 415-9

Study Characteristics

Study type	Mixed-methods
Country/ies where study was carried out	UK
Setting	Primary care
Data collection and analysis	Participants completed an online survey, which included both quantitative and open-ended qualitative questions. Some participants were also interviewed by telephone. The survey and interview results were combined. Qualitative data were analysed by one researcher using inductive thematic analysis, which involved coding, followed by the identification and clustering of themes and production of a descriptive summary. Reliability was addressed by a second researcher analysing a selection of transcripts, followed by discussion and consensus about themes. A brief summary of the findings was sent to all GPs who took part in the interviews, some of whom responded with comments.
Recruitment strategy	Sixty-four GP practices across Bath and North East Somerset, Wiltshire, Swindon and Bristol were contacted through emails and letters to Practice Managers, who were asked to pass information about the study to the GPs in their practice. Two GP education networks also circulated information about the study via their distribution lists.
Study dates	Not reported
Sources of funding	Grant from Oxford Health NHS Foundation Trust FH1062
Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=28 GPs (n=28 completed the survey; of those n=10 were also interviewed)
Participant characteristics	**Mean age (range):** Not reported (20 to 60 years)

	Sex (female/ male): 21/ 7 **Role:** GP: 28 **Setting:** Primary care **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: GPs' skills, knowledge and perceptions about young people and self-harm *Example quote: "she's using this as a way of coping with stress and you can't suddenly stop her from doing it because actually that's a coping mechanism she's developed and it's going to take some time for her to be able to change that behaviour and putting more pressure on her isn't going to help" p. 417* *"I think not everyone feels confident in asking about it. I think a lot of it depends on how much you see and how much you kind of get used to doing it" p. 417*

	Author theme: Identifying, talking to and supporting young people who self-harm *Example quote: "if you think you have got an eleven, twelve, thirteen year old who is self -harming you could probably get in there quite quickly, do a bit of work and help them to process emotional distress in a safer way" p. 417* *"some people who are feeling like this might cut themselves or burn themselves or do other things like that, you know, have you ever done that or thought about doing it? If they think that it's something that other people do and it's okay to say that, they're more likely to sort of open up about it" p. 417* *"you're not getting a rapport with someone by asking them questions or getting them to fill something in. If you're going to get somebody to talk to you about something that is causing them distress, you've got to be open to what they're saying and listening. Not saying, "Oh right, okay fill this in"" p. 417* *"think we have to adapt the language and the difficulty of conversation to the individual and the situation. I don't think there is a one size fits all, especially over that age range" p. 417*

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

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 *(Insufficient discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Gorton, 2019

Bibliographic Reference	Gorton, Hayley C.; Littlewood, Donna; Lotfallah, Christine; Spreadbury, Matthew; Wong, Kai Ling; Gooding, Patricia; Ashcroft, Darren M.; Current and potential contributions of community pharmacy teams to self-harm and suicide prevention: A qualitative interview study; PloS one; 2019; vol. 14; e0222132

Study Characteristics

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

Setting	Community pharmacies
Data collection and analysis	Semi-structured, face-to-face interviews were transcribed and analysed using an inductive analysis approach. 5 researchers took part in the analysis. The transcripts were coded individually and then discussed in a group to generate a more extensive coding framework. Codes were then grouped to develop the initial themes. Finally, group meetings were held to agree the final themes and to ensure the thematic structure reflected the original data.
Recruitment strategy	Participants were recruited to the study via email invitations that were distributed by professional pharmacy networks, and poster advertisements were circulated on social media websites such as Twitter. A purposive sampling strategy was used in to get views from those with different job roles in the community pharmacy team. Participants were reimbursed for their time and travel expenses.
Study dates	Not reported (likely 2017 or later)
Sources of funding	Funded by the National Institute for Health Research through the Greater Manchester Primary Care Patient Safety Translational Research Centre (NIHR GM PSTRC), grant No GMPSTRC-2012-1.
Inclusion criteria	Individuals currently employed in a community pharmacy, aged 18 years or over, and who spoke fluent English
Exclusion criteria	Not reported.
Sample size	N=25
Participant characteristics	**Mean age (range):** Not reported (18 to >65 years) **Sex (female/ male):** 18/ 7 **Role:** Dispensing / pharmacy assistants: 10 Pharmacists: 8 Pharmacy technicians, pre-registration pharmacists or delivery drivers: 7

	Setting: Community pharmacies **Mean years in post/ experience (SD):** Not reported **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Relationship with patient *Example quote: "And I think there's a massive role because our teams are all based in the community here, they know the people, we know our customers really, really well. Anybody who comes in, we're on first name basis. So we have that relationship with them. We see them very, very often and we can recognise a decrease in symptoms, alarming symptoms, any sort of changes in presentation, we recognise, and we can help and support them quite quickly." (P19, Pharmacist)' p. 5* *"When they come in, there's one lady in particular who can come in and she can be quite juddery, shaking and being very erratic and quite blunt, and you know straight away that she's not having a good day. I always sort of go over and sit by her if the shop's not too busy and just have a little chat to her, how's she doing, anything I can help her with and stuff like that." (P16, Dispensing Assistant)' p. 6* *"In a community pharmacy you might have, today's pharmacists might be qualified 30 years, tomorrow's six months, you know, because they're running on locums, or whatever. So, that's where maybe training the regular staff might actually be more of a benefit than training a pharmacist" (P8, Pharmacist)' p. 6*

Author theme: Pharmacy environment

Example quote: "As a team we could do a lot more to help with mental health issues, spot things better. But there are people who would have to have training because they haven't had experience of it, which is only right. If you haven't got the experience you're not going to know what to look for." (P16, Dispensing Assistant)' p. 7

Author theme: Training

Example quote: "I do believe that if we had more training in it then I feel like we could be a bit more effective, and I feel like with the mental health burden, I think pharmacists can produce some positive outcomes." (P2, Pharmacist) p. 8

Author theme: Facilitated referral pathway

Example quote: "It's just basically if we find someone how would you deal with it but the only way we know how to deal with it would be to send them to the doctors." (P25, Dispensing Assistant)' p. 10

"there's not very good referral systems, so it would be good if a patient came in and they have any mental health problems or you are feeling suicidal, or have been self-harming, I could call someone, you know, I know I could call someone, almost like log it, that this had been an issue. And then it would, they would get seen, do you know what I mean?" (P1, Pharmacist)' p. 10

"I also know that I have seen [once]-weekly scripts and daily scripts for people who I'm guess [ing] are at risk, I don't know whether it's something that they have maybe tried to commit suicide or maybe they are just at risk and they have ended up

	on daily scripts or weekly scripts, cause we have dispensed those. These are all things that I sort of put together and sort of come to this conclusion." (P14, Pharmacist)' p. 10 Author theme: Restricting access to means *Example quote: "I think as pharmacists regardless of which area or sector you work in, you know, one of the main . . .not main but one of the ways people, you know, attempt suicide is that they stockpile medication, you know, so, you know, that's a role for a pharmacist [. . .] but you get very little- . . .you get some pharmacists, oh, don't want to deal with that, you know, so . . .I think it's to do with the undergraduate course, you just don't get . . .you don't get access to, you know, mental health. Maybe it's changed, you know." (Pharmacist, P22)' p. 11*

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

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 *(Insufficient discussion of researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Hoifodt, 2006

Bibliographic Reference	Hoifodt, T. S.; Talseth, A. G.; Dealing with suicidal patients - A challenging task: A qualitative study of young physicians' experiences; BMC Medical Education; 2006; vol. 6; 44

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Norway
Setting	See Hoifodt 2007.
Data collection and analysis	See Hoifodt 2007.
Recruitment strategy	See Hoifodt 2007.
Study dates	See Hoifodt 2007.
Sources of funding	See Hoifodt 2007.
Inclusion criteria	See Hoifodt 2007.

Exclusion criteria	See Hoifodt 2007.
Sample size	See Hoifodt 2007.
Participant characteristics	See Hoifodt 2007.
Results	Author theme: Striving for relatedness *Example quote: "When I feel a good connection, I think that the patient is being honest and is telling me as much as possible. When the patient finishes his story and one can reply, then you could perhaps get eye contact saying "I can understand what you mean", you receive this glimpse, and a little pause, and then you go on talking." p. 4* *"I tried to see if I could get through to him some way... We talked a little about school, what he had done the last days, but I could not find an opening. When I asked whether he had some problems, he would not go into them." p. 4* Author theme: Intervening competently *Example quote: "I try to get an impression of the social situation, friends, family, job, how he feels in his relationship to these people and his life situation, how he looks upon his future and perhaps the past, experiences of his daily life, his life situation, how he thinks about himself and his relations to these different elements in his life situation." p. 4* *"He was so serious all the time. You could see that he was striving, he couldn't loosen up, and he carried a burden with him all the time. He ate well, slept well, was well kept, but his [pent up] emotions dominated the situation." p. 4* *"As long as I know that a plan has been established, it may be an admission to hospital, as an emergency or the next day or in some other way of following the patient up... that one has made some decision and provided a guarantee for the patient." p. 5*

	Author theme: Being emotionally involved *Example quote: "It was a very close experience, but I do not think it has made things more difficult for me, rather somehow easier." p. 5* *"When people do things like that, I get angry; I try to keep that to myself, because it is not very useful in the relationship with the patient. You get angry with a person because he just drives into an oncoming trailer. He didn't really have huge problems. His action was indefensible." 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?	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?	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 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.)*

Hoifodt, 2007

Bibliographic Reference	Hoifodt, T. S.; Talseth, A. G.; Olstad, R.; A qualitative study of the learning processes in young physicians treating suicidal patients: From insecurity to personal pattern knowledge and self-confidence; BMC Medical Education; 2007; vol. 7; 21

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	Norway
Setting	Primary and secondary care (newly graduated doctors)
Data collection and analysis	Individual narrative interviews with clarifying questions were held. Analysis involved transcribing the interviews, reading these several times, and dividing the text into meaning units. Analysis involved transcribing the interviews, reading these several times, and dividing the text into meaning units, which were simplified and organised into themes. Finally, the original texts were considered as a whole alongside the themes and research questions.
Recruitment strategy	Participants were invited to participate through a larger project on the development of psychiatric competence among medical students.
Study dates	January to June 2002
Sources of funding	Supported by a grant from Psychiatric Research Centre of Northern Norway
Inclusion criteria	Medical graduates of the University of Tromso who had completed an 18-month internship following graduation (including internal medicine, surgery and primary health care) within the last 6 months.
Exclusion criteria	Not reported
Sample size	N=13 newly graduated doctors
Participant characteristics	**Mean age (SD):** Not reported. Authors reported participants were around 30 years. **Sex (female/ male):** 6/ 7 **Role:** Newly qualified doctors: 13 **Setting:**

	Primary care: 9 Secondary care (non-psychiatric) : 4 **Mean years in post/ experience (SD):** Not reported. All participants had completed their graduate internship during the last 6 months prior to the interview. **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Preparing for practice *Example quote: "It was some kind of a recipe, using several questions and in a way, developing a score for moderate and high risk." p. 4* *"I think it is very important to have the opportunity to role-play those types of situations...Some do not like role-playing and sneer at it, but it is incredible how one can identify with the situation. I think it is very important to play both the role of the suicidal person and the helper, to attempt to get into the mood of a person who is thinking about committing suicide." p. 4* Author theme: Participating in the professional community *Example quote: "It is invaluable support to have people around you, who know these things. We had a very skilled homecare nurse who knew everybody and exactly what the problem was." p. 5*

	"To exchange experiences with colleagues has been rewarding, especially when you get to talk to a more experienced colleague and tell about one's own experiences, not necessarily to hear if you did right or wrong, but to describe and go through the situation." 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?	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
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.)*

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 Behaviours 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 *Self-reported. 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 data: 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 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* *"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: Structural issues *Example quote: "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.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Participants all self-identified as having attempted suicide. 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: 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* Author theme: Negative factors: Provider-related factors *Example quote: "The first doctor I went to said, 'Oh, you have OCD and there's medication for it. It's a chemical imbalance. The anxiety and depression are probably part of the OCD.' Never went into my past, never asked me a lot of questions or really talked to me." p. 178* *"They treated me like dirt. When I went in, the doctor was talking down to me: 'We had someone come in here tonight who was attacked. They're in here, they didn't ask to be in here, and yet here you are" 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* *"Nobody asked me my thoughts. Nobody asked me my opinion. Nobody asked me what was or wasn't working." 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
Ethical Issues	Have ethical issues been taken into consideration?	No
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	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 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 (Emergency department, 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 and 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 (emergency department, 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 young people who had self-harmed (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. All participants had first self-harmed at most 6 months before data were collected.

	Suicide attempts: Not reported.
Results	Author theme: Am I really in good hands? *Example quote: "Well, I've got a note and an appointment so it hasn't been a problem, it's just getting there on time [...] that I have to call them myself and that I think it's so difficult so, no, I'd rather just not bother." 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* Author theme: Making yourself better 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?	Yes
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?	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 specialist settings but included patients providing data regarding skills for non-specialist staff. Study not conducted in the UK.)*

Jelinek, 2013

Bibliographic Reference	Jelinek, G. A.; Weiland, T. J.; Mackinlay, C.; Gerdtz, M.; Hill, N.; Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: Findings from a national qualitative study; International Journal of Emergency Medicine; 2013; vol. 6; 2

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	Emergency department
Data collection and analysis	Interview questions were emailed in advance to participants before semi-structured interviews were held via telephone. The interviews were recorded, transcribed and sent back to the participants so they could verify the contents. All interviews were done by the same researcher. The transcribed data were analysed for themes by 2 researchers using methods outlined in Ritchie J, Spencer L (Eds): Qualitative Research Practice: A guide for social science students and researchers. London: Sage Publication Ltd; 2003.
Recruitment strategy	People working in a clinical role in an Australian emergency department (ED) and members of either the Australasian College for Emergency Medicine (ACEM; emergency doctors) or the College of Emergency Nurses Australasia (CENA; emergency nurses) were contacted via email. For those who expressed an interest, stratified sampling (by metropolitan and rural/regional EDs, the Australian states and territories, and ED seniority) was used to select participants for interview.
Study dates	Not reported
Sources of funding	A grant from the Windermere Foundation.
Inclusion criteria	People working in a clinical role in an Australian ED and members of either the Australasian College for Emergency Medicine (ACEM; emergency doctors) or the College of Emergency Nurses Australasia (CENA; emergency nurses).
Exclusion criteria	Not reported
Sample size	N=36 ED staff
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** Not reported

	Role: Emergency department nurses: 16 Emergency department doctors - ED directors: 5 Emergency department doctors - ED staff specialists: 8 Emergency department doctors - registrars: 7 **Setting:** Emergency department **Mean years in post/ experience (SD):** not reported **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Perceived knowledge gaps *Example quote: "Knowledge of current [assessment] tools is perhaps not what it should be." p. 3* *I think we didn't understand all the diagnoses. I think we would have loved a bit more training on different illnesses with mental health. . ." p. 4*

	". . .the kind of brief intervention, for people who are not acutely disturbed, but need some counselling. . . " p. 4 *"I've never been properly taught in terms of who I should sedate, how I should sedate them (IV, IM, orally) and when/what the implications are for sedation so I think I would like to have some more guidelines for sedation." p. 3* *"Certainly things like new medications. . ., there's obviously been a change in medication management. . . That sort of cutting edge stuff is stuff you hope you can stay abreast of, but trouble is often you don't know what deficits you may or may not have." p. 3* *"I did a one-day course on management of aggression training. It was quite useful about talking to people, and trying to talk them down. It's something that certainly ED registrars would be good to have as part of their training. . . " pp. 3-4* *"I think that ED registrars would also benefit from more psychiatric training. I did quite a bit of psych in my ED training. I think it's something that people working in the ED probably could do with more training, particularly in the registrar phase when they are learning new skills anyway." p. 4* *"I think that we are not really formerly taught about the legal requirements about forms and transport issues" p. 4* Author theme: Confidence

	Example quote: ". . .it's really something to get used to over time. It really did used to make me quite nervous when I first started working in medicine, and I was much less confident in my decisions. I think it's timely experience as much as anything. . ." p.4 *"And also the knowledge of how to discharge patients into good outpatient care because there are a range of outpatient initiatives in our region. . ." 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?	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?	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 discussion of researcher reflexivity, plus minor concerns due to lack of information regarding data collection methods, though authors link to their methods processes.)*
Overall risk of bias and relevance	Relevance	Relevant *(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	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. 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 people who had self-harmed
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: Help-seeking avenues *Example quote: "And the first person I spoke to, was the pharmacist … he was totally calm about it … but it was the changing point in my life that I actually realised that it's not something to be ashamed of." p. 8* Author theme: Barriers to seeking help from general practice *Example quote: "'But he sort of went 'okay we'll just put you on anti-depressants and see you every two weeks and let's see what does, see if your mood increases, if anything happens, if you stop self-harming, if things decrease'… I ended up maxing out on the amount you can get with anti-depressants within like six months, and they weren't sitting well with me" p. 9*

	"It was… hmphh [small sigh]… it was pretty positive, I mean he was, he was understanding, very non-judgemental, warm, I felt comfortable telling him everything […] one thing that did not feel quite right was the way he responded […] like I told him I don't know… 'I have a sore throat'" p. 9 *"I thought they'd hospitalise me immediately. I thought they'd panic and push me away as if, 'no, you've gotta – you know, you've got to go into an inpatient unit, and we've got to inform your family, and you've got to quit your course'." p. 10* *"I left the conversation feeling perhaps I was assigning more importance to this that it requires […] because I said 'if the GP is not too concerned, I shouldn't be' […] I felt I needed to tell him […] that I'm actually overdosing on them [prescribed antidepressants]… I did tell him, and once again I didn't get any reaction […] so I decided to stop my medication without telling him and I never attended another appointment with him […] I've never been to see the GP since and it's been six months" p. 10* Author theme: Facilitators to accessing care *Example quote: "Yeah, yeah, yeah it was erm, yeah, my GP here is very helpful, he gives me different, he gives me options and then explains to me which erm, how each go, which things that would be best for me" p. 11* *"His patience and lack of judgement was amazing, just to listen to my experiences of what happens for emotionally when I'm self-harming, erm, it was incredible." p. 12* *"He didn't over-react… he was really good in the way he handled things […] the way he felt comfortable to talk to me about it made me comfortable, even though I didn't feel anything at that time, I didn't feel as though I was being judged […] I was*

	on citalopram and he discussed in detail what the side effects were, what would happen, what the benefit of sertraline were and he said, if you need me to speak to your therapist, I will […] he was amenable to helping me with my self-harm" p. 12 *"'He could have found out more, asked to find out more and then talked to me more, or at least talked to me about maybe what I wanted to do" p. 12* *"Continuity and a good frequency of GP appointments is really helpful. You don't build up a rapport in one appointment, it's 10 minutes, and some place it's five minutes, you need time to do that, quite often they'll book double appointments knowing that I've only got one problem." 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
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

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	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Ngune, 2020

Bibliographic Reference	Ngune, I.; Wynaden, D.; McGough, S.; Janerka, C.; Hasking, P.; Rees, C.; Emergency nurses' experience of providing care to patients who self-harm; Australasian emergency care; 2020

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting	Emergency department
Data collection and analysis	Individual semi-structured interviews were held via telephone, recorded and transcribed. Data was analysed using inductive content analysis: - by 4 researchers in collaboration. First, the transcripts were coded by identifying meaningful words or phrases. These codes were then grouped into content related categories. Critical categories and sub-categories were identified. The final step was to identify the abstracted meaning that brought categories into a framework to provide an overview of the interpretation of data presented as findings
Recruitment strategy	Participants were recruited through the College of Emergency Nursing Australasia (CENA). The College sent an email to all emergency nurses who were members of CENA with information about the study.
Study dates	November 2018 to January 2019
Sources of funding	No funding received.

Inclusion criteria	Not reported
Exclusion criteria	Not reported
Sample size	N=18 ED nurses
Participant characteristics	**Mean age (SD):** 46.06 (11.49) **Sex (female/ male):** 14/ 4 **Role:** Qualified nurses: 18 **Setting:** Emergency department **Mean years in post/ experience (SD):** More than 10 years: 10 6 to 10 years: 3 1 to 5 years: 1 **Client group (adults, children/ CYP):**

	Adults: 8 All age groups: 10
Results	Author theme: Nurses' level of comfort to work with people who self-harm *Example quote: "When I first got to ED, I was very uncomfortable (to work with people who self-harm). I didn't know how to ask the questions ¨Do you feel suicidal? Do you feel like self-harming?" p. 3* *"[I] spent some time with the PLN [psychiatric liaison nurse]. . . .I feel much more comfortable particularly in a triage setting..[Previously] I found it difficult to triage people who came in with self-harm or thoughts of suicide. Now I'm comfortable. . . ..I know what questions are appropriate and I think I'm better at [assessing] patients and [determining] who is high risk." p. 3* *"There is a culture [from colleagues] about why are you over triaging this person . . . [allocating a triage category higher than the actual level of acuity]. . . .. There is a culture of they've not got a physical thing wrong with them [so] why did you make them a category 2, to be seen within 10 min? [Even when the person is] at risk of self-harm and at risk of absconding and [they] have no support person with them. . . .. [There is a culture of] just pop them in a chair over there and keep an eye on them until someone is ready to see them rather than triaging them up and getting them to see the right person, speedily." p. 3* *"I've noticed improvements within my own attitudes but that's because it needed to change. [I] have . . .. more knowledge and. . ..understanding [about self-harm]. I know my attitudes have changed." p. 3*

	Author theme: Nursing role *Example quote: "[My role is] to accurately apply the national triage scale section which applies to mental health. . . .. I am confident that triaging according to it actually triages people quite high. . . ..From a triage point of view, it's about knowing what to do. . .. Making sure they are triaged [up]. Being able to justify and defend those decisions. . . .. [It's about] advocating for them to go into a space [in the ED]. . .. [I] also try to front load some of the assessments." p.3* *"It's about getting patients comfortable enough that they can be assessed properly in an environment they perceive as fairly safe while actually keeping them safe . . . not giving them opportunity to harm themselves further" p. 3* *"The first thing I think of is their physical health. If they have presented and if they've got deep cuts, you want to address that and make sure they've got good pain relief. [Check if the cut] needs suturing. We address [physical health] first and then mental health." p. 3* *"[Understanding] the reason for the self-harm. . .. what's been going on and trying to put things in place for them to be able to deal with those reasons and resolve the crisis they are in at the time." p. 4* *"Try to work with them in practical ways to give them alternatives [to reduce further self-harm]. Referring them to someone that is going to . . .. teach them enduring ways of dealing with their distress." p. 4* Author theme: Facilitators and barriers *Example quote: "Having a background understanding [of] the reasons why people may self-harm [is important]. . . .. [How] they want us to approach them. . . .. Do they want us to be very direct and ask very direct questions?" p. 4*

	"I think they leave too soon [for us] to be able to provide the optimal health care that they need." p. 4 *"The patients themselves [are a barrier depending] how closed [reluctant to communicate] some of them are. . . .. I think it [is] because of the lack of understanding of where they are at. . ..I [don't] probe in on too many questions [as] to why the self-harm is occurring." p. 4* Author theme: Education and training *Example quote: "I don't think [self-harm] is covered well by comprehensive, undergraduate [26] education. [A lot] of what you learn is either by self-education or by trial and error [or by] working with more expert colleagues, seniors. . . .. I don't think we have an inherent comfort. I think you learn it through discomfort." p. 4* *"[Having education that is] interactive. . . .. providing some educational resources for people if they would like to read up [on self-harm] before or after [caring for a patient]. . . ..[Where] everyone is involved in actually practicing and having these conversations. . . .. Getting actors or people that are happy [to act] the different ways that people present." 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

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?	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?	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 due to insufficient information regarding recruitment of participants, specifically whether the sample was representative of the population. Limited discussion on researcher reflexivity and on how the authors handled the effects of the research on participants during and after the study.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Highly relevant

Rees, 2017

Bibliographic Reference	Rees, N.; Rapport, F.; Snooks, H.; John, A.; Patel, C.; How do emergency ambulance paramedics view the care they provide to people who self harm?: Ways and means; International journal of law and psychiatry; 2017; vol. 50; 61-67

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	UK
Setting	Community (ambulance service)
Data collection and analysis	Individual semi-structured interviews were held, recorded and transcribed. Researchers also noted context and emotion during the interviews. The transcriptions were coded in stages: first data were compared for similarities, differences and questions about emergent concepts. Then concepts were refined under higher-level themes and the researchers attempted to identify the basic social process around which all other categories revolved. Finally, they attempted to connect all levels of their analysis to form a Grounded Theory.
Recruitment strategy	A poster requesting volunteer paramedics for the study was distributed in one UK ambulance service, covering a population of three million people. Following responses to the poster call, potential participants were selected using stratified sampling methods, based on the characteristics of age, gender, years of paramedic experience, rural or urban setting, and educational development. Participants were recruited / interviewed until no new information was gained (thematic saturation).
Study dates	2014 to 2016
Sources of funding	Supported by a Falck Foundation grant.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.

Sample size	N=11 paramedics
Participant characteristics	**Mean age (SD):** Not reported **Sex (female/ male):** 4/ 7 **Role:** Paramedic: 11 **Setting:** Community (ambulance service) **Range of years in post/ experience:** 2-40 years **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Professional, legal and ethical tensions *Example quote: "you can't get hold of mental health practitioners to be able to help you, the lack of advice and support. The lack of referral facilities. Shouldn't there be a facility that we can refer directly to a mental health crisis team unit, and be able to go directly there instead of A&E?" p. 62*

	"You can speak to a clinical support desk, you can speak to a doctor at a hospital, or you can speak to an on call GP. And ultimately they'll virtually say the same thing, you know, you're the clinician on the scene, you have to make that decision" And when questioned: "And how do you feel about that?" The answer was: "Lonely"' p. 62
	"Everybody needs to be treated with dignity and respect. I think perhaps that wasn't there in the past, that people were often dealt with contempt, and very little understanding. And it can only be a more professional thing for our standing." p. 62
	"He was saying, "I'm not going, I'm refusing to go. I want to kill myself," and I think would it be possibly legal for me to assess his mental capacity and he's refusing to go, fill in a form and he'd have been happy for me to go, but ethically and morally I think it would have been wrong to do that. So instead I was there for hours." p. 63
	"... whether it's right or wrong, if I believe, even half believe that a person had taken an amount of medication that would seriously damage their health, and they were refusing to go in…I'd rather get into trouble ethically for taking somebody against their will than somebody die, and I left them there to die." p. 63
	"I think the question of suicidal intent, as interpreted by myself as a paramedic, anybody who causes them self, self-harm then, you know, we automatically assume, and perhaps wrongly on occasions, that the intent is always an attempt at suicide" p. 63
	"Now the ethicacy of that doesn't sit well with me, but if the gentleman is going to die from this overdose then, you know, what's more important life or ethics" p. 63

	Author theme: Relationships with police and coercion *Example quote: "they are deployed to save that person's life by force if necessary" p. 63* *"I'd rather get into trouble ethically for taking somebody against their will than somebody die, and I left them there to die. So then I think I would use whatever means I had to force them to a place of care." p. 64*

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

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Rees, 2018

Bibliographic Reference	Rees, Nigel; Porter, Alison; Rapport, Frances; Hughes, Sarah; John, Ann; Paramedics' perceptions of the care they provide to people who self-harm: A qualitative study using evolved grounded theory methodology; PloS one; 2018; vol. 13; e0205813

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	UK
Setting	See Rees 2017.
Data collection and analysis	See Rees 2017.
Recruitment strategy	See Rees 2017.
Study dates	See Rees 2017.
Sources of funding	See Rees 2017.
Inclusion criteria	See Rees 2017.
Exclusion criteria	See Rees 2017.
Sample size	N=11 paramedics
Participant characteristics	**Mean age (SD):** Not reported

	Sex (female/ male): 3/ 8 **Role:** Paramedic: 11 **Setting:** Community (ambulance service) **Range of years in post/ experience:** 1-38 years **Client group (adults, children/ CYP):** Not reported.
Results	Author theme: Context *Example quote: "Alcohol can affect somebody's judgement, their mood, and you know, the way that they see things, and then they can be quite easily sort of wound up." p. 5* Author theme: Judgements and values *Example quote: "The 'whys' the 'hows'. Having a comprehension of what goes on in that person's head to make them want to cut themselves, to make them want to put a rope around their neck. To make them want to take every tablet they can get their hands on. I think we need to understand the why behind that." p. 5*

	"Opens his neck up and that is bloody scary when he does that, there's blood everywhere like and he's bloody hysterical. . .he has learned not to be awkward with us mainly because we are not awkward with him. . . We know him quite well. . . I mean he's just a person with issues" p. 6 Author theme: Isolation and system failure *Example quote: "The Emergency Department is often busy, noisy, can be confrontational. Staff don't have time to deal with a patient on an individual basis, which is what's required."* Author theme: Managing Risk *Example quote: "when you walk through the door and she is still holding the kitchen knife, and she says, you know, "I don't want to live, you're not going to save me," and she waves the knife at you then, obviously, there's a little bit of feeling of self preservation, and turning around and walking out the door" p. 7* Author theme: Competence at the boundary of mental and physical health needs *Example quote: "how do we treat that sort of mental health issue rather than the physical injuries 'cause I feel that we're quite appropriately trained to do that" p. 8*

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	Highly relevant

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 people who had self-harmed
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: 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?	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 *(Insufficient discussion regarding researcher reflexivity.)*
Overall risk of bias and relevance	Relevance	Relevant *(Very little data provided regarding non-specialist staff. Study not conducted in the UK.)*

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	Emergency departments

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	Participants had to report they had self-harmed before they were 16 years old.
Exclusion criteria	Not reported
Sample size	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)
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: "I've always been fobbed off with antidepressants and that." p. 73* *"I was pleased that he had done something but really I didn't want to be put on antidepressants. I would have preferred to have just been able to talk to somebody. I think that's probably what I needed, rather than just take tablets or something." p. 73*

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

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?	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?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Authors did not clearly state the goals of their research, though they can be deduced. 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.)*

Section	Question	Answer
Overall risk of bias and relevance	Relevance	Relevant *(Very little data provided regarding non-specialist staff.)*

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	Phenomenological
Country/ies where study was carried out	Norway
Setting	Acute psychiatric units
Data collection and analysis	Participants were interviewed using a semi-structured guide 2 weeks after a 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.
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	Recent suicide attempt, non-psychotic, able to verbalize experiences and access to a therapist
Exclusion criteria	None reported
Sample size	N=10 people who had attempted suicide
Participant characteristics	**Mean age (range):** Not reported (21-52 years)

	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
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* *"I called him: he was fantastic when I had that depression last year. And so I told him over the phone that . . . , well, now I just tried to take my own life. 'Would you like to come in and talk about it?' he replied. So I got an appointment right away, and while I sat there, he wrote an application to the emergency ward and called them, and then all I had to do was go directly to the emergency ward." 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.)*
Overall risk of bias and relevance	Relevance	Relevant *(Study was conducted in a specialist setting but included patients*

Section	Question	Answer
		providing data regarding skills for non-specialist staff. 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	Individual semi-structured interviews were held. 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 young people with experience of living in foster care or residential homes who had self-harmed
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: Not wanting to talk *Example quote: … they [will have to] get involved and get someone else involved" p. 371*

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
Overall risk of bias and relevance	Relevance	Relevant *(Very little data provided regarding non-specialist staff.)*

Wand, 2019

Bibliographic Reference	Wand, Anne Pamela Frances; Peisah, Carmelle; Draper, Brian; Brodaty, Henry; Carer insights into self-harm in the very old: A qualitative study; International journal of geriatric psychiatry; 2019; vol. 34; 594-600

Study Characteristics

Study type	Grounded theory
Country/ies where study was carried out	Australia
Setting	Tertiary general hospitals and their affiliated community sites.
Data collection and analysis	Carers were interviewed individually, within a month of the self-harm episode. Open-ended questions addressed help-seeking prior to, and purported intent of, the self-harm, the effect of the self-harm on the carer, potential approaches to addressing the contributing factors, and perceptions of clinical care. Each interview was transcribed and coded into themes and subthemes using an iterative approach to re-examine previously analysed data in light of emergent themes. Results between the two analysts were compared and discussed until agreement was reached.
Recruitment strategy	Older people who self-harmed over a 1-month period were recruited from two tertiary general hospitals and their affiliated community centres. Their carers were approached to take part.
Study dates	Not reported
Sources of funding	No grants, funding or sponsors.
Inclusion criteria	Participants were nominated relatives or close friends of patients aged 80+ who had self-harmed in the previous month.
Exclusion criteria	None reported.
Sample size	N=32 carers of n=30 older people who had self-harmed.
Participant characteristics	**Mean age (SD):** Not reported. **Sex (female/ male)**: 17/15

	Relationship to person who has self-harmed: Adult child: 24 Spouse: 5 Sibling: 1 Grandchild: 1 Friend: 1
Results	Author theme: Barriers to seeking help prior to self-harm *Example quote: "I don't think he would have confided in [the GP] in regards to the self-harm because I think if he did [the GP] would act, or he would do something, or he would tell us". P. 597* *"Well he asked that many times [for medication for dizziness], and she [GP] sort of blew him off. And then, when all this happened [self-harm] …. the first thing she [GP] said …. was 'I'll give you that prescription for Serc that you've been asking for.' Now why didn't she damn well give them to him months ago? And this wouldn't have happened." p. 597* Author theme: Potential solutions *Example quote: "So I think it would be a good idea [that] the GP can coordinate into this and keep contact with the family member. … So if some issue happening I can reach him at least." p. 597*

	Author theme: Perceptions of clinical care *Example quote: "In hospital what has been positive is just having around-the-clock watching of him. Because he does actually need that supervision … he can't be trusted at the moment." p. 598* *"One doctor I spoke to … he was really dismissive … dismissing with a wave of the hand the observation of someone who'd known him [patient] for a long time." p. 598*

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?	Can't tell

Section	Question	Answer
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 due to a lack of justification for research design and a lack of information regarding ethical considerations. Additionally, 2 of the authors were involved in the care of 12 patient participants, however the authors implemented a reflexive approach to enable consideration of this relationship and enhance methodological rigor. One researcher additionally interviewed their relative/ friend. However, the authors argue the breadth of responses indicates these considerations did not affect data collection.)*
Overall risk of bias and relevance	Relevance	Relevant *(The study included 1 friend of a person who had self-harmed (3%) but did not clarify whether they were their carer. Study not conducted in the UK.)*

Appendix E Forest plots

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

Table 6: Summary of evidence (GRADE CERQual): 1 Self-harm prevention

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: Ability to accurately assess risk of self-harm					
11 (Borrill 2005, Cullen 2019, Doyle 2007, Fox 2015, Gorton 2019, Hoifodt 2006/ Hoifodt 2007, Hom 2020a, Idenfors 2015, Jelinek 2013, Ngune 2020, Rees 2017/ Rees 2018)	5 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using structured interviews; 2 studies using open-ended questionnaires; 1 study using surveys; 1 study using open-ended surveys and semi-structured interviews	Because people who had self-harmed often presented to non-specialist staff first (whether for self-harm specifically or for another reason), non-specialist staff recognised that a large part of their roles was recognising when patients either had already self-harmed or were at risk for self-harm. Emergency Department (ED) nurses, for example, said a main part of their role was accurately assessing which patients could be at risk for acts of suicidal behaviour, including self-harm. ED staff said assessing risk was a part of their role when triaging patients, and some were concerned that other ED staff did not take risk of self-harm seriously, which could lead to denying patients triage when they needed it. These participants said part of this skill included knowledge of current assessment tools and the ability to justify decisions made regarding risk assessment. Paediatricians and General Practitioners (GPs) also felt risk assessment was an important skill, as well as early detection of self-harm. GPs clarified that detection of self-harm in young people allowed them to help young patients develop safer methods to process emotional distress, which reduced the likelihood of repeat self-harm later in life. Pharmacy staff felt that having familiarity and rapport with people who had self-harmed enabled them to spot changes in patients that could indicate elevated risk for self-harm. Physicians said they needed to use information gathering, diagnostic, and observational skills to discern whether patients seemed to be at risk for of self-harm, for example assessing how patients spoke about their future plans, looking for signs the person was not taking care of themselves, and noticing unusual behaviour. Similarly to pharmacy staff, physicians noted that spotting these indications of risk required a familiarity with the patients, but also noted that generally having experience with suicidal patients also allowed them to assess risk more easily. Physicians who had recently graduated said that at the beginning, using categories to assess patient risk (as 'moderate' or 'high', for example)	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	High
			Relevance	Minor concerns: Some evidence is from a substantially different context to the review question *(4 studies not conducted in the UK; 1 study included staff working with people with suicidal behaviour which did not necessarily include self-harm)*	
			Coherence	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**
		was useful. Paramedics were regularly required to assess whether a patient's risk of further self-harm was high enough to justify coercive measures, which influenced their decision-making. They said they tended to assume that all self-harm had suicidal intent and therefore that all patients who had self-harmed were high risk patients, although they admitted they knew this may sometimes be an incorrect assumption to make. Some patient participants agreed it was important that non-specialist staff could detect suicidal ideation early, as this could enable staff to prevent self-harm before it occurs. Patients who were in prison agreed that when staff had the ability to recognise when something was wrong and react accordingly, this could have the effect of preventing self-harm or suicide. However, these patients reported some prison staff could not always tell when patients were masking their emotional pain, which was a sentiment that other patient participants echoed about other non-specialist healthcare staff. *"And I think there's a massive role because our teams are all based in the community here, they know the people, we know our customers really, really well. Anybody who comes in, we're on first name basis. So we have that relationship with them. We see them very, very often and we can recognise a decrease in symptoms, alarming symptoms, any sort of changes in presentation, we recognise, and we can help and support them quite quickly." (P19, Pharmacist)' p. 5* (Gorton 2019) *"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* (Hom 2020a) *"I knew the officers would come and check on me but ... I thought I had at least 15 minutes. But I didn't - I think he (the SPC) knew something was wrong. (SPC) told an officer to keep an eye on me and five minutes later he came back. If he hadn't come I wouldn't be here" p. 64* (Borrill 2005)	Adequacy	No or very minor concerns	
Sub-theme 1.2: Preventing further self-harm during care					
6 (Doyle 2007, Jelinek 2013, Mughal 2021, Ngune 2020, Rees 2017/	4 studies using semi-structured interviews; 1 study using interviews with	Some non-specialist staff said an important part of their role was ensuring patients did not repeat self-harm while under their care. One aspect of this was behaviour management and de-escalation for patients who could be aggressive, distressed or hostile. ED doctors and nurses agreed and felt that de-escalation would be a useful skill for registrars to have as well.	Methodological limitations	Minor concerns about methodological limitations as per CASP	High

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Rees 2018, Wand 2019)	open-ended questions; 1 study using open-ended questionnaires	Paramedics said that they had to be aware of the influence that patient- or incident-related factors like alcohol could have on a patient's capacity and amend their care accordingly to prevent further harm to the patient or to staff. Paramedics said they usually prioritised the patient's physical safety even if this meant acting paternalistically, or using coercion to take the patient to hospital. They also said that the main role of police when working with people who had self-harmed was to ensure no further harm came to the person or others, by force if necessary. They recognised this presented ethical dilemmas, but felt their most important task was to prevent further harm by any means necessary. On the other hand, ED staff said that creating an environment which the patients perceived as safe was just as important as creating an environment that was actually physically safe, where the patient could not self-harm further. These participants said they achieved this by limiting means of self-harm. Patient participants did not say whether they thought preventing self-harm while receiving health care was as important as staff participants did. However, they did report they had a fear of forced hospitalisation, coercion and loss of confidentiality, which dissuaded them from seeking help from non-specialist staff like GPs. As a result, coercive measures to prevent self-harm as described by some staff participants could result in repeat self-harm in the long term if it resulted in patients avoiding accessing those services. Family members and carers of elderly people who had self-harmed felt it was important that staff provided observation for the patient because they felt the patient needed it to prevent repeat self-harm. However, they acknowledged this could come at the cost of the person's autonomy. *“Now the ethicacy [sic] of that doesn't sit well with me, but if the gentleman is going to die from this overdose then, you know, what's more important life or ethics” p. 63* (Rees 2017) *"It’s about getting patients comfortable enough that they can be assessed properly in an environment they perceive as fairly safe while actually keeping them safe . . . not giving them opportunity to harm themselves further" p. 3* (Ngune 2020) *"I thought they’d hospitalise me immediately. I thought they’d panic and push me away as if, ‘no, you’ve gotta – you know, you’ve got to go into an inpatient*		qualitative checklist	
			Relevance	No or very minor concerns *(2 studies not conducted in the UK, unlikely to affect relevance of the theme)*	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Some evidence is ambiguous or contradictory without a credible explanation for differences	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		unit, and we've got to inform your family, and you've got to quit your course'." p. 10 (Mughal 2021) *"In hospital what has been positive is just having around-the-clock watching of him. Because he does actually need that supervision … he can't be trusted at the moment." p. 598* (Wand 2019)			
Sub-theme 1.3: Ensuring continuity of care paths					
11 (Bailey 2019, Behrman 2019, Cullen 2019, Doyle 2007, Gorton 2019, Hoifodt 2006, Idenfors 2015, Jelinek 2013, Mughal 2021, Rees 2017/ Rees 2018, Vatne 2016)	5 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using structured interviews; 2 studies using open-ended questionnaires; 2 studies using surveys	GPs expressed it is important to know when it is appropriate to refer a patient on to more specialist staff. ED staff also felt being able to refer patients on to appropriate care was an important skill, and expressed that referral should be done quickly as a way to facilitate movement between services. These participants wanted more information about community resources so they could feel more confident about discharging patients into outpatient care. Paediatricians felt non-specialist staff could be too quick to refer out with no follow-up, and that this was linked to stigma surrounding self-harm. Pharmacy staff said a large part of their role was referring patients on to other healthcare staff. They said they relied on signposting patients to GPs because they were unsure where else to refer patients to, and identified this as a knowledge gap. Physicians felt that it was important to establish follow-up care for patients by referring them on to specialist services, or arranging admission to hospital. Paramedics acknowledged the importance of continuing care pathways in their role but felt this was hampered by the lack of referral facilities. They thought that they should be able to refer patients directly to mental health crisis team units instead of to Accident and Emergency units (A&E), because they often felt the ED was not the best place for patients to go in the moment. Some patient participants felt dismissed when they were referred elsewhere, and saw signposting as an indication that the staff member did not want to see them. However, other patients appreciated formal referrals because they found it difficult to contact healthcare services themselves. Patients wanted staff to be able to provide patients with options regarding next steps as well as information regarding which path would be best for them. Some patient participants could also feel abandoned if follow-up treatment or a referral was not scheduled for them, especially if a staff member had made promises regarding further treatment. These participants reported that the additional worry about whether they had been forgotten could lead to repeat self-harm.	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Minor concerns: Some evidence is from a substantially different context to the review question *(4 studies not conducted in the UK; 2 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)*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		"there's not very good referral systems, so it would be good if a patient came in and they have any mental health problems or you are feeling suicidal, or have been self-harming, I could call someone, you know, I know I could call someone, almost like log it, that this had been an issue. And then it would, they would get seen, do you know what I mean?" (P1, Pharmacist)' p. 10 (Gorton 2020) *One young person suggested that their GP did not "really want to pay us much attention", while another in the same focus group said: "When I try to see my doctor they always refer, just send me to a nurse instead of the actual GP which is annoying because he is my GP and he is supposed to be able to see me" [FG8].' p. 624* (Bailey 2019) *"I called him: he was fantastic when I had that depression last year. And so I told him over the phone that . . . , well, now I just tried to take my own life. 'Would you like to come in and talk about it?' he replied. So I got an appointment right away, and while I sat there, he wrote an application to the emergency ward and called them, and then all I had to do was go directly to the emergency ward." p. 302* (Vatne 2016)	Coherence	Minor concerns: Some evidence is ambiguous or contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	
Sub-theme 1.4: Ability to provide medication appropriately					
12 (Bailey 2019, Behrman 2019, Borrill 2005, Gorton 2021, Hom 2020a, Hom 2020b, Idenfors 2015, Jelinek 2013, Mughal 2021, Ngune 2020, Storey 2005, Wand 2019)	5 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using structured interviews; 1 study using interviews with open-ended questions; 1 study using interviews; 2 studies using focus groups; 1 study using surveys	GPs acknowledged that they often offered medication as an initial treatment step because people presenting with self-harm were usually co-presenting with a comorbidity such as depression. They felt it was important to express to patients that medication was a first step and that there was further treatment that could be provided. Paediatricians, however, felt that staff could be too eager to prescribe medication, which could be unhelpful for the patient. Pharmacy staff did not tend to believe patients were likely to attempt self-harm using medication they provided, although those with multisector experience acknowledged it was a possibility. Pharmacy staff who had worked in other sectors said an important part of their role was to be aware the prevalence of medication stockpiling among people who self-harm and prevent it happening. ED doctors and nurses felt that a knowledge of newer medications was important because best practice for medication management tended to change often. ED staff also said that an important part of their role was providing adequate pain relief and suturing cuts, as they often needed to attend to physical health needs of people who had self-harmed before any mental health needs. Overall, non-specialist staff wanted more knowledge regarding how to provide medication appropriately to patients who had self-harmed.	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Minor concerns: Some evidence is from a substantially different context to the review question *(6 studies not conducted in the UK; 1 study included staff working with/*	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		Patient participants acknowledged medication could be helpful for treating comorbidities but some disagreed with staff views and felt that medication should either be prescribed alongside psychiatric interventions, or be a last resort after other treatment options had been explored. Many patients saw being prescribed medicine immediately after presenting to non-specialist staff as impersonal, an act of dismissal, and an indication that staff had not listened to their concerns. Another patient participant said they had suffered harm due to being overmedicated by staff. However, some patients reported that their medication helped them stop self-harming, and one patient who was in prison noted that she repeat self-harmed when her medication was provided late. One patient said they appreciated when non-specialist staff could provide in-depth knowledge about the medication they were prescribed, as it made them feel more comfortable about the prescription. The patient participants' experiences highlight the importance of non-specialist staff's ability to recognise the benefits and limitations of medication, and provide it when appropriate, without overly relying on it for treatment. Parents echoed that they thought medication was too quickly prescribed by non-specialist staff. However, family members and carers of elderly people who had self-harmed were frustrated when staff dismissed their insistence that the patient needed medication for another problem, and did not provide any until after the patient had self-harmed. They felt that self-harm should not be a catalyst to provide medication that should have been given pre-emptively. *'"Stigma of mental illness persists even among physicians, we are either too quick to prescribe Rx or refer out with no follow up." p. 876'* (Behrman 2019) *"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) *"I've always been fobbed off with antidepressants and that." p. 73* (Storey 2005) *"Well he asked that many times [for medication for dizziness], and she [GP] sort of blew him off. And then, when all this happened [self-harm] …. the first thing she [GP] said …. was 'I'll give you that prescription for Serc that you've*		*people with suicidal behaviour which did not necessarily include self-harm, and parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	Minor concerns: Some evidence is ambiguous or 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**
		been asking for.' Now why didn't she damn well give them to him months ago? And this wouldn't have happened." p. 597 (Wand 2019)			
Sub-theme 1.5: Ability to recommend coping techniques					
7 (Behrman 2019, Fox 2015, Hom 2020a, Idenfors 2015, Jelinek 2013, Ngune 2020, Vatne 2016)	3 studies using semi-structured interviews; 1 study using structured interviews; 1 study using open-ended surveys and semi-structured interviews; 1 study using focus groups; 1 study using surveys	GPs saw self-harm as a coping mechanism in and of itself and felt it was important to recognise that immediately trying to stop patients from self-harming could be harmful to them in the long-term. ED staff acknowledged that alternative coping techniques needed to be provided to patients. They said they wanted to be able to provide brief psychotherapeutic interventions that would help people with mental health related presentations establish alternative, non-harmful strategies to cope with distress. Patient participants wanted to be given techniques to cope with their problems and felt it was unhelpful when non-specialist staff (such as paediatricians) did not provide this aspect of care. They also felt that non-specialist staff often failed to prepare the patient for the fact that relapses could occur as a normal part of recovery, which patients said was an important piece of advice that could have helped them when repeat self-harm occurred. *"she's using this as a way of coping with stress and you can't suddenly stop her from doing it because actually that's a coping mechanism she's developed and it's going to take some time for her to be able to change that behaviour and putting more pressure on her isn't going to help" p. 417* (Fox 2015) *"Try to work with them in practical ways to give them alternatives [to reduce further self-harm]. Referring them to someone that is going to . . .. teach them enduring ways of dealing with their distress." p. 4* (Ngune 2020) *"Medication is only one part of the solution. We need therapy as well. We need coping mechanisms." p. 5* (Hom 202a) *"I think they (pediatricians) left out a really important thing. And every single one of them left it out. And it's that you're going to mess up. So, preparing us for downs and for relapses is really important." p. 876* (Behrman 2019)	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 *(4 studies not conducted in the UK; 1 study included staff working with/ people with suicidal behaviour which did not necessarily include self-harm, and 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 Knowledge

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 2.1: Formal training on working with people who have self-harmed					
11 (Awenat 2017, Behrman 2019, Chapman 2014, Cullen 2019, Fox 2015, Gorton 2019, Hoifodt 2007, Jelinek 2013, Ngune 2020, Rees 2017/ Rees 2018, Vatne 2016)	6 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using open-ended surveys and semi-structured interviews; 2 studies using open-ended questionnaires; 1 study using focus groups	Many non-specialist staff noted that they had a lack of knowledge of best practice for caring for people who had self-harmed, or mental health-focused care in general. Most staff participants felt that training should have a communication focus (see theme 'Creating an open line of communication'). GPs and ED staff felt that having experience working with mental health patients was also important in helping them build confidence. GPs stressed that training in the following areas would be useful: addressing myths around self-harm; how to raise the topic of self-harm; language to discuss self-harm, including questions to ask; how to handle consultations with parents of people who have self-harmed. GPs and ED staff wanted training to involve people with personal experience of self-harm, and to be available in a range of formats, including interactive, online, face-to-face, and through the provision of resources. GPs also mentioned it was important for practice nurses (PNs), health care assistants and reception staff to receive training because of their role in identifying and supporting people who have self-harmed. Pharmacy staff had concerns about discussing self-harm with patients without sufficient training and were unsure whether it was a part of their job role. They wanted training so they could be sure they had interacted with people who have self-harmed appropriately. Pharmacists mentioned that it might be more useful to train pharmacy support staff than pharmacists regarding self-harm, because support staff were more likely to be familiar with the local community. ED nurses wanted training on establishing therapeutic rapport and caring for people who had self-harmed with a variety of backgrounds and experiences, including people presenting with self-harm for the first time. All ED staff wanted broader psychiatric training as well as general education about why people self-harm, and felt it was important that ED registrars in particular received this training. ED staff and paediatricians both wanted training on how to care for patients with co-morbidities (such as substance use/ abuse). Paediatricians noted they needed training in early detection skills as well as education on how to prescribe (see theme 'Ability to prescribe medication appropriately'). All staff participants wanted training on risk factors for self-harm and identifying patients at risk (see theme 'Ability to accurately assess risk of self-harm'). A number of participants, including physicians who had recently graduated said role-playing situations with patients was an important facet of training as it allowed them to empathise with patients better and learn how to communicate effectively with people who had self-harmed in a low-stakes setting. ED staff noted that the lack of training about self-harm, particularly in undergraduate education, meant that many non-specialist staff	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 conducted in the UK; 3 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	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		members were required to learn these skills on the job through trial and error. Paramedics reported their over-reliance on coercive strategies for patients who had self-harmed was because their training and competence did not support their decision-making (see theme 'Preventing further self-harm during care'). *"We are lacking early detection skills and education on depression, anxiety, and dual diagnosis" p. 877* (Behrman 2019) *"educate nurses on identifying patients at risk and establishing a therapeutic rapport" p. 5* (Cullen 2019) *"I think that ED registrars would also benefit from more psychiatric training. I did quite a bit of psych in my ED training. I think it's something that people working in the ED probably could do with more training, particularly in the registrar phase when they are learning new skills anyway." p. 4* (Jelinek 2013)			
Sub-theme 2.2: Ability to recognise the underlying causes of self-harm					
8 (Behrman 2019, Borrill 2005, Hom 2020a, Hom 2020b, Jelinek 2013, Mughal 2021, Ngune 2020, Rees 2018)	5 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using focus groups; 1 study using surveys	Some staff participants felt it was important to establish the context or reasoning behind self-harm, and for many staff this included the ability to diagnose patients who had self-harmed with potential co-morbidities. ED staff and paediatricians felt that they had knowledge gaps in this area and therefore wanted training on differentiating psychiatric disorders, diagnosing personality disorders, and dual diagnosis. ED staff also more generally referred to the need to understand the patient's reason for self-harm, which they described as being a separate issue from diagnosis. They said that having a background understanding of why people self-harm would allow them to interact with patients more effectively and elicit their personal reason for self-harming, which staff could then address. Patients wanted non-specialist staff to get to the heart of the issue so they could receive the appropriate care. Some participants felt this involved exploring their background, history and cultural factors. Patients also said it was unhelpful when staff made assumptions about them without attempting to listen to their concerns. For example, some patients reported that being given a diagnosis without being asked any questions about their personal life made them feel as though staff had minimised the patient's concerns about other underlying causes. This was seen as particularly unhelpful when it was	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Minor concerns: Some evidence is from a substantially different context to the review question *(4 studies not conducted in the UK; 1 study included staff working with/ 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**
		accompanied by a prescription for a diagnosis the patient did not necessarily agree they had. Patient participants tended to view diagnoses from non-specialist staff negatively, however this was usually when they felt staff had not effectively opened communication and actively listened to them. *I think we didn't understand all the diagnoses. I think we would have loved a bit more training on different illnesses with mental health. . ." p. 4* (Jelinek 2013) *"[Understanding] the reason for the self-harm. . .. what's been going on and trying to put things in place for them to be able to deal with those reasons and resolve the crisis they are in at the time."* p. 4 (Ngune 2020) *"The first doctor I went to said, 'Oh, you have OCD and there's medication for it. It's a chemical imbalance. The anxiety and depression are probably part of the OCD.' Never went into my past, never asked me a lot of questions or really talked to me." p. 178* (Hom 2020b)		*behaviour which did not necessarily include self-harm, and parents of people who had died by suicide or were receiving mental health services)*	
			Coherence	Minor concerns: Some evidence is contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	
Sub-theme 2.3: Knowledge of formal processes					
6 (Cullen 2019, Gorton 2020, Hom 2020a, Hom 2020b, Jelinek 2013, Rees 2017)	3 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using open-ended surveys; 1 study using surveys	ED staff felt it was important to have an understanding of formal processes, including how legal requirements for filling out documentation for patients who had self-harmed, and what was expected of staff when handling inpatient stays. These participants also mentioned that they had knowledge gaps in understanding mental health legislation in general. ED staff also wanted guidelines about sedation, which they said should include guidance on how and which patients to sedate. Pharmacy staff wanted a well-defined formal process or Standard Operating Procedure (SOP) to be created for referral, which they said would allow them to refer people to the correct staff and ensure patients got the help they needed (see theme 'Ensuring continuity of care paths'). Paramedics reported that knowledge of legality relating to care for patients who had self-harmed was vital to their role in order to avoid sanctions, loss of professional registration, or being held legally accountable for adverse events. However, they felt that they needed to have the ability to balance legality and their own judgment of good practice, as there were sometimes conflicts between the two. Some felt that although they wanted to meet legal requirements, their priority was providing care that they felt met the best interests of the patient, even if this was against the wishes of a	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	Minor concerns: Some evidence is from a different context to the review question *(4 studies not conducted in the UK)*	
			Coherence	Minor concerns: Some evidence	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		patient with capacity to make decisions (see theme 'Preventing further self-harm during care'). This highlights the fact that a knowledge of legal processes needs to be supplemented by support for decision-making in situations where the best course of action is not always clear. 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. *"clear accreditation guidelines on what is required for interval assessment and documentation on self-harm patients, …guidance and training…if an ED provider is to ever be 'releasing' a involuntary psych hold patient before the expiration of that hold. Also if an ED stay awaiting an inpatient bed extends over the 24 hour time frame, is there required expectations of the ED provider" p. 5* (Cullen 2019) *"He was saying, "I'm not going, I'm refusing to go. I want to kill myself," and I think would it be possibly legal for me to assess his mental capacity and he's refusing to go, fill in a form and he'd have been happy for me to go, but ethically and morally I think it would have been wrong to do that. So instead I was there for hours." p. 63* (Rees 2017) *"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* (Hom 2020b)		is contradictory without a credible explanation for differences No or very minor concerns	
Sub-theme 2.4: Sharing information with colleagues					
8 (Behrman 2019, Borrill 2005, Gorton 2021, Hoifodt 2007, Mughal 2021, Ngune 2020, Rees 2017, Vatne 2016)	6 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using focus groups	All staff participants said they valued the ability to share knowledge and information regarding patients who have self-harm with other staff. Pharmacy staff said they had to infer information about patients based on their prescriptions, including whether a patient was at risk of self-harm. They wanted better communication from other healthcare staff regarding patients who had self-harmed so they could understand, for example, why people were prescribed repeat medication in small quantities. Physicians who had recently graduated felt they picked up a lot of knowledge and skills from more experienced staff (whether specialist or non-specialist), and valued working in	Methodological limitations Relevance	Minor concerns about methodological limitations as per CASP qualitative checklist Minor concerns: Some evidence	High

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		inter-disciplinary teams for this reason. They also reported that having the ability to share their own experiences working with patients who have self-harmed with other staff helped them reflect on how they could improve their skills and receive feedback, which helped boost confidence. ED staff felt that having specialist staff to talk to about mental health presentations enabled them to learn how to care more effectively for patients who had self-harmed. Paramedics said they needed far more support and information sharing from other healthcare professionals, and the fact that they rarely received this made them feel isolated, especially when they had to make decisions about a patient's care alone. For example, paramedics felt confused and put in an uncomfortable position when they had to make decisions about a patient's capacity without advice from other healthcare professionals. Patient participants, specifically patients in prison, reported the difficulty of having to repeat their concerns to multiple different people. Other patient participants reported that communication and collaboration between specialist and non-specialist staff was helpful and allowed them to feel more secure regarding decisions made about their care. Parents of people who had self-harmed agreed with patients that it is a failure of the mental health care system when providers do not communicate regarding the patient's care. *"To exchange experiences with colleagues has been rewarding, especially when you get to talk to a more experienced colleague and tell about one's own experiences, not necessarily to hear if you did right or wrong, but to describe and go through the situation." p. 5* (Hoifodt 2007) *'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.'* (Vatne 2016) *"they (providers) don't talk to each other." p. 876* (Behrman 2019)		is from a substantially different context to the review question *(2 studies not conducted in the UK; 1 study included staff working with/ people with suicidal behaviour which did not necessarily include self-harm, and 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 8: Summary of evidence (GRADE CERQual): 3 Engagement with the patient

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 3.1: Creating an open line of communication					
18 (Awenat 2017, Bailey 2019, Behrman 2019, Borrill 2005, Chapman 2014, Doyle 2007, Fox 2015, Gorton 2019, Hoifodt 2006, Hom 2020a, Idenfors 2015, Mughal 2021, Ngune 2020, Rees 2018, Storey 2005, Vatne 2016, Wadman 2018, Wand 2019)	8 studies using semi-structured interviews; 1 study using narrative interviews; 1 study using structured interviews; 1 study using interviews with open-ended questions; 1 study using interviews; 2 studies using open-ended questionnaires; 1 study using surveys; 1 study using open-ended surveys and semi-structured interviews; 2 studies using focus groups	Non-specialist staff felt that confidence and competence in communicating with patients who have self-harmed was an important skill. For example, ED nurses and pharmacy staff felt that they helped patients when they actively listened and talked with them, while physicians said that establishing a good connection allowed them to trust that the patient was telling them the truth. Staff recognised that a poor line of communication was a barrier to effective care to the detriment of the patient, but were sometimes uncertain how to talk to people who had self-harmed and reported a lack of confidence in their communication skills. This could prevent them from effectively communicating with the patient at all. ED staff and physicians could not always manage to find a way to encourage patients to talk about their problems if the patients were reluctant to discuss them or 'uncooperative', and felt this affected their ability to provide appropriate care. GPs also lacked confidence in talking to people about self-harm and said that communication with people who had self-harmed was a skill they wanted to develop further. One aspect that GPs thought helped to facilitate open communication was gauging whether conversations with young people regarding self-harm should be held alone so they could talk more candidly, or with family members or carers present as an element of support. This required the skill to assess the patient's maturity and confidence levels, as well as negotiating issues around parental rights and responsibilities versus the patient's best interest. Paramedics agreed that they often had to make judgments around whether it was best for family members to be present when attending to patients who had self-harmed, and reported that patients tended to communicate more openly when family members were not there. GPs additionally said that adapting their language to the individual and mentioning the fact that other people self-harm were techniques that encouraged young people to open up about their self-harm as it made them feel less alone and reduced stigma around self-harm. GPs felt that screening questionnaires could be a barrier to creating an open line of communication because they were too formal and limited discussion time in an appointment. Patient participants wanted to be listened to and to engage in useful discussions with non-specialist staff regarding self-harm and their concerns. This was because sharing their concerns gave some participants a sense of relief and lightened their emotional burden. One participant said they appreciated being able to talk to their family doctor because they provided a sense of confidentiality that they could not get from family or friends. On the	Methodological limitations	Minor concerns about methodological limitations as per CASP qualitative checklist	High
			Relevance	Minor concerns: Some evidence is from a substantially different context to the review question *(5 studies not conducted in the UK; 3 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	

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
		other hand, patients who had been in foster care or residential homes were hesitant to talk to social workers about their self-harm because they knew doing so would result in other people getting involved. Patients wanted to be spoken to as individuals, with their own specific problems, wants and needs beyond just their self-harm or any other diagnosis. This was facilitated when non-specialist staff developed a rapport with the patient, which could happen when there was continuity with staff like GPs. Patients felt as though they were not being heard if their distress was minimised, disbelieved, or dismissed - this dissuaded communication when patients wanted to have their concerns heard and believed by staff. Young participants in particular noted that their distress might not be taken seriously because of their age. Patients who were in prison appreciated when prison staff spoke and listened to them after their self-harm, and those who were not given this opportunity said they felt deprived of this aspect of care when they most needed to talk to someone. Patient participants felt that empathy was an important aspect of active listening and allowed staff to get to the heart of the problem (see theme 'Positive attitude'). These participants appreciated being encouraged to open up about their feelings and felt that this had a positive effect on their mental health, which was echoed by other patient participants who wanted to be asked the 'right questions' and invited to tell their narrative. Some patient participants gave useful suggestions as to what non-specialist staff could do when they were not sure what to say in response to disclosure of self-harm, such as using self-help materials as a conversation prompt. Family members and carers for elderly patients who had self-harmed were not convinced that the person they cared for were honest with non-specialist staff about their self-harm. As a result, they thought staff should attempt to communicate with family and carers in order to receive the full picture regarding the patient's self-harm. They, too, felt frustrated when staff dismissed their concerns when they knew the patient well and therefore had a lot of information regarding their self-harm. *". . .it makes me feel useful when caring for patient with [deliberate self-poisoning]. . . . maybe it would make a difference or changes patient view by active listening, talking with them, being supportive . . ." p. 143* (Chapman 2014) *"Take time to listen and make sure you're not jumping to conclusions." p. 6* (Hom 2020a)			

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		"I was pleased that he had done something but really I didn't want to be put on antidepressants. I would have preferred to have just been able to talk to somebody. I think that's probably what I needed, rather than just take tablets or something." p. 73 (Storey 2005) *"One doctor I spoke to … he was really dismissive … dismissing with a wave of the hand the observation of someone who'd known him [patient] for a long time." p. 598* (Wand 2019)			
Sub-theme 3.2: Making time for the patient					
5 (Bailey 2019, Borrill 2005, Chapman 2014, Mughal 2021, Ngune 2020)	3 studies using semi-structured interviews; 1 study using focus groups; 1 study using open-ended questionnaires	GPs in particular reported it was an important skill to balance the time constraints of appointments with the necessity of addressing peoples' concerns regarding self-harm or suicidality. GPs knew it was important to both provide information and have a conversation about self-harm, but said this was very difficult to do in the time allotted. They tentatively suggested double appointments as a way to enable staff to make time for patients. In contrast, some ED nurses felt that making time for patients was not a necessary skill. These participants said the ED was an inappropriate place to explore mental health-related issues linked to self-harm because their focus was on emergency care and therefore they could not make time for mental health concerns. Other ED staff agreed that they did not have enough time to provide the care that patients who had self-harmed needed because their role was often limited to physical care, but found this to be a source of frustration because they thought that having time to care for people who had self-harm was important. Patient participants agreed that GP and PN consultations often felt rushed and that double appointments would be useful. Patients who were in prison found it difficult to approach staff who they perceived to be too busy to have time for them, which discouraged patients from speaking up about their concerns. *"Mental health disorders often come in a 10 minute consultation and it often takes 20 minutes. When you are at 15 minutes perhaps we might not have made time for that question but I think now many of us do" p. 624* (Bailey 2019) *". . .In the ED the focus of care is on the emergency not the mental health/counselling. I feel as if I 1) don't have time to explore MH [mental*	Methodological limitations	Moderate concerns about methodological limitations as per CASP qualitative checklist	Moderate
			Relevance	No or very minor concerns *(1 study not conducted in the UK, unlikely to affect relevance of the theme)*	
			Coherence	Minor concerns: Some evidence is ambiguous or contradictory without a credible explanation for differences	
			Adequacy	Minor concerns: Findings were based on 5 studies with a large sample size but understanding of the theme would	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		health] issues, 2) aren't encouraged to explore MH issues, 3) don't feel as though the department is the right place to explore this. The emergency room is designated to deal with emergencies. . . ." p. 143 (Chapman 2014) *"Continuity and a good frequency of GP appointments is really helpful. You don't build up a rapport in one appointment, it's 10 minutes, and some place it's five minutes, you need time to do that, quite often they'll book double appointments knowing that I've only got one problem." p. 12* (Mughal 2021)		benefit from richer data	
Sub-theme 3.3: Being collaborative					
4 (Behrman 2019, Hom 2020b, Mughal 2021, Vatne 2016)	2 studies using semi-structured interviews; 1 study using unstructured interviews; 1 study using focus groups	Some patients said it was helpful when staff adapted their care to the patient's needs. They wanted to be consulted before decisions were made about their care, especially when being prescribed medication. Parent participants echoed this concern. Patients wanted to be involved with discussions regarding their care and care planning because they felt this facilitated help-seeking and provided a sense of security. Patients said it was unhelpful when they were given instructions without any further information about why they were being told to do something. *"Nobody asked me my thoughts. Nobody asked me my opinion. Nobody asked me what was or wasn't working." p. 178* (Hom 2020b)	Methodological limitations	Moderate 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 *(3 studies not conducted in the UK; including 1 study which included staff working with/ people with suicidal behaviour which did not necessarily include self-harm, and parents of people who had died by suicide*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
				or were receiving mental health services)	
			Coherence	No or very minor concerns	
			Adequacy	Minor concerns: Findings were based on 4 studies with a moderate sample size but understanding of the theme would benefit from richer data from more/ different groups of participants	

Table 9: Summary of evidence (GRADE CERQual): 4 Communication style

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 4.1: Evasive versus candid					
7 (Awenat 2017, Bailey 2019, Behrman 2019, Fox 2015, Hom 2020a, Ngune 2020, Rowe 2017)	3 studies using semi-structured interviews; 1 study using open-ended surveys and semi-structured interviews; 1 study using surveys; 2 studies using focus groups	Non-specialist staff were conflicted about whether it was more helpful to address the topic of self-harm in conversation or to avoid it. Some staff had concerns about opening the conversation up to discussion of sensitive topics because they were worried about causing harm to patients by discussing self-harm or suicidality, while others were guarded because they were concerned about being held responsible if a patient self-harmed or attempted suicide. These participants used euphemistic language, avoided direct conversation about self-harm or suicide, or changed the subject if the patient mentioned it. The participants who were evasive recognised this may not be to the benefit of the patient, but they were not confident enough to maintain conversation about self-harm. Other staff had the opposite issue where they felt their method of raising the subject of self-harm was too confrontational. Some staff felt that talking to a patient about sensitive topics was valuable, but said bringing up the subject sensitively was an important skill. They said it was	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 *(3*	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
		important to be candid about the reality of self-harm and suicide rather than avoiding acknowledgement of these issues, and that they had a duty as caregivers to learn the appropriate language to discuss sensitive topics. GPs, for example, felt that the topic should never be ignored. They preferred to directly ask about self-harm, though they used specific techniques to lessen the impact of stigma and distress which could arise when discussing self-harm (see theme 'Creating an open line of communication'), and were careful to raise the subject in a sensitive manner, after establishing rapport with the patient. ED staff in particular wanted to know patients' opinions on how they should approach the topic of self-harm. Patients said they did not appreciate when sensitive topics such as suicidal ideation were avoided by staff. Participants who mentioned this theme wanted staff to broach these topics instead of being left to bring them up themselves. Even if patients did not expect non-specialist staff to treat their mental health, participants said they wanted staff members to acknowledge they were unwell, which allowed them to feel comfortable receiving care. Parents felt that clinicians' reluctance to acknowledge and discuss sensitive subjects could result in patients at risk being 'missed'. *"It can make them [staff] very risk-averse, it makes people defensive, not defensible… They will constantly exercise on the side of caution… to the detriment of the patient really… where they are actually almost inert… they're just… frozen." (Nurse: 01)' p. 106* (Awenat 2017) *"Everyone was like "you can't say words like that!" and I was like "well I can say words like that", because we're people and we're professional services. So I think, learning how to say those words, you know, "if you want to kill yourself, or if you're attempting suicide", sometimes being stark about it is actually beneficial because I think... it's putting a situation into reality." (Nurse assistant/ support worker: 02)' p. 105* (Awenat 2017) *"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)		*studies not conducted in the UK; 2 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	Moderate concerns: Most evidence is ambiguous or contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	
Sub-theme 4.2: Positive attitude					
15 (Bailey 2019, Behrman 2019,	6 studies using semi-structured	Patient participants wanted communication with non-specialist staff to be empathetic, compassionate and positive, with assurances of hope for the	Methodological limitations	Moderate concerns about	Low

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Borrill 2005, Chapman 2014, Cullen 2019, Doyle 2007, Gorton 2019, Hoifodt 2006, Hom 2020a, Hom 2020b, Idenfors 2015, Mughal 2021, Ngune 2020, Rees 2017/ Rees 2018, Vatne 2016)	interviews; 1 study using narrative interviews; 1 study using structured interviews; 1 study using unstructured interviews; 3 studies using open-ended questionnaires; 1 study using surveys; 2 studies using focus groups	future. Hopeful communication was defined as staff expressing conviction that patients could stop self-harming and that their mental health concerns could improve. Patients also wanted to be treated with dignity; this meant being spoken to with respect, in a polite and non-judgmental manner. They reported fear of being perceived negatively due to stigma around mental health and self-harm, which discouraged them from disclosing self-harm to non-specialist staff. Overreactions to disclosure of self-harm reinforced stigma, whereas being spoken to without blame, fear or stigma allowed them to realise that they did not need to feel ashamed. This helped establish trust, which made them feel validated and broke down some of the barriers to accessing care. On the other hand, some patient participants received what they felt was a disproportionately casual response to their disclosure of self-harm; this was a reaction that dissuaded them from help seeking in the future because they interpreted this as meaning the clinician did not think self-harm was a concerning behaviour. Patient participants, including patients who were in prison, reported that negative or shaming comments (such as the implication that other patients were more deserving of treatment) were belittling and distressing. Patients did not want to be made to feel guilty for having repeat self-harmed and wanted staff to be patient with them. At the same time, patient participants did not want to feel as though they were being pitied by staff. Staff participants said that a main facilitator for positive communication was having the ability to empathise with patients. Those who previously had negative perceptions of patients who had self-harmed reported that a change in attitude to be more understanding improved their caring ability. ED staff agreed that showing empathy and understanding to patients was an important aspect of their role because they had a duty of care to treat patients with respect and dignity. Physicians said that having empathy for patients allowed them to relate to patients, which aided with communication. Pharmacy staff felt it was important to develop their personal attitudes about self-harm in order to combat stigma. Paramedics thought it was important they learned about the reasoning behind self-harm as this could allow them to overcome their own negative attitudes and therefore improve their interactions with patients who had self-harmed. Even when stigma of mental illness persisted among non-specialist staff, participants agreed it was important not to let negative perceptions affect their communication with the patient. For example, some physicians said that even if they could not relate to their patients, they knew that expressing those negative opinions would be unhelpful.		methodological limitations as per CASP qualitative checklist	
			Relevance	Moderate concerns: Most evidence is from a substantially different context to the review question *(7 studies not conducted in the UK; 2 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	Minor concerns: Some evidence is ambiguous or contradictory without a credible explanation for differences	
			Adequacy	No or very minor concerns	

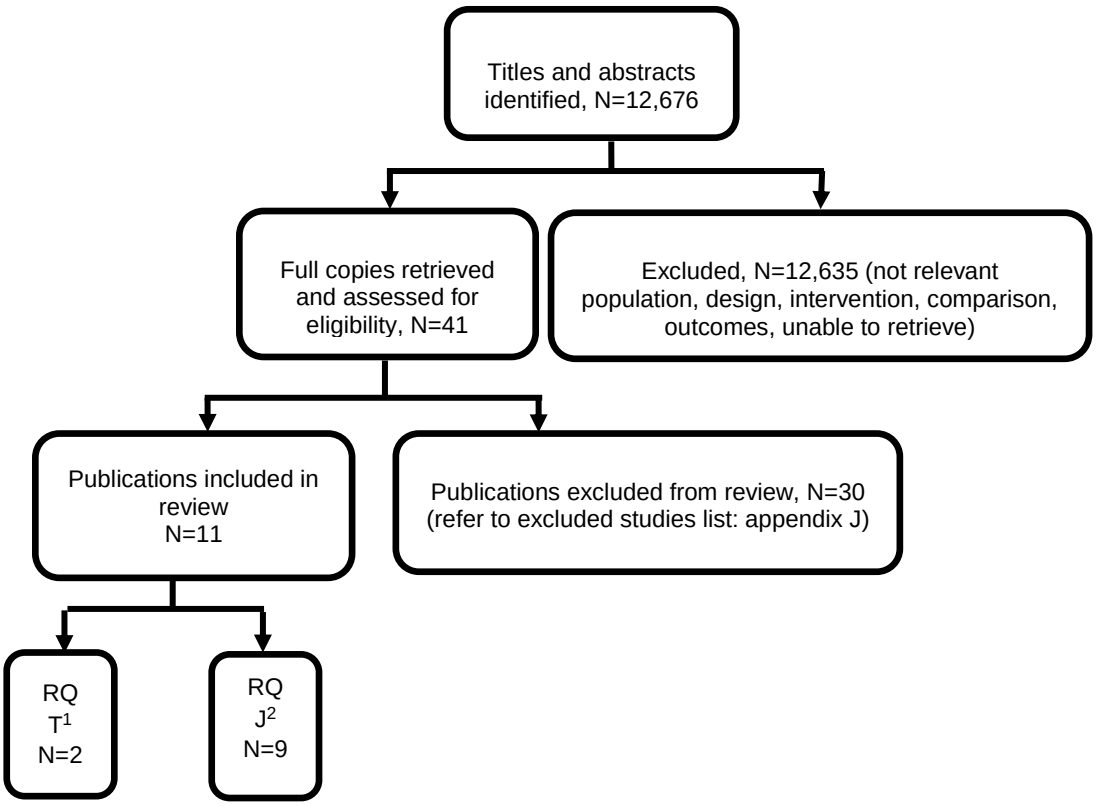
Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		"[shame], 'tough love,' and pity aren't effective responses to someone who's just attempted to end their life." p. 4 (Hom 2020a) *"And the first person I spoke to, was the pharmacist … he was totally calm about it … but it was the changing point in my life that I actually realised that it's not something to be ashamed of." p. 8* (Mughal 2021) *"It was… hmphh [small sigh]… it was pretty positive, I mean he was, he was understanding, very non-judgemental, warm, I felt comfortable telling him everything […] one thing that did not feel quite right was the way he responded […] like I told him I don't know… 'I have a sore throat'" p. 9* (Mughal 2021) *"I've noticed improvements within my own attitudes but that's because it needed to change. [I] have . . .. more knowledge and. . ..understanding [about self-harm]. I know my attitudes have changed." p. 3* (Ngune 2020) *"Everybody needs to be treated with dignity and respect. I think perhaps that wasn't there in the past, that people were often dealt with contempt, and very little understanding. And it can only be a more professional thing for our standing." p. 62* (Rees 2017)			

Appendix G Economic evidence study selection

Study selection for review question: What are the views and preferences of staff in non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 P (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?), 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?), and S (What are the views and preferences of staff in non-specialist settings about what supervision is required for staff in specialist 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 107 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 (107-77 =) 30 studies not listed in the excluded studies tables below, which are are studies that met the inclusion criteria for review questions P, Q, 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*
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 services among people who self-harm:	- Systematic review - included studies checked for relevance

Study	Code [Reason]
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 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist 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 non-specialist settings, people who have self-harmed and their family members/carers about what skills are required for staff in non-specialist settings who assess and treat people who have self-harmed?

Table 12: Theme 1: Self-harm prevention

Study	Evidence
Sub-theme 1.1: Ability to accurately assess risk of self-harm	
Borrill 2005	"I knew the officers would come and check on me but ... I thought I had at least 15 minutes. But I didn't - I think he (the SPC) knew something was wrong. (SPC) told an officer to keep an eye on me and five minutes later he came back. If he hadn't come I wouldn't be here" p. 64
Borrill 2005	"If they see you smiling they think you're all right.. but I'm just trying to be strong for my friend" p. 64
Cullen 2019	“educate nurses on identifying patients at risk and establishing a therapeutic rapport” p. 5
Doyle 2007	‘Many of the nurses reported that undertaking an assessment of the patient was their main role in caring for patients with suicidal behaviour. This assessment mainly focused on risk assessment including recognizing the potential risk of further acts of suicidal behaviour.’ p. 1219
Fox 2015	"if you think you have got an eleven, twelve, thirteen year old who is self - harming you could probably get in there quite quickly, do a bit of work and help them to process emotional distress in a safer way" p. 417
Gorton 2019	‘“And I think there’s a massive role because our teams are all based in the community here, they know the people, we know our customers really, really well. Anybody who comes in, we’re on first name basis. So we have that relationship with them. We see them very, very often and we can recognise a decrease in symptoms, alarming symptoms, any sort of changes in presentation, we recognise, and we can help and support them quite quickly.” (P19, Pharmacist)' p. 5
Hoifodt 2006	‘Sometimes physicians did not manage to establish a solid dialogue and were insecure about how the patient was feeling. However, with the patients who showed signs of serious mental illness, the doctors knew what to do and found the situation easier to handle. […] "I try to get an impression of the social situation, friends, family, job, how he feels in his relationship to these people and his life situation, how he looks upon his future and perhaps the past, experiences of his daily life, his life situation, how he thinks about himself and his relations to these different elements in his life situation."’ p. 4
Hoifodt 2006	"He was so serious all the time. You could see that he was striving, he couldn't loosen up, and he carried a burden with him all the time. He ate well, slept well, was well kept, but his [pent up] emotions dominated the situation." p. 4
Hoifodt 2007	"It was some kind of a recipe, using several questions and in a way, developing a score for moderate and high risk." p. 4
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

Study	Evidence
Idenfors 2015	'One interview person described how it was too easy to pretend that she was feeling fine, which led to a premature discharge.' p. 203
Jelinek 2013	"Knowledge of current [assessment] tools is perhaps not what it should be." p. 3
Ngune 2020	"There is a culture [from colleagues] about "why are you over triaging this person ... [allocating a triage category higher than the actual level of acuity]. ... There is a culture of they've not got a physical thing wrong with them [so] why did you make them a category 2, to be seen within 10 min? [Even when the person is] at risk of self-harm and at risk of absconding and [they] have no support person with them. ... [There is a culture of] just pop them in a chair over there and keep an eye on them until someone is ready to see them rather than triaging them up and getting them to see the right person, speedily." p. 3
Ngune 2020	"[My role is] to accurately apply the national triage scale section which applies to mental health. ... I am confident that triaging according to it actually triages people quite high. ...From a triage point of view, it's about knowing what to do. ... Making sure they are triaged [up]. Being able to justify and defend those decisions. . ... [It's about] advocating for them to go into a space [in the ED]. ... [I] also try to front load some of the assessments." p.3
Rees 2017	"I think the question of suicidal intent, as interpreted by myself as a paramedic, anybody who causes them self, self-harm then, you know, we automatically assume, and perhaps wrongly on occasions, that the intent is always an attempt at suicide" p. 63
Rees 2018	'When 'on-scene', contextual factors continued to influence care, although crews now emphasised the importance of patient and incident related influences. […] "Alcohol can affect somebody's judgement, their mood, and you know, the way that they see things, and then they can be quite easily sort of wound up."' p. 5
Sub-theme 1.2: Preventing further self-harm during care	
Doyle 2007	'Another role identified in the data was the creation of a safe environment for the patient and many participants spoke about observation and removal of harmful objects as being their primary interventions.' p. 1219
Doyle 2007	'Skills which were more psychologically based, such as intervening with a patient who is threatening suicide or patients who are violent and aggressive, were also identified as a challenge. The lack of these important skills impacted on the ED nurses' ability to provide appropriate care to this challenging patient group. The lack of these important skills also left some nurses feeling as though they were out of their depth.' p. 1220
Jelinek 2013	"I did a one-day course on management of aggression training. It was quite useful about talking to people, and trying to talk them down. It's something that certainly ED registrars would be good to have as part of their training... " pp. 3-4
Ngune 2020	"It's about getting patients comfortable enough that they can be assessed properly in an environment they perceive as fairly safe while actually keeping them safe ... not giving them opportunity to harm themselves further" p. 3
Mughal 2021	'Young people vividly shared fears of hospitalisation, loss of confidentiality, and stigma, as barriers for accessing support from general practice […] "I thought they'd hospitalise me immediately. I thought they'd panic and push me away as if, 'no, you've gotta – you know, you've got to go into an inpatient unit, and we've got to inform your family, and you've got to quit your course'."' p. 10
Rees 2017	"... whether it's right or wrong, if I believe, even half believe that a person had taken an amount of medication that would seriously damage their health, and they were refusing to go in…I'd rather get into trouble ethically for taking

Study	Evidence
	somebody against their will than somebody die, and I left them there to die." p. 63
Rees 2017	"Now the ethicacy of that doesn't sit well with me, but if the gentleman is going to die from this overdose then, you know, what's more important life or ethics" p. 63
Rees 2017	'The rationale for attendance of the police was to avoid further harm—to the patient, healthcare staff or other third parties […] "they are deployed to save that person's life by force if necessary"' p. 63
Rees 2018	'Sometimes police were used in the detainment of a person who had self-harmed, but in most cases they were there to protect the safety of the ambulance staff, the patient and others. If they were not already deployed to the scene, they would often be called out by the paramedics […] "when you walk through the door and she is still holding the kitchen knife, and she says, you know, "I don't want to live, you're not going to save me," and she waves the knife at you then, obviously, there's a little bit of feeling of self preservation, and turning around and walking out the door"' p. 7
Wand 2019	'There was tension between the carer's desire to keep the person safe and prevent further self-harm through hospitalization, and acknowledgement of the cost to the person's autonomy and dignity. […] "In hospital what has been positive is just having around-the-clock watching of him. Because he does actually need that supervision … he can't be trusted at the moment."' p. 598
Sub-theme 1.3: Ensuring continuity of care paths	
Bailey 2019	'"it's what you do say if they say something that's serious. I would get a doctor" [FG6]' p. 624
Bailey 2019	'One young person suggested that their GP did not "really want to pay us much attention", while another in the same focus group said: "When I try to see my doctor they always refer, just send me to a nurse instead of the actual GP which is annoying because he is my GP and he is supposed to be able to see me" [FG8].' p. 624
Behrman 2019	"Stigma of mental illness persists even among physicians, we are either too quick to prescribe Rx or refer out with no follow up." p. 876
Cullen 2019	"Immediate referral to an OP facility with followup by a case worker/case manager… I feel we do excellent emergent care and work diligently to get patients referred to an appropriate location, but then they are no longer followed by anyone…, until they return to the ED and the cycle begins again." p. 5
Doyle 2007	'Once the physical aspect of care was attended to, the next priority identified in the care process was the referral of the patient to the psychiatric services and all of the participants reported this to be part of their role.' p. 1219
Gorton 2019	'"It's just basically if we find someone how would you deal with it but the only way we know how to deal with it would be to send them to the doctors." (P25, Dispensing Assistant)' p. 10
Gorton 2020	'"there's not very good referral systems, so it would be good if a patient came in and they have any mental health problems or you are feeling suicidal, or have been self-harming, I could call someone, you know, I know I could call someone, almost like log it, that this had been an issue. And then it would, they would get seen, do you know what I mean?" (P1, Pharmacist)' p. 10
Hoifodt 2006	"As long as I know that a plan has been established, it may be an admission to hospital, as an emergency or the next day or in some other way of following the patient up... that one has made some decision and provided a guarantee for the patient." p. 5

Study	Evidence
Idenfors 2015	"Well, I've got a note and an appointment so it hasn't been a problem, it's just getting there on time [...] that I have to call them myself and that I think it's so difficult so, no, I'd rather just not bother." p. 202
Idenfors 2015	"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
Jelinek 2013	'Knowledge of available services was cited as a cause of lack of confidence by four doctors […] "And also the knowledge of how to discharge patients into good outpatient care because there are a range of outpatient initiatives in our region..."' p. 6
Mughal 2021	"Yeah, yeah, yeah it was erm, yeah, my GP here is very helpful, he gives me different, he gives me options and then explains to me which erm, how each go, which things that would be best for me" p. 11
Mughal 2021	"He didn't over-react… he was really good in the way he handled things […] the way he felt comfortable to talk to me about it made me comfortable, even though I didn't feel anything at that time, I didn't feel as though I was being judged […] I was on citalopram and he discussed in detail what the side effects were, what would happen, what the benefit of sertraline were and he said, if you need me to speak to your therapist, I will […] he was amenable to helping me with my self-harm" p. 12
Rees 2017	"you can't get hold of mental health practitioners to be able to help you, the lack of advice and support. The lack of referral facilities. Shouldn't there be a facility that we can refer directly to a mental health crisis team unit, and be able to go directly there instead of A&E?" p. 62
Rees 2018	"The Emergency Department is often busy, noisy, can be confrontational. Staff don't have time to deal with a patient on an individual basis, which is what's required." p. 6
Vatne 2016	"I called him: he was fantastic when I had that depression last year. And so I told him over the phone that..., well, now I just tried to take my own life. 'Would you like to come in and talk about it?' he replied. So I got an appointment right away, and while I sat there, he wrote an application to the emergency ward and called them, and then all I had to do was go directly to the emergency ward." p. 302
Sub-theme 1.4: Ability to provide medication appropriately	
Bailey 2019	'These findings suggest that for some young people the help they receive for their self-harm will be exclusively provided by their GP surgery. This was explored in the focus groups and GPs explained that this was often the case when they were prescribing medication for depression that co-presented with self-harm. […] "You might want to look at this [referring to self-harm]. This is part of your depression or your anxiety but look you're on the first couple of rungs and there's a whole ladder beyond here" [FG3].' p. 625
Bailey 2019	'"there should be like a set procedure to be honest, like, step one, if…that doesn't work…two, three, four, then, last resort, it's on medication" [FG9].' p. 625
Behrman 2019	"Stigma of mental illness persists even among physicians, we are either too quick to prescribe Rx or refer out with no follow up." p. 876
Behrman 2019	"feeling inadequate in making diagnoses along with sufficient knowledge of medications that are efficacious and considered best practices." p. 878
Borrill 2005	"... yesterday they left me until night time before they gave me a dose... and that's when I burnt myself ... cause the largactil's to make me calmer, and when you don't have it your whole mind just flips and turns, you don't know what you're doing'." p. 61

Study	Evidence
Gorton 2021	'Pharmacists who described concerns regarding the use of prescribed medication in poisoning often had multisector experience, such as the ambulance service or mental health pharmacy. […] "I think as pharmacists regardless of which area or sector you work in, you know, one of the main ...not main but one of the ways people, you know, attempt suicide is that they stockpile medication, you know, so, you know, that's a role for a pharmacist [...] but you get very little- ...you get some pharmacists, oh, don't want to deal with that, you know, so ...I think it's to do with the undergraduate course, you just don't get …you don't get access to, you know, mental health. Maybe it's changed, you know." (Pharmacist, P22)' p. 11
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	"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	'The interviewees considered increased self-insight, activation, new coping strategies, and medication to be helpful.' p. 202
Jelinek 2013	"Certainly things like new medications..., there's obviously been a change in medication management... That sort of cutting edge stuff is stuff you hope you can stay abreast of, but trouble is often you don't know what deficits you may or may not have." p. 3
Ngune 2020	"The first thing I think of is their physical health. If they have presented and if they've got deep cuts, you want to address that and make sure they've got good pain relief. [Check if the cut] needs suturing. We address [physical health] first and then mental health." p. 3
Mughal 2021	"'But he sort of went 'okay we'll just put you on anti-depressants and see you every two weeks and let's see what does, see if your mood increases, if anything happens, if you stop self-harming, if things decrease'… I ended up maxing out on the amount you can get with anti-depressants within like six months, and they weren't sitting well with me" p. 9
Mughal 2021	"He didn't over-react… he was really good in the way he handled things […] the way he felt comfortable to talk to me about it made me comfortable, even though I didn't feel anything at that time, I didn't feel as though I was being judged […] I was on citalopram and he discussed in detail what the side effects were, what would happen, what the benefit of sertraline were and he said, if you need me to speak to your therapist, I will […] he was amenable to helping me with my self-harm" p. 12
Storey 2005	"I've always been fobbed off with antidepressants and that." p. 73
Wand 2019	"Well he asked that many times [for medication for dizziness], and she [GP] sort of blew him off. And then, when all this happened [self-harm] … the first thing she [GP] said … was 'I'll give you that prescription for Serc that you've been asking for.' Now why didn't she damn well give them to him months ago? And this wouldn't have happened." p. 597
Sub-theme 1.5: Ability to recommend coping techniques	
Behrman 2019	"I think they (pediatricians) left out a really important thing. And every single one of them left it out. And it's that you're going to mess up. So, preparing us for downs and for relapses is really important." p. 876

Study	Evidence
Behrman 2019	“He (pediatrician) didn’t help, like he really didn’t show me any ways to cope with problems.” p. 876
Fox 2015	"she’s using this as a way of coping with stress and you can’t suddenly stop her from doing it because actually that’s a coping mechanism she’s developed and it’s going to take some time for her to be able to change that behaviour and putting more pressure on her isn’t going to help" p. 417
Hom 2020a	“Medication is only one part of the solution. We need therapy as well. We need coping mechanisms.” p. 5
Idenfors 2015	‘The interviewees considered increased self-insight, activation, new coping strategies, and medication to be helpful.’ p. 202
Jelinek 2013	"...the kind of brief intervention, for people who are not acutely disturbed, but need some counselling... " p. 4
Ngune 2020	"Try to work with them in practical ways to give them alternatives [to reduce further self-harm]. Referring them to someone that is going to ... teach them enduring ways of dealing with their distress." p. 4
Vatne 2016	‘The interviewees talked about meetings with professionals who had made a difference and who had helped them in various ways. […] 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.’ p. 302

Table 13: Theme 2: Knowledge

Study	Evidence
Sub-theme 1.1: Ability to accurately assess risk of self-harm	
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	‘Pediatricians who participated in the focus groups did acknowledge that more communication training is needed. […] “We are lacking early detection skills and education on depression, anxiety, and dual diagnosis”’ p. 877
Behrman 2019	“feeling inadequate in making diagnoses along with sufficient knowledge of medications that are efficacious and considered best practices.” p. 878
Chapman 2014	“...training in how to deal with each type (adolescent, psychiatric past, drug issues, first presentation) would be ideal...” p. 143
Cullen 2019	“educate nurses on identifying patients at risk and establishing a therapeutic rapport” p. 5
Fox 2015	‘All GPs felt that education about, and training in talking to young people about self-harm would be useful. It was suggested that training should be available to GP’s via a range of formats (e.g. online/face to face) and would be most useful if linked to local resources. Suggestions for the content of training included; myth busting; risk factors for self-harm and how it presents in young people; raising the issue; using the right language, including phrases and questions to ask and techniques for dealing with difficult consultations with anxious parents. Training was identified as being especially effective when people with personal experience of self-harm are involved. Participants reported that practice nurses, health care assistants and reception staff also play a role in the identification and support of young people who are self-harming and highlighted the importance of training for these professionals.’ p. 417
Gorton 2019	‘“In a community pharmacy you might have, today’s pharmacists might be qualified 30 years, tomorrow’s six months, you know, because they’re running

Study	Evidence
	on locums, or whatever. So, that's where maybe training the regular staff might actually be more of a benefit than training a pharmacist" (P8, Pharmacist)' p. 6
Gorton 2019	'"As a team we could do a lot more to help with mental health issues, spot things better. But there are people who would have to have training because they haven't had experience of it, which is only right. If you haven't got the experience you're not going to know what to look for." (P16, Dispensing Assistant)' p. 7
Gorton 2019	"I do believe that if we had more training in it then I feel like we could be a bit more effective, and I feel like with the mental health burden, I think pharmacists can produce some positive outcomes." (P2, Pharmacist) p. 8
Hoifodt 2007	"I think it is very important to have the opportunity to role-play those types of situations...Some do not like role-playing and sneer at it, but it is incredible how one can identify with the situation. I think it is very important to play both the role of the suicidal person and the helper, to attempt to get into the mood of a person who is thinking about committing suicide." p. 4
Jelinek 2013	"I think often that needs more education - teaching and perhaps role-playing and that sort of thing to learn about managing... And trying to defuse violence..." p. 4
Jelinek 2013	"I think that ED registrars would also benefit from more psychiatric training. I did quite a bit of psych in my ED training. I think it's something that people working in the ED probably could do with more training, particularly in the registrar phase when they are learning new skills anyway." p. 4
Jelinek 2013	"...it's really something to get used to over time. It really did used to make me quite nervous when I first started working in medicine, and I was much less confident in my decisions. I think it's timely experience as much as anything..." p.4
Ngune 2020	"I don't think [self-harm] is covered well by comprehensive, undergraduate [26] education. [A lot] of what you learn is either by self-education or by trial and error [or by] working with more expert colleagues, seniors. . ... I don't think we have an inherent comfort. I think you learn it through discomfort." p. 4
Ngune 2020	"We need more knowledge around, why people [self-harm] so we can be more empathetic and address their needs." p. 4
Ngune 2020	"[Having education that is] interactive ... providing some educational resources for people if they would like to read up [on self-harm] before or after [caring for a patient]. ...[Where] everyone is involved in actually practicing and having these conversations. ... Getting actors or people that are happy [to act] the different ways that people present." p. 5
Rees 2017	'Paramedics were aware that detaining people who SH in such a way may breach ethical and legal principles, however they reported a lack of confidence in this area which almost paralysed decision making. [...] Paramedics were uneasy with this position, and felt these strategies had emerged from a situation where their training, competence and legislation did not support their decision making' p. 64
Rees 2018	'Paramedics pointed out that their training and education focussed on technical and physical conditions such as trauma and cardiac presentations at the expense of mental health related issues. They suggested that better training should focus on "how do we treat that sort of mental health issue rather than the physical injuries 'cause I feel that we're quite appropriately trained to do that".' p. 8
Vatne 2016	'The interviewees talked about meetings with professionals who had made a difference and who had helped them in various ways. They emphasized the importance of being met by professionals who […] possessed professional knowledge' p. 302

Study	Evidence
Sub-theme 2.2: Ability to recognise the underlying causes of self-harm	
Behrman 2019	“We are lacking early detection skills and education on depression, anxiety, and dual diagnosis” p. 877
Behrman 2019	“feeling inadequate in making diagnoses along with sufficient knowledge of medications that are efficacious and considered best practices.” p. 878
Borrill 2005	"they don't get at the root of the problem -just say she's upset and it's her way" p. 64
Hom 2020a	‘They explained that it is concerning when diagnoses are made prematurely (e.g., with insufficient information, in the midst of a suicidal crisis) and when the contribution of life stressors to patients’ distress is minimized. […]“Avoid immediately resorting to diagnosing survivors with specific mental illnesses ... focus on the triggers and symptoms instead of the possible diagnosis.”’ pp. 5-7
Hom 2020a	“... make an effort to detect serious problems in [a] survivor’s history and environment (spouse, family of origin, church, culture, etc.)” p. 7
Hom 2020b	“The first doctor I went to said, ‘Oh, you have OCD and there’s medication for it. It’s a chemical imbalance. The anxiety and depression are probably part of the OCD.’ Never went into my past, never asked me a lot of questions or really talked to me.” p. 178
Hom 2020b	“They said I had bipolar, which I had never, never had any kind of a discussion about. Still don’t believe it.” p. 178
Jelinek 2013	I think we didn't understand all the diagnoses. I think we would have loved a bit more training on different illnesses with mental health..." p. 4
Mughal 2021	‘Some participants vividly described experiences of feeling that a GP did not fully explore their problem and seemed to rely on prescribing as a management option’ p. 9
Ngune 2020	"[Understanding] the reason for the self-harm ... what’s been going on and trying to put things in place for them to be able to deal with those reasons and resolve the crisis they are in at the time." p. 4
Ngune 2020	"Having a background understanding [of] the reasons why people may self-harm [is important]. ... [How] they want us to approach them. ... Do they want us to be very direct and ask very direct questions?" p. 4
Rees 2018	‘Paramedics recognised how important it was to gain understanding of why people SH […] “The ‘whys’ the ‘hows’. Having a comprehension of what goes on in that person’s head to make them want to cut themselves, to make them want to put a rope around their neck. To make them want to take every tablet they can get their hands on. I think we need to understand the why behind that.”’ p. 5
Sub-theme 2.3: Knowledge of formal processes	
Cullen 2019	“clear accreditation guidelines on what is required for interval assessment and documentation on self-harm patients, …guidance and training…if an ED provider is to ever be ‘releasing’ a involuntary psych hold patient before the expiration of that hold. Also if an ED stay awaiting an inpatient bed extends over the 24 hour time frame, is there required expectations of the ED provider” p. 5
Gorton 2020	‘A few participants suggested the creation of a Standard Operating Procedure (SOP) would help to streamline referral processes. […] “there’s not very good referral systems, so it would be good if a patient came in and they have any mental health problems or you are feeling suicidal, or have been self-harming, I could call someone, you know, I know I could call someone, almost like log it, that this had been an issue. And then it would, they would get seen, do you know what I mean?” (P1, Pharmacist)' p. 10

Study	Evidence
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
Jelinek 2013	"I’ve never been properly taught in terms of who I should sedate, how I should sedate them (IV, IM, orally) and when/what the implications are for sedation so I think I would like to have some more guidelines for sedation." p. 3
Jelinek 2013	‘[…] seven doctors reported knowledge gaps in understanding mental health legislation […] "I think that we are not really formerly taught about the legal requirements about forms and transport issues"’ p. 4
Rees 2017	Paramedics pointed to sanctions that could be imposed on them: being held accountable in law, such as in coroners' hearings and litigation; by their employer; or loss of professional registration. They recognised that their approach may be wrong, and counter to professional standards. “They're fearful of complaints and litigation against them, and fearful of losing their professional status” pp. 62-63
Rees 2017	“He was saying, “I'm not going, I'm refusing to go. I want to kill myself,” and I think would it be possibly legal for me to assess his mental capacity and he's refusing to go, fill in a form and he'd have been happy for me to go, but ethically and morally I think it would have been wrong to do that. So instead I was there for hours.” p. 63
Sub-theme 2.4: Sharing information with colleagues	
Behrman 2019	‘Parents of both groups, along with community mental health workers, identified the lack of collaboration and communication among health care teams as a primary pitfall during recovery. […] “they (providers) don’t talk to each other.”’ p. 876
Borrill 2005	‘One woman described the difficulty of having to talk to a succession of different officers: "I feel like a ball being passed from one to another"’ p. 64
Gorton 2021	‘In addition to one-way referral from pharmacy to other providers, a gap in the two-way communication between community pharmacy teams and other healthcare professionals was evident. Improvement is needed in two-way communication particularly regarding patients who may have been prescribed small quantities of medication due to increased vulnerability for self-poisoning. […] “I also know that I have seen [once]-weekly scripts and daily scripts for people who I’m guess [ing] are at risk, I don’t know whether it’s something that they have maybe tried to commit suicide or maybe they are just at risk and they have ended up on daily scripts or weekly scripts, cause we have dispensed those. These are all things that I sort of put together and sort of come to this conclusion.” (P14, Pharmacist)' p. 10
Hoifodt 2007	"It is invaluable support to have people around you, who know these things. We had a very skilled homecare nurse who knew everybody and exactly what the problem was." p. 5
Hoifodt 2007	"To exchange experiences with colleagues has been rewarding, especially when you get to talk to a more experienced colleague and tell about one's own experiences, not necessarily to hear if you did right or wrong, but to describe and go through the situation." p. 5

Study	Evidence
Mughal 2021	"He didn't over-react… he was really good in the way he handled things […] the way he felt comfortable to talk to me about it made me comfortable, even though I didn't feel anything at that time, I didn't feel as though I was being judged […] I was on citalopram and he discussed in detail what the side effects were, what would happen, what the benefit of sertraline were and he said, if you need me to speak to your therapist, I will […] he was amenable to helping me with my self-harm" p. 12
Ngune 2020	"[I] spent some time with the PLN [psychiatric liaison nurse]. ...I feel much more comfortable particularly in a triage setting... [Previously] I found it difficult to triage people who came in with self-harm or thoughts of suicide. Now I'm comfortable. ...I know what questions are appropriate and I think I'm better at [assessing] patients and [determining] who is high risk." p. 3
Rees 2017	'"You can speak to a clinical support desk, you can speak to a doctor at a hospital, or you can speak to an on call GP. And ultimately they'll virtually say the same thing, you know, you're the clinician on the scene, you have to make that decision" And when questioned: "And how do you feel about that?" The answer was: "Lonely"' p. 62
Vatne 2016	'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.' p. 302

Table 14: Theme 3: Engagement with the patient

Study	Evidence
Sub-theme 3.1: Creating an open line of communication	
Awenat 2017	'Participants expressed uncertainty about how to initiate and conduct useful conversations that would not cause further distress […] "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
Bailey 2019	"I think they [clinicians] can be thinking like…what problems can you have 'cause you're, what, fifteen or something but no one knows what is happening at home" [FG8]' p. 625
Bailey 2019	'In terms of using the self-help materials, young people suggested that they could act as a conversation prompt when GPs or PNs were not sure what to say when a young person disclosed self-harm […] "I'd say like obviously get them out and look at them with the young person together" [FG9].' p. 625
Behrman 2019	'While pediatric residents noted the importance of learning how to communicate with adolescents, they also expressed concerns of not knowing what questions to ask, whom to ask (parent or child) and acknowledged the importance of being competent and comfortable when discussing depression and suicide.' p. 876
Behrman 2019	"They don't even listen to you," p. 877
Borrill 2005	'The women talked a lot about the importance of listening.' p. 64
Borrill 2005	"They said if you need to talk please open up - they were brilliant. Their kindness made a difference" p. 64
Chapman 2014	"...it makes me feel useful when caring for patient with DSP. ... maybe it would make a difference or changes patient view by active listening, talking with them, being supportive ..." p. 143
Doyle 2007	'Many of the participants identified a lack of communication skills as being a key challenge and this was perceived as impacting negatively on the efficacy of their interventions, for example, participants spoke about not being equipped with the

Study	Evidence
	relevant skills to communicate with 'uncooperative', 'manipulative' or 'distressed' patients.' p. 1220
Fox 2015	"I think not everyone feels confident in asking about it. I think a lot of it depends on how much you see and how much you kind of get used to doing it" p. 417
Fox 2015	'GPs therefore gauge the need to talk to a young person alone and then negotiate conflicting issues around parental rights and responsibilities and the best interests of the young person. Deciding whether to discuss self-harm with a young person on their own is sometimes dependent on their age, although their maturity and confidence were seen as more important factors than age.' p. 417
Fox 2015	"some people who are feeling like this might cut themselves or burn themselves or do other things like that, you know, have you ever done that or thought about doing it? If they think that it's something that other people do and it's okay to say that, they're more likely to sort of open up about it" p. 417
Fox 2015	'most interviewees felt that screening questionnaires were too formal, too hard to fit into a 10-minute consultation and may be a barrier to listening […] "you're not getting a rapport with someone by asking them questions or getting them to fill something in. If you're going to get somebody to talk to you about something that is causing them distress, you've got to be open to what they're saying and listening. Not saying, "Oh right, okay fill this in""' p. 417
Fox 2015	"think we have to adapt the language and the difficulty of conversation to the individual and the situation. I don't think there is a one size fits all, especially over that age range" p. 417
Gorton 2019	'"When they come in, there's one lady in particular who can come in and she can be quite juddery, shaking and being very erratic and quite blunt, and you know straight away that she's not having a good day. I always sort of go over and sit by her if the shop's not too busy and just have a little chat to her, how's she doing, anything I can help her with and stuff like that." (P16, Dispensing Assistant)' p. 6
Hoifodt 2006	"When I feel a good connection, I think that the patient is being honest and is telling me as much as possible. When the patient finishes his story and one can reply, then you could perhaps get eye contact saying "I can understand what you mean", you receive this glimpse, and a little pause, and then you go on talking." p. 4
Hoifodt 2006	"I tried to see if I could get through to him some way... We talked a little about school, what he had done the last days, but I could not find an opening. When I asked whether he had some problems, he would not go into them." p. 4
Hom 2020a	"Take time to listen and make sure you're not jumping to conclusions." p. 6
Idenfors 2015	'Participants described how important it was to have a contact person in whom they had confidence. A precondition for them to speak openly was being listened to in a nonjudgmental manner and being allowed and invited to tell their narrative. Although it was expressed that it could be easier to talk to friends and family – whom they trusted more than professional helpers – it was also described how they could talk to friends about less serious issues and to professionals about more difficult problems.' p. 201
Ngune 2020	"The patients themselves [are a barrier depending] how closed [reluctant to communicate] some of them are. ... I think it [is] because of the lack of understanding of where they are at. ...I [don't] probe in on too many questions [as] to why the self-harm is occurring." p. 4
Mughal 2021	"His patience and lack of judgement was amazing, just to listen to my experiences of what happens for emotionally when I'm self-harming, erm, it was incredible." p. 12

Study	Evidence
Mughal 2021	"Continuity and a good frequency of GP appointments is really helpful. You don't build up a rapport in one appointment, it's 10 minutes, and some place it's five minutes, you need time to do that, quite often they'll book double appointments knowing that I've only got one problem." p. 12
Rees 2018	"put[ting] the relative in the front, and that's generally when we find that your patient will talk to you more about the problems they find. They just don't want friends/family knowing what they're going through." p. 5
Storey 2005	"I was pleased that he had done something but really I didn't want to be put on antidepressants. I would have preferred to have just been able to talk to somebody. I think that's probably what I needed, rather than just take tablets or something." p. 73
Vatne 2016	'The interviewees provided examples of good dialogues they had had with professionals, and it was exactly this kind of dialogue that they would have preferred to have more often. Sharing makes the day a little lighter, said one of the young interviewees who had difficulty expressing thoughts and feelings in words' p. 302
Wadman 2018	'Some participants said they did not want to talk about self-harm and their distress, or felt they were not able to talk about it […] This young person preferred not to speak to people (for instance, social workers) about self-harm because speaking to people resulted in consequences […] "they [will have to] get involved and get someone else involved"' p. 371
Wand 2019	"I don't think he would have confided in [the GP] in regards to the self-harm because I think if he did [the GP] would act, or he would do something, or he would tell us" P. 597
Wand 2019	"So I think it would be a good idea [that] the GP can coordinate into this and keep contact with the family member. … So if some issue happening I can reach him at least." p. 597
Wand 2019	"One doctor I spoke to … he was really dismissive … dismissing with a wave of the hand the observation of someone who'd known him [patient] for a long time." p. 598
Sub-theme 3.2: Making time for the patient	
Bailey 2019	"Mental health disorders often come in a 10 minute consultation and it often takes 20 minutes. When you are at 15 minutes perhaps we might not have made time for that question but I think now many of us do" p. 624
Bailey 2019	'"Ten minute slot it's quite short and then the doctor feels rushed" [FG9].' p. 625
Borrill 2005	"The senior officer said if I get suicidal again, talk to an officer. But the officers seemed so busy they didn't want to know" p. 64
Chapman 2014	"...In the ED the focus of care is on the emergency not the mental health/counselling. I feel as if I 1) don't have time to explore MH [mental health] issues, 2) aren't encouraged to explore MH issues, 3) don't feel as though the department is the right place to explore this. The emergency room is designated to deal with emergencies. ..." p. 143
Ngune 2020	"I think they leave too soon [for us] to be able to provide the optimal health care that they need." p. 4
Mughal 2021	"Continuity and a good frequency of GP appointments is really helpful. You don't build up a rapport in one appointment, it's 10 minutes, and some place it's five minutes, you need time to do that, quite often they'll book double appointments knowing that I've only got one problem." p. 12
Sub-theme 3.3: Being collaborative	

Study	Evidence
Behrman 2019	“I (adolescent) was never talked to, like, they never asked me, ‘Oh how do you feel about taking medications?’ Instead, ‘no, you’re going to take this medicine.’ If I knew what was going on it would’ve probably been easier.” p. 877
Hom 2020b	“Nobody asked me my thoughts. Nobody asked me my opinion. Nobody asked me what was or wasn’t working.” p. 178
Mughal 2021	‘Participants reflected that they want GPs to personalise their care and support to them, which may facilitate help-seeking in young people, and reduce self-harm behaviour […] "He could have found out more, asked to find out more and then talked to me more, or at least talked to me about maybe what I wanted to do"’ p. 12
Vatne 2016	‘Being met by available professional who adapted their help to the needs of the interviewee was cited as a meaningful resource that also included the family’s need to feel secure.’ p. 302

Table 15: Theme 4: Communication style

Study	Evidence
Sub-theme 4.1: Evasive versus candid	
Awenat 2017	‘"Everyone was like "you can't say words like that!" and I was like "well I can say words like that", because we're people and we're professional services. So I think, learning how to say those words, you know, "if you want to kill yourself, or if you're attempting suicide", sometimes being stark about it is actually beneficial because I think... it's putting a situation into reality." (Nurse assistant/ support worker: 02)' p. 105
Awenat 2017	‘"So usually during the course of conversation if someone says "I'm suicidal, I'm gonna die, I'm gonna do this" and then you kinda like… talk about something else… then say "oh, you're going on holiday next year?", "you're doing something over the summer?"" (Nurse: 05)' p. 105
Awenat 2017	‘Participants were concerned about the potential to cause harm by discussing suicidality with patients which could inhibit such conversations. This view, though common, was not ubiquitous and some senior staff felt encouraging patients to talk about their distress was valuable. [...] Nevertheless, staff were preoccupied with the need for detailed documentation to exonerate themselves of negligence should a suicide occur. This led to cautious and guarded conversations in case patients would reveal suicidal thoughts. […] "It can make them [staff] very risk-averse, it makes people defensive, not defensible… They will constantly exercise on the side of caution… to the detriment of the patient really… where they are actually almost inert… they're just… frozen." (Nurse: 01)' p. 106
Bailey 2019	‘"asking a young person about their self-harm, do you risk making it worse?" [FG7].' p. 625
Bailey 2019	‘Despite their concerns about disclosure, young people reflected that being asked about their selfharm was alright, provided that it was asked about in an empathic way. […] "Just sort of reassure you that it’s gonna be ok"’ p. 625
Behrman 2019	“they are missing it; not asking the right questions, the gravity of the issue was lost.” p. 878
Fox 2015	‘The majority of GPs interviewed raise the issue of self-harm directly […] In interviews GPs indicated that they do not necessarily raise the issue of self-harm during the first consultation, unless they have major concerns, instead preferring to establish rapport with a young person over time. […] "some people who are feeling like this might cut themselves or burn themselves or do other things like

Study	Evidence
	that, you know, have you ever done that or thought about doing it? If they think that it's something that other people do and it's okay to say that, they're more likely to sort of open up about it"' p. 417
Hom 2020a	'Finally, some participants expressed an appreciation for the routine, direct assessment of suicidality. […] "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
Ngune 2020	'When participants began working in the ED, they did not feel comfortable to provide care and reported asking the patient about their self-harm confronting: "When I first got to ED, I was very uncomfortable (to work with people who self-harm). I didn't know how to ask the questions ¨Do you feel suicidal? Do you feel like self-harming?"' p. 3
Ngune 2020	"Having a background understanding [of] the reasons why people may self-harm [is important]. ... [How] they want us to approach them. ... Do they want us to be very direct and ask very direct questions?" p. 4
Rowe 2017	'Participants did not expect non-psychiatric health professionals to address their mental health issues. However, they needed all health professionals with whom they interacted to recognise and acknowledge that they were unwell; this acknowledgment was crucial to building relationships in care, and for patients to accept and be comfortable in receiving that care.' p. 282
Sub-theme 4.2: Positive attitude	
Bailey 2019	"Just sort of reassure you that it's gonna be ok" p. 625
Bailey 2019	'Young people talked about their fears of disclosing self-harm to a GP or PN in case they were considered 'crazy' […] "I was scared to talk to the doctor….I just didn't feel confident enough" [FG9].' p. 625
Behrman 2019	"someone has to care for you and tell you they want you to succeed and that you're going to grow out of this." p. 876
Behrman 2019	'While pediatric residents noted the importance of learning how to communicate with adolescents, they also expressed concerns of not knowing what questions to ask, whom to ask (parent or child) and acknowledged the importance of being competent and comfortable when discussing depression and suicide.' p. 876
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
Borrill 2005	"I would like them to have sat down and talked to me - it looked like I'd been punished for being angry" p. 63
Borrill 2005	'Another commented that staff made her feel guilty for continuing to self-harm despite their efforts to help […] "You can't expect someone to stop self-harming just because you're talking to them. A lot of issues are not going to be dealt with overnight just by having a chat"' p. 64
Chapman 2014	"...Anyone has the right to be treated with respect and dignity whatever their presenting problem..." p. 143
Chapman 2014	"...it makes me feel useful when caring for patient with DSP. ... maybe it would make a difference or changes patient view by active listening, talking with them, being supportive ..." p. 143
Cullen 2019	"educate nurses on identifying patients at risk and establishing a therapeutic rapport" p. 5
Doyle 2007	'Overall, participants did not mention caring for the patients' psychological well being as being part of their role. However, displaying 'empathy' and 'understanding' was identified by a minority of participants as being important to

Study	Evidence
	their role when caring for patients who present with suicidal behaviour.' pp. 1219-1220
Gorton 2019	'Whilst the overall attitude of participants regarding having conversations about suicide was positive, a few concerns were raised. Some participants felt their colleagues might have reservations in relation to the scope of their job role, personal views, attitudes, lack of personal experience and potential stigma.' p. 7
Hoifodt 2006	"When people do things like that, I get angry; I try to keep that to myself, because it is not very useful in the relationship with the patient. You get angry with a person because he just drives into an oncoming trailer. He didn't really have huge problems. His action was indefensible." p. 5
Hom 2020a	"[shame], 'tough love,' and pity aren't effective responses to someone who's just attempted to end their life." p. 4
Hom 2020a	"[Be] compassionate and understanding [about] what can lead to a person attempting suicide ..." p. 6
Hom 2020b	"They treated me like dirt. When I went in, the doctor was talking down to me: 'We had someone come in here tonight who was attacked. They're in here, they didn't ask to be in here, and yet here you are'" p. 178
Idenfors 2015	'Participants described how important it was to have a contact person in whom they had confidence. A precondition for them to speak openly was being listened to in a nonjudgmental manner and being allowed and invited to tell their narrative. Although it was expressed that it could be easier to talk to friends and family – whom they trusted more than professional helpers – it was also described how they could talk to friends about less serious issues and to professionals about more difficult problems.' p. 201
Ngune 2020	"I've noticed improvements within my own attitudes but that's because it needed to change. [I] have ... more knowledge and ...understanding [about self-harm]. I know my attitudes have changed." p. 3
Mughal 2021	"And the first person I spoke to, was the pharmacist … he was totally calm about it … but it was the changing point in my life that I actually realised that it's not something to be ashamed of." p. 8
Mughal 2021	"It was… hmphh [small sigh]… it was pretty positive, I mean he was, he was understanding, very non-judgemental, warm, I felt comfortable telling him everything […] one thing that did not feel quite right was the way he responded […] like I told him I don't know… 'I have a sore throat'" p. 9
Mughal 2021	"I left the conversation feeling perhaps I was assigning more importance to this that it requires […] because I said 'if the GP is not too concerned, I shouldn't be' […] I felt I needed to tell him […] that I'm actually overdosing on them [prescribed antidepressants]… I did tell him, and once again I didn't get any reaction […] so I decided to stop my medication without telling him and I never attended another appointment with him […] I've never been to see the GP since and it's been six months" p. 10
Mughal 2021	"He didn't over-react… he was really good in the way he handled things […] the way he felt comfortable to talk to me about it made me comfortable, even though I didn't feel anything at that time, I didn't feel as though I was being judged […] I was on citalopram and he discussed in detail what the side effects were, what would happen, what the benefit of sertraline were and he said, if you need me to speak to your therapist, I will […] he was amenable to helping me with my self-harm" p. 12
Rees 2017	"Everybody needs to be treated with dignity and respect. I think perhaps that wasn't there in the past, that people were often dealt with contempt, and very

Study	Evidence
	little understanding. And it can only be a more professional thing for our standing." p. 62
Rees 2018	'Paramedics recognised how important it was to gain understanding of why people SH […] "The 'whys' the 'hows'. Having a comprehension of what goes on in that person's head to make them want to cut themselves, to make them want to put a rope around their neck. To make them want to take every tablet they can get their hands on. I think we need to understand the why behind that."' p. 5
Rees 2018	"Opens his neck up and that is bloody scary when he does that, there's blood everywhere like and he's bloody hysterical...he has learned not to be awkward with us mainly because we are not awkward with him... We know him quite well... I mean he's just a person with issues" p. 6
Vatne 2016	'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. […] "I called him: he was fantastic when I had that depression last year. And so I told him over the phone that ..., well, now I just tried to take my own life. 'Would you like to come in and talk about it?' he replied. So I got an appointment right away, and while I sat there, he wrote an application to the emergency ward and called them, and then all I had to do was go directly to the emergency ward."' p. 302