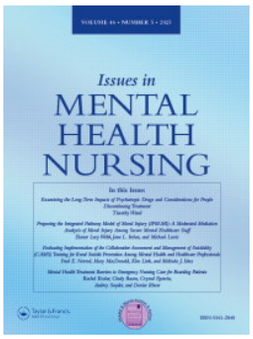

Issues in Mental Health Nursing

ISSN: 0161-2840 (Print) 1096-4673 (Online) Journal homepage: www.tandfonline.com/journals/imhn20

Quantitative Evidence for Relational Care Approaches to Assessing and Managing Self-Harm and Suicide Risk in Inpatient Mental Health and Emergency Department Settings: A Scoping Review

Jessica L. Griffiths, Una Foye, Ruth Stuart, Ruby Jarvis, Beverley Chipp, Raza Griffiths, Tamar Jeynes, Lizzie Mitchell, Jennie Parker, Rachel Rowan Olive, Kieran Quirke, John Baker, Geoff Brennan, Gary Lamph, Mick McKeown, Brynmor Lloyd-Evans, Kylee Trevillion & Alan Simpson

To cite this article: Jessica L. Griffiths, Una Foye, Ruth Stuart, Ruby Jarvis, Beverley Chipp, Raza Griffiths, Tamar Jeynes, Lizzie Mitchell, Jennie Parker, Rachel Rowan Olive, Kieran Quirke, John Baker, Geoff Brennan, Gary Lamph, Mick McKeown, Brynmor Lloyd-Evans, Kylee Trevillion & Alan Simpson (05 May 2025): Quantitative Evidence for Relational Care Approaches to Assessing and Managing Self-Harm and Suicide Risk in Inpatient Mental Health and Emergency Department Settings: A Scoping Review, Issues in Mental Health Nursing, DOI: 10.1080/01612840.2025.2488335

To link to this article: https://doi.org/10.1080/01612840.2025.2488335

ISSUES IN MENTAL HEALTH NURSING
https://doi.org/10.1080/01612840.2025.2488335

Quantitative Evidence for Relational Care Approaches to Assessing and Managing Self-Harm and Suicide Risk in Inpatient Mental Health and Emergency Department Settings: A Scoping Review

Jessica L. Griffiths, DClinPsy[a], Una Foye, PhD[a], Ruth Stuart, BSc[a], Ruby Jarvis, MSc[b], Beverley Chipp, Lived Experience[c], Raza Griffiths, MA[c], Tamar Jeynes, MSc[c], Lizzie Mitchell, BSc[c], Jennie Parker, MSc[c,d], Rachel Rowan Olive, MA[c,e], Kieran Quirke, RMN[f], John Baker, PhD, MPhil, MSc, BNurs(hons), RN(MH)[g], Geoff Brennan, MA, RMN[h,i], Gary Lamph, PhD, RMN, BABCP (Accred)[j,k], Mick McKeown, PhD, DPSN, RGN, RMN[l], Brynmor Lloyd-Evans, PhD, DipSW[b], Kylee Trevillion, PhD[a] and Alan Simpson, PhD, RMN, PGDip Counselling[a]

[a]NIHR Policy Research Unit in Mental Health (MHPRU), Department of Health Service and Population Research (HSPR), Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK; [b]NIHR Policy Research Unit in Mental Health (MHPRU), Division of Psychiatry, University College London, London, UK; [c]Lived Experience Working Group, NIHR Mental Health Policy Research Unit Lived Experience Working Group, NIHR Policy Research Unit in Mental Health (MHPRU), Division of Psychiatry, University College London, London, UK; [d]Psychologically Informed Consultation and Training Team, Berkshire Healthcare NHS Foundation Trust, Reading, UK; [e]Department of Primary Care and Public Health, Brighton & Sussex Medical School, University of Sussex, Brighton, UK; [f]Nursing for Mental Health, King's College Hospital NHS Foundation Trust, London, UK; [g]School of Healthcare, Faculty of Medicine and Health, Worsley Building, University of Leeds, Leeds, UK; [h]Department of Health Service and Population Research (HSPR), Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK; [i]Department of Mental Health Nursing, Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London, London, UK; [j]School of Nursing and Midwifery, Faculty of Medicine and Health Sciences, Keele University, Keele, UK; [k]Research and Innovation Department, Midlands Partnership University NHS Foundation Trust, Stafford, UK; [l]School of Nursing and Midwifery, University of Central Lancashire, Lancashire, UK

ABSTRACT

There is an over-reliance on structured risk assessments and restrictive practices for managing self-harm and suicidality in inpatient mental health and emergency department (ED) settings, despite a lack of supporting evidence. Alternative "relational care" approaches prioritising interpersonal relationships are needed. We present a definition of "relational care," co-produced with academic and lived experience researchers and clinicians, and conducted a scoping review, following PRISMA guidelines. We aimed to examine quantitative evidence for the impact of "relational care" in non-forensic inpatient mental health and ED settings on self-harm and suicide. We identified 29 relevant reviews, covering 62 relational care approaches, reported in 87 primary papers. Evidence suggests some individual-, group-, ward- and organisation-level relational care approaches can reduce self-harm and suicide in inpatient mental health and ED settings, although there is a lack of high-quality research overall. Further co-produced research is needed to clarify the meaning of "relational care," its core components, and develop a clear framework for its application and evaluation. Further high-quality research is needed evaluating its effectiveness, how it is experienced by patients, carers, and staff, and exploring what works best for whom, under what circumstances, and why.

Acronyms: A&E: Accident and Emergency; ABFT: Attachment-Based Family Therapy; ASSIP: The Attempted Suicide Short Intervention Program; BPD: Borderline Personality Disorder; BIC: Brief Intervention and Contact; CAMS: Collaborative Assessment and Management of Suicidality; CBSP: Cognitive-Behavioural Suicide Prevention Therapy; CBT: Cognitive Behavioural Therapy; CCTV: Closed-Circuit Television; CYP: Children and Young People; DBT: Dialectical Behaviour Therapy; ED: Emergency Department; FBCI: Family-Based Crisis Intervention; FISP: Family Intervention for Suicide Prevention; HCP: Healthcare Professional; IPSST: Interpersonal Problem-Solving Skills Training; ISRCTN: International Standard Randomised Controlled Trial Number; LGBTIQ: Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning; MACT: Manual-Assisted Cognitive Behavioural Therapy; MBT: Mentalisation-Based Therapy; MHPRU: Policy Research Unit in Mental Health; NHS: National Health Service; NIHR: National Institute for Health and Care Research; NICE: National Institute for Health and Care Excellence; NSSI: Non-Suicidal Self Injury; RCT: Randomised Controlled Trial; SAFTI:

CONTACT Jessica L. Griffiths jessica.griffiths@kcl.ac.uk NIHR Policy Research Unit in Mental Health (MHPRU), Department of Health Service and Population Research (HSPR), Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK.

Supplemental data for this article can be accessed online at https://doi.org/10.1080/01612840.2025.2488335.

Safety Assessment and Follow-Up Telephone Intervention; SNAP: Successful Negotiation Acting Positively therapy; SPI+: Safety Planning Intervention with follow-up; STAT-ED: Suicidal Teens Accessing Treatment After an Emergency Department Visit; STEPPS: Systems Training for Emotional Predictability and Problem Solving therapy; STEPS: Steps to Enhance Positivity therapy; TOC: Teen Options for Change; UK: United Kingdom; USA: United States of America

Introduction

Suicidality and self-harm remain key reasons for inpatient admissions in both acute and mental health hospitals. Therefore, a key purpose of inpatient mental health services and emergency departments (EDs) is to provide a safe environment for people presenting with, and at-risk of, self-harm and/or suicide (Bowers et al., 2005; The Royal College of Emergency Medicine, 2021). Despite this intention to provide a safe environment, people admitted to hospital are still dying by suicide and engaging in self-harm within these settings.

During the years 2011–21, 28% of people in the UK who died by suicide were patients in acute care settings (inpatients, under crisis resolution/home treatment teams, or recently discharged from inpatient care) (University of Manchester & Healthcare Quality Improvement Partnership, 2024). Rates of inpatient suicide per 10,000 admissions fell by 33% over this 11-year period. There were on average 31 deaths by suicide on UK wards annually during this period (University of Manchester & Healthcare Quality Improvement Partnership, 2024).

In England alone, there are approximately 220,000 self-harm presentations to EDs annually (Cooper et al., 2015; Health Services Safety Investigations Body, 2021) and such individuals have a 49 times greater relative risk of suicide than that of the general population (Hawton et al., 2015). Self-harm is the most frequently reported incident in mental health services and rates of self-harm have increased over time (Woodnutt et al., 2024). Self-harm rates on inpatient mental health wards vary, with studies reporting between 4% and 70% of patients harming themselves during admission to inpatient services (James, Stewart, Bowers, et al., 2012). Self-harm has been found to most often be a private act, which takes place in bedrooms, bathrooms and toilets, and during the evening hours (James, Stewart, Wright, et al. 2012).

Given the prevalence of self-harm and suicidality in inpatient mental health and ED settings, these patient groups have been identified as a priority within national suicide prevention strategies (Department of Health & Social Care, 2023). Efforts to enhance their safety have been made, including the implementation of varied interventions, policies and guidelines (The Royal College of Emergency Medicine, 2021; University of Manchester & Healthcare Quality Improvement Partnership, 2024). This includes, more recently, the use of surveillance technologies, such as vision-based patient monitoring and management, body worn cameras, and closed-circuit television (CCTV). However, there is a lack of evidence for their effectiveness in improving patient safety, ethical concerns about their potential to negatively impact patients' human rights, privacy, dignity and recovery (Griffiths et al., 2024), and a view that the application of such technologies might undermine relational practice (McKeown et al., 2024). Inpatient and ED settings remain challenging environments in which to deliver appropriate and effective care (Gilburt & Mallorie, 2024; McCarthy et al., 2024; Østervang et al., 2022; The Royal College of Emergency Medicine, 2023).

Both inpatient mental health and ED settings are often fast-paced and over-stimulating environments, with high levels of distress, limited therapeutic options, lack of patient choice, inadequate involvement of families and carers, negative staff attitudes towards people who self-harm, and poor continuity of care. The consequences of this include high rates of conflict, coercion and restrictive practices (DeLeo et al., 2022; Johnson et al., 2022; Roennfeldt et al., 2021). Specific challenges faced by emergency departments also include their single-visit nature, high numbers of visitors, long waiting times, and brief durations of each human encounter (Greenwald et al., 2023). In both settings, these challenges are compounded by systemic issues including rising demands on services, increasing acuity of patients' presentations, temporary and under-staffing, and inadequate funding and resourcing (Gilburt & Mallorie, 2024; The Royal College of Emergency Medicine, 2023). A recent independent rapid review on mental health inpatient care identified key safety issues facing inpatient settings (Department of Health & Social Care, 2024).

Those who present to EDs in emotional distress and requiring interventions and treatment for self-harm injuries may be directly or indirectly excluded by services, owing to prioritisation of others with physical health conditions, public discourse about system strain, and efforts to divert mental health cases elsewhere. Although they might be seen initially within an hour, their stay in the ED, or separate decision unit, can be as long as 48–72 h as they wait for an outcome such as hospital admission. Most ED settings have mental health liaison services attached but these are often underutilised (Scott et al., 2017; Walker et al., 2018, p. 2). Frequent attendance at ED settings is likely driven by limitations within other services in the healthcare system, rejection by other services, lack of clarity of service provisions available, and in some cases convenience. For example, it is often the only local or out-of-hours service accessible to people (O'Keeffe et al., 2021).

These challenges contribute to an over-reliance in inpatient mental health and ED settings on using structured risk assessments and risk stratification to assess self-harm and suicide risk, and the use of restrictive practices, such as physical restraint, seclusion, rapid tranquilisation, and special observations to manage concerns over risk and safety (Hawton et al., 2015; NICE, 2022b; O'Keeffe et al., 2021; Walker et al., 2018). This is despite research consistently demonstrating the ineffectiveness of risk assessment checklists for predicting self-harm and suicide risk and the

potential for restrictive practices to undermine therapeutic relationships and cause physical and psychological harm to patients and staff (Baker et al., 2021; James, Stewart, Wright, et al. 2012; Kennedy et al., 2019; NICE, 2022b). There is, therefore, a growing need for alternative approaches in the assessment and management of self-harm and suicide risk in inpatient mental health and ED settings.

Positive relationships between staff and the people they support are fundamental to a person-centred care environment and have been identified as key to a positive culture of care in new guidance for mental health inpatient services (NHS England, 2024a). Positive therapeutic relationships between patients and clinicians are central to high-quality mental health care, and strong, consistent predictors of positive outcomes across a range of intervention types and settings (NHS England, 2024b; Priebe & Mccabe, 2008; Staniszewska et al., 2019). Therapeutic relationships can underpin interventions and practices and can also be "therapy in and of itself" (Priebe & Mccabe, 2008). Research indicates that patients value genuine listening, validation, warmth and curiosity within therapeutic relationships with clinicians, and that this can help build trust and facilitate disclosures about risk (Hawton & Harriss, 2008; O'Keeffe et al., 2021; Royal College of Psychiatrists, 2010; Shah et al., 2024; Sunnqvist et al., 2022). There has, therefore, been an increasing interest in approaches to risk assessment and management which prioritise therapeutic interpersonal relationships—i.e., "relational" approaches to care.

What is "relational care"?

There is no widely agreed definition of "relational care." It has been described across a diverse range of sectors, including health, education, criminal justice and social work (Lamph et al., 2023). It also forms an integral part of practices and professional identities within professions such as nursing, psychology, social work, criminal justice, and medicine, as well as in peer support work (Cooper et al., 2024). Alongside the lack of an agreed consistent definition is also the challenge that across the sectors there is not a consistent descriptor or term used. Instead, there are many variations that all ultimately describe similar concepts. Furthermore, it is not a new concept—elements of it have been described for centuries. The conceptualisation of "relational care" has therefore varied across time and contexts, and despite this term becoming increasingly used and topical, defining it remains a complex task, especially in the context of inpatient mental health care, where many types of relationships are involved (e.g., patient–patient, patient–staff, staff–staff and the overall ward or ED milieu).

For this project, a necessary working definition of "relational care" within inpatient mental health and ED settings was co-produced by our working group, comprising academic and lived experience researchers and clinicians, as follows: "*Relational care can be practised at individual, group, organisational or systemic levels. It prioritises interpersonal relationships grounded in values such as respect, trust, humility, compassion, and shared humanity, and involves personalised and holistic care, addressing power imbalances, and promoting effective collaboration between staff, patients and their social networks*."[1]

An organisational commitment to relational care, and reducing restrictive practices, is essential to provide the basis for developing and sustaining therapeutic relationships between staff and patients (NHS England, 2024a), from first contact (such as with paramedics and ambulance staff), in EDs, and on inpatient wards.

It is important to acknowledge the tensions involved in practising relational care in a setting that most patients experience as initially coercive and restrictive. In inpatient mental health services, there are pronounced power imbalances between staff and patients, and patients have limited choice and agency. Democratisation of care in these services may, therefore, be considered aspirational at present. In striving for relational care, it is important to both acknowledge and take active steps towards addressing these power imbalances (Kennedy et al., 2019).

The environments in which relational interactions take place are important to consider as they need to be conducive to impact positively upon relational care experience, and we can conceive of configurations of space and place that are systemically more likely to support relational practice (Lamph et al., 2023). For example, ward designs that maximise shared spaces, rather than demarcate space into designated staff and patient areas, or ward and ED layouts featuring outside areas and few confined spaces (Reavey et al., 2019; Shepley et al., 2016; Simonsen & Duff, 2020).

Though not their only defining characteristic, "relational care" is a fundamental part of other approaches to care, such as trauma-informed, person-centred, or recovery-focused care. All these approaches can be applied at the level of individual interactions and across broader organisational and systemic levels. Each has a distinct focus. Trauma-informed care recognises and responds to the impact of previous psychological trauma and aims to prevent iatrogenic trauma during the care experience. Person-centred care respects individuals' unique preferences and needs and involves them in discussions about their care where possible. Recovery-focused care supports individuals on their journey to "recovery" which is personally defined rather than a standard benchmark, and with the emphasis on reinforcing personal assets and resilience. All these approaches involve more meaningful dialogue with patients, moving towards a "working with" rather than a "doing to" ethos. The values and principles of relational care—such as trust, respect, compassion, personalised and holistic treatment, and collaboration—are central to all of them.

Relational care is also integral to psychological therapies, encompassing the soft skills needed to foster the therapeutic relationships between staff and patients that are fundamental to effective therapy. In this paper, psychological therapies are therefore included as relational care.

Review objective

This scoping review aimed to answer the following research question: What is the quantitative evidence for the impact of

"relational care" in non-forensic inpatient mental health and ED settings on self-harm and suicide-related outcomes?

A scoping review methodology was deemed most appropriate due to the lack of a consistent definition of "relational care," its conceptual complexity, and the limited research on this emerging topic. This approach allowed us to broadly and systematically map relevant existing literature, and to identify gaps, key issues and themes.

Materials and methods

This scoping review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The PRISMA-ScR checklist can be seen in Appendix C. The review was conducted by the National Institute for Health and Care Research (NIHR) Policy Research Unit in Mental Health (MHPRU) based at King's College London and University College London. The MHPRU conducts research in response to policymaker need (e.g., in the Department of Health and Social Care or NHS England). A working group comprising academic and lived experience researchers, and clinicians, met regularly throughout the course of the project.

Eligibility criteria

Our review's inclusion and exclusion criteria are described below. A table summary is available in Appendix D.

Population

Patients of any age, gender and ethnicity were included. Staff, family members/carers or non-mental health patients were excluded.

Setting

We included reviews that focused on care delivered within non-forensic inpatient mental health settings, including acute and longer-term inpatient services, and emergency departments. We excluded reviews focused on forensic inpatient mental health services, non-psychiatric medical inpatient services, services specifically for people with intellectual disabilities or autistic people, neurorehabilitation services, services specifically for people living with dementia, and community-based services.

Intervention

We included reviews that reported on relational care approaches to assessing and managing self-harm and suicide risk in inpatient mental health and emergency department settings. These approaches were required to have involved a focus on interpersonal relationships and at least some of the values and/or principles described in our co-produced definition of "relational care," provided above. We excluded pharmacological interventions, surveillance technologies, restrictive interventions (e.g., physical restraint, seclusion room use, rapid tranquilisation), structured risk assessment checklists and risk stratification, approaches focused only on the physical design of the environment, and standard aspects of inpatient mental health and ED care (e.g., psychosocial assessments, ward rounds).

Outcomes

We included reviews that examined self-harm and/or suicide-related outcomes, such as measures of suicidal ideation, frequency of self-harm or suicide attempts, time to next self-harm or suicide attempt, and rates of completed suicides. We excluded reviews that focused solely on risks to or from others, other patient outcomes, or staff or carer outcomes.

Types of studies

We opted to scope published reviews rather than primary research studies, due to preliminary literature searches revealing numerous existing reviews on the effectiveness of interventions for assessing and managing self-harm and suicide in inpatient mental health and ED settings. Quantitative and mixed-methods reviews were eligible for inclusion, including systematic, scoping, integrative, rapid, and narrative reviews. Both peer-reviewed and non-peer-reviewed sources were eligible for inclusion. We excluded primary research studies, books, commentaries, editorials, PhD/MSc/BSc theses, opinion pieces, blog posts and social media content. We applied no date restrictions but only included studies published in English. These restrictions were applied to narrow our scope, ensuring this review could be completed within the required timescales.

Literature searching

We searched three academic databases (Medline, PsycINFO and CINAHL) for reviews which examined the impact of relational care approaches on self-harm and suicide-related outcomes in inpatient mental health and ED settings. Database searches were conducted on 11/06/24 and were limited to review articles. No date or language search restrictions were applied.

Our search strategy included key terms relating to "relational care" and "relational practice" as well as terms for searching more generally for approaches to assessing and managing self-harm or suicide risk in inpatient mental health and ED settings. Previous work (Lamph et al., 2023) has shown that studies may not always explicitly use the terms "relational care" or "relational practice" despite describing care approaches that are relational in nature and align with our working definition. To account for this, our search terms were sufficiently broad to capture reviews likely to include relational care approaches. The search terms were drafted by JG and further refined through consultation with the working group. The full search terms used can be seen in Appendix E. The results of the database searches were exported into Endnote and duplicates were removed.

Additional relevant literature was also identified through searching Google Scholar, the National Institute for Health and Care Excellence (NICE) website, reference and citation lists of included reviews, and recommendations from members of our working group.

Selection of sources of evidence

All studies identified through database searches were independently double screened at title and abstract (JG, UF, RS). 10% of full texts were independently double screened (JG, UF). To assess each review's eligibility, full texts were examined to determine whether they included studies of interventions that aligned with our co-produced definition of relational care and met our other eligibility criteria (e.g., were conducted in inpatient mental health or ED settings, and measured the intervention's impact on self-harm and/or suicide-related outcomes). Any disagreements during screening were resolved through discussion between JG and UF, and any remaining uncertainties about eligibility were discussed with the wider working group. Screening was conducted in Rayyan (Ouzzani et al., 2016). Studies identified through searching Google Scholar, the NICE website, expert recommendations and forwards and backwards citation searching were screened by JG and RS.

Data charting and data items

Two data extraction forms were developed in Microsoft Word and collaboratively revised with the working group. The first summarised the eligible reviews, including their design, aims, search strategies, eligibility criteria, and identified relational care approaches, and paraphrased the review authors' relevant key findings and overall conclusions. The second summarised each of the relevant primary studies in these reviews, including information about their designs, locations, samples, interventions, any control/comparison groups, and reported quantitative evidence for the impact of the relational care intervention on self-harm and suicide-related outcomes. Data were extracted into these forms by two researchers (JG, RS), and all entries were double-checked for accuracy. Disagreements were resolved through discussion. No systematic quality appraisal of the included reviews or primary studies was conducted.

Synthesis

Synthesis was led by two researchers (JG, RS), with input from the working group. The characteristics and findings of the included reviews were tabulated (Appendix G) and summarised narratively. Similarly, the characteristics and results of relevant primary studies within these reviews were tabulated and narratively described, grouped by setting and relational care approach. Only quantitative evidence for the impact of relational care approaches on self-harm or suicide-related outcomes was synthesised.

More detailed tables and narrative descriptions summarising evidence from primary studies are provided in the appendices (see Supplementary File 1 for relational care approaches in inpatient mental health settings, and Supplementary File 2 for ED settings).

Results

Database searches returned 2,424 studies. After removing duplicates, 2,118 records remained for title and abstract screening. 2,064 studies were excluded, leaving 54 studies for full-text screening. Additional search methods identified 18 studies. Overall, 29 reviews met our inclusion criteria and were included in this scoping review. A list of studies excluded at full-text screening, with reasons for their exclusion, is provided in Appendix F. Figure 1 presents the PRISMA flow diagram (Page et al., 2021). A table of included review characteristics is available in Appendix G.

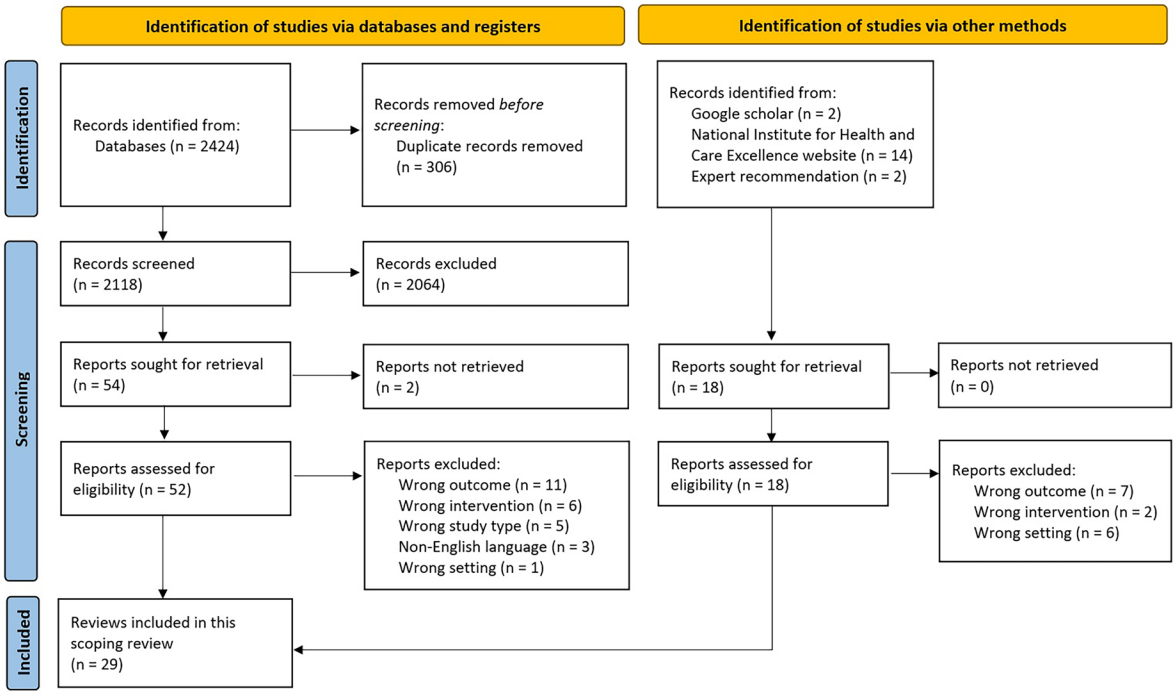

Figure 1. PRISMA flow diagram.

Characteristics of included reviews

All reviews identified studies by searching academic databases. Thirteen reviews also searched grey literature sources (e.g., clinical trial registries, Google Scholar, ResearchGate, relevant governmental and non-governmental websites, contacted authors for unpublished research) (Broadway-Horner et al., 2022; Evans et al., 2022; Falcone et al., 2017; Finch et al., 2022; Huber et al., 2024; Manna, 2010; Navin et al., 2019; Newton et al., 2010; Nugent et al., 2024; Reen et al., 2020; Thibaut et al., 2019; Ward-Stockham et al., 2022; Yiu et al., 2021). Search strategies and eligibility criteria were not clearly stated in one review (De Santis et al., 2015).

Out of the 29 included reviews, there was one systematic review with meta-analysis (Yiu et al., 2021), 14 systematic reviews without meta-analyses (Austin et al., 2024; Bloom et al., 2012; Chaudhary et al., 2020; Finch et al., 2022; Griffiths et al., 2022; Helleman et al., 2014; Huber et al., 2024; McCabe et al., 2018; NICE, 2022a; Nawaz et al., 2021; Newton et al., 2010; Reen et al., 2020; Thibaut et al., 2019; Ward-Stockham et al., 2022), two rapid reviews (Evans et al., 2022; Virk et al., 2022), one integrative review (Mullen et al., 2022), two scoping reviews (Broadway-Horner et al., 2022; Nugent et al., 2024), and nine non-systematic narrative reviews (Chammas et al., 2022; Cox et al., 2010; De Santis et al., 2015; Falcone et al., 2017; James, Stewart, Bowers, et al., 2012; Luxton et al., 2013; Manna, 2010; Navin et al., 2019; Timberlake et al., 2020).

Eighteen of the reviews focused on inpatient mental health settings only (Bloom et al., 2012; Chammas et al., 2022; Cox et al., 2010; De Santis et al., 2015; Evans et al., 2022; Finch et al., 2022; Griffiths et al., 2022; Helleman et al., 2014; James, Stewart, Bowers, et al., 2012; Manna, 2010; Mullen et al., 2022; Navin et al., 2019; Nawaz et al., 2021; Reen et al., 2020; Thibaut et al., 2019; Timberlake et al., 2020; Ward-Stockham et al., 2022; Yiu et al., 2021), six focused on ED settings only (Austin et al., 2024; Broadway-Horner et al., 2022; McCabe et al., 2018; Newton et al., 2010; Nugent et al., 2024; Virk et al., 2022), and five included inpatient and ED settings (Chaudhary et al., 2020; Falcone et al., 2017; Huber et al., 2024; Luxton et al., 2013; NICE, 2022a).

Eighteen reviews included self-harm and suicide as outcomes of interest (Austin et al., 2024; Bloom et al., 2012; Cox et al., 2010; Falcone et al., 2017; Finch et al., 2022; Helleman et al., 2014; Huber et al., 2024; James, Stewart, Bowers, et al., 2012; Manna, 2010; Mullen et al., 2022; NICE, 2022a; Nawaz et al., 2021; Newton et al., 2010; Nugent et al., 2024; Reen et al., 2021; Thibaut et al., 2019; Ward-Stockham et al., 2022; Yiu et al., 2021), three reviews included self-harm only (Broadway-Horner et al., 2022; Griffiths et al., 2022; Timberlake et al., 2020), and eight reviews included suicide-related outcomes only (Chammas et al., 2022; Chaudhary et al. 2020; De Santis et al., 2015; Evans et al., 2022; Luxton et al., 2013; McCabe et al., 2018; Navin et al., 2019; Virk et al., 2022).

None of the included reviews used the term "relational" to describe the interventions they examined. However, our assessment confirmed that they implicitly covered interventions aligning with our working definition of relational care. This is consistent with broader literature, where relational care is often not explicitly conceptualised despite a focus on recognisably relational approaches. The included reviews captured "relational" approaches by either searching broadly for any intervention for assessing and/or managing self-harm or suicide risk, or by specifically investigating "non-pharmacological," "non-restrictive," "psychological," or "psychosocial" interventions. There was considerable overlap in the primary studies included in the reviews.

Characteristics of primary papers

In the 29 included reviews, 87 relevant primary papers were identified, reporting on 82 primary studies. 32 (39.0%) primary studies were conducted in the USA (Asarnow et al., 2011; Barley et al., 1993; Bentley et al., 2017; Brown et al., 2005; Catanach et al., 2019; Celano et al., 2017; Currier et al., 2010; Deykin et al., 1986; Diamond et al., 2010; Donaldson et al., 1997, 2005; Drew, 2001; Ellis et al., 2012, 2015; Ercole-Fricke et al., 2016; Ghahramanlou-Holloway et al., 2020; Grupp-Phelan et al., 2019; King et al., 2015; LaCroix et al., 2018; Liberman & Eckman, 1981; McDonell et al., 2010; Miller et al., 2017; Motto, 1976; Motto & Bostrom, 2001; Patsiokas & Clum, 1985; Pfeiffer et al., 2019; Potter et al., 2005; Rotheram-Borus et al., 1996, 2000; Springer et al., 1996; Stanley et al., 2018; Tebbett-Mock et al., 2020; Wharff et al., 2019; Yen et al., 2019), 22 (26.8%) in the UK (Bennewith et al., 2014; Bowers et al., 2003, 2006; Bowers et al., 2008; Bowers et al., 2008; Bowers et al., 2011, 2015; Dodds & Bowles, 2001; Evans et al., 1999, 2005; Fletcher & Stevenson, 2001; Gordon et al., 2004; Guthrie et al., 2001; Haddock et al., 2019; Kapur et al., 2013; Morgan et al., 1993; Ougrin et al., 2013; Reen et al., 2021; Stevenson et al., 2002; Stewart et al., 2009, 2012; Stewart & Bowers, 2012; Tyrer et al., 2004), 4 (4.9%) in Ireland (Booth et al., 2014; Gibson et al., 2014; McAuliffe et al., 2014; McLeavey et al., 1994), 4 (4.9%) in Germany (Bohus et al., 2000, 2004; Edel et al., 2017; Kleindienst et al., 2008), 4 (4.9%) in France (Exbrayat et al., 2017; Mouaffak et al., 2015; Normand et al., 2018; Vaiva et al., 2006), 3 (3.7%) in Canada (Greenfield et al., 2002; Katz et al., 2004; Termansen & Bywater, 1975), 3 (3.7%) in Switzerland (Andreoli et al., 2016; Berrino et al., 2011; Gysin-Maillart et al., 2016), 2 (2.4%) in Australia (Berntsen et al., 2011; Dickens et al., 2020), and 1 (1.2%) each in New Zealand (Beautrais et al., 2010), French Polynesia (Amadéo et al., 2015), Japan (Inui-Yukawa et al., 2021), Taiwan (Lin et al., 2020), South Korea (Shin et al., 2019), Spain (Cebria et al., 2015; Cebrià et al., 2013), and Italy (Alesiani et al., 2014). One study (1.2%) had sites in Brazil, India, Sri Lanka, Iran and China (Bertolote et al., 2010; Fleischmann et al., 2008). This shows that most of the included primary studies on relational care approaches were conducted in high-income countries, the majority in the USA and UK.

Overall, 49 primary papers reported on adult samples, 20 on children and young people (CYP) samples, 12 on adult and CYP samples, and six did not specify the age of

participants. More detailed breakdowns of sample ages by primary study are provided in Tables 1 and 2.

Sixty-two relevant relational care approaches were identified which had been evaluated in terms of their impact on self-harm and/or suicide risk in inpatient or ED settings, across the 87 primary papers. Many of these were psychological interventions delivered at individual or group levels. However, some ward- and organisation-level approaches were also identified. The primary studies reporting on them varied in design, from RCTs and controlled studies, to pre-post and cross-sectional studies.

Thirty different relational care approaches were identified from the included reviews which had been quantitatively examined in terms of their impact on self-harm and/

Table 1. Overview of relational care approaches identified and their impact on self-harm and suicide-related outcomes in non-forensic inpatient mental health settings.

Primary study	Design	Intervention	Age group	Effect on self-harm	Effect on suicide
Dialectical behaviour therapy-based approaches					
Barley et al. (1993)	Pre-post with control	Adapted inpatient DBT	Adults & CYP	Positive	Not measured
Bohus et al. (2000)	Prospective pilot without control	Adapted inpatient DBT	Adults & CYP	Positive	Not measured
Bohus et al. (2004)	Non-randomised trial	Adapted inpatient DBT	Adults	Positive	Not measured
Booth et al. (2014)	Pre-post without control	Adapted inpatient DBT	Adults	Positive	
Edel et al. (2017)	Pilot study with control	Adapted inpatient DBT	Adults	Not significant	Not measured
Gibson et al. (2014)	Non-randomised trial	Adapted inpatient DBT	Adults	Positive	Not measured
Katz et al. (2004)	Non-randomised trial	Adapted inpatient DBT	CYP	Positive	Positive
Kleindienst et al. (2008)	Naturalistic follow up without control	Adapted inpatient DBT	Adults	Positive	Not significant
McDonell et al. (2010)	Pre-post with historic control	Adapted inpatient DBT	CYP	Positive	Not measured
Springer et al. (1996)*	RCT	Adapted inpatient DBT	Adults	No significance testing	Positive
Tebbett-Mock et al. (2020)	Pre-post with historic control	Adapted inpatient DBT	CYP	Positive	Positive
Cognitive behaviour therapy-based approaches					
Alesiani et al. (2014)	Pre-post without controls	Systems Training for Emotional Predictability and Problem Solving (STEPPS) therapy	Adults	Positive	Positive
Bentley et al. (2017)*	Proof of concept RCT	Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders	Adults	Not measured	Not significant
Ghahramanlou-Holloway et al. (2020)*	Pilot RCT	Post-Admission Cognitive Therapy (PACT)	Adults	Not measured	Not significant
Haddock et al. (2019)*	RCT	Cognitive-behavioural suicide prevention (CBSP) therapy	Adults	Not measured	Not significant
LaCroix et al. (2018)*	Pilot RCT	Post-Admission Cognitive Therapy (PACT)	Adults	Not measured	Negative
Liberman and Eckman (1981)*	RCT	Behavioural therapy	Adults	Not measured	Positive
Patsiokas and Clum (1985)*	RCT	Cognitive restructuring	Not reported	Not measured	Not significant
		Problem-solving therapy (PST)		Not measured	Not significant
Other psychological approaches					
Berrino et al. (2011)	Cohort study with control	Brief admission crisis intervention program	Adults	No significance testing	Positive
Celano et al. (2017)	RCT	Phone-based positive psychology	Adults	No significance testing	No significance testing
		Cognition-focused intervention		No significance testing	No significance testing
Edel et al. (2017)	Pilot study with controls	Combined DBT and MBT group therapies	Adults	Positive	Not measured
Ellis et al. (2012)	Open trial, case-focused design without control	Collaborative Assessment and Management of Suicidality (CAMS)	Adults	Not measured	Positive
Ellis et al. (2015)	Naturalistic non-randomised comparison trial with control	Collaborative Assessment and Management of Suicidality (CAMS)	Adults	Not measured	Positive
Katz et al. (2004)	Non-randomised trial	Psychodynamic-oriented crisis assessment and treatment	CYP	Positive	Positive
Liberman and Eckman (1981)	RCT	Insight-oriented psychotherapy	Adults	Not measured	Positive
Yen et al. (2019)	Pre-post without control	Steps to Enhance Positivity (STEPs) therapy	CYP	Not measured	Positive
Staff training					
Bowers et al. (2006)	Before-and-after trial without controls	City nurses	Adults	Positive	Not significant
Bowers, Flood et al. (2008)	RCT	City nurses	Not reported	Not significant	
Ercole-Fricke et al. (2016)	Quasi-experimental without controls	Collaborative problem-solving training for nurses	CYP	Positive	Not measured
Observations					
Bowers et al. (2003)	Cross-sectional	Constant observations	Adults	Negative	Not measured
Bowers, Whittington et al. (2008)	Cross-sectional	Constant observations	Adults	Not significant	Not measured
		Intermittent observation		Positive	Not measured
Bowers et al. (2011)	Cross-sectional	Intermittent observation	Adults and CYP	Not measured	Positive
Stewart et al. (2009)	Longitudinal analysis without controls	Constant observations	Adults	Not significant	Not measured

(*Continued*)

Table 1. Continued.

Primary study	Design	Intervention	Age group	Effect on self-harm	Effect on suicide
Stewart and Bowers (2012)	Cross-sectional	Intermittent observation	Adults	Positive	Not measured
Stewart et al. (2012)	Cross-sectional	Constant observations	Adults	No significance testing	No significance testing
Ward- and organisational-level approaches					
Bowers et al. (2015)	Pragmatic cluster RCT	Safewards	Adults	Positive	
Dickens et al. (2020)	Longitudinal pre-post without controls	Safewards	Adults	Positive	
Dodds and Bowles (2001)	Pre-post without controls	Bradford Refocusing model	Adults	No significance testing	No significance testing
Fletcher and Stevenson (2001)	Pre-post without controls	Tidal model	Adults	No significance testing	Not measured
Gordon et al. (2004)	Pre-post with controls	Tidal model	Adults	No significance testing	Not measured
Reen et al. (2021)	Interrupted time series without controls	Twilight shifts and evening activities programme	CYP	Positive	Not measured
Stevenson et al. (2002)	Pre-post without controls	Tidal model	Adults	No significance testing	No significance testing
Mixed interventions					
Berntsen et al. (2011)	Quantitative descriptive without controls	Staff training in DBT and seclusion and restraint, programme to reward patient behaviour, five patient exercise sessions per week	CYP	No significance testing	Not measured
Pfeiffer et al. (2019)*	RCT	Peer support and DBT strategies	Adults	Not measured	No significance testing
Other approaches					
Bennewith et al. (2014)	Pilot study without controls	Caring letters	Adults	No significance testing	No significance testing
Drew (2001)	Retrospective correlational design with control	No-suicide contracts	Adults	Negative	Negative
Motto (1976) and Motto and Bostrom (2001)	RCT	Caring letters	Adults	Not measured	Positive
Potter et al. (2005)	Pre-post without controls	Safety agreement tool/contract	Adults	Not significant	
Springer et al. (1996)	RCT	Wellness and lifestyle discussion group	Adults	Positive	Positive

The "self-harm" column summarises the effect of the relational care approach in each primary study on self-harm outcomes, including self-harm frequency, severity, and frequency of presentations to services for self-harm. The "suicide" column similarly summarises the effect of the relational care approach in each primary study on suicide-related outcomes, such as completed suicides, suicide attempts, suicidal ideation, and presentations to services for suicidality. In both columns, "positive" and green shading indicates significant improvement in the outcome, "negative" and red shading significant negative impact, and "not significant" and yellow shading no significant effect. "No significance testing" and grey shading indicates a lack of statistical analysis, and "not measured" and grey shading shows that the outcome was not measured in the primary study. The "effect on self-harm" and "effect on suicide" columns are merged in studies where no distinction was made between suicidal and non-suicidal self-injury. * Indicates that the study was included in Yiu et al.'s (2021) systematic review and meta-analysis of psychosocial interventions in inpatient settings, which included 10 RCTs (examining DBT interventions, CBT interventions, and gratitude journalling), and concluded that psychosocial interventions were not any more effective than control interventions. RCT = Randomised Controlled Trial; DBT = Dialectical Behaviour Therapy; MBT = Mentalisation-Based Therapy.

or suicide-related outcomes in inpatient mental health settings, in 46 primary papers (see Table 1 for an overview).

Thirty-two different relational care approaches were identified from the included reviews which had been quantitatively examined in terms of their impact on self-harm and/or suicide-related outcomes in ED settings, in 41 primary papers (see Table 2 for an overview).

Overall conclusions of the reviews

Overall, recurrent themes in the conclusions of the reviews included: a lack of high-quality evidence for the impact of these interventions on self-harm and suicide in inpatient mental health and ED settings; poor descriptions of some interventions, their underlying theoretical assumptions, and mechanisms of change; a lack of consistency in methods and outcomes measured across studies; and a lack of lived experience involvement in the research. None of the reviews addressed how good relational care may be provided for neurodivergent individuals. This is important given that they often face barriers in accessing and benefiting from mental health care which can be mitigated with simple, reasonable adjustments, such as communication accommodations (e.g., using simple and preferred language) and environmental adjustments (e.g., reducing sensory distractions) (Pemovska et al., 2024; Loizou et al., 2024). Nevertheless, the reviews did highlight some approaches with some supporting evidence for a positive change in key outcomes, summarised below.

Inpatient settings

We identified a systematic review and meta-analysis by Yiu et al. (2021) which included 10 RCTs evaluating psychosocial interventions in inpatient settings (including Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) and gratitude journalling) (Yiu et al., 2021). It concluded that psychosocial interventions did not significantly reduce suicidal ideation or suicide attempts compared to controls post-intervention (95% CI = −0.38 to 0.10; $p = 0.26$) or at follow-up (95% CI = −0.15 to 0.59; $p = 0.24$) (Yiu et al., 2021). However, it only included some of the primary studies identified in this scoping review, in part due to only including RCTs, whereas we included primary studies of any quantitative design.

Table 2. Overview of relational care approaches identified and their impact on self-harm and suicide-related outcomes in emergency department settings.

	Primary study	Design	Intervention	Age group	Effect on self-harm	Effect on suicide
Approaches based only in the ED	Relational approaches to risk assessments					
	Ougrin et al. (2013)	RCT	Therapeutic assessment	CYP	Not significant	
	Interventions based solely in the emergency department					
	Wharff et al. (2019)	RCT	Family-Based Crisis Intervention (FBCI)	CYP	Not measured	Not significant
Approaches initiated in the ED and continued post-discharge	Psychoeducation/information-based emergency department session with follow-up					
	Amadéo et al. (2015)	RCT	Brief Intervention and Contact (BIC)	Not reported	Not measured	Not significant
	Fleischmann et al. (2008); Bertolote et al. (2010)	RCT	Brief Intervention and Contact (BIC)	Adults & CYP	Not measured	Positive
	Miller et al. (2017)	Interrupted time series with historical controls	Safety Assessment and Follow-Up Telephone Intervention (SAFTI)	Adults	Not measured	Positive
	Stanley et al. (2018)	Cohort comparison with controls	Safety Planning Intervention with follow-up (SPI+)	Adults	Not measured	Positive
	Cognitive behavioural therapy-based emergency department session with follow-up					
	Asarnow et al. (2011)	RCT	Family Intervention for Suicide Prevention (FISP)	CYP	Not measured	Not significant
	Rotheram-Borus et al. (1996); Rotheram-Borus et al. (2000)	Non-random quasi-experimental with controls	Successful Negotiation Acting Positively (SNAP) therapy	CYP	Not measured	Not significant
	Motivational interviewing-based emergency department session with follow-up					
	Grupp-Phelan et al. (2019)	RCT	Suicidal Teens Accessing Treatment After an Emergency Department Visit (STAT-ED)	CYP	Not measured	Not significant
	King et al. (2015)	RCT	Teen Options for Change (TOC)	CYP	Not measured	Not significant
	Other approaches					
	Greenfield et al. (2002)	Non-randomised trial	Rapid response outpatient team	CYP	Not measured	Positive
	Inui-Yukawa et al. (2021)	RCT	Assertive case management	Adults	Positive	Positive
Approaches starting after ED discharge	Psychological interventions					
	Andreoli et al. (2016)	RCT	Abandonment psychotherapy	Adults	Not measured	Positive
	Brown et al. (2005)	RCT	Cognitive Behavioural Therapy (CBT)	Adults	Not measured	Positive
	Diamond et al. (2010)	RCT	Attachment-Based Family Therapy (ABFT)	CYP	Not measured	Positive
	Donaldson et al. (2005)	Pilot RCT	Skills-based cognitive behavioural therapy	CYP	Not measured	Positive
			Non-directive supportive relationship treatment		Not measured	Positive
	Guthrie et al. (2001)	RCT	Brief psychodynamic interpersonal therapy	Adults	Positive	Positive
	Gysin-Maillart et al. (2016)	RCT	The Attempted Suicide Short Intervention Program (ASSIP)	Not reported	Not measured	Positive
	Lin et al. (2020)	RCT	Cognitive behavioural therapy with case management	Adults	Not measured	Not significant
	McAuliffe et al. (2014)	RCT	Problem-Solving Therapy (PST)	Adults	Not significant	No significance testing
	McLeavey et al. (1994)	RCT	Interpersonal Problem-Solving Skills Training (IPSST)	Adults & CYP	No significance testing	
			Brief problem-oriented approach		No significance testing	
	Tyrer et al. (2004)	RCT	Manual-Assisted Cognitive Behaviour Therapy (MACT)	Adults & CYP	Not significant	Not measured
	On demand access to crisis support					
	Evans et al. (1999); Evans et al. (2005)	RCT	Crisis cards	Not reported	Not significant	Not measured
	Morgan et al. (1993)	RCT	Green cards	Adults	Not significant	No significance testing
	Follow-up contacts only					
	Beautrais et al. (2010)	RCT	Postcard follow-up contacts	Adults & CYP	Not significant	Not measured
	Catanach et al. (2019)	Prospective pilot without control	Telephone follow-up contacts	Adults & CYP	Not measured	No significance testing
	Cebrià et al. (2013); Cebria et al. (2015)	Case-control	Telephone follow-up contacts	Adults & CYP	Not measured	Positive
	Donaldson et al. (1997)	Non-randomised trial	Telephone follow-up contacts	CYP	Not measured	No significance testing
	Exbrayat et al. (2017)	Pre-post study with historical controls	Telephone follow-up contacts	Adults	Not measured	Positive
	Kapur et al. (2013)	Pilot RCT	Telephone and letter follow-up contacts	Adults	Negative	
	Mouaffak et al. (2015)	RCT	Crisis card and telephone follow-up contacts	Adults	Not measured	Not significant
	Normand et al. (2018)	Cohort study without control	Telephone and letter follow-up contacts	Adults & CYP	Not measured	No significance testing
	Termansen and Bywater (1975)	Quasi-experimental four group cohort	Telephone follow-up contacts	Not reported	Not measured	Positive
	Vaiva et al. (2006)	RCT	Telephone follow-up contacts	Adults	Not measured	Positive
	Other approaches					
	Currier et al. (2010)	RCT	Mobile crisis team	Adults	Not measured	Not significant
	Deykin et al. (1986)	Quasi-experimental with control	Specialist direct service for youths	CYP	Not measured	Not significant
	Shin et al. (2019)	Cross-sectional	Case management	Adults	Not measured	Positive

The "self-harm" column summarises the effect of the relational care approach in each primary study on self-harm outcomes, including self-harm frequency, severity, and frequency of presentations to services for self-harm. The "suicide" column similarly summarises the effect of the relational care approach in each primary study on suicide-related outcomes, such as completed suicides, suicide attempts, suicidal ideation, and presentations to services for suicidality. In both columns, "positive" and green shading indicates significant improvement in the outcome, "negative" and red shading significant negative impact, and "not significant" and yellow shading no significant effect. "No significance testing" and grey shading indicates a lack of statistical analysis, and "not measured" and grey shading shows that the outcome was not measured in the primary study. The "effect on self-harm" and "effect on suicide" columns are merged in studies where no distinction was made between suicidal and non-suicidal self-injury. ED = Emergency Department; RCT = Randomised Controlled Trial.

Other reviews we identified in this setting provided some evidence suggesting that the following approaches can have a significant positive effect on self-harm: adapted inpatient DBT (in 9/11 studies) (Barley et al., 1993; Bohus et al., 2000, 2004; Booth et al., 2014; Gibson et al., 2014; Katz et al., 2004; Kleindienst et al., 2008; McDonell et al., 2010; Tebbett-Mock et al., 2020), combined DBT and Mentalisation-Based Therapy (MBT) (in 1/1 studies) (Edel et al., 2017), Systems Training for Emotional Predictability and Problem Solving (STEPPS) therapy (in 1/1 studies) (Alesiani et al., 2014), psychodynamic-oriented crisis assessment and treatment (in 1/1 studies) (Katz et al., 2004), city nurses (employing a specialist nurse on each ward to help staff to adopt a low-conflict, therapy-based nursing model) (in 1/2 studies) (Bowers et al., 2006; Bowers et al., 2008), collaborative problem-solving training for nurses (in 1/1 studies) (Ercole-Fricke et al., 2016), intermittent observation (in 2/2 studies) (Bowers et al., 2008; Stewart & Bowers, 2012), and twilight nursing shifts with an evening activities programme (in 1/1 studies) (Reen et al., 2021). Evidence also suggested that Safewards can significantly reduce "conflict" events (including self-harm and suicide attempts amongst other conflict events) (in 2/2 studies) (Bowers et al., 2015; Dickens et al., 2020).

There was also some evidence for a significant positive effect on suicide-related outcomes for adapted inpatient DBT (in 4/5 studies) (Booth et al., 2014; Katz et al., 2004; Springer et al., 1996; Tebbett-Mock et al., 2020), Collaborative Assessment and Management of Suicidality (CAMS) (in 2/2 studies) (Ellis et al., 2012, 2015), Steps to Enhance Positivity (STEPs) (in 1/1 studies) (Yen et al., 2019), psychodynamic-oriented crisis assessment and treatment (in 1/1 studies) (Katz et al., 2004), insight-oriented psychotherapy (in 1/1 studies) (Liberman & Eckman, 1981), a wellness and lifestyle discussion group (in 1/1 studies) (Springer et al., 1996), a brief admission crisis program (in 1/1 studies) (Berrino et al., 2011), intermittent observation (in 1/2 studies) (Bowers et al., 2011), and post-discharge caring letters (in 1/2 studies) (Motto, 1976). Only 2/7 studies of CBT-based approaches in inpatient settings, investigating STEPPS (Alesiani et al., 2014) and behavioural therapy (Liberman & Eckman, 1981), showed a significant positive impact on suicide-related outcomes; the remaining studies either found no significant effect (Bentley et al., 2017; Ghahramanlou-Holloway et al., 2020; Haddock et al., 2019; Patsiokas & Clum, 1985) or a significant negative effect (LaCroix et al., 2018).

There was some evidence that no-suicide contracts (in 1/1 studies) (Drew, 2001), constant observation (in 1/4 studies) (Bowers et al., 2003), and post-admission cognitive therapy (in 1/2 studies) (LaCroix et al., 2018) can have a significant negative impact on self-harm and/or suicide-related outcomes in inpatient settings. Drew (2001) found that patients with no-suicide contracts were significantly more likely to engage in self-harm and suicidal behaviour than those without contracts. However, the authors questioned whether this association was due to patients with higher risks of self-harm and suicide being more likely to be placed on contracts, rather than the no-suicide contracts causing the behaviour. Similarly, Bowers et al. (2003) found a link between self-harm and constant observation; however, the cross-sectional design of the study does not allow for determining the direction of causality in this association. In their pilot RCT, LaCroix et al. (2018) found significantly higher suicidal ideation in individuals receiving post-admission cognitive therapy compared to enhanced usual care controls, though there was no significant difference in suicide reattempts. The authors noted that their analysis was limited by low statistical power due to their small sample size and argued that further, well-powered multisite RCTs are needed to more rigorously assess the therapy's efficacy in reducing suicidal behaviour.

Emergency department settings

In ED settings, there was some evidence that brief psychodynamic interpersonal therapy initiated after ED discharge (in 1/1 studies) (Guthrie et al., 2001) and assertive case management initiated in the ED and continued post-ED discharge (in 1/1 studies) (Inui-Yukawa et al., 2021) significantly reduced self-harm. Other relational care approaches either had no significant impact on self-harm (Beautrais et al., 2010; Evans et al., 1999, 2005; McAuliffe et al., 2014; Morgan et al., 1993; Ougrin et al., 2013; Tyrer et al., 2004) or their impact on self-harm was not investigated or not significance tested.

There was evidence that some approaches initiated in the ED and continued post-ED discharge can significantly improve suicide-related outcomes, including: Safety Assessment and Follow-up Telephone Intervention (SAFTI) (in 1/1 studies) (Miller et al., 2017), Safety Planning Intervention with follow-up (SPI+) (in 1/1 studies) (Stanley et al., 2018), brief intervention and contact (BIC) (in 1/2 studies) (Bertolote et al., 2010; Fleischmann et al., 2008), a rapid response outpatient team (in 1/1 studies) (Greenfield et al., 2002) and assertive case management (in 1/1 studies) (Inui-Yukawa et al., 2021).

There was also some evidence suggesting that the following relational care approaches initiated post-ED discharge significantly improve suicide-related outcomes: CBT-based interventions (in 2/5 studies) (Brown et al., 2005; Donaldson et al., 2005), non-directive supportive relationship treatment (in 1/1 studies) (Donaldson et al., 2005), brief psychodynamic interpersonal therapy (in 1/1 studies) (Guthrie et al., 2001), abandonment psychotherapy (in 1/1 studies) (Andreoli et al., 2016), Attachment-Based Family Therapy (ABFT) (in 1/1 studies) (Diamond et al., 2010), the Attempted Suicide Short Intervention Program (ASSIP) (in 1/1 studies) (Gysin-Maillart et al., 2016), case management (in 1/1 studies) (Shin et al., 2019), and telephone follow-up contacts (in 4/6 studies) (Cebria et al., 2015; Cebrià et al., 2013; Exbrayat et al., 2017; Termansen & Bywater, 1975; Vaiva et al., 2006).

Some relational care approaches, including Family Intervention for Suicide Prevention (FISP), a mobile crisis team (Currier et al., 2010), a specialised direct service for youths (Deykin et al., 1986), Suicidal Teens Accessing Treatment after an ED visit (STAT-ED) (Grupp-Phelan et al., 2019), Teen Options for Change (TOC) (King et al., 2015), a crisis card with telephone follow-up contacts (Mouaffak

et al., 2015), therapeutic assessment (Ougrin et al., 2013), Successful Negotiation Acting Positively (SNAP) therapy (Rotheram-Borus et al., 1996, 2000), and Family-Based Crisis Intervention (FBCI) (Wharff et al., 2019) were found to have no significant effect on suicide-related outcomes. The impact of the remaining relational care approaches on suicide-related outcomes were either not investigated or not significance tested.

One primary study, a pilot RCT, found that combined letter and telephone follow-up contacts were associated with significantly worse self-harm (regardless of suicidal intent) compared to usual care (Kapur et al., 2013). The authors cautioned these findings should be interpreted with care, as the study was not designed as an efficacy trial. They acknowledge that they cannot rule out the possibility of a true increase in the risk of self-harm repetition. However, they also suggest that it could also be partly attributed to the uneven distribution of baseline clinical risk factors between the groups, although adjustments for these factors had little impact on the results. They also propose that repeated hospital presentations for self-harm could indicate a lowered threshold for help-seeking or improved engagement with services due to the intervention.

For a more detailed breakdown of primary study results for each relational care approach in inpatient mental health settings, see Supplementary File 1. For a more detailed breakdown of primary study results for each relational care approach in ED settings, see Supplementary File 2.

Discussion

Key findings

Our scoping review outlines a proposed universal definition of "relational care" and synthesises quantitative evidence for relational care approaches to assessing and managing self-harm and suicide risk in non-forensic inpatient mental health and ED settings. Twenty-nine relevant reviews were identified reporting on 62 relevant relational care approaches. Many of these were psychological interventions delivered at individual or group levels. However, some ward- and organisation-level approaches were also identified. For most of the relational care approaches included, only one primary study was identified assessing its impact on self-harm and/or suicide in inpatient or ED settings.

It is important to acknowledge that none of the included reviews' research questions explicitly used the term "relational care." Instead, the reviews within this scoping review constructed research questions which used the terms "psychosocial," "psychological," "non-restrictive," and "non-pharmacological" approaches. These descriptive terms captured a range of different interventions, some of which aligned with our definition of relational care, and others that did not (e.g., ward design modifications and structured risk assessment checklists). We carefully examined each review, reporting only those findings that related to interventions meeting our criteria for relational care.

In inpatient settings, supporting evidence was identified from controlled studies for some psychological interventions, including adapted inpatient DBT, combined DBT and MBT, CAMS, psychodynamic-oriented crisis assessment and treatment, behavioural therapy, insight-oriented psychotherapy, a wellness and lifestyle discussion group, and a brief admission crisis program. Additionally, controlled studies suggested that Safewards and post-discharge "caring letters" can reduce self-harm and/or suicide. Uncontrolled studies provided some evidence for STEPPS therapy, STEPs, intermittent observation, twilight nursing shifts with evening activities, and certain staff training approaches such as "city nurses" and "collaborative problem-solving training for nurses." There was a lack of evidence, or mixed evidence, regarding the impact of other relational care interventions on self-harm and suicide-related outcomes in inpatient settings. Evidence from a controlled study of no-suicide contracts and an uncontrolled study of constant observation suggested that they can have a significant negative impact on self-harm and/or suicide related outcomes.

In EDs, relational care approaches demonstrated mixed effectiveness. Evidence was identified from controlled studies which suggested that some psychological approaches (e.g., brief psychodynamic interpersonal therapy, abandonment psychotherapy, SAFTI, SPI+, BIC, ABFT, ASSIP, some CBT-based approaches, and non-directive supportive relationship treatment), rapid response outpatient teams, assertive case management, and post-discharge telephone contacts can have a significant positive impact on self-harm and/or suicide-related outcomes. An uncontrolled cross-sectional study provided evidence supporting a post-discharge case management intervention. Evidence from controlled studies indicated that therapeutic assessments, other psychological approaches, on-demand crisis support (e.g., crisis cards, green cards), a specialist direct service for youths, mobile crisis teams, postcard follow-up contacts, and combined crisis card and telephone follow-up contacts, did not have a significant effect on self-harm or suicide-related outcomes. Evidence from one controlled study suggested that combined telephone and letter follow-up contacts could significantly worsen self-harm and suicide-related outcomes.

Overall, the identified reviews highlighted a lack of high-quality research in this area, noting poorly described interventions and mechanisms of change, and inconsistent methodologies and outcome measures in primary studies. However, it is essential to consider that absence of evidence is not evidence of a lack of value in these approaches. It may instead reflect some of the challenges in researching "relational care" and its impact on self-harm and suicide in inpatient and ED settings, explored below.

Challenges defining "relational care"

As identified earlier, the term "relational care" is not widely used within inpatient or ED mental health academic research. This is despite the concept having a longstanding history and underpinning many clinical approaches in mental health, including in inpatient and ED settings (Bolsinger et al., 2019; NHS England, 2022; Priebe & Mccabe, 2008). Reviews on "relational care" in a mental health context are only just

beginning to emerge. For example, Lamph et al. (in prep) are conducting a conceptual analysis of "relational practice," drawing upon global, cross-sector papers to report some of its key components.

The concept of "relational care" also extends beyond mental healthcare; it has been described and applied across a range of other contexts, including education, criminal justice, and social work. For example, in social work, "relational-based practice" is seen as core to social workers' interactions and roles, and it is also cited within a variety of mental health nursing education texts (Hewitt et al. n.d.; Peplau, 1952; Watkins, 2001). Whilst the concept of relational care exists across different sectors, there is variation in how it is defined and understood by clinicians and service users. For example, different professions have different perspectives on what "relational care" means and how it can be applied in their work, shaped by their professional identities and philosophical and training backgrounds. "Relational care" can be understood and applied differently depending on cultural, contextual, and individual factors. This variability makes it difficult to define, operationalise and research.

Challenges in defining and assessing fidelity to relational care values and principles

Another challenge is to evaluate fidelity to "relational care." Some fundamental components such as respect, authenticity, and shared humanity, can be difficult to measure and depend on the personal qualities of individual health professionals. It is possible that a "relational care" intervention could be delivered in a way that is perfunctory and inconsistent with the values and principles that underpin it. For example, verbal de-escalation encourages staff to validate patients' emotional responses while empathising calmly and is a part of some relational care approaches. While intended to be supportive and comforting, there is a risk that it could be experienced as invalidating or a means of "providing a kinder façade to oppressive practice" (Kennedy et al., 2019). This complexity can make it difficult to operationalise and evaluate adherence to relational care approaches in research.

Difficulties in measuring self-harm and suicide outcomes

Evaluating the impact of any intervention on self-harm and suicide rates in inpatient and ED settings is a challenge. While highly important, it must be considered that the numbers of suicides on inpatient wards remains, thankfully, a relatively rare occurrence (University of Manchester & Healthcare Quality Improvement Partnership, 2024). As a result, it is difficult to evaluate the impact of any intervention on preventing suicides without conducting large-scale studies on multiple wards (e.g., Bowers et al., 2008). Furthermore, the nature of suicidality and reasons people may engage in self-harming behaviours, as well as self-harm methods, are vast, variable, and may change drastically over time, making them difficult to measure. It can also be challenging to distinguish suicidal and non-suicidal self-injury (Samari et al., 2020). Whilst frequency of self-injury is a crude outcome measure, accounting for self-injury severity risks creating a problematic and potentially invalidating hierarchy of methods. The private nature of self-harm also means it is unlikely to be accurately measured. More restrictive approaches may keep people safer in the short term but cause long-term harm, such as physical and psychological injury, dehumanisation, erosion of trust between patients and staff, and (re)traumatisation (Baker et al., 2021; Cusack et al., 2018). There is a need to be person-centred when approaching these topics, as what works to help keep some patients safe may be problematic for others. There is no standard "one size fits all" approach for everyone and all services.

The impact of many relational care approaches on self-harm and suicide has not been researched

There are many other relational care approaches used in inpatient and ED settings which were not captured by these reviews, and thus within this scoping review, because they were not quantitatively evaluated in the academic literature in terms of their impact on self-harm or suicide. There is likely a bias in the research towards approaches such as DBT which were developed with an explicit and direct focus on reducing self-harm and suicide. It is notable that this review identified evidence supporting relational care interventions which take a less behavioural approach, for example, brief psychodynamic interpersonal therapy (Guthrie et al., 2001). Other therapies and approaches that also have positive effects in the long- or short-term are likely to exist, though their direct impact on self-harm and suicide may not have been evaluated in research and so they will not have been identified in this scoping paper.

Approaches that have an indirect impact on self-harm and suicide, including interventions aimed at changing ward cultures and environments may, therefore, be overlooked within these reviews. Such approaches include evidence-based approaches such as Safewards (Dickens et al., 2020; Finch et al., 2022; Fletcher et al., 2017) and the Assured intervention (Shah et al., 2024). Other approaches include Open Dialogue (Freeman et al., 2019; *The ODDESSI Trial*, 2024), therapeutic communities (Campling, 2001; Malivert et al., 2012), and Enabling Environments (*Enabling Environments (EE)*, 2024). These examples offer valuable insights into the potential benefits of relational care interventions, values, and practices which address systemic and cultural factors affecting self-harm and suicide risk management.

Barriers and facilitators to implementing relational care approaches in these settings

While this scoping review found evidence for the use of some relational care approaches within inpatient and ED settings to reduce suicide and self-harm, it is important to acknowledge that consistently and effectively implementing relational care in these contexts is difficult. Whilst implementing complex interventions in any real-world setting is inherently challenging and requires careful consideration of

active and dynamic factors that either facilitate or hinder implementation (Laker et al., 2019; Nilsen & Birken, 2020), these specialist settings introduce additional unique barriers.

Firstly, inpatient mental health and ED environments are dynamic with a diverse mix of different staff, patients, and visitors, each with their unique backgrounds and personalities. There are therefore many different relationships at play, between patients, between staff and patients, and between different staff. There may naturally be variability in the provision of relational care between services, wards, staff teams, and people on different shifts. Individuals with certain personal qualities (e.g., people who are caring, kind and empathetic) may provide relational care more naturally, whereas others may struggle to engage relationally. Furthermore, an individual's capacity to provide relational care may vary over time, for example, depending on their personal circumstances and other factors such as stress levels, burnout, and other stressors (Care Quality Commission, 2021). Navigating the boundary between demonstrating these qualities and maintaining safe boundaries and professional limitations also needs to be considered.

Secondly, providing relational care consistently in an inpatient or ED context is further complicated by the changing composition of staff and patients in these settings. Inconsistent shift patterns, high levels of unfilled vacancies (especially for registered nurses), reliance on bank and agency staff, and utilisation of more peripheral team members introduces variability. Patients themselves often have transient experiences in EDs and short stays in inpatient settings, and the NHS Mental Health Implementation Plan is aiming to reduce the length of inpatient psychiatric stays further, to a maximum of 32 days (NHS England, 2019). These factors require careful consideration as they will impact both implementation of relational care at a personal level and influence the broader ward milieu and culture at a more ecological level.

Thirdly, inpatient mental health and ED settings are complex and coercive environments. Many patients—often the majority—are compulsorily detained and may experience interventions and restrictive practices against their will, leading to diminished autonomy and limited choices. There are therefore significant power imbalances between patients and staff, which no doubt create considerable barriers to implementing an intervention based on relationship equality, particularly within a hierarchical, authoritarian system (Kennedy et al., 2019).

Finally, it is crucial to remember that these are contexts where there are significant risks. Getting things wrong can have severe consequences, including physical and psychological harm to patients, devastation to families, and severe distress to staff. In ED settings, there is often a disproportionate focus on mental health presentations as the cause of violence and aggression. This can contribute to staff difficulty distinguishing clinical distress and agitation from actual violence and aggression, increasing staff anxiety and leading to a reliance on restrictive interventions to manage risk, thereby hindering the implementation of relational care. Front-facing staff in ED and inpatient settings who spend the most time with patients often receive the least training, are the lowest paid, and receive the least supervisory support (e.g., supervision and reflective practice). This can result in high levels of burnout and moral injury amongst staff (Williamson et al., 2021). Furthermore, staff face pressure from hospital management, external regulatory agencies, and coroners to document risk assessments. This is in addition to the already substantial burden of administrative tasks, monitoring and reporting required of staff, which reduces time available for direct clinical care. These pressures faced by staff can hinder their ability to effectively implement person-centred, relational care and drive an over-reliance on risk assessment tools and restrictive practices, despite their ineffectiveness in managing risk (University of Manchester & Healthcare Quality Improvement Partnership, 2018).

Strengths and limitations

This paper offers a broad overview of the quantitative evidence for relational care approaches to assessing and managing self-harm and suicide risk in inpatient mental health and ED settings. We have presented a co-produced comprehensive definition of "relational care," laying the groundwork for future research in this area. This review is the result of a collaboration of academic and lived experience researchers and clinicians with expertise in the topic of relational care, ensuring representation of diverse expert perspectives.

However, this report also has some limitations. Firstly, we did not register a protocol a priori for this review. Future studies should consider protocol registration to enhance transparency and reproducibility. Secondly, due to time constraints, we did not systematically search grey literature. This may have limited the scope of the literature identified. However, many of the reviews that we identified did search grey literature (e.g., pre-print servers, Google Scholar, relevant websites, policy documents) more comprehensively. Thirdly, in line with PRISMA guidelines (Tricco et al., 2018), we did not conduct any formal quality appraisal, limiting the certainty of conclusions about the strength of the evidence identified. Fourthly, although we conducted independent double screening of all sources at title/abstract and a subsample of full texts, we did not perform formal double independent data extraction. However, all extracted data were double-checked for accuracy. Finally, qualitative evidence was not included in our synthesis due to time limitations. Further research incorporating it could provide insight into patient, staff and family/carer experiences and views of relational care approaches and, subjectively, what makes a positive difference (Berzins et al., 2020; Dewa et al., 2018).

Implications for research, policy and practice

The current lack of a consistent definition of "relational care" poses a significant challenge for both research and practice. Future research could aim to clarify the meaning of "relational care," its core components, and develop a clear framework for its consistent application and evaluation. Conceptualisations of "relational care" should consider the influence of culture and context, including how it intersects

with the needs of marginalised groups, such Black and minoritised ethnic groups, those facing language barriers, autistic individuals, and people with intellectual disabilities. This is crucial given the inequities that these groups experience in terms of access, experiences, and outcomes in acute mental healthcare (Al Shamsi et al., 2020; Bauer & Alegría, 2010; Feinstein & Holloway, 2002; Freitas et al., 2023; Miteva et al., 2022; NHS England, 2023, NHS England, 2024b; NHS England Digital, 2024). However, the consideration of culture and context should not be limited to marginalised groups; it should be a universal consideration for all patients, staff, services, and healthcare systems.

Further research is needed to evaluate the impact of relational care approaches on quality and safety in inpatient mental health and ED settings, including more large-scale RCTs and studies evaluating long-term outcomes (NHS England, 2024b). This includes research examining the impact of relational care on self-harm and suicide, as well as on other important outcomes such as psychological safety, self-neglect, physical health, iatrogenic harms, staff safety and wellbeing, therapeutic alliance, engagement with services (e.g., length of stay, readmission rates, other service use), and treatment satisfaction. Economic evaluations taking these broader outcomes into account are also needed; cost-effectiveness evidence is important for shaping policy and practice. Further research co-produced with patients, families/carers, staff, policymakers, and commissioners is needed to ensure research addresses the priorities of these key stakeholders.

Future research should also focus on understanding the barriers and facilitators of successfully implementing relational care approaches to assessing and managing self-harm and suicide risk in these settings, including consideration of training and support needs for staff. Furthermore, realist approaches could help to determine what works for whom, in what circumstances, and why (Duncan et al., 2018). This could enable relational care approaches to be more effectively adapted and tailored to different contexts and populations, including those underrepresented in research studies (NHS England, 2024b).

Given the complexity of research in this area there is a considerable need for qualitative studies to explore patient, staff, and family/carer experiences of relational care approaches. Personal stories from qualitative studies could help to understand how relational care can be provided authentically, rather than performatively. Whilst some primary qualitative studies were identified in this scoping exercise, synthesising their findings was beyond our scope. Synthesis of this qualitative literature, and further qualitative research, would help to understand the nuances in both the delivery and experience of these interventions.

While this scoping exercise highlighted a general lack of high-quality evidence for relational care approaches, research has shown that many common practices in inpatient mental health and ED settings are not supported by the evidence, for example, structured risk assessments, no-suicide contracts, and constant observations. It can be argued that it is preferable to implement approaches based on the principles of relational care whilst continuing to develop its evidence base than continue to use approaches with evidence of harm.

Conclusion

This scoping review proposes a co-produced definition of "relational care" and identifies supporting evidence for some relational care approaches to assessing and managing self-harm and suicide risk in inpatient mental health and ED settings, including a variety of individual-, group-, and organisation-level approaches. However, further high-quality research, including larger-scale RCTs, is required to evaluate their effectiveness and long-term impact. Co-produced research is needed to clarify the definition, core components, and develop a framework for applying and evaluating "relational care." Future studies should also focus on understanding barriers and facilitators to implementing relational care and incorporate qualitative methods to capture the perspectives of patients, staff, and carers.

Lived experience commentary by Raza Griffiths, Tamar Jeynes and Lizzie Mitchell

This Lived Experience Commentary comes from the perspective of wanting to strengthen lived experience voices in policy research and positively impacting practice, by ensuring that research reflects the priorities service users themselves have highlighted. In this regard we would like to highlight the following points about this paper.

The paper concentrates on developing the idea of "relational care" and using it to assess and manage suicidality and self-harm. But the impetus for developing the idea of "relational care" does not seem to have come from people with lived experience. The idea itself is innocuous, encapsulating standard tropes about how workers should ideally relate to service users. This semantic repackaging suggests some exciting new developments, whereas in all probability, it may simply become another "buzzword" to mask a lack of real change, as happened with earlier concepts like "recovery" and "trauma informed."

On a practical level, there were difficulties in reviewing literature defining "relational care" differently, and using various methods of measuring, recording and evaluating services. How are staff and services meant to adhere to a standard where there isn't a set definition?

Moreover, the studies reviewed self-defined how "relational" their services were, based on their own definition of services, rather than asking how *we* as service users rated them in terms of relational care.

Even more than this: shouldn't we as service users, be defining what the ideal characteristics of the way staff relate to us should be, rather than using a rubric on what is important which has been developed by someone else? Reviews should not be reinforcing knowledge from research studies which exclude Lived Experience voices.

In its definition of relational care, the paper foregrounds interpersonal relationships, which are crucial and can be therapeutic in themselves. However, relationships exist within powerful political, systemic and cultural constraints and unequal power dynamics, which the paper does not focus on. The bigger picture needs to be addressed, including the impact of severe understaffing and long waiting lists.

A key cultural challenge to relational ways of working, is the reliance on coercive practices, which sits diametrically opposite relational ways of working. Widespread and controversial use of control and restraint in inpatient services is a point of ongoing debate and campaigning within mental health, with the United Nations Convention on the Rights of Persons with Disabilities being an important rallying point for us and our allies. It argues for a move away from biomedical coercive approaches to ones which could be broadly defined as "relational." But will it be possible to mainstream a relational approach in the current system, or can it only ever be tokenistic, given the nature of the mental health system?

Finally, the review highlights a reduction in suicides in inpatient care between 2010 and 2020. The broader context outside wards, however, was of a steep rise in suicide, which was correlated with the financial squeeze, a more onerous benefits regime and cutbacks to mental health services. This highlights the need to focus on the wider social context, entailing joined up action from diverse organisations and central government addressing wider social determinants of self-harm and suicide.

Note

1. When referencing this definition, please cite this paper. Our definition draws upon existing definitions and descriptions of 'relational care' in the literature (3 Trees Care & Support, 2023; Emmamally et al., 2022; Lamph et al., 2023; Novy et al., 2023; Pene et al., 2023; Royal College of General Practitioners, 2021; See Think Act: Your Guide to Relational Security, 2010; Trevillion et al., 2022; Wilson et al., 2021) (see Appendix A). An expanded definition is provided in Appendix B.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This project was funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (grant no. PR-PRU-0916-22003). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. The funders had no role in project design, data collection and analysis, or preparation of this report.

Data availability statement

All data used is publicly available in the published papers included in this study.

ORCID

Jessica L. Griffiths http://orcid.org/0009-0006-0950-8814
Una Foye http://orcid.org/0000-0002-3414-2854
Ruth Stuart http://orcid.org/0000-0002-9764-3840
Beverley Chipp http://orcid.org/0000-0002-2890-8542
Tamar Jeynes http://orcid.org/0000-0002-2184-155X
Lizzie Mitchell http://orcid.org/0000-0002-6329-5673
Jennie Parker http://orcid.org/0000-0001-5179-729X
Rachel Rowan Olive http://orcid.org/0000-0002-0871-9859
John Baker http://orcid.org/0000-0001-9985-9875
Gary Lamph http://orcid.org/0000-0002-4099-2812
Mick McKeown http://orcid.org/0000-0003-0235-1923
Brynmor Lloyd-Evans http://orcid.org/0000-0001-9866-788X
Kylee Trevillion http://orcid.org/0000-0001-5865-4726
Alan Simpson http://orcid.org/0000-0003-3286-9846

References

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal*, *35*(2), e122–e122. https://doi.org/10.5001/omj.2020.40

Alesiani, R., Boccalon, S., Giarolli, L., Blum, N., & Fossati, A. (2014). Systems Training for Emotional Predictability and Problem Solving (STEPPS): Program efficacy and personality features as predictors of drop-out—An Italian study. *Comprehensive Psychiatry*, *55*(4), 920–927. https://doi.org/10.1016/j.comppsych.2014.01.003

Amadéo, S., Rereao, M., Malogne, A., Favro, P., Nguyen, N. L., Jehel, L., Milner, A., Kolves, K., & De Leo, D. (2015). Testing brief intervention and phone contact among subjects with suicidal behavior: A randomized controlled trial in French Polynesia in the frames of the World Health Organization/Suicide Trends in At-Risk Territories study. *Mental Illness*, *7*(2), 5818. https://doi.org/10.4081/mi.2015.5818

Andreoli, A., Burnand, Y., Cochennec, M.-F., Ohlendorf, P., Frambati, L., Gaudry-Maire, D., Di Clemente, T., Hourton, G., Lorillard, S., Canuto, A., & Frances, A. (2016). Disappointed love and suicide: A randomized controlled trial of "abandonment psychotherapy" among borderline patients. *Journal of Personality Disorders*, *30*(2), 271–287. https://doi.org/10.1521/pedi_2015_29_196

Asarnow, J. R., Baraff, L. J., Berk, M., Grob, C. S., Devich-Navarro, M., Suddath, R., Piacentini, J. C., Rotheram-Borus, M. J., Cohen, D., & Tang, L. (2011). An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. *Psychiatric Services (Washington, D.C.)*, *62*(11), 1303–1309. https://doi.org/10.1176/ps.62.11.pss6211_1303

Austin, E. E., Cheek, C., Richardson, L., Testa, L., Dominello, A., Long, J. C., Carrigan, A., Ellis, L. A., Norman, A., Murphy, M., Smith, K., Gillies, D., & Clay-Williams, R. (2024). Improving emergency department care for adults presenting with mental illness: A systematic review of strategies and their impact on outcomes, experience, and performance. *Frontiers in Psychiatry*, *15*, 1368129. https://doi.org/10.3389/fpsyt.2024.1368129

Baker, J., Berzins, K., Canvin, K., Benson, I., Kellar, I., Wright, J., Lopez, R. R., Duxbury, J., Kendall, T., & Stewart, D. (2021). Non-pharmacological interventions to reduce restrictive practices in adult mental health inpatient settings: The COMPARE systematic mapping review. *Health Services and Delivery Research*, *9*(5), 1–184. https://doi.org/10.3310/hsdr09050

Barley, W. D., Buie, S. E., Peterson, E. W., Hollingsworth, A. S., Griva, M., Hickerson, S. C., Lawson, J. E., & Bailey, B. J. (1993). Development of an inpatient cognitive-behavioral treatment program for borderline personality disorder. *Journal of Personality Disorders*, *7*(3), 232–240. https://doi.org/10.1521/pedi.1993.7.3.232

Bauer, A. M., & Alegría, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: A systematic review. *Psychiatric Services (Washington, D.C.)*, *61*(8), 765–773. https://doi.org/10.1176/ps.2010.61.8.765

Beautrais, A. L., Gibb, S. J., Faulkner, A., Fergusson, D. M., & Mulder, R. T. (2010). Postcard intervention for repeat self-harm: Randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, *197*(1), 55–60. https://doi.org/10.1192/bjp.bp.109.075754

Bennewith, O., Evans, J., Donovan, J., Paramasivan, S., Owen-Smith, A., Hollingworth, W., Davies, R., O'Connor, S., Hawton, K., Kapur, N., & Gunnell, D. (2014). A contact-based intervention for people recently discharged from inpatient psychiatric care: A pilot study. *Archives of Suicide Research*, *18*(2), 131–143. https://doi.org/10.1080/13811118.2013.838196

Bentley, K. H., Sauer-Zavala, S., Cassiello-Robbins, C. F., Conklin, L. R., Vento, S., & Homer, D. (2017). Treating suicidal thoughts and behaviors within an emotional disorders framework: Acceptability and feasibility of the unified protocol in an inpatient setting. *Behavior Modification*, *41*(4), 529–557. https://doi.org/10.1177/0145445516689661

Berntsen, E., Starling, J., Durheim, E., Hainsworth, C., De Kloet, L., Chapman, L., & Hancock, K. (2011). Temporal trends in self harm and aggression on a paediatric mental health ward. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, *19*(1), 64–69. https://doi.org/10.3109/10398562.2010.526212

Berrino, A., Ohlendorf, P., Duriaux, S., Burnand, Y., Lorillard, S., & Andreoli, A. (2011). Crisis intervention at the general hospital: An appropriate treatment choice for acutely suicidal borderline patients. *Psychiatry Research*, *186*(2–3), 287–292. https://doi.org/10.1016/j.psychres.2010.06.018

Bertolote, J. M., Fleischmann, A., De Leo, D., Phillips, M. R., Botega, N. J., Vijayakumar, L., De Silva, D., Schlebusch, L., Nguyen, V. T., Sisask, M., Bolhari, J., & Wasserman, D. (2010). Repetition of suicide attempts: data from emergency care settings in five culturally different low- and middle-income countries participating in the WHO SUPRE-MISS Study. *Crisis*, *31*(4), 194–201. https://doi.org/10.1027/0027-5910/a000052

Berzins, K., Baker, J., Louch, G., & Albutt, A. (2020). A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *23*(3), 549–561. https://doi.org/10.1111/hex.13025

Bloom, J. M., Woodward, E. N., Susmaras, T., & Pantalone, D. W. (2012). Use of dialectical behavior therapy in inpatient treatment of borderline personality disorder: A systematic review. *Psychiatric Services (Washington, D.C.)*, *63*(9), 881–888. https://doi.org/10.1176/appi.ps.201100311

Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., Lieb, K., & Linehan, M. M. (2004). Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: A controlled trial. *Behaviour Research and Therapy*, *42*(5), 487–499. https://doi.org/10.1016/S0005-7967(03)00174-8

Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Böhme, R., & Linehan, M. (2000). Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder—A prospective study. *Behaviour Research and Therapy*, *38*(9), 875–887. https://doi.org/10.1016/S0005-7967(99)00103-5

Bolsinger, J., Jaeger, M., Hoff, P., & Theodoridou, A. (2019). Challenges and opportunities in building and maintaining a good therapeutic relationship in acute psychiatric settings: A narrative review. *Frontiers in Psychiatry*, *10*, 965. https://doi.org/10.3389/fpsyt.2019.00965

Booth, R., Keogh, K., Doyle, J., & Owens, T. (2014). Living through distress: A skills training group for reducing deliberate self-harm. *Behavioural and Cognitive Psychotherapy*, *42*(2), 156–165. https://doi.org/10.1017/S1352465812001002

Bowers, L., Brennan, G., Flood, C., Lipang, M., & Oladapo, P. (2006). Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City nurses. *Journal of Psychiatric and Mental Health Nursing*, *13*(2), 165–172. https://doi.org/10.1111/j.1365-2850.2006.00931.x

Bowers, L., Dack, C., Gul, N., Thomas, B., & James, K. (2011). Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency. *International Journal of Nursing Studies*, *48*(12), 1459–1465. https://doi.org/10.1016/j.ijnurstu.2011.05.008

Bowers, L., Flood, C., Brennan, G., & Allan, T. (2008). A replication study of the City nurse intervention: Reducing conflict and containment on three acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, *15*(9), 737–742. https://doi.org/10.1111/j.1365-2850.2008.01294.x

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J, SUGAR. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, *52*(9), 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.05.001

Bowers, L., Simpson, A., & Alexander, J. (2003). Patient-staff conflict: Results of a survey on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology*, *38*(7), 402–408. https://doi.org/10.1007/s00127-003-0648-x

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005). The nature and purpose of acute psychiatric wards: The Tompkins acute ward study. *Journal of Mental Health*, *14*(6), 625–635. https://doi.org/10.1080/09638230500389105

Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K., & Flood, C. (2006). The city 128 study of observation and outcomes on acute psychiatric wards. Report to the NHS SDO Programme.

Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K., Hackney, D., Allan, T., & Simpson, A. (2008). Relationship between service ecology, special observation and self-harm during acute in-patient care: City-128 study. *The British Journal of Psychiatry: The Journal of Mental Science*, *193*(5), 395–401. https://doi.org/10.1192/bjp.bp.107.037721

Broadway-Horner, M., Kar, A., Pemberton, M., & Ventriglio, A. (2022). Psychological therapies and non-suicidal self-injury in LGBTIQ in accident and emergency departments in the UK: A scoping review. *International Review of Psychiatry (Abingdon, England)*, *34*(3–4), 413–422. https://doi.org/10.1080/09540261.2022.2108313

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *Journal of the American Medical Association*, *294*(5), 563–570. https://doi.org/10.1001/jama.294.5.563

Campling, P. (2001). Therapeutic communities. *Advances in Psychiatric Treatment*, *7*(5), 365–372. https://doi.org/10.1192/apt.7.5.365

Care Quality Commission. (2021). *The state of health care and adult social care in Englnad 2020/21*. Care Quality Commission. https://www.cqc.org.uk/publication/state-care-202021

Catanach, B., Betz, M. E., Tvrdy, C., Skelding, C., Brummett, S., & Allen, M. H. (2019). Implementing an emergency department telephone follow-up program for suicidal patients: Successes and challenges. *Joint Commission Journal on Quality and Patient Safety*, *45*(11), 725–732. https://doi.org/10.1016/j.jcjq.2019.07.009

Cebrià, A. I., Parra, I., Pàmias, M., Escayola, A., García-Parés, G., Puntí, J., Laredo, A., Vallès, V., Cavero, M., Oliva, J. C., Hegerl, U., Pérez-Solà, V., & Palao, D. J. (2013). Effectiveness of a telephone management programme for patients discharged from an emergency department after a suicide attempt: Controlled study in a Spanish population. *Journal of Affective Disorders*, *147*(1–3), 269–276. https://doi.org/10.1016/j.jad.2012.11.016

Cebria, A. I., Pérez-Bonaventura, I., Cuijpers, P., Kerkhof, A., Parra, I., Escayola, A., García–Parés, G., Oliva, J. C., Puntí, J., López, D., Valles, V., Pamias, M., Hegerl, U., Pérez-Sola, V., & Palao, D. J. (2015). Telephone management program for patients discharged from an emergency department after a suicide attempt: A 5-year follow-up study in a Spanish population. *Crisis*, *36*(5), 345–352. https://doi.org/10.1027/0227-5910/a000331

Celano, C. M., Beale, E. E., Mastromauro, C. A., Stewart, J. G., Millstein, R. A., Auerbach, R. P., Bedoya, C. A., & Huffman, J. C. (2017). Psychological interventions to reduce suicidality in high-risk patients with major depression: A randomized controlled trial. *Psychological Medicine*, *47*(5), 810–821. https://doi.org/10.1017/S0033291716002798

Chammas, F., Januel, D., & Bouaziz, N. (2022). Inpatient suicide in psychiatric settings: Evaluation of current prevention measures. *Frontiers in Psychiatry*, *13*, 997974. https://doi.org/10.3389/fpsyt.2022.997974

Chaudhary, A. M. D., Memon, R. I., Dar, S. K., Bhullar, D. K., Dar, K. R., & Naveed, S. (2020). Suicide during transition of care: A review of targeted interventions. *The Psychiatric Quarterly*, *91*(2), 417–450. https://doi.org/10.1007/s11126-020-09712-x

Cooper, J., Steeg, S., Gunnell, D., Webb, R., Hawton, K., Bennewith, O., House, A., & Kapur, N. (2015). Variations in the hospital management of self-harm and patient outcome: A multi-site observational study in England. *Journal of Affective Disorders*, *174*, 101–105. https://doi.org/10.1016/j.jad.2014.11.037

Cooper, R. E., Saunders, K. R. K., Greenburgh, A., Shah, P., Appleton, R., Machin, K., Jeynes, T., Barnett, P., Allan, S. M., Griffiths, J., Stuart, R., Mitchell, L., Chipp, B., Jeffreys, S., Lloyd-Evans, B., Simpson, A., & Johnson, S. (2024). The effectiveness, implementation, and experiences of peer support approaches for mental health: A systematic umbrella review. *BMC Medicine*, *22*(1), 72. https://doi.org/10.1186/s12916-024-03260-y

Cox, A., Hayter, M., & Ruane, J. (2010). Alternative approaches to 'enhanced observations' in acute inpatient mental health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *17*(2), 162–171. https://doi.org/10.1111/j.1365-2850.2009.01507.x

Currier, G. W., Fisher, S. G., & Caine, E. D. (2010). Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: A randomized controlled trial. *Academic Emergency Medicine*, *17*(1), 36–43. https://doi.org/10.1111/j.1553-2712.2009.00619.x

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing*, *27*(3), 1162–1176. https://doi.org/10.1111/inm.12432

De Santis, M. L., Myrick, H., Lamis, D. A., Pelic, C. P., Rhue, C., & York, J. (2015). Suicide-specific safety in the inpatient psychiatric unit. *Issues in Mental Health Nursing*, *36*(3), 190–199. https://doi.org/10.3109/01612840.2014.961625

DeLeo, K., Maconick, L., McCabe, R., Broeckelmann, E., Sheridan Rains, L., Rowe, S., & Johnson, S. (2022). Experiences of crisis care among service users with complex emotional needs or a diagnosis of "personality disorder", and other stakeholders: Systematic review and meta-synthesis of the qualitative literature. *BJPsych Open*, *8*(2), e53. https://doi.org/10.1192/bjo.2022.1

Department of Health & Social Care. (2023). *Suicide prevention in England: 5-year cross-sector strategy*. Department of Health & Social Care. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy

Department of Health & Social Care. (2024). *Rapid review into data on mental health inpatient settings: Final report and recommendations*. Department of Health & Social Care. https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations

Dewa, L. H., Murray, K., Thibaut, B., Ramtale, S. C., Adam, S., Darzi, A., & Archer, S. (2018). Identifying research priorities for patient safety in mental health: An international expert Delphi study. *BMJ Open*, *8*(3), e021361. https://doi.org/10.1136/bmjopen-2017-021361

Deykin, E. Y., Hsieh, C.-C., Joshi, N., & Mcnamarra, J. J. (1986). Adolescent suicidal and self-destructive behavior. *Journal of Adolescent Health Care*, *7*(2), 88–95. https://doi.org/10.1016/S0197-0070(86)80002-X

Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(2), 122–131. https://doi.org/10.1097/00004583-201002000-00006

Dickens, G. L., Tabvuma, T., & Frost, S. A., SWSLHD Safewards Steering Group. (2020). Safewards: Changes in conflict, containment, and violence prevention climate during implementation. *International Journal of Mental Health Nursing*, *29*(6), 1230–1240. https://doi.org/10.1111/inm.12762

Doane, G. H., & Varcoe, C. (2007). Relational practice and nursing obligations. *ANS. Advances in Nursing Science*, *30*(3), 192–205. https://doi.org/10.1097/01.ANS.0000286619.31398.fc

Dodds, P., & Bowles, N. (2001). Dismantling formal observation and refocusing nursing activity in acute inpatient psychiatry: A case study: Commentary. *Journal of Psychiatric and Mental Health Nursing*, *8*(2), 183–188. https://doi.org/10.1046/j.1365-2850.2001.0365d.x

Donaldson, D., Spirito, A., & Esposito-Smythers, C. (2005). Treatment for adolescents following a suicide attempt: Results of a pilot trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(2), 113–120. https://doi.org/10.1097/00004583-200502000-00003

Donaldson, D., Spirito, A., Arrigan, M., & Aspel, J. W. (1997). Structured disposition planning for adolescent suicide attempters in a general hospital: Preliminary findings on short-term outcome. *Archives of Suicide Research*, *3*(4), 271–282. https://doi.org/10.1080/13811119708258279

Drew, B. L. (2001). Self-harm behavior and no-suicide contracting in psychiatric inpatient settings. *Archives of Psychiatric Nursing*, *15*(3), 99–106. https://doi.org/10.1053/apnu.2001.23748

Duffey, T., & Somody, C. (2011). The role of relational-cultural theory in mental health counseling. *Journal of Mental Health Counseling*, *33*(3), 223–242. https://doi.org/10.17744/mehc.33.3.c10410226u275647

Duncan, C., Weich, S., Fenton, S.-J., Twigg, L., Moon, G., Madan, J., Singh, S. P., Crepaz-Keay, D., Parsons, H., & Bhui, K. (2018). A realist approach to the evaluation of complex mental health interventions. *The British Journal of Psychiatry: The Journal of Mental Science*, *213*(2), 451–453. https://doi.org/10.1192/bjp.2018.96

Edel, M., Raaff, V., Dimaggio, G., Buchheim, A., & Brüne, M. (2017). Exploring the effectiveness of combined mentalization-based group therapy and dialectical behaviour therapy for inpatients with borderline personality disorder—A pilot study. *The British Journal of Clinical Psychology*, *56*(1), 1–15. https://doi.org/10.1111/bjc.12123

Ellis, T. E., Green, K. L., Allen, J. G., Jobes, D. A., & Nadorff, M. R. (2012). Collaborative assessment and management of suicidality in an inpatient setting: Results of a pilot study. *Psychotherapy (Chicago, Ill.)*, *49*(1), 72–80. https://doi.org/10.1037/a0026746

Ellis, T. E., Rufino, K. A., Allen, J. G., Fowler, J. C., & Jobes, D. A. (2015). Impact of a suicide-specific intervention within inpatient psychiatric care: The collaborative assessment and management of suicidality. *Suicide & Life-Threatening Behavior*, *45*(5), 556–566. https://doi.org/10.1111/sltb.12151

Emmamally, W., Erlingsson, C., & Brysiewicz, P. (2022). In-hospital interventions to promote relational practice with families in acute care settings: A scoping review. *Health SA = SA Gesondheid*, *27*, 1694. https://doi.org/10.4102/hsag.v27i0.1694

Enabling Environments (EE). (2024). Royal College of Psychiatrists. https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/enabling-environments-network-ee

Ercole-Fricke, E., Fritz, P., Hill, L. E., & Snelders, J. (2016). Effects of a collaborative problem-solving approach on an inpatient adolescent psychiatric unit. *Journal of Child and Adolescent Psychiatric Nursing*, *29*(3), 127–134. https://doi.org/10.1111/jcap.12149

Evans, J., Evans, M., Morgan, H. G., Hayward, A., & Gunnell, D. (2005). Crisis card following self-harm: 12-month follow-up of a randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, *187*(2), 186–187. https://doi.org/10.1192/bjp.187.2.186

Evans, M. O., Morgan, H. G., Hayward, A., & Gunnell, D. J. (1999). Crisis telephone consultation for deliberate self-harm patients: Effects on repetition. *The British Journal of Psychiatry: The Journal of Mental Science*, *175*(1), 23–27. https://doi.org/10.1192/bjp.175.1.23

Evans, N., Edwards, D., & Chick, P. (2022). Managing suicidality in inpatient care: A rapid review. *The Journal of Mental Health Training, Education and Practice*, *17*(6), 479–494. https://doi.org/10.1108/JMHTEP-05-2020-0023

Exbrayat, S., Coudrot, C., Gourdon, X., Gay, A., Sevos, J., Pellet, J., Trombert-Paviot, B., & Massoubre, C. (2017). Effect of telephone follow-up on repeated suicide attempt in patients discharged from an emergency psychiatry department: A controlled study. *BMC Psychiatry*, *17*(1), 96. https://doi.org/10.1186/s12888-017-1258-6

Falcone, G., Nardella, A., Lamis, D. A., Erbuto, D., Girardi, P., & Pompili, M. (2017). Taking care of suicidal patients with new technologies and reaching-out means in the post-discharge period. *World Journal of Psychiatry*, *7*(3), 163–176. https://doi.org/10.5498/wjp.v7.i3.163

Feinstein, A., & Holloway, F. (2002). Evaluating the use of a psychiatric intensive care unit: Is ethnicity a risk factor for admission? *The International Journal of Social Psychiatry*, *48*(1), 38–46. https://doi.org/10.1177/002076402128783073

Finch, K., Lawrence, D., Williams, M. O., Thompson, A. R., & Hartwright, C. (2022). A Systematic review of the effectiveness of safewards: Has enthusiasm exceeded evidence? *Issues in Mental Health Nursing*, *43*(2), 119–136. https://doi.org/10.1080/01612840.2021.1967533

Fleischmann, A., Bertolote, J. M., Wasserman, D., De Leo, D., Bolhari, J., Botega, N. J., De Silva, D., Phillips, M., Vijayakumar, L., Värnik, A., Schlebusch, L., & Thanh, H. T. T. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization*, *86*(9), 703–709. https://doi.org/10.2471/BLT.07.046995

Fletcher, E., & Stevenson, C. (2001). Launching the Tidal Model in an adult mental health programme. *Nursing Standard (Royal College of Nursing (Great Britain): 1987)*, *15*(49), 33–36. https://doi.org/10.7748/ns2001.08.15.49.33.c3074

Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing*, *26*(5), 461–471. https://doi.org/10.1111/inm.12380

Fletcher, J. K. (1998). Relational practice: A feminist reconstruction of work. *Journal of Management Inquiry*, *7*(2), 163–186. https://doi.org/10.1177/1056492698720012

Freeman, A. M., Tribe, R. H., Stott, J. C. H., & Pilling, S. (2019). Open dialogue: A review of the evidence. *Psychiatric Services (Washington, D.C.)*, *70*(1), 46–59. https://doi.org/10.1176/appi.ps.201800236

Freitas, D. F., Walker, S., Nyikavaranda, P., Downs, J., Patel, R., Khondoker, M., Bhui, K., & Hayes, R. D. (2023). Ethnic inequalities in involuntary admission under the Mental Health Act: An exploration of mediation effects of clinical care prior to the first admission. *The British Journal of Psychiatry: The Journal of Mental Science*, *222*(1), 27–36. https://doi.org/10.1192/bjp.2022.141

Ghahramanlou-Holloway, M., LaCroix, J. M., Perera, K. U., Neely, L., Grammer, G., Weaver, J., Novak, L. A., Colborn, V., & Lee-Tauler, S. Y. (2020). Inpatient psychiatric care following a suicide-related hospitalization: A pilot trial of post-admission cognitive therapy in a military medical center. *General Hospital Psychiatry*, *63*, 46–53. https://doi.org/10.1016/j.genhosppsych.2018.11.006

Gibson, J., Booth, R., Davenport, J., Keogh, K., & Owens, T. (2014). Dialectical behaviour therapy-informed skills training for deliberate self-harm: A controlled trial with 3-month follow-up data. *Behaviour Research and Therapy*, *60*, 8–14. https://doi.org/10.1016/j.brat.2014.06.007

Gilburt, H., Mallorie, S. (2024). *Mental health 360: Workforce*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce

Gordon, W., Morton, T., Brooks, G. (2004). *The Tidal Model and the Reform of Nursing Practice*. Birmingham & Solihull NHS Mental Health Trust. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=35dcd6430a166ed2e4822fe446a06cb80e18068b

Greenfield, B., Larson, C., Hechtman, L., Rousseau, C., & Platt, R. (2002). A rapid-response outpatient model for reducing hospitalization rates among suicidal adolescents. *Psychiatric Services (Washington, D.C.)*, *53*(12), 1574–1579. https://doi.org/10.1176/appi.ps.53.12.1574

Greenwald, A., Kelly, A., Mathew, T., & Thomas, L. (2023). Trauma-informed care in the emergency department: Concepts and recommendations for integrating practices into emergency medicine. *Medical Education Online*, *28*(1), 2178366. https://doi.org/10.1080/10872981.2023.2178366

Griffiths, J. L., Saunders, K. R. K., Foye, U., Greenburgh, A., Regan, C., Cooper, R. E., Powell, R., Thomas, E., Brennan, G., Rojas-Garcia, A., Lloyd-Evans, B., Johnson, S., & Simpson, A. (2024). The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: A systematic review. *BMC Medicine*, *22*(1), 564. https://doi.org/10.1186/s12916-024-03673-9

Griffiths, R., Dawber, A., McDougall, T., Midgley, S., & Baker, J. (2022). Non-restrictive interventions to reduce self-harm amongst children in mental health inpatient settings: Systematic review and narrative synthesis. *International Journal of Mental Health Nursing*, *31*(1), 35–50. https://doi.org/10.1111/inm.12940

Grupp-Phelan, J., Stevens, J., Boyd, S., Cohen, D. M., Ammerman, R. T., Liddy-Hicks, S., Heck, K., Marcus, S. C., Stone, L., Campo, J. V., & Bridge, J. A. (2019). Effect of a motivational interviewing–based intervention on initiation of mental health treatment and mental health after an emergency department visit among suicidal adolescents: A randomized clinical trial. *JAMA Network Open*, *2*(12), e1917941. https://doi.org/10.1001/jamanetworkopen.2019.17941

Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., Sanderson, S., Turpin, C., Boddy, G., Tomenson, B., & Patton, G. C. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning commentary: Another kind of talk that works? *BMJ (Clinical Research Ed.)*, *323*(7305), 135–138. https://doi.org/10.1136/bmj.323.7305.135

Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M., & Michel, K. (2016). A novel brief therapy for patients who attempt suicide: A 24-months follow-up randomized controlled study of the Attempted Suicide Short Intervention Program (ASSIP). *PLoS Medicine*, *13*(3), e1001968. https://doi.org/10.1371/journal.pmed.1001968

Haddock, G., Pratt, D., Gooding, P. A., Peters, S., Emsley, R., Evans, E., Kelly, J., Huggett, C., Munro, A., Harris, K., Davies, L., & Awenat, Y. (2019). Feasibility and acceptability of suicide prevention therapy on acute psychiatric wards: Randomised controlled trial. *BJPsych Open*, *5*(1), e14. https://doi.org/10.1192/bjo.2018.85

Hartrick, G. (1997). Relational capacity: The foundation for interpersonal nursing practice. *Journal of Advanced Nursing*, *26*(3), 523–528. https://doi.org/10.1046/j.1365-2648.1997.t01-12-00999.x

Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owens, D., Sakinofsky, I., & Träskman-Bendz, L. (1998). Deliberate self harm: Systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ (Clinical Research ed.)*, *317*(7156), 441–447. https://doi.org/10.1136/bmj.317.7156.441

Hawton, K., & Harriss, L. (2008). How often does deliberate self-harm occur relative to each suicide? A study of variations by gender and age. *Suicide & Life-Threatening Behavior*, *38*(6), 650–660. https://doi.org/10.1521/suli.2008.38.6.650

Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: Findings from the Multicentre Study of self-harm in England, 2000–2012. *Journal of Affective Disorders*, *175*, 147–151. https://doi.org/10.1016/j.jad.2014.12.062

Health Services Safety Investigations Body. (2021). *Investigation report: Provision of mental helath care to patients presenting at the emergency department*. Health Services Safety Investigations Body. https://www.hssib.org.uk/patient-safety-investigations/provision-mental-health-care-patients-presenting-emergency-department/investigation-report/#executive-summary

Helleman, M., Goossens, P. J. J., Kaasenbrood, A., & Van Achterberg, T. (2014). Evidence base and components of brief admission as an intervention for patients with borderline personality disorder: a review of the literature: evidence base and components of brief admission as an intervention for patients with borderline personality disorder. *Perspectives in Psychiatric Care*, *50*(1), 65–75. https://doi.org/10.1111/ppc.12023

Hewitt, J., Coffey, M., & Rooney, G. (n.d.). Forming, sustaining and ending therapeutic interactions. In *Mental Health Nursing Skills*. Oxford University Press. https://www.researchgate.net/publication/252322577_Hewitt_J_Coffey_M_and_Rooney_G_2009_Forming_sustaining_and_ending_therapeutic_interactions_in_Callaghan_P_Playle_J_and_Cooper_L_eds_Mental_Health_Nursing_Skills_Oxford_Oxford_University_Press

Huber, J. P., Milton, A., Brewer, M. C., Norrie, L. M., Hartog, S. M., & Glozier, N. (2024). The effectiveness of brief non-pharmacological interventions in emergency departments and psychiatric inpatient units for people in crisis: A systematic review and narrative synthesis. *The Australian and New Zealand Journal of Psychiatry*, *58*(3), 207–226. https://doi.org/10.1177/00048674231216348

Inui-Yukawa, M., Miyaoka, H., Yamamoto, K., Kamijo, Y., Takai, M., Yonemoto, N., Kawanishi, C., Otsuka, K., Tachikawa, H., & Hirayasu, Y. (2021). Effectiveness of assertive case management for patients with suicidal intent. *Psychiatry Research*, *304*, 114125. https://doi.org/10.1016/j.psychres.2021.114125

James, K., Stewart, D., & Bowers, L. (2012). Self-harm and attempted suicide within inpatient psychiatric services: A review of the Literature. *International Journal of Mental Health Nursing*, *21*(4), 301–309. https://doi.org/10.1111/j.1447-0349.2011.00794.x

James, K., Stewart, D., Wright, S., & Bowers, L. (2012). Self harm in adult inpatient psychiatric care: A national study of incident reports in the UK. *International Journal of Nursing Studies*, *49*(10), 1212–1219. https://doi.org/10.1016/j.ijnurstu.2012.04.010

Johnson, S., Dalton-Locke, C., Baker, J., Hanlon, C., Salisbury, T. T., Fossey, M., Newbigging, K., Carr, S. E., Hensel, J., Carrà, G., Hepp, U., Caneo, C., Needle, J. J., & Lloyd-Evans, B. (2022). Acute psychiatric care: Approaches to increasing the range of services and improving access and quality of care. *World Psychiatry*, *21*(2), 220–236. https://doi.org/10.1002/wps.20962

Jordan, J. V. (2010). Relational-cultural therapy. In *Handbook of counseling women* (pp. 63–73). SAGE Publications.

Kapur, N., Gunnell, D., Hawton, K., Nadeem, S., Khalil, S., Longson, D., Jordan, R., Donaldson, I., Emsley, R., & Cooper, J. (2013). Messages from Manchester: Pilot randomised controlled trial following self-harm. *The British Journal of Psychiatry: The Journal of Mental Science*, *203*(1), 73–74. https://doi.org/10.1192/bjp.bp.113.126425

Katz, L. Y., Cox, B. J., Gunasekara, S., & Miller, A. L. (2004). Feasibility of dialectical behavior therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(3), 276–282. https://doi.org/10.1097/00004583-200403000-00008

Kennedy, H., Roper, C., Randall, R., Pintado, D., Buchanan-Hagen, S., Fletcher, J., & Hamilton, B. (2019). Consumer recommendations for enhancing the Safewards model and interventions. *International Journal of Mental Health Nursing*, *28*(2), 616–626. https://doi.org/10.1111/inm.12570

King, C. A., Gipson, P. Y., Horwitz, A. G., & Opperman, K. J. (2015). Teen options for change: An intervention for young emergency patients who screen positive for suicide risk. *Psychiatric Services (Washington, D.C.)*, *66*(1), 97–100. https://doi.org/10.1176/appi.ps.201300347

Kleindienst, N., Limberger, M. F., Schmahl, C., Steil, R., Ebner-Priemer, U. W., & Bohus, M. (2008). Do improvements after inpatient dialectial behavioral therapy persist in the long term? A naturalistic follow-up in patients with borderline personality disorder. *The Journal of Nervous and Mental Disease*, *196*(11), 847–851. https://doi.org/10.1097/NMD.0b013e31818b481d

LaCroix, J. M., Perera, K. U., Neely, L. L., Grammer, G., Weaver, J., & Ghahramanlou-Holloway, M. (2018). Pilot trial of post-admission cognitive therapy: Inpatient program for suicide prevention. *Psychological Services*, *15*(3), 279–288. https://doi.org/10.1037/ser0000224

Laker, C., Cella, M., Callard, F., & Wykes, T. (2019). Why is change a challenge in acute mental health wards? A cross-sectional investigation of the relationships between burnout, occupational status and nurses' perceptions of barriers to change. *International Journal of Mental Health Nursing*, *28*(1), 190–198. https://doi.org/10.1111/inm.12517

Lamph, G., Nowland, R., Boland, P., Pearson, J., Connell, C., Jones, V., Wildbore, E., L Christian, D., Harris, C., Ramsden, J., Gardner, K., Graham-Kevan, N., & McKeown, M. (2023). Relational practice in health, education, criminal justice, and social care: A scoping review. *Systematic Reviews*, *12*(1), 194. https://doi.org/10.1186/s13643-023-02344-9

Liberman, R. P., & Eckman, T. (1981). Behavior therapy vs insight-oriented therapy for repeated suicide attempters. *Archives of General Psychiatry*, *38*(10), 1126–1130. https://doi.org/10.1001/archpsyc.1981.01780350060007

Lin, Y., Liu, S., Chen, S., Sun, F., Huang, H., Huang, C., & Chiu, Y. (2020). Brief cognitive-based psychosocial intervention and case management for suicide attempters discharged from the emergency department in Taipei, Taiwan: A randomized controlled study. *Suicide & Life-Threatening Behavior*, *50*(3), 688–705. https://doi.org/10.1111/sltb.12626

Loizou, S., Pemovska, T., Stefanidou, T., Foye, U., Cooper, R., Kular, A., Greenburgh, A., Baldwin, H., Griffiths, J., Saunders, K. R. K., Barnett, P., Minchin, M., Brady, G., Ahmed, N., Parker, J., Chipp, B., Olive, R. R., Jackson, R., Timmerman, A., … Johnson, S. (2024). Approaches to improving mental healthcare for autistic people: Systematic review. *BJPsych Open*, *10*(4), e128. https://doi.org/10.1192/bjo.2024.707

Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis*, *34*(1), 32–41. https://doi.org/10.1027/0227-5910/a000158

Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: A systematic review. *European Addiction Research*, *18*(1), 1–11. https://doi.org/10.1159/000331007

Manna, M. (2010). Effectiveness of formal observation in inpatient psychiatry in preventing adverse outcomes: The state of the science. *Journal of Psychiatric and Mental Health Nursing*, *17*(3), 268–273. https://doi.org/10.1111/j.1365-2850.2009.01512.x

McAuliffe, C., McLeavey, B. C., Fitzgerald, T., Corcoran, P., Carroll, B., Ryan, L., O'Keeffe, B., Fitzgerald, E., Hickey, P., O'Regan, M., Mulqueen, J., & Arensman, E. (2014). Group problem-solving skills training for self-harm: Randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, *204*(5), 383–390. https://doi.org/10.1192/bjp.bp.111.101816

McCabe, R., Garside, R., Backhouse, A., & Xanthopoulou, P. (2018). Effectiveness of brief psychological interventions for suicidal presentations: A systematic review. *BMC Psychiatry*, *18*(1), 120. https://doi.org/10.1186/s12888-018-1663-5

McCarthy, M., McIntyre, J., Nathan, R., Ashworth, E., & Saini, P. (2024). Staff perspectives of emergency department pathways for people attending in suicidal crisis: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *31*(3), 313–324. https://doi.org/10.1111/jpm.12991

McDonell, M. G., Tarantino, J., Dubose, A. P., Matestic, P., Steinmetz, K., Galbreath, H., & McClellan, J. M. (2010). A pilot evaluation of dialectical behavioural therapy in adolescent long-term inpatient care. *Child and Adolescent Mental Health*, *15*(4), 193–196. https://doi.org/10.1111/j.1475-3588.2010.00569.x

McKeown, M., Poursanidou, K., & Baker, C. (2024). The mental health nurse as cyborg: Technology, a blessing or a curse? *Journal of Psychiatric and Mental Health Nursing*, *31*(6), 1202–1204. https://doi.org/10.1111/jpm.13080

McLeavey, B. C., Daly, R. J., Ludgate, J. W., & Murray, C. M. (1994). Interpersonal problem-solving skills training in the treatment of self-poisoning patients. *Suicide & Life-Threatening Behavior*, *24*(4), 382–394. https://doi.org/10.1111/j.1943-278X.1994.tb00817.x

Miller, I. W., Camargo, C. A., Arias, S. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., Manton, A. P., Espinola, J. A., Jones, R., Hasegawa, K., & Boudreaux, E. D., for the ED-SAFE Investigators. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry*, *74*(6), 563–570. https://doi.org/10.1001/jamapsychiatry.2017.0678

Miteva, D., Georgiadis, F., McBroom, L., Noboa, V., Quednow, B. B., Seifritz, E., Vetter, S., & Egger, S. T. (2022). Impact of language proficiency on mental health service use, treatment and outcomes: "Lost in Translation". *Comprehensive Psychiatry*, *114*, 152299. https://doi.org/10.1016/j.comppsych.2022.152299

Morgan, H. G., Jones, E. M., & Owen, J. H. (1993). Secondary prevention of non-fatal deliberate self-harm: The Green Card study. *The British Journal of Psychiatry: The Journal of Mental Science*, *163*(1), 111–112. https://doi.org/10.1192/bjp.163.1.111

Motto, J. A. (1976). Suicide prevention for high-risk persons who refuse treatment*. *Suicide & Life-Threatening Behavior*, *6*(4), 223–230. https://doi.org/10.1111/j.1943-278X.1976.tb00880.x

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services (Washington, D.C.)*, *52*(6), 828–833. https://doi.org/10.1176/appi.ps.52.6.828

Mouaffak, F., Marchand, A., Castaigne, E., Arnoux, A., & Hardy, P. (2015). OSTA program: A French follow up intervention program for suicide prevention. *Psychiatry Research*, *230*(3), 913–918. https://doi.org/10.1016/j.psychres.2015.11.024

Mullen, A., Browne, G., Hamilton, B., Skinner, S., & Happell, B. (2022). Safewards: An integrative review of the literature within inpatient and forensic mental health units. *International Journal of Mental Health Nursing*, *31*(5), 1090–1108. https://doi.org/10.1111/inm.13001

Navin, K., Kuppili, P. P., Menon, V., & Kattimani, S. (2019). Suicide prevention strategies for general hospital and psychiatric inpatients: A narrative review. *Indian Journal of Psychological Medicine*, *41*(5), 403–412. https://doi.org/10.4103/IJPSYM.IJPSYM_169_19

Nawaz, R. F., Reen, G., Bloodworth, N., Maughan, D., & Vincent, C. (2021). Interventions to reduce self-harm on in-patient wards: Systematic review. *BJPsych Open*, *7*(3), e80. https://doi.org/10.1192/bjo.2021.41

Newton, A. S., Hamm, M. P., Bethell, J., Rhodes, A. E., Bryan, C. J., Tjosvold, L., Ali, S., Logue, E., & Manion, I. G. (2010). Pediatric suicide-related presentations: A systematic review of mental health care in the emergency department. *Annals of Emergency Medicine*, *56*(6), 649–659.e2. https://doi.org/10.1016/j.annemergmed.2010.02.026

NHS England Digital. (2024). *Mental Health Act Statistics, Annual Figures, 2022–23*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2022-23-annual-figures#

NHS England. (2019). *NHS Mental Health Implementation Plan 2019/20–2023/24*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NHS England. (2022). *The mental health nurse's handbook*. https://www.england.nhs.uk/long-read/the-mental-health-nurses-handbook/

NHS. England. (2023). *Acute inpatient mental health care for adults and older adults*. https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#key-elements-of-the-inpatient-pathway

NHS England. (2024a). *Culture of care standards for mental health inpatient services*. https://www.england.nhs.uk/publication/culture-of-care-standards-for-mental-health-inpatient-services/

NHS England. (2024b). *Research demand signalling: Mental health nursing*. https://www.england.nhs.uk/publication/research-demand-signalling-mental-health-nursing/

NICE. (2022a). *Self-harm: Assessment, management and preventing recurrence; [F] Evidence review for assessment in specialist settings*. https://www.nice.org.uk/guidance/ng225/evidence/f-assessment-in-specialist-settings-pdf-11196377251

NICE. (2022b). *Self-harm: Assessment, management and preventing recurrence. NICE Guideline NG225*. National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ng225

Nilsen, P., & Birken, S. A. (Eds.). (2020). *Handbook on implementation science*. Edward Elgar Publishing.

Normand, D., Colin, S., Gaboulaud, V., Baubet, T., & Taieb, O. (2018). How to stay in touch with adolescents and young adults after a suicide attempt? Implementation of a 4-phones-calls procedure over 1 year after discharge from hospital, in a Parisian suburb. *L'Encephale*, *44*(4), 301–307. https://doi.org/10.1016/j.encep.2017.10.011

Novy, C., Thomas, R., Grassau, P., Gifford, W., & Hosseini, M. (2023). Relational care, dementia, and communication challenges in long-term care: A meta-ethnography. *Canadian Journal on Aging = La Revue Canadienne du Vieillissement*, *42*(2), 259–270. https://doi.org/10.1017/S0714980822000253

Nugent, S. M., Anderson, J., & Young, S. K. (2024). Behavioural mental health interventions delivered in the emergency department for suicide, overdose and psychosis: A scoping review. *BMJ Open*, *14*(3), e080023. https://doi.org/10.1136/bmjopen-2023-080023

O'Keeffe, S., Suzuki, M., Ryan, M., Hunter, J., & McCabe, R. (2021). Experiences of care for self-harm in the emergency department: Comparison of the perspectives of patients, carers and practitioners. *BJPsych Open*, *7*(5), e175. https://doi.org/10.1192/bjo.2021.1006

Østervang, C., Geisler Johansen, L., Friis-Brixen, A., & Myhre Jensen, C. (2022). Experiences of nursing care for patients who self-harm and suggestions for future practices: The perspectives of emergency care nurses. *International Journal of Mental Health Nursing*, *31*(1), 70–82. https://doi.org/10.1111/inm.12933

Ougrin, D., Boege, I., Stahl, D., Banarsee, R., & Taylor, E. (2013). Randomised controlled trial of therapeutic assessment versus usual assessment in adolescents with self-harm: 2-year follow-up. *Archives of Disease in Childhood*, *98*(10), 772–776. https://doi.org/10.1136/archdischild-2012-303200

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—A web and mobile app for systematic reviews. *Systematic Reviews*, *5*(1), 210. https://doi.org/10.1186/s13643-016-0384-4

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ (Clinical Research ed.)*, *372*, n71. https://doi.org/10.1136/bmj.n71

Patsiokas, A. T., & Clum, G. A. (1985). Effects of psychotherapeutic strategies in the treatment of suicide attempters. *Psychotherapy: Theory, Research, Practice, Training*, *22*(2), 281–290. https://doi.org/10.1037/h0085507

Pemovska, T., Loizou, S., Appleton, R., Spain, D., Stefanidou, T., Kular, A., Cooper, R., Greenburgh, A., Griffiths, J., Barnett, P., Foye, U., Baldwin, H., Minchin, M., Brady, G., Saunders, K. R. K., Ahmed, N., Jackson, R., Olive, R. R., Parker, J., … Johnson, S. (2024). Approaches to improving mental health care for autistic children and young people: A systematic review and meta-analysis. *Psychological Medicine*, *54*(10), 2313–2343. https://doi.org/10.1017/S0033291724001089

Pene, B., Gott, M., Clark, T. C., & Slark, J. (2023). Conceptualising relational care from an Indigenous Māori perspective: A scoping review. *Journal of Clinical Nursing*, *32*(19–20), 6879–6893. https://doi.org/10.1111/jocn.16794

Peplau, H. (1952). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. G. P. Putnam's Sons.

Pfeiffer, P. N., King, C., Ilgen, M., Ganoczy, D., Clive, R., Garlick, J., Abraham, K., Kim, H. M., Vega, E., Ahmedani, B., & Valenstein, M. (2019). Development and pilot study of a suicide prevention intervention delivered by peer support specialists. *Psychological Services*, *16*(3), 360–371. https://doi.org/10.1037/ser0000257

Potter, M. L., Vitale-Nolen, R., & Dawson, A. M. (2005). Implementation of safety agreements in an acute psychiatric facility. *Journal of the American Psychiatric Nurses Association*, *11*(3), 144–155. https://doi.org/10.1177/1078390305277443

Priebe, S., & Mccabe, R. (2008). Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself? *International Review of Psychiatry (Abingdon, England)*, *20*(6), 521–526. https://doi.org/10.1080/09540260802565257

Reavey, P., Brown, S. D., Kanyeredzi, A., McGrath, L., & Tucker, I. (2019). Agents and spectres: Life-space on a medium secure forensic psychiatric unit. *Social Science & Medicine (1982)*, *220*, 273–282. https://doi.org/10.1016/j.socscimed.2018.11.012

Reen, G. K., Bailey, J., Maughan, D. L., & Vincent, C. (2020). Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards. *International Journal of Mental Health Nursing*, *29*(3), 372–386. https://doi.org/10.1111/inm.12696

Reen, G. K., Bailey, J., McGuigan, L., Bloodworth, N., Nawaz, R. F., & Vincent, C. (2021). Environmental changes to reduce self-harm on an adolescent inpatient psychiatric ward: An interrupted time series analysis. *European Child & Adolescent Psychiatry*, *30*(8), 1173–1186. https://doi.org/10.1007/s00787-020-01607-3

Roennfeldt, H., Wyder, M., Byrne, L., Hill, N., Randall, R., & Hamilton, B. (2021). Subjective experiences of mental health crisis care in emergency departments: A narrative review of the qualitative literature. *International Journal of Environmental Research and Public Health*, *18*(18), 9650. https://doi.org/10.3390/ijerph18189650

Rotheram-Borus, M. J., Piacentini, J., Cantwell, C., Belin, T. R., & Song, J. (2000). The 18-month impact of an emergency room intervention for adolescent female suicide attempters. *Journal of Consulting and Clinical Psychology*, *68*(6), 1081–1093. https://doi.org/10.1037/0022-006X.68.6.1081

Rotheram-Borus, M. J., Piacentini, J., Van Rossem, R., Graae, F., Cantwell, C., Castro-Blanco, D., Miller, S., & Feldman, J. (1996). Enhancing treatment adherence with a specialized emergency room program for adolescent suicide attempters. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(5), 654–663. https://doi.org/10.1097/00004583-199605000-00021

Royal College of General Practitioners. (2021). *The power of relationships: What is relationship-based care and why is it important?* Royal College of General Practitioners. https://www.rcgp.org.uk/getmedia/ca3e21e7-f742-47d7-9538-77e59bbb1ec7/power-of-relationships-rcgp-2021.pdf

Royal College of Psychiatrists. (2010). *Self-harm, suicide and risk: Helping people who self-harm*. Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr158.pdf?sfvrsn=fcf95b93_2

Samari, E., Shahwan, S., Abdin, E., Zhang, Y., Sambasivam, R., Teh, W. L., Ong, S. H., Chong, S. A., & Subramaniam, M. (2020). An exploration of differences between deliberate self-harm with and without suicidal intent amongst a clinical sample of young people in Singapore: A cross-sectional study. *International Journal of Environmental Research and Public Health*, *17*(4), 1429. https://doi.org/10.3390/ijerph17041429

Scott, J., Aitken, P., Peters, T., & Kumar, K. (2017). Liaison psychiatry explained. *BMJ (Clinical Research ed.)*, *357*, j1757. https://doi.org/10.1136/sbmj.j1757

See Think Act: Your guide to relational security. (2010). Department of Health. https://assets.publishing.service.gov.uk/media/5a7d8931ed915d497af70081/See_Think_Act_2010.pdf

Shah, N., O'Keeffe, S., Hayward, S., Suzuki, M., & McCabe, R. (2024). Re-imagining crisis care: Experiences of delivering and receiving the Assured brief psychological intervention for people presenting to Emergency Departments with self-harm. *Frontiers in Psychiatry*, *15*, 1271674. https://doi.org/10.3389/fpsyt.2024.1271674

Shepley, M. M., Watson, A., Pitts, F., Garrity, A., Spelman, E., Kelkar, J., & Fronsman, A. (2016). Mental and behavioral health environments: Critical considerations for facility design. *General Hospital Psychiatry*, *42*, 15–21. https://doi.org/10.1016/j.genhosppsych.2016.06.003

Shin, H. J., Park, G. J., In, Y. N., Kim, S. C., Kim, H., & Lee, S. W. (2019). The effects of case management program completion on suicide risk among suicide attempters: A 5-year observational study. *The American Journal of Emergency Medicine*, *37*(10), 1811–1817. https://doi.org/10.1016/j.ajem.2018.12.034

Simonsen, T. P., & Duff, C. (2020). Healing architecture and psychiatric practice: (Re)ordering work and space in an in-patient ward in Denmark. *Sociology of Health & Illness*, *42*(2), 379–392. https://doi.org/10.1111/1467-9566.13011

Springer, T., Lohr, N. E., Buchtel, H. A., & Silk, K. R. (1996). A preliminary report of short-term cognitive-behavioral group therapy for inpatients with personality disorders. *The Journal of Psychotherapy Practice and Research*, *5*(1), 57–71.

Staniszewska, S., Mockford, C., Chadburn, G., Fenton, S.-J., Bhui, K., Larkin, M., Newton, E., Crepaz-Keay, D., Griffiths, F., & Weich, S. (2019). Experiences of in-patient mental health services: Systematic review. *The British Journal of Psychiatry: The Journal of Mental Science*, *214*(6), 329–338. https://doi.org/10.1192/bjp.2019.22

Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, *75*(9), 894–900. https://doi.org/10.1001/jamapsychiatry.2018.1776

Stevenson, C., Barker, P., & Fletcher, E. (2002). Judgement days: Developing an evaluation for an innovative nursing model. *Journal of Psychiatric and Mental Health Nursing*, *9*(3), 271–276. https://doi.org/10.1046/j.1365-2850.2002.00472.x

Stewart, D., & Bowers, L. (2012). Under the gaze of staff: Special observation as surveillance. *Perspectives in Psychiatric Care*, *48*(1), 2–9. https://doi.org/10.1111/j.1744-6163.2010.00299.x

Stewart, D., Bowers, L., & Ross, J. (2012). Managing risk and conflict behaviours in acute psychiatry: The dual role of constant special observation. *Journal of Advanced Nursing*, *68*(6), 1340–1348. https://doi.org/10.1111/j.1365-2648.2011.05844.x

Stewart, D., Bowers, L., & Warburton, F. (2009). Constant special observation and self-harm on acute psychiatric wards: A longitudinal analysis. *General Hospital Psychiatry*, *31*(6), 523–530. https://doi.org/10.1016/j.genhosppsych.2009.05.008

Sunnqvist, C., Berngarn, A., Ezinne Ekezie, P., Lundgren, E., Nilsson, E., & Örmon, K. (2022). A pilot evaluation of a prehospital emergency psychiatric unit: The experiences of patients, psychiatric and mental health nurses, and significant others. *Perspectives in Psychiatric Care*, *58*(4), 2255–2262. https://doi.org/10.1111/ppc.13055

Tebbett-Mock, A. A., Saito, E., McGee, M., Woloszyn, P., & Venuti, M. (2020). Efficacy of dialectical behavior therapy versus treatment as usual for acute-care inpatient adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *59*(1), 149–156. https://doi.org/10.1016/j.jaac.2019.01.020

Termansen, P. E., & Bywater, C. (1975). S.A.F.E.R.: A follow-up service for attempted suicide in Vancouver. *Canadian Psychiatric Association Journal*, *20*(1), 29–34. https://doi.org/10.1177/070674377502000106

The ODDESSI Trial. (2024). UCL. https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/oddessi/oddessi-trial

The Royal College of Emergency Medicine. (2021). *Mental Health in Emergency Departments: A toolkit for improving care*. The Royal College of Emergency Medicine. https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf

The Royal College of Emergency Medicine. (2023). *RCEM warns "The emergency care system is under severe pressure."* https://rcem.ac.uk/rcem-warns-the-emergency-care-system-is-under-severe-pressure/

Thibaut, B., Dewa, L. H., Ramtale, S. C., D'Lima, D., Adam, S., Ashrafian, H., Darzi, A., & Archer, S. (2019). Patient safety in inpatient mental health settings: A systematic review. *BMJ Open*, *9*(12), e030230. https://doi.org/10.1136/bmjopen-2019-030230

Timberlake, L. M., Beeber, L. S., & Hubbard, G. (2020). Nonsuicidal self-injury: Management on the inpatient psychiatric unit. *Journal of the American Psychiatric Nurses Association*, *26*(1), 10–26. https://doi.org/10.1177/1078390319878878

Trees Care & Support. (2023). *What is relational care?* https://3tcs.co.uk/social-care/what-is-relational-care/#:~:text=Relational%20care%20is%20an%20approach,%2C%20and%20psychological%20well%2Dbeing

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., Dale, O., Haigh, R., Moran, P., McNicholas, S., Nicholls, V., Foye, U., Simpson, A., Lloyd-Evans, B., Johnson, S., & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: A co-produced qualitative interview study. *BMC Psychiatry*, *22*(1), 55. https://doi.org/10.1186/s12888-021-03605-4

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., … Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tyrer, P., Tom, B., Byford, S., Schmidt, U., Jones, V., Davidson, K., Knapp, M., MacLeod, A., & Catalan, J, POPMACT Group. (2004). Differential effects of manual assisted cognitive behavior therapy in the treatment of recurrent deliberate self-harm and personality disturbance: The Popmact Study. *Journal of Personality Disorders*, *18*(1), 102–116. https://doi.org/10.1521/pedi.18.1.102.32770

University of Manchester & Healthcare Quality Improvement Partnership. (2018). *The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health*. https://documents.manchester.ac.uk/display.aspx?DocID=38466

University of Manchester & Healthcare Quality Improvement Partnership. (2024). *National Confidential Inquiry into Suicide and Safety in Mental Health. Annual report 2024: UK patient and general population data 2011–2021*. https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

Vaiva, G., Vaiva, G., Ducrocq, F., Meyer, P., Mathieu, D., Philippe, A., Libersa, C., & Goudemand, M. (2006). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: Randomised controlled study. *BMJ (Clinical Research ed.)*, *332*(7552), 1241–1245. https://doi.org/10.1136/bmj.332.7552.1241

Virk, F., Waine, J., & Berry, C. (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. *BJPsych Open*, *8*(2), e56. https://doi.org/10.1192/bjo.2022.21

Walker, A., Barrett, J. R., Lee, W., West, R. M., Guthrie, E., Trigwell, P., Quirk, A., Crawford, M. J., & House, A. (2018). Organisation and delivery of liaison psychiatry services in general hospitals in England: Results of a national survey. *BMJ Open*, *8*(8), e023091. https://doi.org/10.1136/bmjopen-2018-023091

Ward-Stockham, K., Kapp, S., Jarden, R., Gerdtz, M., & Daniel, C. (2022). Effect of Safewards on reducing conflict and containment and the experiences of staff and consumers: A mixed-methods systematic review. *International Journal of Mental Health Nursing*, *31*(1), 199–221. https://doi.org/10.1111/inm.12950

Watkins, P. (2001). *Mental health nursing: The art of compassionate care*. Butterworth-Heinemann.

Wharff, E. A., Ginnis, K. B., Ross, A. M., White, E. M., White, M. T., & Forbes, P. W. (2019). Family-based crisis intervention with suicidal adolescents: A randomized clinical trial. *Pediatric Emergency Care*, *35*(3), 170–175. https://doi.org/10.1097/PEC.0000000000001076

Williamson, V., Murphy, D., Phelps, A., Forbes, D., & Greenberg, N. (2021). Moral injury: The effect on mental health and implications for treatment. *The Lancet. Psychiatry*, *8*(6), 453–455. https://doi.org/10.1016/S2215-0366(21)00113-9

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing*, *30*(23–24), 3539–3555. https://doi.org/10.1111/jocn.15859

Woodnutt, S., Hall, S., Libberton, P., Flynn, M., Purvis, F., & Snowden, J. (2024). Analysis of England's incident and mental health nursing workforce data 2015–2022. *Journal of Psychiatric and Mental Health Nursing*, *31*(5), 716–728. https://doi.org/10.1111/jpm.13027

Yen, S., Ranney, M. L., Tezanos, K. M., Chuong, A., Kahler, C. W., Solomon, J. B., & Spirito, A. (2019). Skills to enhance positivity in suicidal adolescents: Results from an open development trial. *Behavior Modification*, *43*(2), 202–221. https://doi.org/10.1177/0145445517748559

Yiu, H. W., Rowe, S., & Wood, L. (2021). A systematic review and meta-analysis of psychosocial interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients. *Psychiatry Research*, *305*, 114175. https://doi.org/10.1016/j.psychres.2021.114175

Zou, P. (2016). Relational practice in nursing: A case analysis. *Nursing and Health Care*, *1*(1), 9–13. https://doi.org/10.33805/2573-3877.102

Appendices

Appendix A: Definitions drawn upon in co-producing a working definition of "relational care"

Source	Definition
Lamph et al. (2023) *(Systematic review of "relational practice" in health, education, criminal justice and social care)*	Relational practice: "Practices and/or interventions that prioritise interpersonal relationships in service provision, in relation to both external (organisational contexts) and internal (how this is received by workers and service users) aspects"
Royal College of General Practitioners (2021) *(Report on what "relationship-based care" is and why it is important in the context of General Practitioners)*	Relationship-based care: "Relationship-based care describes care in which the process and outcomes of care are enhanced by a high-quality relationship between doctor and patient. The relationship will often, though not always, have developed over time and is characterised by trust, mutual respect and sharing of power between doctor and patient. It leads to better understanding of the patient's ideas and expectations, a better understanding of the family and community in which the patient is living and the opportunity for a therapeutic relationship to develop."
See Think Act: Your guide to relational security (2010) *(Guide to relational security)*	Relational security: "Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. Relational security is not simply about having 'a good relationship' with a patient. Safe and effective relationships between staff and patients must be professional, therapeutic and purposeful, with understood limits. Limits enable staff to maintain their professional integrity and say 'no' when boundaries are being tested."
Novy et al. (2023) *(A meta-ethnography of relational care, dementia and communication challenges in long-term care)*	Relational care: "a bidirectional process, one in which the agency of both people—those who give and receive are—is recognised (Tronto, 1993)."
3 Trees Care and Support (2023)	Relational care: "Relational care is an approach to caregiving that emphasises building and maintaining meaningful relationships between caregivers and care recipients. It recognises that care is about meeting physical needs and attending to emotional, social, and psychological well-being." It lists some key aspects of relational care, including: relationship-focussed care, person-centred care, empathy and compassion, communication, trust and respect, continuation and consistency, emotional support, and collaboration and empowerment.
Trevillion et al. (2022) *(Coproduced qualitative interview study exploring service user perspectives of community mental health services for people with complex emotional needs)*	Relational practice: "Relational practice comprises staff delivering care in a non-stigmatising, individualised and compassionate way, and delivering care that is trauma-informed… when staff work holistically and collaboratively with service users to coordinate support for their complex needs… when service structures allow for flexibility and continuity of care, accommodate the ongoing and changing nature of service users' needs, and implement joint-working practices with other services."
Wilson et al. (2021) *(Literature review of Māori models of health to create an Indigenous Māori-centred model of relational health)*	Relational care: "Relational care refers to the deliberate nurturing of respectful and meaningful relationships with Māori and their whānau [extended family]. Relational care is a person- and whānau-centred holistic healthcare practice that evolves through mindful reflection and deliberation."
Pene et al. (2023) *(A scoping review conceptualising relational care from an indigenous Māori perspective)*	This paper described key attributes of relational care necessary to develop a therapeutic relationship from an indigenous Māori perspective. They included: trust, respect, compassion, and empathy. Other key processes included: effective communication (e.g., respectful and caring communication, active listening, providing timely information and engaging authentically), including family (whānau), appreciating different worldviews, cultural safety, and whanaungatanga (connectedness).
Emmamally et al. (2022) *(A scoping review of in-hospital interventions to promote relational practice with families in acute care settings)*	Relational practice: "Relational practice is characterised by genuine interaction between families and healthcare professionals (HCPs) that promotes trust and empowerment… Core elements of relational practice include individuals consciously connecting and growing towards each other, authenticity in caring, whereby individuals are transparent and genuine in their emotions, being attuned to each other's needs whilst honouring differences, mutual trust and respect between individuals leading to self-empowerment (Fletcher, 1998; Jordan, 2010). Self-reflection in relational practice encourages HCPs to confront prejudices that may be present in family encounters (Duffey & Somody, 2011; Hartrick, 1997). Relational practice is about HCPs creating safe environments for families through therapeutic communication (Doane & Varcoe, 2007). The authors elaborate that in creating safe environments, HCPs promote feelings of security that facilitates families to share their emotions. Healthcare professionals are encouraged to acknowledge the contextual factors that may shape a patient's and family's responses to experiences and interactions with people (Zou, 2016). These include personal characteristics, and socio-political, cultural and geographical factors that affect how patients and families manage their illness. Jordan (2010) speaks about the element of HCPs being fully involved in relationships with families thus supporting families to grow."

Appendix B: Expanded definition of "relational care" co-produced by our working group of academic and lived experience researchers and clinicians

Relational care can be practised at individual, group, organisational or systemic levels. It relates to how care is delivered, rather than the specific content or format of interventions. Relational care prioritises interpersonal relationships, acknowledging their central role in effective treatment and recovery. It is grounded in values such as respect, dignity, empathy, humility, authenticity, compassion, empowerment, trust, and shared humanity. Relational care is guided by principles that include: understanding individuals within the context of their lives, providing personalised and holistic care, promoting cultural safety, fostering effective communication, believing in patients and inspiring hope. It is also guided by the principle of democratisation—actively involving patients and the people close to them (e.g., family, friends, partners) in decisions about their care and the functioning of the care environment. This requires power imbalances to be acknowledged and addressed.

Appendix C: Preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	Page 1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	Page 1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	Pages 2–3
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualise the review questions and/or objectives.	Page 3
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	Page 4
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	Pages 4–5
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	Appendix E
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	Pages 4–5
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	Page 5
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Page 5
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarising the data that were charted.	Page 5
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	Page 5 and Figure 1
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	Pages 5–7, and Appendix G
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Pages 5–11, Appendix G, Supplementary files 1 & 2
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	Pages 5–11, Appendix G, Supplementary files 1 & 2
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	Pages 11–13
Limitations	20	Discuss the limitations of the scoping review process.	Page 13
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	Pages 13–14
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	Page 15

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.

Appendix D: Inclusion and exclusion criteria for reviews in this report

	Included	Excluded
Population	• Mental health patients (of any age, ethnicity, sex, or gender)	• Reviews only including staff or family/ carers, or non-mental health patients
Intervention/approach	• Relational care approaches to assessing and managing self-harm and suicide risk in inpatient mental health and emergency department settings. These approaches must include a focus on interpersonal relationships and involve at least some of the values and/or principles outlined in the definition of "relational care" (see above).	• Pharmacological interventions • Surveillance technologies • Restrictive interventions (e.g., seclusion room use, rapid tranquilisation, physical restraint) • Structured risk assessment checklists and risk stratification • Standard aspects of inpatient mental health or emergency department care (e.g., ward rounds, psychosocial assessments) • Approaches focusing only on the physical design of the environment
Comparators/control	• Reviews examining any comparator/control groups were eligible to be included • Reviews of studies with no comparator/control groups	• None
Outcomes	• Self-harm (e.g., frequency, severity) • Suicide (e.g., suicidal ideation, suicide attempt frequency, time to suicide attempts, completed suicides)	• Risk to others • Risk from others • Other patient outcomes • Staff outcomes • Carer outcomes
Setting	• Non-forensic inpatient mental health settings (including acute and longer-term inpatient services) • Emergency departments	• Forensic inpatient mental health services • Services specifically for people with an intellectual disability • Services specifically for autistic people • Non-psychiatric medical inpatient services • Services specifically for people living with dementia • Neurorehabilitation wards • Community-based services
Study type	• Reviews (e.g., systematic reviews, scoping reviews, rapid reviews, narrative reviews) • Peer-reviewed and non-peer reviewed reviews • Reviews published any date • Reviews published in English • Studies conducted in any country	• Primary research studies • Books • Commentaries • Editorials • PhD/MSc/BSc theses • Opinion pieces • Blog posts • Social media content • Non-English language papers

Appendix E: Search strings

1. (Psychiatri* or "mental health").mp.
2. (inpatient or hospital* or ward* or facility* or unit* or PICU or "136-suite" or "136 suite" or "place* of safety" or emergency department* or A&E).mp.
3. (Intervention* or approach* or strateg* or program* or manag* or protocol* or therap* or initiative* or mileu* or environment* or anti* or prevent* or improv* or trauma-informed or trauma informed or safeguard* or protect* or precaution* or reduc* or mitigat* or secur* or risk assessment* or model* or train* or policy* or policies* or leadership* or activit* or group* or session* or practice* or treatment* or QI or project* or peer or counselling* or de-escalat* or skill* or technique* or implement* or meeting* or communit* or scheme*).mp.
4. (Suicid* or ligature* or ligation or hang* or strangle* or strangulation* or asphyxi* or parasuicid* or self-harm* or self harm* or self-injur* or self injur* or self-mutilat* or self mutilat* or DSH or NSSI or self-poison* or self poison* or incident* or safety).mp.
5. 1 and 2 and 3 and 4
6. limit 5 to "review articles"

Appendix F: Excluded full texts and reasons for exclusion

References	Reason for exclusion
Babeva, K., Hughes, J. L., & Asarnow, J. (2016). Emergency Department screening for suicide and mental health risk. *Current Psychiatry Reports, 18*(11), 100. https://doi.org/10.1007/s11920-016-0738-6	Wrong publication type
Baldwin, G., & Beazley, P. (2023). A systematic review of the efficacy of psychological treatments for people detained under the Mental Health Act. Journal of *Psychiatric and Mental Health Nursing*, *30*(4), 600–619. https://doi.org/10.1111/jpm.12897	Wrong outcome
Belsiyal, C. X., Rentala, S., & Das, A. (2022). Use of therapeutic milieu interventions in a psychiatric setting: A systematic review. *Journal of Education and Health Promotion, 11*, 234. https://doi.org/10.4103/jehp.jehp_1501_21	Wrong outcome
Campbell, L. A., & Kisely, S. R. (2009). Advance treatment directives for people with severe mental illness. *The Cochrane Database of Systematic Reviews*, 2009(1), CD005963. https://doi.org/10.1002/14651858.CD005963.pub2	Wrong outcome
Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital management of self-harm patients and risk of repetition: Systematic review and meta-analysis. *Journal of Affective Disorders, 168*, 476–483. https://doi.org/10.1016/j.jad.2014.06.027	Wrong intervention
Castaigne, E., Hardy, P., & Mouaffak, F. (2017). La veille sanitaire dans la prise en charge des suicidants. Quels outils, quels effets, comment les évaluer ? [Follow-up interventions after suicide attempt. What tools, what effects and how to assess them?]. *L'Encephale, 43*(1), 75–80. https://doi.org/10.1016/j.encep.2016.08.004	Non-English language
Ceniti, A. K., Heinecke, N., & McInerney, S. J. (2020). Examining suicide-related presentations to the emergency department. *General Hospital Psychiatry*, *63*, 152–157. https://doi.org/10.1016/j.genhosppsych.2018.09.006	Wrong intervention
Evans, R., Connell, J., Ablard, S., Rimmer, M., O'Keeffe, C., & Mason, S. (2019). The impact of different liaison psychiatry models on the emergency department: A systematic review of the international evidence. *Journal of Psychosomatic Research, 119*, 53–64. https://doi.org/10.1016/j.jpsychores.2019.01.013	Wrong outcome

(*Continued*)

Appendix F. Continued.

References	Reason for exclusion
Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse-patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, *102*, 103490. https://doi.org/10.1016/j.ijnurstu.2019.103490	Wrong outcome
Lipczynska S. (2013). RESPECT and Starwards: What are they, and do they impact on safety in acute ward settings?. *Journal of Mental Health* (Abingdon, England), *22*(6), 570–574. https://doi.org/10.3109/09638237.2013.841877	Wrong study type
Lorillard, S., Schmitt, L., & Andreoli, A. (2011). How to treat deliberate self-harm: From clinical research to effective treatment choice? Part 1: An update treatment efficacy among unselected patients referred to emergency room with deliberate self-harm. In *Annales Médico-Psychologiques* (Vol. 169, No. 4, pp. 221–228). Elsevier Publishing.	Non-English language
Lynch, M. A., & Matthews, J. M. (2008). Assessment and management of hospitalised suicidal patients. *Journal of Psychosocial Nursing & Mental Health Services, 46*(7), 45.	Wrong outcome
McIntyre, H., Reeves, V., Loughhead, M., Hayes, L., & Procter, N. (2022). Communication pathways from the emergency department to community mental health services: A systematic review. *International Journal of Mental Health Nursing, 31*(6), 1282–1299.	Wrong outcome
Molloy, L., Brady, M., Beckett, P., & Pertile, J. (2014). Near-hanging and its management in the acute inpatient mental health setting. *Journal of Psychosocial Nursing and Mental Health Services, 52*(5), 41–45.	Wrong intervention
Newton, A. S., Hartling, L., Soleimani, A., Kirkland, S., Dyson, M. P., & Cappelli, M. (2017). A systematic review of management strategies for children's mental health care in the emergency department: Update on evidence and recommendations for clinical practice and research. *Emergency Medicine Journal, 34*(6), 376–384.	Wrong intervention
Nienaber, A., Schulz, M., Hemkendreis, B., & Loehr, M. (2013). Special observation in inpatient treatment of people with mental illness. *Psychiatrische Praxis, 40*(1), 14–20.	Non-English language
Phillips, R., Pinto, C., McSherry, P., & Maguire, T. (2022). EMDR therapy for posttraumatic stress disorder symptoms in adult inpatient mental health settings: A systematic review. *Journal of EMDR Practice and Research, 16*(1).	Wrong outcome
Polacek, M. J., Allen, D. E., Damin-Moss, R. S., Schwartz, A. J. A., Sharp, D., Shattell, M., … & Delaney, K. R. (2015). Engagement as an element of safe inpatient psychiatric environments. *Journal of the American Psychiatric Nurses Association, 21*(3), 181–190.	Wrong outcome
Powsner, S., Goebert, D., Richmond, J. S., & Takeshita, J. (2023). Suicide risk assessment, management, and mitigation in the emergency setting. *Focus*, *21*(1), 8–17.	Wrong outcome
Price, N. (2007). Improving emergency care for patients who self harm. *Emergency Nurse, 15*(8).	Wrong study type
Puntil, C., York, J., Limandri, B., Greene, P., Arauz, E., & Hobbs, D. (2013). Competency-based training for PMH nurse generalists: Inpatient intervention and prevention of suicide. *Journal of the American Psychiatric Nurses Association, 19*(4), 205–210.	Wrong study type
Repper, J. (1999). A review of the literature on the prevention of suicide through interventions in accident and emergency departments. *Journal of Clinical Nursing, 8*(1), 3–12.	Wrong setting
Reynolds, E. K., Gorelik, S., Kook, M., & Kellermeyer, K. (2020). Acute psychiatric care for paediatric patients. International Review of Psychiatry, *32*(3), 272–283.	Wrong outcome
Ronquillo, L., Minassian, A., Vilke, G. M., & Wilson, M. P. (2012). Literature-based recommendations for suicide assessment in the emergency department: A review. *The Journal of Emergency Medicine, 43*(5), 836–842.	Wrong intervention
Smedslund, G., Dalsbø, T. K., & Reinar, L. M. (2016). Effects of secondary preventive interventions against self-harm [Internet].	Wrong study type
Wood, L., & Newlove, L. (2022). Crisis-focused psychosocial interventions for borderline personality disorder: Systematic review and narrative synthesis. *BJPsych Open, 8*(3), e94.	Wrong outcome
Zhang, R. W. (2022). Evidence-based suicide screening and prevention protocol for licenced nursing staff: a systematic literature review and recommendations. *Journal of Psychosocial Nursing and Mental Health Services, 60*(4), 21–27.	Wrong intervention
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [A] Evidence review for information and support needs of people who have self-harmed. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/a-information-and-support-needs-of-people-who-have-selfharmed-pdf-11196377246	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [B] Information and support needs of families and carers of people who have self-harmed. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/b-information-and-support-needs-of-families-and-carers-of-people-who-have-selfharmed-pdf-11196377247	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [C] Evidence review for consent, confidentiality and safeguarding. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/c-consent-confidentiality-and-safeguarding-pdf-11196377248	Wrong setting
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [D] Evidence review for involving family and carers in the management of people who have self-harmed. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/d-involving-family-and-carers-in-the-management-of-people-who-have-selfharmed-pdf-11196377249	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [G] Evidence review for risk assessment and formulation. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/g-risk-assessment-and-formulation-pdf-11196377252	Wrong intervention
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [H] Evidence review for admission to hospital. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/h-admission-to-hospital-pdf-11196377253	Wrong intervention
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [J] Evidence reviews for psychological and psychosocial interventions. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/j-psychological-and-psychosocial-interventions-pdf-403069580821	Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [L] Evidence review for harm minimisation strategies. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/l-harm-minimisation-strategies-pdf-403069580823	Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [M] Evidence review for therapeutic risk taking strategies. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/m-therapeutic-risk-taking-strategies-pdf-403069580824	Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [N] Evidence reviews for supporting people to be safe after self-harm. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/n-supporting-people-to-be-safe-after-selfharm-pdf-403069580825	Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [P] Evidence review for skills required by staff in specialist settings. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/p-skills-required-by-staff-in-specialist-settings-pdf-403069580827	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [Q] Evidence reviews for supervision required for staff in specialist mental health settings. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/q-supervision-required-for-staff-in-specialist-mental-health-settings-pdf-403069580828	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [Q] Evidence reviews for supervision required for staff in specialist mental health settings. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/t-models-of-care-for-people-who-have-selfharmed-pdf-403069580857	Wrong outcome (only included qualitative studies)
National Institute for Health and Care Excellence (2022). Self-harm assessment, management and preventing recurrence. [T] Evidence reviews for models of care for people who have self-harmed. NICE guideline number NG225. https://www.nice.org.uk/guidance/ng225/evidence/t-models-of-care-for-people-who-have-selfharmed-pdf-403069580857	Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)

Appendix G: Table of review characteristics

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Austin et al. (2024) Title: Improving emergency department care for adults presenting with mental illness: A systematic review of strategies and their impact on outcomes, experience, and performance Systematic review (46 included studies)	Synthesise the research evidence associated with strategies used to improve ED care delivery outcomes, experience, and performance for adults presenting with mental illness.	ED	Searched: Academic databases Designs: Included empirical peer-reviewed research articles. Excluded literature reviews, conference posters or abstracts, grey literature and case reports. Only included articles published in English. Population: Adult mental health presentations (e.g., undifferentiated, suicidal, deliberate self-harm, scheduled, substance-related and addictive disorders, depressive and anxiety disorders). Excluded studies involving people aged under 18 or focused on disability or neurodiversity. Setting: Included EDs. Excluded interventions conducted primarily in the pre-hospital, post-hospital or a ward/clinic setting other than the ED. Outcomes: Included measures of system performance (e.g., waiting time, length of stay, time to treatment/assessment, admissions, referrals), patient outcomes (e.g., self-harm, suicide-related outcomes, readmission, adverse events, medical errors, missing diagnoses, pain, quality of life), patient experience, or staff experience. Intervention: Implemented models of care or system changes. Excluded studies that did not report an intervention, or that screened presentations without intervention in the ED. Comparators: Usual care or other form of care.	Assertive case management	This review identified various strategies to improve ED care for individuals experiencing mental health difficulties, including suicidality and self-harm. It included a wide range of approaches, beyond just relational care approaches. Relevant to this scoping review, it included one study which the authors stated showed that assertive case management was associated with reduced self-harm. More broadly, the authors highlighted how heterogeneity in study samples, intervention strategies, and outcome measures makes adopting existing strategies challenging. They emphasised the complexity of providing mental health care in ED settings and the need for strategies that align ED system goals with patient goals and staff experience.
Bloom et al. (2012) Title: Use of Dialectical behaviour therapy in inpatient treatment of borderline personality disorder: A systematic review Systematic review (11 included papers)	To characterise different modifications of standard DBT that have been delivered in inpatient settings and to report on the effectiveness of the DBT treatment strategies implemented in such settings to reduce target symptoms associated with the disorder.	Inpatient	Searched: Academic databases only Designs: Included published, peer-reviewed empirical studies. Population: Patients with a diagnosis of BPD or self-reported recent suicidal or out-of-control behaviours. Settings: Inpatient settings Outcomes: Looked at a range of outcomes, including self-harm behaviour, suicidal ideation, depressive symptoms, dissociative experiences, anxiety symptoms, anger and hostility, violent behaviour, interpersonal problems, global adjustment, and identity disturbance. Interventions: Any form of DBT. Treatment had to aim to address BPD symptoms (including but not limited to self-harm, suicidal behaviour or overtly aggressive behaviour) as well as other psychiatric symptoms (e.g., symptoms of depression and anxiety). Excluded DBT addressing symptoms not related to BPD, DBT not adapted from Linehan's published DBT text, or not administered in an inpatient mental health setting.	DBT	The authors stated that this review found considerable variation in how DBT is implemented for inpatients with BPD, including differences in its structure and duration. The authors suggested that when standard DBT practices and principles are applied with fidelity to the treatment model, inpatient DBT appears to be effective in improving global functioning and reducing some BPD symptoms, including self-harm, suicidal ideation, and symptoms of anxiety and depression. Evidence for its impact on anger and violent behaviour was more mixed. The authors highlighted the need for further research to standardise inpatient DBT delivery and outcome measurement, identify critical mechanisms of symptom and behaviour change, and to evaluate the effectiveness of follow-up outpatient treatment.
Broadway-Horner et al. (2022) Title: Psychological therapies and non-suicidal self-injury in LGBTIQ in accident and emergency departments in the UK: A scoping review Scoping review (7 included papers)	To recognise and assess the results from all studies including randomised control trials (RCTs) that have studied the efficiency of psychiatric and psychological assessment of people who have depression that undergo non-suicidal self-injury (NSSI) by self-poisoning, presenting to UK Accident and Emergency Departments.	ED	Searched: Academic databases and Google Scholar Designs: Only included RCTs. Excluded studies included in Hawton et al. (1998). Population: LGBTIQ and non-binary study participants aged 18 years and over who have engaged in non-suicidal self-injury by overdose shortly before entry to the study. Settings: Included A&E departments in the UK. Excluded studies with no A&E involvement. Outcomes: Included repetition of non-suicidal self-harm behaviour. Excluded studies focusing on suicide. Interventions: Psychiatric and psychological therapy treatments	Manual-assisted cognitive therapy (MACT) Brief psychodynamic interpersonal therapy Crisis cards	The authors stated that this review found a lack of evidence on the most effective treatments for non-suicidal self-injury by overdosing in LGBTQI and non-binary populations. The authors reported that evidence indicates that psychodynamic interpersonal therapy was significantly more effective than standard care in reducing non-suicidal self-injury by overdosing, while manual-assisted cognitive therapy and crisis cards were not. They concluded that the best available evidence supports problem-solving therapies which have a particular focus on interpersonal issues.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Chammas et al. (2022) Title: Inpatient suicide in psychiatric settings: Evaluation of current prevention measures Non-systematic review Number of included studies not stated.	Provide an overview of the progress that has been made in the field of inpatient suicide prevention in recent years, discuss the problems that remain, and the future potential developments.	Inpatient	Searched: One academic database (PubMed) Designs: No inclusion or exclusion criteria stated. Populations: Inpatient mental health populations. No restrictions specified. Settings: Inpatient mental health services Outcomes: Suicide-related outcomes Interventions: Suicide prevention measures in inpatient mental health services Comparators: Not stated	Anti-suicide contracts Collaborative Assessment and Management of Suicidality (CAMS) Dialectical behaviour therapy (DBT)	This review provides a broad overview of the epidemiology of suicide in inpatient mental health settings, key risk factors, and approaches to suicide assessment and prevention in inpatient settings, including, but not limited to, relational care approaches. Relevant to this focus of this scoping review, the authors highlighted evidence supporting CAMS as an effective tool for assessing suicide risk. They noted that certain suicide prevention techniques, such as anti-suicide contracts, are outdated. The authors identified CBT and DBT as the most widely used and effective psychotherapies for reducing suicide risk in inpatient settings. They also suggested other promising approaches, including mindfulness-based interventions, the Attempted Suicide Short Intervention Program, Systems Training for Emotional Predictability and Problem Solving, and comprehensive contact interventions. However, the only inpatient-specific evidence they cited on self-harm or suicide-related outcomes related to anti-suicide contracts, CAMS, and DBT.
Chaudhary et al. (2020) Title: Suicide during transition of care: A review of targeted interventions Systematic review (40 included studies)	Summarise the evidence for interventions providing care during the first few weeks after discharge from a healthcare facility (when risk of suicide is highest).	Inpatient and ED	Searched: Academic databases Designs: Included all original studies, including RCTs and non-randomised trials. They excluded case reports, case series, letters to editors, study protocols, theses, reviews, commentaries, conference papers, abstract-only articles, book chapters and news articles. Population: People discharged from a medical facility to the community. No restriction on race, place, sex, age, ethnicity. Setting: Not stated. Intervention: Interventions targeting suicidal behaviours after discharge from a medical facility. Outcomes: Suicide-related outcomes	Green cards Caring letters Postcards Letter and telephone contact Telephone contacts Brief Intervention and Contact (BIC) Family Intervention for Suicide Prevention (FISP) Mobile crisis team intervention	The authors of this review described how patients are at high risk of suicide when transitioning from medical care facilities to the community. The review examines evidence on the effectiveness of targeted interventions during this period, including telephone contacts, letters, green cards, postcards, structured visits, and community outreach programs. The authors stated that although evidence suggests that these interventions are effective in connecting patients to outpatient services, evidence for their impact on suicidal behaviours is inconsistent. They noted that evidence was particularly limited for individuals with repetitive suicidal behaviours. The authors emphasised the importance therefore of psychosocial interventions such as CBT and DBT, and argue that targeted interventions are needed post-hospitalisation based on risk categorisation using evidence-based tools.
Cox et al. (2010) Title: Alternative approaches to "enhanced observations" in acute inpatient mental health care: A review of the literature Non-systematic review (5 included papers)	To critically review the empirical evidence base for alternative approaches to "enhanced observations" from those proposed in the Standing Nursing and Midwifery Advisory Committee guidelines (SNMAC DoH 1999) on individuals receiving care on open acute inpatient mental health wards.	Inpatient	Searched: Academic databases only Designs: Included empirical papers. Excluded non-empirical papers. Populations: Not specified Settings: Included acute inpatient mental health settings. Excluded prisons, forensic mental health settings, or any other permanently locked inpatient mental healthcare setting. Outcomes: Range of outcomes reported (including suicide and self-harm rates) Interventions: Alternative approaches to "observations," structured programmes of change to nurses' beliefs, attitudes and practice or changes to policy or changes in therapeutic functions of the ward environment with direct relevance to managing individuals at risk and reducing "observations"	Bradford Refocusing model City nurses Special observations	This review identified six potential interventions for developing alternatives to enhanced observations in inpatient mental health settings: assessment, nurse autonomy, ward management initiatives, engagement and collaboration, a team approach, and intermittent observations. Relevant to this scoping review, the authors highlighted evidence from one study suggesting that the Bradford Refocusing model significantly reduced self-harm without increasing completed suicides (Dodds & Bowles, 2001), from another study showing that "city nurses" significantly reduced self-harm rates (Bowers et al., 2006), and from a third study indicating that intermittent observations were associated with significantly reduced self-harm, while constant observation had no effect on self-harm rates (Bowers et al., 2006). The authors emphasised that developing alternatives to enhanced observations is a complex task requiring careful planning. They noted a lack of empirical evidence for alternatives, and the need to review current best practices due to dissatisfaction from both patients and staff. Overall, the authors stated that the studies did not directly assess alternatives to enhanced observations, but rather focused on strategies that could reduce the need for them. They suggested that future research could evaluate these strategies in different combinations and settings and explore how successful changes can be sustained.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
De Santis et al. (2015) Title: Suicide-specific safety in the inpatient psychiatric unit Non-systematic review Number of included studies not stated	Assist psychiatric mental health nurses in advance practice, education, leadership and administration, to review and update training, policies, and procedures specific to suicide prevention in inpatient units.	Inpatient	Search strategy and eligibility criteria not stated. Focus was on suicide-related outcomes in inpatient mental health units.	No-suicide contracts Collaborative Assessment and Management of Suicidality (CAMS)	This review summarised literature on suicide-specific safety in inpatient psychiatric units, including interventions to prevent suicide. It identified relational care interventions relevant to this scoping review, including CAMS (reporting that two studies indicate that it reduces suicidality) and no-suicide contracts (reporting that there is no evidence of effectiveness in reducing suicide-related outcomes). The authors conclude that suicide prevention in inpatient psychiatric units extends beyond immediate risk reduction to include discharge planning and maintenance of reduced risk. They argue that effective suicide prevention in inpatient psychiatric services involves enhancing services, restricting access to lethal means, fostering patient collaboration, implementing best practices, addressing acute symptoms, promoting healthy coping and problem-solving skills, strengthening interpersonal connections, and ensuring compassionate care. They also stated that there is a particular need to monitor high-risk populations, such as new patients and those with unknown risk. The authors identified gaps in the evidence base, particularly regarding inpatient psychotherapeutic and multicomponent interventions, observation and monitoring strategies, and the overall effectiveness of hospitalisation in reducing suicidality.
N. Evans et al. (2022) Title: Managing suicidality in inpatient care: A rapid review. Rapid review	Identify the barriers and facilitators to implementing relational and environmental risk management approaches that address suicidality in inpatient mental health and learning disability services.	Inpatient	Searched: Academic databases for English language citations between 2009–2019 and Google searching to identify relevant policy and guideline documents. Designs: Included quantitative and qualitative research, and policies, guidance and reports Population: Inpatients in mental health and learning disability services Settings: Inpatient mental health and learning disability services Outcomes: Suicidality Interventions: Relational and environmental risk management approaches that address suicidality	Special observations No-suicide contracts Tidal model	This review examined evidence for a broad range of approaches to managing suicidality in inpatient care, not just approaches that could be considered relational care. The authors summarised that evidence indicates that regular monitoring of the environment, closer engagement, and observation according to an agreed protocol by informed nursing staff are important for managing suicidality in inpatient settings. They noted that increased engagement is particularly important at admission, and when reducing observation levels, as these are periods of higher risk. The authors emphasised the importance of standardisation, staff training, and individual patient risk formulations. They noted that research evidence has focused on locking wards, observation levels, and care planning for leave from the ward. The authors called for more research on "engagement activities" and their effectiveness. They argue that new, innovative approaches to managing suicide risk on inpatient psychiatric wards are needed that combine meaningful engagement with patient safety.
Falcone et al. (2017) Title: Taking care of suicidal patients with new technologies and reaching-out means in the post-discharge period Non-systematic review Number of included studies not stated	To understand the role of new technologies for reducing self-harm, suicide attempt, and death by suicide, while paying particular attention to post-discharge from an ED or psychiatric ward.	Inpatient and ED	Searched: Academic databases and ResearchGate Designs: Papers in English between 1977–2016. Population: Patients discharged from inpatient psychiatric wards or from an ED Setting: Psychiatric wards or EDs Intervention: New technologies (e.g., postcards/letters, text messages, crisis cards, telephone contacts, online interventions) in suicide prevention Outcomes: Self-harm and suicide attempts post-discharge, suicide deaths post-discharge	Caring letters Postcards Letters and Telephone contacts Telephone contacts Brief intervention and contact	The authors summarised that the evidence suggests that brief contact interventions (e.g., letters, green cards, phone calls, postcards) show promise in reducing repeated self-harm and/ or suicide attempts following discharge from inpatient psychiatric units or EDs. They argued that these interventions should be used in combination with standard treatments, noting that patients find them usable, effective, secure, and efficient. They called for more RCTs to explore the potential benefits of these interventions.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Finch et al. (2022) Title: A systematic review of the effectiveness of Safewards: Has enthusiasm exceeded evidence? Systematic review (13 included studies)	Examine whether Safewards is effective in reducing conflict and containment events; and improving ward climate.	Inpatient	Searched: Academic databases, grey literature (including dissertation, conference and white papers) using university search engines and dissertation repositories, Google Scholar Designs: Included journal-published quantitative, qualitative and mixed methods studies written in English Populations: Not stated Settings: Inpatient settings Outcomes: Conflict (including self-harm and suicide), containment, ward climate. Excluded studies looking at other factors (e.g., staff experiences of training or challenges with implementation) Intervention: Safewards Comparators: No restrictions stated	Safewards	The authors concluded that there is evidence showing that the Safewards model is effective in reducing conflict (including self-harm and suicide attempts), and containment (e.g., seclusion, restraint, special observations) in mental health services. However, they noted that there is insufficient high-quality empirical evidence for its effectiveness in other settings. The authors suggested that further research with robust designs and larger, more representative samples is needed to determine the effectiveness of the Safewards model across the range of other contexts in which its currently being applied.
Griffiths et al. (2022) Title: Non-restrictive interventions to reduce self-harm amongst children in mental health inpatient settings: Systematic review and narrative synthesis Systematic review (7 included papers)	To identify interventions to reduce self-harm amongst children in mental health inpatient settings that do not rely on using restrictive practices, and evidence of their effectiveness.	Inpatient	Searched: Academic databases only Designs: Included quantitative, qualitative and mixed methods primary research. Excluded reviews, case studies, single case designs, conference papers, unpublished theses. Population: Included CYP inpatients. Excluded studies where >50% of the population were over 18 years old. Settings: Included CYP inpatient mental health settings. Outcomes: Self-harm Interventions: Non-restrictive interventions designed to reduce self-harm	DBT-informed interventions Nursing twilight shift and evening activities programme Staff training in DBT and seclusion and restraint, programme to reward patient behaviour, 5 patient exercise sessions per week	This review examined interventions to reduce self-harm in inpatient mental health settings for children and young people. The authors noted that this review identified a relatively small number of relevant studies ($n = 7$). These evaluated the impact of DBT-based interventions ($n = 5$), a safe kit intervention ($n = 1$) and twilight nursing shifts with structured evening activities ($n = 1$), on self-harm in inpatient mental health settings for children and young people. Relevant to this scoping review, the authors stated that 3/5 studies on DBT-based interventions showed significant reductions in rates of self-harm, 1/5 showed significant reductions in parasuicidal behaviour in both the DBT group and a psychodynamically-informed control group, and 1/5 reported a reduction in the aggregate number of self-harm incidents. They also stated that the study evaluating twilight nursing shifts with structured evening activities reported no significant change in overall rates of self-harm, but a significant decrease in the proportion of patients engaging in self-harm. The authors stated that the studies were generally of low methodological quality, with unclear theoretical assumptions and mechanisms of change underlying the interventions. The authors stated that there is a lack of high-quality research to guide clinical practice in this area, that effective, non-restrictive interventions to reduce self-harm for children in inpatient mental health services are needed, and that their development needs to be theoretically informed and involve people with lived experience.
Helleman et al. (2014) Title: Evidence base and components of Brief Admission as an intervention for patients with borderline personality disorder: A review of the literature Systematic review (10 included papers)	To identify the key components of Brief Admission as a crisis intervention for patients with a BPD and the evidence base for the components of Brief Admission.	Inpatient	Searched: Academic databases Designs: Included quantitative studies, qualitative studies, reviews and practice reports. Excluded articles published before 1985. Populations: Patients with a BPD diagnosis Settings: Any inpatient setting where brief admission was described as being used Outcomes: Any (including self-harm and suicide) Interventions: Brief admissions for people with BPD. Excluded articles that did not describe the components of Brief Admission.	Green cards Brief Admission crisis intervention program	The authors reported that they found limited research on "Brief Admission" for BPD. They stated that key components for success included: discussion of goals of the Brief Admission with patients before admission, documented Brief Admission treatment plans, shared understanding of admission procedures, clearly described interventions, and agreed premature discharge conditions. The authors stated that the evidence suggests that Brief Admission can prevent self-harm and suicide, and promote coping skills, among patients with BPD. The authors suggested that further quantitative and qualitative research is needed to build on this evidence base, and to explore patients' experiences of Brief Admission, including its impact on patients' autonomy, empowerment, and self-management.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Huber et al. (2024) Title: The effectiveness of brief non-pharmacological interventions in emergency departments and psychiatric inpatient units for people in crisis: A systematic review and narrative synthesis Systematic review (39 included studies)	To create a taxonomy of brief non-pharmacological interventions, and review their evaluation methods and effectiveness	Inpatient and ED	Searched: Academic databases, and government health websites for references, plus key non-government organisation crisis resources Designs: Included RCTs, non-RCTs, cohort and case–control studies, case series and case reports, surveys and qualitative studies were included. Excluded all evidence syntheses, expert opinion and descriptive studies Populations: Included people in crisis presenting to emergency departments with any complaint related to mental or behavioural health, or an inpatient on a psychiatric ward experiencing self-harm thoughts/behaviours or agitation/ aggression. Excluded people with solely drug and/or alcohol presentations. Settings: Emergency departments and psychiatric wards (included treatments initiated in emergency departments and continued in inpatient settings). Excluded interventions started in the emergency department and continued in outpatient settings, and interventions in general medical wards, aged care facilities, group homes, jails, and other non-hospital settings). Outcomes: No outcome measures were excluded (therefore included both self-harm and suicide-related outcomes) Interventions: Included all primarily brief non-pharmacological interventions aimed at addressing psychiatric complaints. Incidental medication use was not an exclusion criterion. Interventions that were used during crisis admissions, even if they were not used on a crisis unit, were included. Only included clinical interventions, not processes of care pathways. Excluded interventions if medications were identified as a component of the intervention, and interventions lasting longer than a week.	Special observation No suicide contracts/ safety plans Short admissions Specialised suicide-specific therapies in the ED (including post-admission cognitive therapy, Successful Negotiation Acting Positively therapy, family-based crisis intervention)	The authors concluded that there is a significant need for high-quality research on brief non-pharmacological interventions in inpatient psychiatric units and ED settings. They stated that the current evidence base is limited, inconsistent, and lacks standardised outcome measures, making it difficult to determine which interventions are most effective for which populations. The authors reported that few interventions had consistent evidence, but that short admissions may reduce suicide attempts and readmissions when combined with psychotherapy, and suicide-specific interventions in the ED may improve depressive symptoms, but not suicide rates. The authors stated that there was evidence that brief non-pharmacological interventions do not reduce incidents of self-harm in inpatient mental health settings. They stated that they did not find any evidence supporting common practices such as no-suicide contracts, special observation, or inpatient self-harm interventions. The authors argued that while some interventions, such as "means restriction" or "special observation" are "too obviously clinically required to need evidence", all interventions carry potential risks and benefits and these need to be weighed up. They suggested that researchers need to define theories of change for interventions, align outcome measures with treatment goals, and use pre-existing frameworks to help clinicians and policymakers make informed decisions.
James, Stewart, Bowers, et al. (2012) Title: Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature Non-systematic review (88 included studies)	To examine the prevalence, characteristics, and antecedents of self-harm incidents on psychiatric wards, the measures used by wards to manage self-harm, and the experiences of psychiatric nurses.	Inpatient	Searched: Academic databases only Designs: Included empirical studies of self-harm and attempted suicide in adult psychiatric inpatient services published in English between 1960–2010. Population: Included adults, older adults, adolescents and CYP. Excluded people with a history of self-harm who did not self-harm during their inpatient stay. Settings: Included a range of inpatient mental health services (e.g., acute, forensic, PICU, rehabilitation wards). Excluded studies conducted in older adult, adolescent or CYP mental health services. Outcomes: Self-harm and attempted suicide Interventions: NA	Special observations Zero suicide contracts	The authors stated that they found that wards attempted to manage self-harm using a wide range of interventions. They noted that whilst there is some evidence to suggest that intermittent observations are effective in reducing self-harm and suicide attempt rates, there has overall been very little research into the effectiveness of these containment strategies. The authors argued that more research is needed investigating the effectiveness of management strategies and therapeutic interventions for people who self-harm in inpatient settings. They also recommended future research on the views and experiences of individuals who self-harm or attempt suicide during inpatient stays, as well as into the challenges staff face in providing support and how these challenges impact their practice. They suggested that studies should also explore differences in factors linked to self-harm and suicide attempts and develop reliable methods to distinguish between self-harm and suicidal behaviours.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Luxton et al. (2013) Title: Can post discharge follow-up contacts prevent suicide and suicidal behaviour? A review of the evidence Non-systematic review (11 included papers)	Evaluate the evidence for the effectiveness of suicide prevention interventions that involve follow-up contacts with patients	Inpatient and ED	Searched: Academic databases Designs: Included published articles Populations: Included inpatient psychiatric patients or emergency room patients being discharged home Settings: Inpatient mental health services or emergency departments Outcomes: Had to include measurement of suicidal behaviours (suicide, suicide attempts or suicidal ideation). Interventions: Follow-up interventions with at least one form of follow-up contact with patients (e.g., letters, postcards, phone calls, in-person visits, electronic contact). The contacts had to be pre-planned, systematic, directed specifically to the patient and initiated by the care providers, but not part of a larger psychotherapy or pharmacotherapy intervention.	Caring letters Postcard follow-up contacts Telephone follow-up contacts	This review included various follow-up contact interventions to prevent suicide and suicidal behaviours after discharge from inpatient mental health or ED settings, including phone, letter, postcard, in-person, and technology-based (e-mail and text) contacts. The authors concluded that repeated follow-ups appear to reduce suicidal behaviour, with 5/11 studies showing a significant reduction, 4/11 showing mixed results with trends towards a preventative effect, and 2/11 showing no effect. They recommended that future research is needed, particularly RCTs, to identify which follow-up methods are most effective.
Manna (2010) Title: Effectiveness of formal observation in inpatient psychiatry in preventing adverse outcomes: The state of the science Non-systematic review (10 included studies)	To determine whether research supports the use of formal observation as an effective strategy in preventing potential harm to patients or others; identify any therapeutic benefit; and identify gaps in the research.	Inpatient	Searched: Academic databases, American Psychiatric Association, American Psychiatric Nurses Association. Designs: No limits on study design stated. Included quantitative, qualitative and mixed methods literature. Included reviews. Population: People in psychiatric inpatient settings Setting: Psychiatric inpatient services Intervention: Observation in a psychiatric inpatient setting Outcomes: Indications for the use of observation, impact on self-harm, suicide, violence, elopements, and its positive and negative therapeutic merits. Nurses' and patients' perceptions on its usefulness and impact were also included.	Bradford Refocusing Model	This review synthesised research on the effectiveness of formal observation in preventing adverse outcomes, including self-harm and suicide, in inpatient psychiatric settings. The author noted that no RCTs were identified and that there was a lack of research on this topic. They concluded that despite formal observations being widely considered as important for maintaining safety, its efficacy in reducing patient risk (including self-harm and suicide) remains unclear, and there is no consensus around how they should be conducted.
McCabe et al. (2018) Title: Effectiveness of brief psychological interventions for suicidal presentations: A systematic review Systematic review (4 included papers)	Systematically review the effectiveness of brief psychological interventions in addressing suicidal thoughts and behaviour in healthcare settings.	ED	Searched: Academic databases Designs: Included published controlled studies (cluster randomised controlled trials, randomised controlled trials, controlled before-and-after studies and controlled pre-test/post-test designs). Excluded non-controlled studies. Population: Participants of any age and gender at risk of suicide. Excluded assisted suicide and self-harm without intent to die. Settings: Any healthcare setting (all results were from emergency departments) Outcomes: Primary outcome was suicidal ideation, using any measure. Other outcomes included: identification of suicide risk, suicide attempts, suicide, hope, patient distress and depression. Intervention: Involve interactions between professionals/ paraprofessionals (e.g., lay mental health workers, nursing assistants, educators, volunteers) and patients addressing suicidal thoughts and plans. Two-way communication (i.e., not one-way communication in the form of letters/postcards/text messages or exclusively self-guided questionnaires/instruments) between at least one professional/ paraprofessional and one patient (other people can be present). The focus must be on suicidal thoughts and plans rather than diagnostic conditions e.g., depression, anxiety, BPD. Focus on routine clinical encounters. Brief interventions (defined as up to three sessions delivered in/soon after presenting episode) which can be supplemented by further follow-up contact.	Brief intervention and contact The Attempted Suicide Short Intervention Program Teen Options for Change Safety Assessment and Follow-up Telephone Intervention Crisis intervention program	The authors concluded that, despite limited research, brief psychological interventions in ED settings appear to be effective in reducing suicide and suicide attempts, but do not impact suicidal ideation. They suggested that this is because the interventions influence behaviour rather than impacting distress levels. Studies so far have all been conducted in ED settings, but the authors suggested that these interventions could be adapted for inpatient and outpatient care. They stated that it is unclear to what extent their benefits are attributable to specific psychological techniques or increased contact frequency, warranting future research. They highlighted the potential value of early engagement and theory-based therapeutic interventions, sustained through follow-up contacts.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Mullen et al. (2022) Title: Safewards: An integrative review of the literature within inpatient and forensic mental health units Integrative review (19 included studies)	Synthesise the current knowledge and understanding about the implementation, effectiveness, acceptability of Safewards and how it meets the needs of consumers within inpatient and forensic mental health units.	Inpatient	Searched: Academic databases Designs: Included all peer-reviewed articles Populations: Inpatients in mental health settings Settings: Mental health inpatient settings (forensic and non-forensic) Outcomes: implementation outcomes (including staff acceptability), effectiveness outcomes (conflict [including self-harm and suicide attempts amongst other conflict events] and containment), consumer experiences of care Interventions: Safewards Comparators: Stated "not applicable"	Safewards	The authors concluded that evidence indicates that Safewards can be effective in reducing containment and conflict (including self-harm and suicide attempts, amongst other conflict events) in forensic and non-forensic inpatient mental health units. They highlighted limitations in fidelity measures and the need for staff involvement in implementation. The authors suggested that more research is needed to align the Safewards model with patient experiences and recovery-oriented care, which would require co-production with patients.
Navin et al. (2019) Title: Suicide prevention strategies for general hospital and psychiatric inpatients: A narrative review Non-systematic review (24 included articles)	To provide an overview of various proposed suicide prevention approaches in the general hospital, including psychiatric inpatient settings, and their evidence base.	Inpatient	Searched: Academic databases, Google Scholar Designs: Included peer-reviewed articles in English language journals. Excluded conference proceedings. Population: Patients in inpatient psychiatric or medical/surgical settings Settings: Inpatient psychiatric services or medical/surgical inpatient services Interventions: Suicide prevention approaches Outcomes: Suicide	Post-Admission Cognitive Therapy (PACT) Collaborative Assessment and Management of Suicidality (CAMS)	This review explored evidence on suicide prevention strategies in general and mental health inpatient settings. The authors found a lack of research on their effectiveness in reducing inpatient suicidal behaviours and emphasised the need for more rigorous studies. Relevant to this scoping review, they noted limited but promising evidence for psychotherapies targeting the immediate post-admission period (including PACT and CAMS) in reducing inpatient suicides. Given the ethical and methodological challenges of studying inpatient suicide as a primary outcome, they recommended that future research should focus on intermediate measures, such as staff knowledge, attitudes, and skills.
Nawaz et al. (2021) Title: Interventions to reduce self-harm on in-patient wards: Systematic review Systematic review (23 included papers)	Assess the efficacy of interventions that may be used to reduce the incidence and severity of self-harm and suicide attempts in adolescent and adult psychiatric inpatient settings.	Inpatient	Searched: Academic databases only Designs: Any study with a quantitative component. Excluded qualitative studies, commentaries and reviews. Populations: Included inpatients of all ages. Excluded people with intellectual disabilities. Settings: Included all mental health ward types (e.g., acute, adolescent, PICU, forensic). Excluded A&E, community settings, other general hospital settings. Outcomes: Self-harm and suicide Interventions: Interventions with any aim if impact on self-harm was a reported outcome	DBT Problem-solving therapy Steps to Enhance Positivity (STEPs) therapy Systems Training for Emotional Predictability and Problem Solving (STEPPS) therapy Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders Phone-based positive psychology Post-admission cognitive therapy Safewards City nurses Collaborative problem-solving training for nurses Twilight nursing shift and structured evening activities programme Bradford Refocusing model	This review identified a range of interventions to reduce self-harm or suicide in psychiatric inpatient units, including individual therapeutic approaches, and ward-based strategies aimed at improving patient-staff communication and overall ward milieu. The authors stated that DBT was the most commonly implemented and effective intervention, with 7/8 studies showing some benefit in reducing self-harm or suicide-related outcomes. They reported that evidence indicated that 3/6 ward-based interventions reduced self-harm (collaborative problem-solving training for nurses, city nurses, the Bradford Refocusing model), whereas the other three did not (a behavioural checklist and Safewards). The authors reported that both combined approaches (twilight nursing shifts with structured evening activities, and zonal nursing in a forensic setting) significantly lowered self-harm rates. The authors reported that study quality varied, and some interventions were poorly described, but none showed harmful effects. They concluded that whilst several approaches appear promising, the evidence remains too weak to recommend a specific method for reducing self-harm or suicide in inpatient psychiatric units. They recommended that more rigorous research is needed to develop effective, evidence-based strategies that provide both immediate and long-term benefits for patients.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Newton et al. (2010) Title: Paediatric suicide-related presentations: A systematic review of mental health care in the emergency department Systematic review (10 included studies)	Evaluate the effectiveness of interventions for paediatric patients with suicide-related emergency department visits.	ED	Searched: Academic databases, clinicaltrials.gov and contacted authors for unpublished research Designs: Included experimental and quasi-experimental studies. No restrictions placed on comparison groups. Population: CYP (aged < 18 years) or only partially including this age range, or parents or emergency department staff Settings: Interventions initiated in the emergency department or immediately after Outcomes: At least one clinically relevant primary outcome needed. Could be health-related (rates of self-injurious behaviour, death by suicide, suicidal ideation), parent-related (reporting of means restriction) or care-related (service-delivery, consultation, documentation) Interventions: Mental-health based, suicide-prevention focused intervention initiated in the emergency department or immediately after emergency department discharge through direct referral/enrolment	Interventions started after discharge from the ED Interventions starting in the ED and continuing post-ED	The authors reported that transition interventions (starting in the ED and continuing post-discharge) appear most promising for reducing suicide-related outcomes and improving treatment adherence. However, they noted that evidence is limited, the overall the quality of studies was low, and methods and outcomes were inconsistent across studies. The authors recommended that future research addressing these methodological limitations should be conducted to further evaluate established clinical interventions to establish their utility. They suggested that future research should include: process evaluations to determine the effectiveness of individual intervention components; well-defined control groups; differentiation of short- and long-term outcomes; multi-site studies focused on paediatric populations; and sample subsets of suicide-related behaviours (e.g., highly suicidal individuals). The authors stated that evaluating similar interventions and outcome measures across studies would make it possible to make stronger clinical recommendations.
National Institute for Health and Care Research (NICE) (2022a) Systematic review (4 included studies)	Explore how assessment for people who have self-harmed should be undertaken in specialist settings.	Mixed (specialist MH settings including inpatient, A&E, and community services)	Searched: Academic databases Designs: Included systematic reviews of RCTs or non-randomised comparative prospective and retrospective cohort studies; RCTs; non-randomised comparative prospective cohort studies with $N \geq 100$ per treatment arm; non-randomised comparative retrospective cohort studies with $N \geq 100$ per treatment arm. Excluded conference abstracts Populations: Included all people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability, who have presented to specialist mental health services. Excluded people displaying repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability Settings: Included specialist mental health settings such as community mental health services, A&E (by specialist staff), inpatient mental health settings. Excluded non-specialist settings. Outcomes: Critical outcomes: self-harm repetition (for example, self-poisoning or self-cutting); service user satisfaction (dignity, compassion and respect); suicide. Important outcomes: quality of life; initiation of safeguarding procedures; distress; engagement with after-care Interventions: Included assessment including principles of active listening; therapeutic assessment; comprehensive biopsychosocial assessment; assessment performed by different professions [e.g., psychiatric nurses], culturally sensitive assessment. Comparators: assessment not including principles of active listening, triage assessment, assessment performed by different professions [such as doctors]; uniform assessment (that is, not taking culture into account).	Therapeutic assessment	This review identified few studies comparing different models of self-harm assessment in specialist mental health settings for people who have self-harmed. The authors described how the included studies found no significant differences in self-harm outcomes between therapeutic assessment and standard assessment in adolescents, or between assessments conducted by psychiatrists and psychiatric nurses, in EDs. They reported that study quality was low or low-moderate, and that no included studies reported on suicide, quality of life, or initiation of safeguarding procedures.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Nugent et al. (2024) Title: Behavioural mental health interventions delivered in the emergency department for suicide, overdose and psychosis: A scoping review Scoping review (40 included studies)	Identify and describe evidence on brief ED-delivered behavioural and care process interventions among patients presenting with suicide attempt or acute suicidal ideation, substance overdose, or psychosis.	ED	Searched: Academic databases, ClinicalTrials.gov. Designs: Included RCTs and observational studies. Limited systematic reviews to those published in the last 7 years, but no date limits on primary research. Populations: Adults presenting to EDs or urgent care centres with suicidality (attempt or acute ideation), substance overdose, or acute psychotic symptoms (where psychosis was the primary diagnosis). Settings: EDs Interventions: Included brief mental health interventions, including screening or risk assessment; triage; referral to inpatient, residential or outpatient settings; behavioural interventions; or treatment of agitation related to substance withdrawal. Excluded legal hold interventions, medication comparative effectiveness trials, primary medical interventions and cardiopulmonary stabilisation and crisis care management of use of reversal agents. Outcomes: Included studies reporting on engagement in outpatient, residential or inpatient mental healthcare, severity of acute symptoms (e.g., suicidality), ED or urgent care outcomes, patient or staff safety outcomes (e.g., self-harm or suicide attempts) or adverse events or harms of interventions. Comparators: Not specified	Cognitive abandonment psychotherapy Cognitive behavioural therapy (CBT) Attempted Suicide Short Intervention Program (ASSIP) Brief Intervention and Contact (BIC) Telephone follow-up contacts Safety Assessment and Follow-up Telephone Intervention (SAFTI) Case management Safety Planning Intervention+ (SPI+)	The authors reported that this review found that most suicide prevention studies showed that brief psychological, psychosocial, or screening and triage interventions are effective in reducing suicide and suicide attempts following an ED visit. They stated that most clinical trial interventions were multicomponent and included at least one follow-up. However, the authors noted that existing evidence on their effectiveness is often limited by methodological inconsistencies, ethical challenges related to randomisation, and implementation barriers at the setting level. They recommended that future research should explore differences in effectiveness based on patient clinical and sociodemographic characteristics, intervention characteristics (e.g., duration, modality, family involvement) and ED setting characteristics (e.g., rural versus urban settings, bed capacity). The authors also suggested that, when a comparator is not ethical or feasible, studies should compare outcomes before and after the intervention. They also called for more consistent reporting of adverse events.
Reen et al. (2020) Title: Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards Systematic review (16 included studies)	To describe and categorise all interventions relevant to constant observations and integrate learning from these interventions to improve this widespread practice and to minimise its restrictive use on psychiatric wards.	Inpatient	Searched: Academic databases and Google Scholar Designs: Peer-reviewed studies, in English, published in any year, any country. All study designs could be included provided the other eligibility criteria are met. Studies offering recommendations on best practice of constant observation, or commentary and discussion pieces on specific interventions were excluded. Populations: Adult psychiatric inpatient populations Settings: Inpatient psychiatric wards, including acute, intensive and forensic psychiatric wards. Excluded physical health settings or services other than adult inpatient psychiatric wards. Intervention: Interventions designed to impact constant observation on an inpatient psychiatric ward. Constant observation was defined as close monitoring and supervision of patients by at least one member of clinical staff either by keeping them within eyesight or at arm's length. Interventions were even included if they were designed for an inpatient psychiatric population but not actually implemented on an inpatient psychiatric ward. Excluded interventions addressing only general observation practice or intermittent observation. Outcomes: No restrictions on included outcome measures (so included both self-harm and suicide-related outcomes) Comparators: None specified	Bradford Refocusing Model Constant observation Intermittent observation	This review examined interventions aimed at improving the quality and safety of constant observation in adult psychiatric inpatient units. The authors stated that constant observation is regularly used to manage vulnerable patients and improve their safety despite limited evidence for its efficacy and a lack of clear guidance. They also noted that constant observation can be coercive, anti-therapeutic and damaging to both patients and staff; describing quantitative evidence suggesting that it can increase rates of violent incidents, and qualitative evidence showing that patients commonly report feelings of anxiety, distress, and isolation whilst under constant observation. Relevant to this scoping review, the authors stated that there is a lack of evidence for the efficacy of constant observation and described mixed evidence for its impact on self-harm and suicide. They reported that some studies found that the Bradford Refocusing model – which replaces control-based constant observation with care-based constant observation – significantly reduced self-harm incidents. However, the authors concluded that there is no consensus on how to improve the safety and quality of constant observation or reduce its unnecessary use. They noted that studies varied widely in design, intervention, and outcome measures, and emphasised the need for further research to better understand the efficacy and risks of constant observation to ensure that future interventions are evidence-based and effectively targeted.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Thibaut et al. (2019) Title: Patient safety in inpatient mental health settings: A systematic review Systematic review (364 included studies)	Identify and synthesise the literature on patient safety within inpatient mental health settings.	Inpatient	Searched: Academic databases, Google Scholar Designs: Empirical peer-reviewed studies with a clear aim or research question, that used primary data, written in English, published between 1st Jan 1999 to 27th June 2019. Excluded secondary data, protocols, editorials, commentaries/clinical case reviews/"snapshot" studies of a patient group, book chapters, conference abstracts, audits, dissertations, epidemiological studies and reviews. No restrictions on comparators. Population: Included mental health inpatients. Excluded studies centred on physical healthcare patients. Settings: Inpatient settings. Excluded amalgamation of data from inpatient and outpatient settings (where inpatient sample cannot be separated out), primary care, outpatient mental health services, community or social care Outcomes: Patient safety outcomes (including self-harm and suicidal behaviour). Excluded studies where patient safety was not the central research question or outcome. Interventions: Excluded interventions where patient safety was not the central aim	DBT informed skills training for self-harm – "Living through distress" Peer support and DBT strategies Special observations Collaborative Management and Assessment of Suicide	This review identified and synthesised literature on patient safety, including harm to self, within inpatient mental health settings. The authors concluded that patient safety in these settings is under-researched compared to other non-mental health inpatient settings. Of relevance to this scoping review, the review included two studies investigating DBT, and one on special observations, which the authors stated all reported reductions in self-harm behaviours. It also included two studies on the CAMS approach, which they reported found significant reductions in suicide-related behaviours and cognitions. The authors argued that inpatient mental health settings present unique challenges for patient safety, which require increased investment in research, policy development, and translation into clinical practice. They highlighted that there is limited rigorous research on patient safety in inpatient mental health settings, and that further studies with large inpatient samples, appropriate intervention testing, and examining safety from different perspectives, are needed. They also emphasised the importance of high-quality research reporting, focusing particularly on sampling, setting characteristics, and ethics.
Timberlake et al. (2020) Title: Nonsuicidal self-injury: Management on the inpatient psychiatric unit Non-systematic review (9 included papers)	To review the latest research on treatment and management of non-suicidal self-injury specific for the acute inpatient psychiatric population.	Inpatient	Searched: Academic databases only Designs: Included peer-reviewed articles. Excluded abstract only/ poster presentations Population: Adolescent, young adult and adult populations. Excluded studies only focusing on CYP or older adult populations, developmentally delayed populations, psychotic disorders and traumatic brain injury populations. Settings: Included inpatient settings. Outcomes: Deliberate self-harm. Excluded studies not focusing on self-harm or that did not distinguish between non-suicidal self-harm or suicidal acts. Interventions: Any	Special observation Safety contracts Combined DBT and mentalisation-based group therapies Safewards Collaborative problem-solving nursing approach	This paper narratively reviewed strategies for treating and managing non-suicidal self-injury in inpatient mental health settings. Relevant to this scoping review, the authors summarised that therapeutic approaches showing promise in reducing non-suicidal self-injury include CBT, DBT, and mentalisation. They emphasised that effective models of care focus on strengthening therapeutic relationships between staff and patients, while fostering an internal shift towards recovery within the patient. The authors noted a lack of empirical research on this topic and called for more controlled studies in inpatient settings. Additionally, they suggested that non-suicidal self-injury should be clearly distinguished from other terms, advocating for greater clarity and precision in the terminology used in the literature.
Virk et al. (2022) Title: To synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation. Rapid review (6 included papers)	To synthesise evidence on interventions that can be implemented in the paediatric emergency department for children and adolescents presenting with suicidal ideation.	ED	Searched: Academic databases Designs: Included RCTs with any comparator published after January 2010. Excluded non-randomised controlled trials. Population: CYP aged 6–19 years old. At least 25% needed to be recruited from a paediatric emergency department. Settings: Paediatric emergency departments. Outcomes: Suicidal ideation, engagement with outpatient services, incidence of depressive symptoms, hopelessness, family empowerment, hospital admission and feasibility of interventions. Interventions: Any psychological/ psychosocial/ non-pharmacological intervention used with children or young people in the paediatric emergency department. Excluded interventions employed outside the clinical setting.	Family-based interventions Motivational interviewing	This review synthesised evidence on paediatric ED-initiated interventions, including four studies on family-based interventions and two on motivational interviewing interventions. The authors summarised that the evidence suggests that both types of interventions can be effective in reducing suicidal ideation and improving patient engagement with outpatient services. Additionally, they stated that family-based interventions initiated in the paediatric ED were found to reduce suicidality and improve family empowerment, hopelessness, and depressive symptoms. The authors noted however that the studies were generally small and varied in quality, and that further research is needed. However, they concluded that both family-based and motivational interviewing interventions can be feasibly and effectively implemented in paediatric ED settings.

(*Continued*)

Appendix G. Continued.

Author, date, title, review type	Review aim	Setting (inpatient/ emergency department)	Review scope	Relational interventions identified	Summary of authors' relevant key findings and conclusions
Ward-Stockham et al. (2022) Title: Effect of Safewards on reducing conflict and containment and the experiences of staff and consumers: A mixed-methods systematic review Systematic review (14 included studies)	To evaluate the effect of Safewards on conflict and containment events in inpatient units and the perceptions of staff and consumers	Inpatient	Searched: Academic databases, and unpublished and grey literature repositories Designs: Quantitative, qualitative or mixed methods studies Populations: Healthcare staff and inpatient consumers Settings: Any inpatient setting globally Outcomes: Rates of conflict (including self-harm and suicide attempts), rates of containment, or staff or consumer experience of safety or perspectives of Safewards Interventions: Safewards Comparators: No restrictions stated	Safewards	This review evaluated the effect of the Safewards model on conflict (including self-harm and suicide attempts, amongst other conflict events) and containment events in inpatient units, as well as staff and patient perspectives. Relevant to this scoping review, the authors stated that four studies reported reduced rates of conflict (which included self-harm and suicide attempts), while one study showed non-significant reductions. In cases where reductions were not observed, the authors stated that qualitative evidence identified barriers to implementation, such as staff resistance to change, inadequate training, and staff turnover. The authors cautioned that while reductions in conflict and containment are possible, Safewards should be implemented cautiously until more robust evidence is available. They emphasised the importance of addressing barriers to implementation and ensuring organisational commitment and support from senior staff and management for successful implementation.
Yiu et al. (2021) Title: A systematic review and meta-analysis of psychosocial interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients Systematic review and meta-analysis (10 included papers)	To examine the effectiveness of psychosocial interventions for suicide or self-harm in acute mental health inpatient settings on suicidality, self-harm (primary outcomes), depression, hopelessness, and suicide attempts (secondary outcomes).	Inpatient	Searched: Academic databases and ISRCTN Registry (trial registry) Designs: Only included RCTs Population: Included adult inpatients Settings: Inpatient mental health settings Outcomes: Self-harm and suicide were primary outcomes Interventions: Included psychosocial interventions (non-pharmacological intervention targeting psychological or social factors that can reduce self-harm and suicide in people with mental health problems)	CBT DBT Peer support and DBT strategies City nurses	This systematic review and meta-analysis examined the types and effectiveness of psychosocial interventions in inpatient settings in reducing the risk of self-harm and suicidality. The authors stated that included studies had a low to moderate risk of bias on most indicators, with the exception of participant blinding, where all studies had a high risk of bias. The authors summarised that all studies focused on suicide prevention interventions, but none targeted self-harm. They stated that most of the interventions were DBT or CBT, though these were not adapted for inpatient settings. They concluded from their meta-analysis that these psychosocial interventions were no more effective than control interventions in reducing suicidality, suicide attempts, depression, or hopelessness, either post-therapy or at follow-up. However, they noted that most of the studies were small pilot or feasibility RCTs. The authors emphasised the need for further large-scale RCTs to provide more definitive findings and recommended that future research should include studies focused on self-harm, as no RCTs on this topic were identified. Additionally, the authors argued that future research should not limit itself to adapting outpatient psychosocial interventions for inpatient use.

A&E = Accident and Emergency; BPD = Borderline Personality Disorder; CAMS = Collaborative Assessment and Management of Suicidality; CBT = Cognitive Behavioural Therapy; CYP = Children and Young People; DBT = Dialectical Behaviour Therapy; ED = Emergency Department; LGBTIQ = Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer or Questioning; NICE = National Institute for Health and Care Excellence; PACT = Post-Admission Cognitive Therapy; RCT = Randomised Controlled Trial.