

1 Quantitative evidence for relational care approaches to
2 assessing and managing self-harm and suicide risk in
3 inpatient mental health and emergency department
4 settings: a scoping review

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32 **Abstract**

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

47

48 **Keywords:** Inpatient mental health care; crisis care; acute care; emergency departments; accident
49 and emergency; relational care; safety; self-harm; suicide; risk assessment; risk management

50

51 **Introduction**

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

58

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

65

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

75

76 Given the prevalence of self-harm and suicidality in inpatient mental health and ED settings, these
77 patient groups have been identified as a priority within national suicide prevention strategies

78 (Department of Health & Social Care, 2023). Efforts to enhance their safety have been made,
79 including the implementation of varied interventions, policies and guidelines (The Royal College of
80 Emergency Medicine, 2021; University of Manchester & Healthcare Quality Improvement
81 Partnership, 2024). This includes, more recently, the use of surveillance technologies, such as vision-
82 based patient monitoring and management, body worn cameras, and closed-circuit television
83 (CCTV). However, there is a lack of evidence for their effectiveness in improving patient safety,
84 ethical concerns about their potential to negatively impact patients' human rights, privacy, dignity
85 and recovery (J. L. Griffiths et al., 2024), and a view that the application of such technologies might
86 undermine relational practice (McKeown et al., 2024). Inpatient and ED settings remain challenging
87 environments in which to deliver appropriate and effective care (Gilburt & Mallorie, 2024; McCarthy
88 et al., 2024; Østervang et al., 2022; The Royal College of Emergency Medicine, 2023).

89

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

102

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

113

114 These challenges contribute to an over-reliance in inpatient mental health and ED settings on using
115 structured risk assessments and risk stratification to assess self-harm and suicide risk, and the use of
116 restrictive practices, such as physical restraint, seclusion, rapid tranquilisation, and special
117 observations to manage concerns over risk and safety (6,22–24). This is despite research consistently
118 demonstrating the ineffectiveness of risk assessment checklists for predicting self-harm and suicide
119 risk and the potential for restrictive practices to undermine therapeutic relationships and cause
120 physical and psychological harm to patients and staff (Baker et al., 2021; James, Stewart, Wright, et
121 al., 2012; Kennedy et al., 2019; NICE, 2022). There is, therefore, a growing need for alternative
122 approaches in the assessment and management of self-harm and suicide risk in inpatient mental
123 health and ED settings.

124

125 Positive relationships between staff and the people they support are fundamental to a person-
126 centred care environment and have been identified as key to a positive culture of care in new
127 guidance for mental health inpatient services (NHS England, 2024a). Positive therapeutic
128 relationships between patients and clinicians are central to high-quality mental health care, and

129 strong, consistent predictors of positive outcomes across a range of intervention types and settings
130 (NHS England, 2024b; Priebe & McCabe, 2008; Staniszewska et al., 2019). Therapeutic relationships
131 can underpin interventions and practices and can also be “therapy in and of itself” (Priebe &
132 McCabe, 2008). Research indicates that patients value genuine listening, validation, warmth and
133 curiosity within therapeutic relationships with clinicians, and that this can help build trust and
134 facilitate disclosures about risk (Hawton & Harriss, 2008; O’Keeffe et al., 2021; Royal College of
135 Psychiatrists, 2010; Shah et al., 2024; Sunnqvist et al., 2022). There has, therefore, been an
136 increasing interest in approaches to risk assessment and management which prioritise therapeutic
137 interpersonal relationships – i.e. ‘relational’ approaches to care.

138

139 **What is ‘relational care’?**

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

151

152 For this project, a necessary working definition of ‘relational care’ within inpatient mental health and
153 ED settings was coproduced by our working group, comprising academic and lived experience
154 researchers and clinicians, as follows: “*Relational care can be practised at individual, group,*
155 *organisational or systemic levels. It prioritises interpersonal relationships grounded in values such as*

156 *respect, trust, humility, compassion, and shared humanity, and involves personalised and holistic*
157 *care, addressing power imbalances, and promoting effective collaboration between staff, patients*
158 *and their social networks.”¹*
159

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

164
165 It is important to acknowledge the tensions between practising relational care in a setting that most
166 patients experience as initially coercive and restrictive. In inpatient mental health services, there are
167 pronounced power imbalances between staff and patients, and patients have limited choice and
168 agency. Democratisation of care in these services may, therefore, be considered aspirational at
169 present. In striving for relational care, it is important to both acknowledge and take active steps
170 towards addressing these power imbalances (Kennedy et al., 2019).

171
172 The environments in which relational interactions take place are important to consider as they need
173 to be conducive to impact positively upon relational care experience, and we can conceive of
174 configurations of space and place that are systemically more likely to support relational practice

¹ When referencing this definition, please cite this paper as follows: [add citation]. 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.

175 (Lamph et al., 2023). For example, ward designs that maximise shared spaces, rather than demarcate
176 space into designated staff and patient areas, or ward and ED layouts featuring outside areas and
177 few confined spaces (Reavey et al., 2019; Shepley et al., 2016; Simonsen & Duff, 2020).

178

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

191

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

195

196 **Review objective**

197 This scoping review aimed to answer the following research question: What is the quantitative
198 evidence for the impact of ‘relational care’ in non-forensic inpatient mental health and ED settings
199 on self-harm and suicide-related outcomes?

200

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

205

206 **Materials and methods**

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

215

216 **Eligibility criteria**

217

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

220

221 **Population**

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

224

225 **Setting**

226 We included reviews that focused on care delivered within non-forensic inpatient mental health
227 settings, including acute and longer-term inpatient services, and emergency departments. We

228 excluded reviews focused on forensic inpatient mental health services, non-psychiatric medical
229 inpatient services, services specifically for people with intellectual disabilities or autistic people,
230 neurorehabilitation services, services specifically for people living with dementia, and community-
231 based services.

232

233 Intervention

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

243

244 Outcomes

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

249

250 Types of studies

251 We opted to scope published reviews rather than primary research studies, due to preliminary
252 literature searches revealing numerous existing reviews on the effectiveness of interventions for
253 assessing and managing self-harm and suicide in inpatient mental health and ED settings.

254 Quantitative and mixed-methods reviews were eligible for inclusion, including systematic, scoping,

255 integrative, rapid, and narrative reviews. Both peer-reviewed and non-peer-reviewed sources were
256 eligible for inclusion. We excluded primary research studies, books, commentaries, editorials,
257 PhD/MSc/BSc theses, opinion pieces, blog posts and social media content. We applied no date
258 restrictions but only included studies published in English. These restrictions were applied to narrow
259 our scope, ensuring this review could be completed within the required timescales.

260

261 **Literature searching**

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

266

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

276

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

280

281 **Selection of sources of evidence**

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

292

293 **Data charting and data items**

294 Two data extraction forms were developed in Microsoft Word and collaboratively revised with the
295 working group. The first summarised the eligible reviews, including their design, aims, search
296 strategies, eligibility criteria, identified relational care approaches, and paraphrased the review
297 authors' relevant key findings and overall conclusions. The second summarised each of the relevant
298 primary studies in these reviews, including information about their designs, locations, samples,
299 interventions, any control/comparison groups, and reported quantitative evidence for the impact of
300 the relational care intervention on self-harm and suicide-related outcomes. Data were extracted into
301 these forms by two researchers (JG, RS), and all entries were double-checked for accuracy.

302 Disagreements were resolved through discussion. No systematic quality appraisal of the included
303 reviews or primary studies was conducted.

304

305 **Synthesis**

306 Synthesis was led by two researchers (JG, RS), with input from the working group. The characteristics
307 and findings of the included reviews were tabulated (Appendix G) and summarised narratively.

308 Similarly, the characteristics and results of relevant primary studies within these reviews were

309 tabulated and narratively described, grouped by setting and relational care approach. Only
310 quantitative evidence for the impact of relational care approaches on self-harm or suicide-related
311 outcomes was synthesised.

312

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

316

317 **Results**

318 Database searches returned 2,424 studies. After removing duplicates, 2,118 records remained for
319 title and abstract screening. 2,064 studies were excluded, leaving 54 studies for full-text screening.

320 Additional search methods identified 18 studies. Overall, 29 reviews met our inclusion criteria and
321 were included in this scoping review. A list of studies excluded at full-text screening, with reasons for
322 their exclusion, are provided in Appendix F. Figure 1 presents the PRISMA flow diagram (Page et al.,
323 2021). A table of included review characteristics is available in Appendix G.

324

325 Characteristics of included reviews

326 All reviews identified studies by searching academic databases. Thirteen reviews also searched grey
327 literature sources (e.g., clinical trial registries, Google Scholar, ResearchGate, relevant governmental
328 and non-governmental websites, contacted authors for unpublished research) (Broadway-Horner et
329 al., 2022; N. Evans et al., 2022; Falcone et al., 2017; Finch et al., 2022; Huber et al., 2023; Manna,
330 2010; Navin et al., 2019; Newton et al., 2010; Nugent et al., 2024; Reen et al., 2020; Thibaut et al.,
331 2019; Ward-Stockham et al., 2022; Yiu et al., 2021). Search strategies and eligibility criteria were not
332 clearly stated in one review (De Santis et al., 2015).

333

334 Out of the 29 included reviews, there was one systematic review with meta-analysis (Yiu et al.,
335 2021), 14 systematic reviews without meta-analyses (Austin et al., 2024; Bloom et al., 2012;

336 Chaudhary et al., 2020; Finch et al., 2022; R. Griffiths et al., 2022; Helleman et al., 2014; Huber et al.,
337 2023; McCabe et al., 2018; National Institute for Health and Care Research (NICE), 2022; Nawaz et
338 al., 2021; Newton et al., 2010; Reen et al., 2020; Thibaut et al., 2019; Ward-Stockham et al., 2022),
339 two rapid reviews (N. Evans et al., 2022; Virk et al., 2022), one integrative review (Mullen et al.,
340 2022), two scoping reviews (Broadway-Horner et al., 2022; Nugent et al., 2024), and nine non-
341 systematic narrative reviews (Chammas et al., 2022; Cox et al., 2010; De Santis et al., 2015; Falcone
342 et al., 2017; James, Stewart, & Bowers, 2012b; Luxton et al., 2013; Manna, 2010; Navin et al., 2019;
343 Timberlake et al., 2020).

344

345 Eighteen of the reviews focused on inpatient mental health settings only (Bloom et al., 2012;
346 Chammas et al., 2022; Cox et al., 2010; De Santis et al., 2015; N. Evans et al., 2022; Finch et al., 2022;
347 R. Griffiths et al., 2022; Helleman et al., 2014; James, Stewart, & Bowers, 2012b; Manna, 2010;
348 Mullen et al., 2022; Navin et al., 2019; Nawaz et al., 2021; Reen et al., 2020; Thibaut et al., 2019;
349 Timberlake et al., 2020; Ward-Stockham et al., 2022; Yiu et al., 2021), six focused on ED settings only
350 (Austin et al., 2024; Broadway-Horner et al., 2022; McCabe et al., 2018; Newton et al., 2010; Nugent
351 et al., 2024; Virk et al., 2022), and five included inpatient and ED settings (Chaudhary et al., 2020;
352 Falcone et al., 2017; Huber et al., 2023; Luxton et al., 2013; National Institute for Health and Care
353 Research (NICE), 2022).

354

355 Eighteen reviews included self-harm and suicide as outcomes of interest (Austin et al., 2024; Bloom
356 et al., 2012; Cox et al., 2010; Falcone et al., 2017; Finch et al., 2022; Helleman et al., 2014; Huber et
357 al., 2023; James, Stewart, & Bowers, 2012b; Manna, 2010; Mullen et al., 2022; National Institute for
358 Health and Care Research (NICE), 2022; Nawaz et al., 2021; Newton et al., 2010; Nugent et al., 2024;
359 Reen et al., 2021; Thibaut et al., 2019; Ward-Stockham et al., 2022; Yiu et al., 2021), three reviews
360 included self-harm only (Broadway-Horner et al., 2022; R. Griffiths et al., 2022; Timberlake et al.,
361 2020), and eight reviews included suicide-related outcomes only (Chammas et al., 2022; De Santis et

362 al., 2015; N. Evans et al., 2022; Luxton et al., 2013; McCabe et al., 2018; Navin et al., 2019; Virk et al.,
363 2022).

364

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

373

374 Characteristics of primary papers

375 In the 29 included reviews, 87 relevant primary papers were identified, reporting on 82 primary
376 studies. 32 (39.0%) primary studies were conducted in the USA (Asarnow et al., 2011; Barley et al.,
377 1993; Bentley et al., 2017; Brown et al., 2005; Catanach et al., 2019; Celano et al., 2017; Currier et
378 al., 2010; Deykin et al., 1986; Diamond et al., 2010; Donaldson et al., 1997, 2005; Drew, 2001; Ellis et
379 al., 2012, 2015; Ercole-Fricke et al., 2016; Ghahramanlou-Holloway et al., 2020; Grupp-Phelan et al.,
380 2019; King et al., 2015; LaCroix et al., 2018; Liberman, 1981; McDonnell et al., 2010; Miller et al.,
381 2017; Motto, 1976; Motto & Bostrom, 2001; Patsiokas & Clum, 1985; Pfeiffer et al., 2019; Potter et
382 al., 2005; Rotheram-Borus et al., 1996, 2000; Springer et al., 1996; Stanley et al., 2018; Tebbett-
383 Mock et al., 2020; Wharff et al., 2019; Yen et al., 2019), 22 (26.8%) in the UK (Bennewith et al., 2014;
384 Bowers et al., 2003, 2006; Bowers, Flood, et al., 2008; Bowers, Whittington, et al., 2008; Bowers et
385 al., 2011, 2015; Dodds & Bowles, 2001; J. Evans et al., 2005; M. O. Evans et al., 1999; E. Fletcher &
386 Stevenson, 2001; Gordon et al., 2004; Guthrie et al., 2001; Haddock et al., 2019; Kapur et al., 2013;
387 Morgan et al., 1993; Ougrin et al., 2013; Reen et al., 2021; Stevenson et al., 2002; Stewart et al.,

388 2009, 2012; Stewart & Bowers, 2012; Tyrer et al., 2004), 4 (4.9%) in Ireland (Booth et al., 2014;
389 Gibson et al., 2014; McAuliffe et al., 2014; McLeavey et al., 1994), 4 (4.9%) in Germany (Bohus et al.,
390 2000, 2004; Edel et al., 2017; Kleindienst et al., 2008), 4 (4.9%) in France (Exbrayat et al., 2017;
391 Mouaffak et al., 2015; Normand et al., 2018; Vaiva et al., 2006), 3 (3.7%) in Canada (Greenfield et al.,
392 2002; Katz et al., 2004; Termansen & Bywater, 1975), 3 (3.7%) in Switzerland (Andreoli et al., 2016;
393 Berrino et al., 2011; Gysin-Maillart et al., 2016), 2 (2.4%) in Australia (Berntsen et al., 2011; Dickens
394 et al., 2020), and 1 (1.2%) each in New Zealand (Beautrais et al., 2010), French Polynesia (Amadéo et
395 al., 2015), Japan (Inui-Yukawa et al., 2021), Taiwan (Lin et al., 2020), South Korea (Shin et al., 2019),
396 Spain (Cebria et al., 2015; Cebrià et al., 2013), and Italy (Alesiani et al., 2014). One study (1.2%) had
397 sites in Brazil, India, Sri Lanka, Iran and China (Bertolote et al., 2010; Fleischmann, 2008). This shows
398 that most of the included primary studies on relational care approaches were conducted in high-
399 income countries, the majority in the USA and UK.

400

401 Overall, 49 primary papers reported on adult samples, 20 on children and young people (CYP)
402 samples, 12 on adult and CYP samples, and six did not specify the age of participants. More detailed
403 breakdowns of sample ages by primary study are provided in Table 1 and Table 2.

404

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

411

412 Thirty different relational care approaches were identified from the included reviews which had
413 been quantitatively examined in terms of their impact on self-harm and/or suicide-related outcomes
414 in inpatient mental health settings, in 46 primary papers (see Table 1 for an overview).

415

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

419

420 **[INSERT FIGURE 1]**

421

422 **[INSERT TABLE 1]**

423

424 **[INSERT TABLE 2]**

425

426 **Overall conclusions of the reviews**

427 Overall, recurrent themes in the conclusions of the reviews included: a lack of high-quality evidence
428 for the impact of these interventions on self-harm and suicide in inpatient mental health and ED
429 settings; poor descriptions of some interventions, their underlying theoretical assumptions, and
430 mechanisms of change; a lack of consistency in methods and outcomes measured across studies;
431 and a lack of lived experience involvement in the research. None of the reviews addressed how good
432 relational care may be provided for neurodivergent individuals. This is important given that they
433 often face barriers in accessing and benefiting from mental health care which can be mitigated with
434 simple, reasonable adjustments, such as communication accommodations (e.g., using simple and
435 preferred language) and environmental adjustments (e.g. reducing sensory distractions) (Pemovska
436 et al., 2024; Sofia Loizou et al., 2023). Nevertheless, the reviews did highlight some approaches with
437 some supporting evidence for a positive change in key outcomes, summarised below.

438

439 Inpatient settings

440 We identified a systematic review and meta-analysis by Yiu et al. (2021) which included 10 RCTs
441 evaluating psychosocial interventions in inpatient settings (including Cognitive Behavioural Therapy
442 (CBT), Dialectical Behaviour Therapy (DBT) and gratitude journalling) (Yiu et al., 2021). It concluded
443 that psychosocial interventions did not significantly reduce suicidal ideation or suicide attempts
444 compared to controls post-intervention (95% CI = -0.38 to 0.10; $p = 0.26$) or at follow-up (95% CI = -
445 0.15 to 0.59; $p = 0.24$) (Yiu et al., 2021). However, it only included some of the primary studies
446 identified in this scoping review, in part due to only including RCTs, whereas we included primary
447 studies of any quantitative design.

448

449 Other reviews we identified in this setting provided some evidence suggesting that the following
450 approaches can have a significant positive effect on self-harm: adapted inpatient DBT (in 9/11
451 studies) (Barley et al., 1993; Bohus et al., 2000, 2004; Booth et al., 2014; Gibson et al., 2014; Katz et
452 al., 2004; Kleindienst et al., 2008; McDonnell et al., 2010; Tebbett-Mock et al., 2020), combined DBT
453 and Mentalisation Based Therapy (MBT) (in 1/1 studies) (Edel et al., 2017), Systems Training for
454 Emotional Predictability and Problem Solving (STEPPS) therapy (in 1/1 studies) (Alesiani et al., 2014),
455 psychodynamic-oriented crisis assessment and treatment (in 1/1 studies) (Katz et al., 2004), city
456 nurses (employing a specialist nurse on each ward to help staff to adopt a low-conflict, therapy-
457 based nursing model) (in 1/2 studies) (Bowers et al., 2006; Bowers, Flood, et al., 2008), collaborative
458 problem-solving training for nurses (in 1/1 studies) (Ercole-Fricke et al., 2016), intermittent
459 observation (in 2/2 studies) (Bowers, Whittington, et al., 2008; Stewart & Bowers, 2012), and
460 twilight nursing shifts with an evening activities programme (in 1/1 studies) (Reen et al., 2021).

461 Evidence also suggested that Safewards can significantly reduce 'conflict' events (including self-harm
462 and suicide attempts amongst other conflict events) (in 2/2 studies) (Bowers et al., 2015; Dickens et
463 al., 2020).

464

465 There was also some evidence for a significant positive effect on suicide-related outcomes for
466 adapted inpatient DBT (in 4/5 studies) (Booth et al., 2014; Katz et al., 2004; Springer et al., 1996;
467 Tebbett-Mock et al., 2020), Collaborative Assessment and Management of Suicidality (CAMS) (in 2/2
468 studies) (Ellis et al., 2012, 2015), Steps to Enhance Positivity (STEPS) (in 1/1 studies) (Yen et al.,
469 2019), psychodynamic-oriented crisis assessment and treatment (in 1/1 studies) (Katz et al., 2004),
470 insight-oriented psychotherapy (in 1/1 studies) (Lieberman, 1981), a wellness and lifestyle discussion
471 group (in 1/1 studies) (Springer et al., 1996), a brief admission crisis program (in 1/1 studies) (Berrino
472 et al., 2011), intermittent observation (in 1/2 studies) (Bowers et al., 2011), and post-discharge
473 caring letters (in 1/2 studies) (Motto, 1976). Only 2/7 studies of CBT-based approaches in inpatient
474 settings, investigating STEPPS (Alesiani et al., 2014) and behavioural therapy (Lieberman, 1981),
475 showed a significant positive impact on suicide-related outcomes; the remaining studies either
476 found no significant effect (Bentley et al., 2017; Ghahramanlou-Holloway et al., 2020; Haddock et al.,
477 2019; Patsiokas & Clum, 1985) or a significant negative effect (LaCroix et al., 2018).

478

479 There was some evidence that no-suicide contracts (in 1/1 studies) (Drew, 2001), constant
480 observation (in 1/4 studies) (Bowers et al., 2003), and post-admission cognitive therapy (in 1/2
481 studies) (LaCroix et al., 2018) can have a significant negative impact on self-harm and/or suicide-
482 related outcomes in inpatient settings. Drew (2001) found that patients with no-suicide contracts
483 were significantly more likely to engage in self-harm and suicidal behaviour than those without
484 contracts. However, the authors questioned whether this association was due to patients with
485 higher risks of self-harm and suicide being more likely to be placed on contracts, rather than the no-
486 suicide contracts causing the behaviour. Similarly, Bowers et al. (2003) found a link between self-
487 harm and constant observation; however, the cross-sectional design of the study does not allow for
488 determining the direction of causality in this association. In their pilot RCT, LaCroix et al. (2018)
489 found significantly higher suicidal ideation in individuals receiving post-admission cognitive therapy
490 compared to enhanced usual care controls, though there was no significant difference in suicide

491 reattempts. The authors noted that their analysis was limited by low statistical power due to their
492 small sample size and argued that further, well-powered multisite RCTs are needed to more
493 rigorously assess the therapy's efficacy in reducing suicidal behaviour.

494

495 Emergency department settings

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

503

504 There was evidence that some approaches initiated in the ED and continued post-ED discharge can
505 significantly improve suicide-related outcomes, including: Safety Assessment and Follow-up
506 Telephone Intervention (SAFTI) (in 1/1 studies) (Miller et al., 2017), Safety Planning Intervention with
507 follow-up (SPI+) (in 1/1 studies) (Stanley et al., 2018), brief intervention and contact (BIC) (in 1/2
508 studies) (Bertolote et al., 2010; Fleischmann, 2008), a rapid response outpatient team (in 1/1
509 studies) (Greenfield et al., 2002) and assertive case management (in 1/1 studies) (Inui-Yukawa et al.,
510 2021).

511

512 There was also some evidence suggesting that the following relational care approaches initiated
513 post-ED discharge significantly improve suicide-related outcomes: CBT-based interventions (in 2/5
514 studies) (Brown et al., 2005; Donaldson et al., 2005), non-directive supportive relationship treatment
515 (in 1/1 studies) (Donaldson et al., 2005), brief psychodynamic interpersonal therapy (in 1/1 studies)
516 (Guthrie et al., 2001), abandonment psychotherapy (in 1/1 studies) (Andreoli et al., 2016),

517 Attachment-Based Family Therapy (ABFT) (in 1/1 studies) (Diamond et al., 2010), the Attempted
518 Suicide Short Intervention Program (ASSIP) (in 1/1 studies) (Gysin-Maillart et al., 2016), case
519 management (in 1/1 studies) (Shin et al., 2019), and telephone follow-up contacts (in 4/6 studies)
520 (Cebria et al., 2015; Cebrià et al., 2013; Exbrayat et al., 2017; Termansen & Bywater, 1975; Vaiva et
521 al., 2006).

522

523 Some relational care approaches, including Family Intervention for Suicide Prevention (FISP), a
524 mobile crisis team (Currier et al., 2010), a specialised direct service for youths (Deykin et al., 1986),
525 Suicidal Teens Accessing Treatment after an ED visit (STAT-ED) (Grupp-Phelan et al., 2019), Teen
526 Options for Change (TOC) (King et al., 2015), a crisis card with telephone follow-up contacts
527 (Mouaffak et al., 2015), therapeutic assessment (Ougrin et al., 2013), Successful Negotiation Acting
528 Positively (SNAP) therapy (Rotheram-Borus et al., 1996; 2000), and Family-Based Crisis Intervention
529 (FBCI) (Wharff et al., 2019) were found to have no significant effect on suicide-related outcomes.

530 The impact of the remaining relational care approaches on suicide-related outcomes were either not
531 investigated or not significance tested.

532

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

542

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

546

547 **Discussion**

548

549 **Key findings**

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

558

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

566

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

580

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

592 one controlled study suggested that combined telephone and letter follow-up contacts could
593 significantly worsen self-harm and suicide-related outcomes.

594

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

601

602 **Challenges defining 'relational care'**

603 As identified earlier, the term 'relational care' is not widely used within inpatient mental health
604 academic research. This is despite the concept having a longstanding history and underpinning many
605 clinical approaches in mental health, including in inpatient and ED settings (Bolsinger et al., 2020;
606 NHS England, 2022; Priebe & McCabe, 2008). Reviews on 'relational care' in a mental health context
607 are only just beginning to emerge. For example, Lamph et al. (in prep) are conducting a conceptual
608 analysis of 'relational practice', drawing upon global, cross-sector papers to report some of its key
609 components.

610

611 The concept of 'relational care' also extends beyond mental healthcare; it has been described and
612 applied across a range of other contexts, including education, criminal justice, and social work. For
613 example, in social work, 'relational-based practice' is seen as core to social workers' interactions and
614 roles, and it is also cited within a variety of mental health nursing education texts (Hewitt et al., n.d.;
615 Peplau, 1952; Watkins, 2001). Whilst the concept of relational care exists across different sectors,
616 there is variation in how it is defined and understood by clinicians and service users. For example,
617 different professions have different perspectives on what 'relational care' means and how it can be

618 applied in their work, shaped by their professional identities and philosophical and training
619 backgrounds. ‘Relational care’ can be understood and applied differently depending on cultural,
620 contextual, and individual factors. This variability makes it difficult to define, operationalise and
621 research.

622

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

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

633

634 **Difficulties in measuring self-harm and suicide outcomes**

635 Evaluating the impact of any intervention on self-harm and suicide rates in inpatient and ED settings
636 is a challenge. While highly important, it must be considered that the numbers of suicides on
637 inpatient wards remains, thankfully, a relatively rare occurrence (University of Manchester &
638 Healthcare Quality Improvement Partnership, 2024). As a result, it is difficult to evaluate the impact
639 of any intervention on preventing suicides without conducting large-scale studies on multiple wards
640 (e.g., Bowers, Whittington et al., 2008). Furthermore, the nature of suicidality and reasons people
641 may engage in self-harming behaviours, as well as self-harm methods, are vast, variable, and may
642 change drastically over time, making them difficult to measure. It can also be challenging to
643 distinguish suicidal and non-suicidal self-injury (Samari et al., 2020). Whilst frequency of self-injury is

644 a crude outcome measure, accounting for self-injury severity risks creating a problematic and
645 potentially invalidating hierarchy of methods. The private nature of self-harm also means it is
646 unlikely to be accurately measured. More restrictive approaches may keep people safer in the short
647 term but cause long-term harm, such as physical and psychological injury, dehumanisation, erosion
648 of trust between patients and staff, and (re)traumatisation (Baker et al., 2021; Cusack et al., 2018).
649 There is a need to be person-centred when approaching these topics, as what works to help keep
650 some patients safe may be problematic for others. There is no standard 'one size fits all' approach
651 for everyone and all services.

652

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

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

664

665 Approaches that have an indirect impact on self-harm and suicide, including interventions aimed at
666 changing ward cultures and environment may, therefore, be overlooked within these reviews. Such
667 approaches include evidence-based approaches such as Safewards (Dickens et al., 2020; Finch et al.,
668 2022; J. Fletcher et al., 2017) and the Assured intervention (Shah et al., 2024). Other approaches
669 include Open Dialogue (Freeman et al., 2019; *The ODESSI Trial*, 2024), therapeutic communities

670 (Campling, 2001; Malivert et al., 2012), and Enabling Environments (*Enabling Environments (EE)*,
671 2024). These examples offer valuable insights into the potential benefits of relational care
672 interventions, values, and practices which address systemic and cultural factors affecting self-harm
673 and suicide risk management.

674

675 **Barriers and facilitators to implementing relational care approaches in these settings**

676 While this scoping review found evidence for the use of some relational care approaches within
677 inpatient and ED settings to reduce suicide and self-harm, it is important to acknowledge that
678 consistently and effectively implementing relational care in these contexts is difficult. Whilst
679 implementing complex interventions in any real-world setting is inherently challenging and requires
680 careful consideration of active and dynamic factors that either facilitate or hinder implementation
681 (Laker et al., 2019; Nilsen & Birken, 2020), these specialist settings introduce additional unique
682 barriers.

683

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

695

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

705

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

712

713 Finally, it is crucial to remember that these are contexts where there are significant risks. Getting
714 things wrong can have severe consequences, including physical and psychological harm to patients,
715 devastation to families, and severe distress to staff. In ED settings, there is often a disproportionate
716 focus on mental health presentations as the cause of violence and aggression. This can contribute to
717 staff difficulty distinguishing clinical distress and agitation from actual violence and aggression,
718 increasing staff anxiety and leading to a reliance on restrictive interventions to manage risk, thereby
719 hindering the implementation of relational care. Front-facing staff in ED and inpatient settings who
720 spend the most time with patients often receive the least training, are the lowest paid, and receive
721 the least supervisory support (e.g., supervision and reflective practice). This can result in high levels

722 of burnout and moral injury amongst staff (Williamson et al., 2021). Furthermore, staff face pressure
723 from hospital management, external regulatory agencies, and coroners to document risk
724 assessments. This is in addition to the already substantial burden of administrative tasks, monitoring
725 and reporting required of staff, which reduces time available for direct clinical care. These pressures
726 faced by staff can hinder their ability to effectively implement person-centred, relational care and
727 drive an over-reliance on risk assessment tools and restrictive practices, despite their ineffectiveness
728 in managing risk (University of Manchester & Healthcare Quality Improvement Partnership, 2018).

729

730 **Strengths and limitations**

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

737

738 However, this report also has some limitations. Firstly, we did not register a protocol a priori for this
739 review. Future studies should consider protocol registration to enhance transparency and
740 reproducibility. Secondly, due to time constraints, we did not systematically search grey literature.
741 This may have limited the scope of the literature identified. However, many of the reviews that we
742 identified did search grey literature (e.g., pre-print servers, Google Scholar, relevant websites, policy
743 documents) more comprehensively. Thirdly, in line with PRISMA guidelines (Tricco et al., 2018), we
744 did not conduct any formal quality appraisal, limiting the certainty of conclusions about the strength
745 of the evidence identified. Fourthly, although we conducted independent double screening of all
746 sources at title/abstract and a subsample of full texts, we did not perform formal double
747 independent data extraction. However, all extracted data were double-checked for accuracy. Finally,

748 qualitative evidence was not included in our synthesis due to time limitations. Further research
749 incorporating it could provide insight into patient, staff and family/carer experiences and views of
750 relational care approaches and, subjectively, what makes a positive difference (Berzins et al., 2020;
751 Dewa et al., 2018).

752

753 **Implications for research, policy and practice**

754 The current lack of a consistent definition of 'relational care' poses a significant challenge for both
755 research and practice. Future research could aim to clarify the meaning of 'relational care', its core
756 components, and develop a clear framework for its consistent application and evaluation.

757 Conceptualisations of 'relational care' should consider the influence of culture and context, including
758 how it intersects with the needs of marginalised groups, such Black and ethnic minority groups,
759 those facing language barriers, autistic individuals, and people with intellectual disabilities. This is
760 crucial given the inequities that these groups experience in terms of access, experiences, and
761 outcomes in acute mental healthcare (Al Shamsi et al., 2020; Bauer & Alegría, 2010; Feinstein &
762 Holloway, 2002; Freitas et al., 2023; Miteva et al., 2022; NHS England, 2023, 2024b; NHS England
763 Digital, 2024). However, the consideration of culture and context should not be limited to
764 marginalised groups; it should be a universal consideration for all patients, staff, services, and
765 healthcare systems.

766

767 Further research is needed to evaluate the impact of relational care approaches on quality and
768 safety in inpatient mental health and ED settings, including more large-scale RCTs and studies
769 evaluating long-term outcomes (NHS England, 2024b). This includes research examining the impact
770 of relational care on self-harm and suicide, as well as on other important outcomes such as
771 psychological safety, self-neglect, physical health, iatrogenic harms, staff safety and wellbeing,
772 therapeutic alliance, engagement with services (e.g., length of stay, readmission rates, other service
773 use), and treatment satisfaction. Economic evaluations taking these broader outcomes into account

774 are also needed; cost-effectiveness evidence is important for shaping policy and practice. Further
775 research co-produced with patients, families/carers, staff, policymakers, and commissioners is
776 needed to ensure research addresses the priorities of these key stakeholders.

777

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

785

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

793

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

800

801 **Conclusion**

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

811

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

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

817

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

825

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

829

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

833

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

838

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

844

845 A key cultural challenge to relational ways of working, is the reliance on coercive practices, which
846 sits diametrically opposite relational ways of working. Widespread and controversial use of control
847 and restraint in inpatient services is a point of ongoing debate and campaigning within mental
848 health, with the United Nations Convention on the Rights of Persons with Disabilities being an
849 important rallying point for us and our allies. It argues for a move away from biomedical coercive
850 approaches to ones which could be broadly defined as 'relational'. But will it be possible to

851 mainstream a relational approach in the current system, or can it only ever be tokenistic, given the
852 nature of the mental health system?

853

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

860

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866

867 **Disclosure statement**

868 The authors report there are no competing interests to declare.

869

870 **Data availability statement**

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

872

873 **Ethics approval and consent to participate**

874 Not applicable.

875

876 **Consent for publication**

877 Not applicable.

878

879 **Acronyms**

880 A&E = Accident and Emergency

881 ABFT = Attachment-Based Family Therapy

882 ASSIP = The Attempted Suicide Short Intervention Program

883 BPD = Borderline Personality Disorder

884 BIC = Brief Intervention and Contact

885 CAMS = Collaborative Assessment and Management of Suicidality

886 CBSP = Cognitive-Behavioural Suicide Prevention Therapy

887 CBT = Cognitive Behaviour Therapy

888 CCTV = Closed-Circuit Television

889 CYP = Children and Young People

890 DBT = Dialectical Behaviour Therapy

891 ED = Emergency Department

892 FBCI = Family-Based Crisis Intervention

893 FISP = Family Intervention for Suicide Prevention

894 HCP = Healthcare Professional

895 IISPT = Interpersonal Problem-Solving Skills Training

896 ISRCTN = International Standard Randomised Controlled Trial Number

897 LGBTIQ = Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning

898 MACT = Manual-Assisted Cognitive Behaviour Therapy

899 MBT = Mentalisation-Based Therapy

900 MHPRU = Policy Research Unit in Mental Health

901 NHS = National Health Service

902 NIHR = National Institute for Health and Care Research

- 903 NICE = National Institute for Health and Care Excellence
- 904 NSSI = Non-Suicidal Self Injury
- 905 RCT = Randomised Controlled Trial
- 906 SAFTI = Safety Assessment and Follow-Up Telephone Intervention
- 907 SNAP = Successful Negotiation Acting Positively therapy
- 908 SPI+ = Safety Planning Intervention with follow-up
- 909 STAT-ED = Suicidal Teens Accessing Treatment After an Emergency Department Visit
- 910 STEPPS = Systems Training for Emotional Predictability and Problem Solving therapy
- 911 STEPS = Steps to Enhance Positivity therapy
- 912 TOC = Teen Options for Change
- 913 UK = United Kingdom
- 914 USA = United States of America
- 915

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- 918 relational-
- 919 care/#:~:text=Relational%20care%20is%20an%20approach,%2C%20and%20psychological%2
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1616 Woodnutt, S., Hall, S., Libberton, P., Flynn, M., Purvis, F., & Snowden, J. (2024). Analysis of England’s
1617 incident and mental health nursing workforce data 2015–2022. *Journal of Psychiatric and
1618 Mental Health Nursing*, jpm.13027. <https://doi.org/10.1111/jpm.13027>

1619 Yen, S., Ranney, M. L., Tezanos, K. M., Chuong, A., Kahler, C. W., Solomon, J. B., & Spirito, A. (2019).
1620 Skills to Enhance Positivity in Suicidal Adolescents: Results From an Open Development Trial.
1621 *Behavior Modification*, 43(2), 202–221. <https://doi.org/10.1177/0145445517748559>
1622 Yiu, H. W., Rowe, S., & Wood, L. (2021). A systematic review and meta-analysis of psychosocial
1623 interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients.
1624 *Psychiatry Research*, 305, 114175. <https://doi.org/10.1016/j.psychres.2021.114175>
1625
1626

1627 **Appendices**

1628 **Appendix A:** Definitions drawn upon in coproducing a working definition of ‘relational care’

Source	Definition
<p>Lamph et al. (2023)</p> <p><i>(Systematic review of ‘relational practice’ in health, education, criminal justice and social care)</i></p>	<p><u>Relational practice</u>: “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”</p>
<p>Royal College of General Practitioners (2021)</p> <p><i>(Report on what ‘relationship-based care’ is and why it is important in the context of General Practitioners)</i></p>	<p><u>Relationship-based care</u>: “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.”</p>
<p>See Think Act: Your Guide to Relational Security (2010)</p> <p><i>(Guide to relational security)</i></p>	<p><u>Relational security</u>: “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.”</p>
<p>Novy et al. (2022)</p> <p><i>(A meta-ethnography of relational care, dementia and communication challenges in long-term care)</i></p>	<p><u>Relational care</u>: “a bidirectional process, one in which the agency of both people – those who give and receive are – is recognised (Tronto, 1993)”.</p>
<p>3 Trees Care and Support (2023)</p>	<p><u>Relational care</u>: “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.</p>

<p>Trevillion et al. (2022)</p> <p><i>(Coproducted qualitative interview study exploring service user perspectives of community mental health services for people with complex emotional needs)</i></p>	<p><u>Relational practice</u>: “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”.</p>
<p>Wilson et al. (2021)</p> <p><i>(Literature review of Māori models of health to create an Indigenous Māori-centred model of relational health)</i></p>	<p><u>Relational care</u>: “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.”</p>
<p>Pene et al. (2023)</p> <p><i>(A scoping review conceptualising relational care from an indigenous Māori perspective)</i></p>	<p>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).</p>
<p>Emmamally et al. (2022)</p> <p><i>(A scoping review of in-hospital interventions to promote relational practice with families in acute care settings)</i></p>	<p><u>Relational practice</u>: “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 2008). 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</p>

	families to grow.”
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1631 **Appendix B:** Expanded definition of ‘relational care’ co-produced by our working group of academic
1632 and lived experience researchers and clinicians
1633
1634 Relational care can be practised at individual, group, organisational or systemic levels. It relates to
1635 how care is delivered, rather than the specific content or format of interventions. Relational care
1636 prioritises interpersonal relationships, acknowledging their central role in effective treatment and
1637 recovery. It is grounded in values such as respect, dignity, empathy, humility, authenticity,
1638 compassion, empowerment, trust, and shared humanity. Relational care is guided by principles that
1639 include: understanding individuals within the context of their lives, providing personalised and
1640 holistic care, promoting cultural safety, fostering effective communication, believing in patients and
1641 inspiring hope. It is also guided by the principle of democratisation – actively involving patients and
1642 the people close to them (e.g., family, friends, partners) in decisions about their care and the
1643 functioning of the care environment. This requires power imbalances to be acknowledged and
1644 addressed.
1645

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 3
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 4-9
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 conceptualize the review questions and/or objectives.	Page 9
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.	Pages 10-11
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 11-12
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.	Page 12
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.	Pages 12-13
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Pages 12-13
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

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	Page 13
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 13 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 13-16, 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 13-20, 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 13-20
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 21-27
Limitations	20	Discuss the limitations of the scoping review process.	Page 28
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.	Page 30
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 33

1648 From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for
1649 Scoping Reviews (PRISMA ScR): Checklist and Explanation. *Ann Intern Med.* 2018;169:467–473. [doi:](https://doi.org/10.7326/M18-0850)
1650 [10.7326/M18-0850](https://doi.org/10.7326/M18-0850).

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1652 **Appendix D:** Inclusion and exclusion criteria for reviews in this report

	Included	Excluded
Population	<ul style="list-style-type: none"> • Mental health patients (of any age, ethnicity, sex, or gender) 	<ul style="list-style-type: none"> • Reviews only including staff or family/carers, or non-mental health patients
Intervention/approach	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • 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/controls	<ul style="list-style-type: none"> • Reviews examining any comparator/control groups were eligible to be included • Reviews of studies with no comparator/control groups 	<ul style="list-style-type: none"> • None
Outcomes	<ul style="list-style-type: none"> • Self-harm (e.g., frequency, severity) • Suicide (e.g., suicidal ideation, suicide attempt frequency, time to suicide attempts, completed suicides) 	<ul style="list-style-type: none"> • Risk to others • Risk from others • Other patient outcomes • Staff outcomes • Carer outcomes
Setting	<ul style="list-style-type: none"> • Non-forensic inpatient mental health settings (including acute and longer-term inpatient services) • Emergency departments 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Reference	Reason for exclusion
Babeva, K., Hughes, J. L., & Asarnow, J. (2016). Emergency Department Screening for Suicide and Mental Health Risk. <i>Current psychiatry reports</i> , 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. <i>Journal of psychiatric and mental health nursing</i> , 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. <i>Journal of education and health promotion</i> , 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. <i>The Cochrane database of systematic reviews</i> , 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. <i>Journal of affective disorders</i> , 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?]. <i>L'Encephale</i> , 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. <i>General hospital psychiatry</i> , 63, 152–157. https://doi.org/10.1016/j.genhosppsy.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. <i>Journal of psychosomatic research</i> , 119, 53–64. https://doi.org/10.1016/j.jpsychores.2019.01.013	Wrong outcome
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. <i>International journal of nursing studies</i> , 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?. <i>Journal of mental health (Abingdon, England)</i> , 22(6), 570–574.	Wrong study type

https://doi.org/10.3109/09638237.2013.841877	
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 <i>Annales Médico-Psychologiques</i> (Vol. 169, No. 4, pp. 221-228). Elsevier Publishing.	Non-English language
Lynch, M. A., & Matthews, J. M. (2008). Assessment and management of hospitalized suicidal patients. <i>Journal of Psychosocial Nursing & Mental Health Services</i> , 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. <i>International journal of mental health nursing</i> , 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. <i>Journal of psychosocial nursing and mental health services</i> , 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. <i>Emergency Medicine Journal</i> , 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. <i>Psychiatrische Praxis</i> , 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. <i>Journal of EMDR Practice and Research</i> , 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. <i>Journal of the American Psychiatric Nurses Association</i> , 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. <i>Focus</i> , 21(1), 8-17.	Wrong outcome
Price, N. (2007). Improving emergency care for patients who self harm. <i>emergency nurse</i> , 15(8).	Wrong study type
Puntill, 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. <i>Journal of the American Psychiatric Nurses Association</i> , 19(4), 205-210.	Wrong study type
Repper, J. (1999). A review of the literature on the prevention of suicide	Wrong setting

through interventions in accident and emergency departments. <i>Journal of Clinical Nursing</i> , 8(1), 3-12.	
Reynolds, E. K., Gorelik, S., Kook, M., & Kellermeyer, K. (2020). Acute psychiatric care for pediatric patients. <i>International Review of Psychiatry</i> , 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. <i>The Journal of emergency medicine</i> , 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. <i>BJPsych Open</i> , 8(3), e94.	Wrong outcome
Zhang, R. W. (2022). Evidence-based suicide screening and prevention protocol for licensed nursing staff: a systematic literature review and recommendations. <i>Journal of psychosocial nursing and mental health services</i> , 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. URL: 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. URL: 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. URL: 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. URL: 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	Wrong intervention

for risk assessment and formulation. NICE guideline number NG225. URL: https://www.nice.org.uk/guidance/ng225/evidence/g-risk-assessment-and-formulation-pdf-11196377252	
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. URL: 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. URL: 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. URL: 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. URL: 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. URL: 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. URL: 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. URL: 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	Wrong outcome

<p>assessment, management and preventing recurrence. [Q] Evidence reviews for supervision required for staff in specialist mental health settings. NICE guideline number NG225. URL: https://www.nice.org.uk/guidance/ng225/evidence/t-models-of-care-for-people-who-have-selfharmed-pdf-403069580857</p>	<p>(only included qualitative studies)</p>
<p>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. URL: https://www.nice.org.uk/guidance/ng225/evidence/t-models-of-care-for-people-who-have-selfharmed-pdf-403069580857</p>	<p>Wrong setting (broad, not focused on inpatient psychiatric or emergency department settings)</p>

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
<p>Austin et al. (2024)</p> <p><u>Title:</u> Improving emergency department care for adults presenting with mental illness: a systematic review of strategies and their impact on outcomes, experience, and performance</p> <p>Systematic review</p> <p>(46 included studies)</p>	<p>Synthesise the research evidence associated with strategies used to improve ED care delivery outcomes, experience, and performance for adults presenting with mental illness.</p>	<p>ED</p>	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> Included empirical peer-reviewed research articles. Excluded literature reviews, conference posters or abstracts, grey literature and case reports. Only included articles published in English.</p> <p><u>Population:</u> 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.</p> <p><u>Setting:</u> Included EDs. Excluded interventions conducted primarily in the pre-hospital, post-hospital or a ward/clinic setting other than the ED.</p> <p><u>Outcomes:</u> Included measures of system performance (e.g., waiting time, length of stay, time to treatment/assessment, admissions, referrals), patient outcomes (e.g.,</p>	<p>Assertive case management</p>	<p>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.</p>

			<p>self-harm, suicide-related outcomes, readmission, adverse events, medical errors, missing diagnoses, pain, quality of life), patient experience, or staff experience.</p> <p><u>Intervention:</u> Implemented models of care or system changes. Excluded studies that did not report an intervention, or that screened presentations without intervention in the ED.</p> <p><u>Comparators:</u> Usual care or other form of care.</p>		
<p>Bloom et al. (2012)</p> <p><u>Title:</u> Use of Dialectical Behavior Therapy in Inpatient Treatment of Borderline Personality Disorder: A Systematic Review</p> <p>Systematic review</p> <p>(11 included papers)</p>	<p>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.</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases only</p> <p><u>Designs:</u> Included published, peer-reviewed empirical studies.</p> <p><u>Population:</u> Patients with a diagnosis of BPD or self-reported recent suicidal or out-of-control behaviours.</p> <p><u>Settings:</u> Inpatient settings</p> <p><u>Outcomes:</u> 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</p>	<p>DBT</p>	<p>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.</p>

			<p>disturbance.</p> <p><u>Interventions:</u> 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.</p>		
<p>Broadway-Horner et al. (2022)</p> <p><u>Title:</u> Psychological therapies and non-suicidal self-injury in LGBTIQ in accident and emergency departments in the UK: a scoping review</p> <p>Scoping review (7 included papers)</p>	<p>To recognize and assess the results from all studies including randomized 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.</p>	ED	<p><u>Searched:</u> Academic databases and Google Scholar</p> <p><u>Designs:</u> Only included RCTs. Excluded studies included in Hawton et al. (1998).</p> <p><u>Population:</u> 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.</p> <p><u>Settings:</u> Included A&E departments in the UK. Excluded studies with no A&E involvement.</p> <p><u>Outcomes:</u> Included repetition of non-suicidal self-harm behaviour. Excluded studies focusing on</p>	<p>Manual-assisted cognitive therapy (MACT)</p> <p>Brief psychodynamic interpersonal therapy</p> <p>Crisis cards</p>	<p>The authors stated that this review found a lack of evidence on the most effective treatments for non-suicidal self-injury by overdosing in LGBTIQ 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.</p>

			suicide. <u>Interventions:</u> Psychiatric and psychological therapy treatments		
Chammas et al. (2022) <u>Title:</u> 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	<u>Searched:</u> One academic database (PubMed) <u>Designs:</u> No inclusion or exclusion criteria stated. <u>Populations:</u> Inpatient mental health populations. No restrictions specified. <u>Settings:</u> Inpatient mental health services <u>Outcomes:</u> Suicide-related outcomes <u>Interventions:</u> Suicide prevention measures in inpatient mental health services <u>Comparators:</u> 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) <u>Title:</u> Suicide during Transition of Care: a Review of Targeted Interventions	Summarise the evidence for interventions providing care during the first few weeks after discharge from a healthcare facility	Inpatient and ED	<u>Searched:</u> Academic databases <u>Designs:</u> 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	Green cards Caring letters Postcards Letter and telephone contact Telephone contacts Brief Intervention and Contact (BIC)	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

<p>Systematic review</p> <p>(40 included studies)</p>	<p>(when risk of suicide is highest).</p>		<p>papers, abstract-only articles, book chapters and news articles.</p> <p><u>Population:</u> People discharged from a medical facility to the community. No restriction on race, place, sex, age, ethnicity.</p> <p><u>Setting:</u> Not stated.</p> <p><u>Intervention:</u> Interventions targeting suicidal behaviours after discharge from a medical facility.</p> <p><u>Outcomes:</u> Suicide-related outcomes</p>	<p>Family Intervention for Suicide Prevention (FISP)</p> <p>Mobile crisis team intervention</p>	<p>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.</p>
<p>Cox et al. (2010)</p> <p><u>Title:</u> Alternative approaches to 'enhanced observations' in acute inpatient mental health care: a review of the literature</p> <p>Non-systematic review</p> <p>(5 included papers)</p>	<p>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.</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases only</p> <p><u>Designs:</u> Included empirical papers. Excluded non-empirical papers.</p> <p><u>Populations:</u> Not specified</p> <p><u>Settings:</u> Included acute inpatient mental health settings. Excluded prisons, forensic mental health settings, or any other permanently locked inpatient mental healthcare setting.</p> <p><u>Outcomes:</u> Range of outcomes reported (including suicide and self-harm rates)</p> <p><u>Interventions:</u> Alternative</p>	<p>Bradford Refocusing model</p> <p>City nurses</p> <p>Special observations</p>	<p>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., 2007).</p> <p>The authors emphasised that developing alternatives to enhanced observations is a complex task requiring</p>

			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'		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.
De Santis et al. (2015) <u>Title:</u> 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) <u>Title:</u> Managing suicidality in inpatient care: a rapid review. The Journal of Mental Health Training, Education and Practice 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	<u>Searched:</u> Academic databases for English language citations between 2009-2019 and Google searching to identify relevant policy and guideline documents. <u>Designs:</u> Included quantitative and qualitative research, and policies, guidance and reports <u>Population:</u> Inpatients in mental health and learning disability services <u>Settings:</u> Inpatient mental health and learning disability services <u>Outcomes:</u> Suicidality <u>Interventions:</u> Relational and environmental risk management approaches that address suicidality	Special observations	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.
				No-suicide contracts	
				Tidal model	
Falcone et al. (2017) <u>Title:</u> Taking care of suicidal patients with new technologies and reaching-out means in the post-discharge period Non-systematic	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	<u>Searched:</u> Academic databases and ResearchGate <u>Designs:</u> Papers in English between 1977-2016. <u>Population:</u> Patients discharged from inpatient psychiatric wards or from an ED <u>Setting:</u> Psychiatric wards or EDs <u>Intervention:</u> New technologies	Caring letters	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.
				Postcards	
				Telephone contacts	
				Letters and telephone contacts	
				Telephone contacts	
				Brief intervention and contact	

review Number of included studies not stated			(e.g., postcards/letters, text messages, crisis cards, telephone contacts, online interventions) in suicide prevention <u>Outcomes:</u> Self-harm and suicide attempts post-discharge, suicide deaths post-discharge		
Finch et al. (2022) <u>Title:</u> 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	<u>Searched:</u> Academic databases, grey literature (including dissertation, conference and white papers) using university search engines and dissertation repositories, Google Scholar <u>Designs:</u> Included journal-published quantitative, qualitative and mixed methods studies written in English <u>Populations:</u> Not stated <u>Settings:</u> Inpatient settings <u>Outcomes:</u> 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) <u>Intervention:</u> Safewards <u>Comparators:</u> 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.	To identify interventions to reduce self-harm	Inpatient	<u>Searched:</u> Academic databases only	DBT-informed interventions Nursing twilight shift and evening activities	This review examined interventions to reduce self-harm in inpatient mental health settings for children and young people. The authors noted that this review

<p>(2022)</p> <p><u>Title:</u> Non-restrictive interventions to reduce self-harm amongst children in mental health inpatient settings: Systematic review and narrative synthesis</p> <p>Systematic review</p> <p>(7 included papers)</p>	<p>amongst children in mental health inpatient settings that do not rely on using restrictive practices, and evidence of their effectiveness.</p>		<p><u>Designs:</u> Included quantitative, qualitative and mixed methods primary research. Excluded reviews, case studies, single case designs, conference papers, unpublished theses.</p> <p><u>Population:</u> Included CYP inpatients. Excluded studies where >50% of the population were over 18 years old.</p> <p><u>Settings:</u> Included CYP inpatient mental health settings.</p> <p><u>Outcomes:</u> Self-harm</p> <p><u>Interventions:</u> Non-restrictive interventions designed to reduce self-harm</p>	<p>programme</p> <p>Staff training in DBT and seclusion and restraint, programme to reward patient behaviour, 5 patient exercise sessions per week</p>	<p>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.</p> <p>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.</p>
<p>Helleman et al. (2014)</p> <p><u>Title:</u> Evidence base and components of Brief Admission</p>	<p>To identify the key components of Brief Admission as a crisis intervention for patients with a BPD and the evidence base for the</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> Included quantitative studies, qualitative studies, reviews and practice reports. Excluded articles published before 1985.</p>	<p>Green cards</p> <p>Brief Admission crisis intervention program</p>	<p>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</p>

<p>as an intervention for patients with borderline personality disorder: a review of the literature</p> <p>Systematic review</p> <p>(10 included papers)</p>	<p>components of Brief Admission.</p>		<p><u>Populations:</u> Patients with a BPD diagnosis</p> <p><u>Settings:</u> Any inpatient setting where brief admission was described as being used</p> <p><u>Outcomes:</u> Any (including self-harm and suicide)</p> <p><u>Interventions:</u> Brief admissions for people with BPD. Excluded articles that did not describe the components of Brief Admission.</p>		<p>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.</p>
<p>Huber et al. (2023)</p> <p><u>Title:</u> The effectiveness of brief non-pharmacological interventions in emergency departments and psychiatric inpatient units for people in crisis: A systematic review and narrative synthesis</p> <p>Systematic review</p> <p>(39 included studies)</p>	<p>To create a taxonomy of brief non-pharmacological interventions, and review their evaluation methods and effectiveness</p>	<p>Inpatient and ED</p>	<p><u>Searched:</u> Academic databases, and government health websites for references, plus key non-government organisation crisis resources</p> <p><u>Designs:</u> 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</p> <p><u>Populations:</u> 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</p>	<p>Special observation</p> <p>No suicide contracts/safety plans</p> <p>Short admissions</p> <p>Specialised suicide-specific therapies in the ED (including post-admission cognitive therapy, Successful Negotiation Acting Positively therapy, family-based crisis intervention)</p>	<p>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</p>

		<p>people with solely drug and/or alcohol presentations.</p> <p><u>Settings:</u> 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).</p> <p><u>Outcomes:</u> No outcome measures were excluded (therefore included both self-harm and suicide-related outcomes)</p> <p><u>Interventions:</u> 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</p>		<p>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.</p>
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James et al. (2012)	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	<p><u>Searched:</u> Academic databases only</p> <p><u>Designs:</u> Included empirical studies of self-harm and attempted suicide in adult psychiatric inpatient services published in English between 1960-2010.</p> <p><u>Population:</u> Included adults, older adults, adolescents and CYP. Excluded people with a history of self-harm who did not self-harm during their inpatient stay.</p> <p><u>Settings:</u> 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.</p> <p><u>Outcomes:</u> Self-harm and attempted suicide</p> <p><u>Interventions:</u> NA</p>	<p>Special observations</p> <p>Zero suicide contracts</p>	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.
<p>Title: Self-harm and attempted suicide within inpatient psychiatric services: a review of the literature</p> <p>Non-systematic review</p> <p>(88 included studies)</p>					
Luxton et al. (2013)	Evaluate the evidence for the effectiveness of	Inpatient and ED	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> Included published articles</p>	<p>Caring letters</p> <p>Postcard follow-up contacts</p>	This review included various follow-up contact interventions to prevent suicide and suicidal behaviours after discharge from inpatient mental

<p><u>Title:</u> Can post discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence</p> <p>Non-systematic review</p> <p>(11 included papers)</p>	<p>suicide prevention interventions that involve follow-up contacts with patients</p>		<p><u>Populations:</u> Included inpatient psychiatric patients or emergency room patients being discharged home</p> <p><u>Settings:</u> Inpatient mental health services or emergency departments</p> <p><u>Outcomes:</u> Had to include measurement of suicidal behaviours (suicide, suicide attempts or suicidal ideation).</p> <p><u>Interventions:</u> 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.</p>	<p>Telephone follow-up contacts</p>	<p>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.</p>
<p>Manna (2010)</p> <p><u>Title:</u> Effectiveness of formal observation in inpatient psychiatry in preventing adverse outcomes: the</p>	<p>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</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases, American Psychiatric Association, American Psychiatric Nurses Association.</p> <p><u>Designs:</u> No limits on study design stated. Included quantitative, qualitative and mixed methods literature. Included reviews.</p> <p><u>Population:</u> People in psychiatric</p>	<p>Bradford Refocusing Model</p>	<p>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.</p>

<p>state of the science</p> <p>Non-systematic review</p> <p>(10 included studies)</p>	<p>the research.</p>		<p>inpatient settings</p> <p><u>Setting:</u> Psychiatric inpatient services</p> <p><u>Intervention:</u> Observation in a psychiatric inpatient setting</p> <p><u>Outcomes:</u> 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.</p>		
<p>McCabe et al. (2018)</p> <p><u>Title:</u> Effectiveness of brief psychological interventions for suicidal presentations: a systematic review</p> <p>Systematic review</p> <p>(4 included papers)</p>	<p>Systematically review the effectiveness of brief psychological interventions in addressing suicidal thoughts and behaviour in healthcare settings.</p>	<p>ED</p>	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> 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.</p> <p><u>Population:</u> Participants of any age and gender at risk of suicide. Excluded assisted suicide and self-harm without intent to die.</p> <p><u>Settings:</u> Any healthcare setting (all results were from emergency departments)</p> <p><u>Outcomes:</u> Primary outcome was</p>	<p>Brief intervention and contact</p> <p>The Attempted Suicide Short Intervention Program</p> <p>Teen Options for Change</p> <p>Safety Assessment and Follow-up Telephone Intervention</p> <p>Crisis intervention program</p>	<p>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.</p>

			<p>suicidal ideation, using any measure. Other outcomes included: identification of suicide risk, suicide attempts, suicide, hope, patient distress and depression.</p> <p><u>Intervention:</u> 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.</p>		
<p>Mullen et al. (2022)</p> <p><u>Title:</u> Safewards: An integrative review of the</p>	<p>Synthesize the current knowledge and understanding about the implementation, effectiveness,</p>	Inpatient	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> Included all peer-reviewed articles</p> <p><u>Populations:</u> Inpatients in mental</p>	Safewards	<p>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</p>

<p>literature within inpatient and forensic mental health units</p> <p>Integrative review</p> <p>(19 included studies)</p>	<p>acceptability of Safewards and how it meets the needs of consumers within inpatient and forensic mental health units.</p>		<p>health settings</p> <p><u>Settings:</u> Mental health inpatient settings (forensic and non-forensic)</p> <p><u>Outcomes:</u> implementation outcomes (including staff acceptability), effectiveness outcomes (conflict [including self-harm and suicide attempts amongst other conflict events] and containment), consumer experiences of care</p> <p><u>Interventions:</u> Safewards</p> <p><u>Comparators:</u> Stated 'not applicable'</p>		<p>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.</p>
<p>Navin et al. (2019)</p> <p><u>Title:</u> Suicide Prevention Strategies for General Hospital and Psychiatric Inpatients: A Narrative Review</p> <p>Non-systematic review</p> <p>(24 included articles)</p>	<p>To provide an overview of various proposed suicide prevention approaches in the general hospital, including psychiatric inpatient settings, and their evidence base.</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases, Google Scholar</p> <p><u>Designs:</u> Included peer-reviewed articles in English language journals. Excluded conference proceedings.</p> <p><u>Population:</u> Patients in inpatient psychiatric or medical/surgical settings</p> <p><u>Settings:</u> Inpatient psychiatric services or medical/surgical inpatient services</p> <p><u>Interventions:</u> Suicide prevention approaches</p>	<p>Post-Admission Cognitive Therapy (PACT)</p> <p>Collaborative Assessment and Management of Suicidality (CAMS)</p>	<p>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.</p>

			<u>Outcomes:</u> Suicide		
Nawaz et al. (2021) <u>Title:</u> 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	<u>Searched:</u> Academic databases only <u>Designs:</u> Any study with a quantitative component. Excluded qualitative studies, commentaries and reviews. <u>Populations:</u> Included inpatients of all ages. Excluded people with intellectual disabilities. <u>Settings:</u> Included all mental health ward types (e.g., acute, adolescent, PICU, forensic). Excluded A&E, community settings, other general hospital settings. <u>Outcomes:</u> Self-harm and suicide <u>Interventions:</u> 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.
Newton et al. (2010) <u>Title:</u> Pediatric suicide-related presentations: a systematic review	Evaluate the effectiveness of interventions for paediatric patients with suicide-related emergency department visits.	ED	<u>Searched:</u> Academic databases, clinicaltrials.gov and contacted authors for unpublished research <u>Designs:</u> Included experimental and quasi-experimental studies. No restrictions placed on comparison	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

<p>of mental health care in the emergency department</p> <p>Systematic review</p> <p>(10 included studies)</p>			<p>groups.</p> <p><u>Population:</u> CYP (aged < 18 years) or only partially including this age range, or parents or emergency department staff</p> <p><u>Settings:</u> Interventions initiated in the emergency department or immediately after</p> <p><u>Outcomes:</u> 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)</p> <p><u>Interventions:</u> Mental-health based, suicide-prevention focused intervention initiated in the emergency department or immediately after emergency department discharge through direct referral/enrolment</p>		<p>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.</p>
<p>National Institute for Health and Care Research (NICE) (2022)</p> <p>Systematic review</p>	<p>Explore how assessment for people who have self-harmed should be undertaken in specialist settings?</p>	<p>Mixed (specialist MH settings including inpatient, A&E, and community services)</p>	<p><u>Searched:</u> Academic databases</p> <p><u>Designs:</u> Included systematic reviews of RCTs or non-randomised comparative prospective and retrospective cohort studies; RCTs; non-randomised comparative prospective cohort studies with</p>	<p>Therapeutic assessment</p>	<p>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</p>

<p>(4 included studies)</p>		<p>N≥100 per treatment arm; non-randomised comparative retrospective cohort studies with N≥100 per treatment arm. Excluded conference abstracts</p> <p><u>Populations:</u> 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</p> <p><u>Settings:</u> Included specialist mental health settings such as community mental health services, A&E (by specialist staff), inpatient mental health settings. Excluded non-specialist settings.</p> <p><u>Outcomes:</u> 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</p>		<p>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.</p>
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			<p><u>Interventions:</u> Included assessment including principles of active listening; therapeutic assessment; comprehensive biopsychosocial assessment; assessment performed by different professions [e.g., psychiatric nurses], culturally sensitive assessment.</p> <p><u>Comparators:</u> 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).</p>		
<p>Nugent et al. (2024)</p> <p><u>Title:</u> Behavioural mental health interventions delivered in the emergency department for suicide, overdose and psychosis: a scoping review</p> <p>Scoping review</p> <p>(40 included studies)</p>	<p>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.</p>	ED	<p><u>Searched:</u> Academic databases, ClinicalTrials.gov.</p> <p><u>Designs:</u> Included RCTs and observational studies. Limited systematic reviews to those published in the last 7 years, but no date limits on primary research.</p> <p><u>Populations:</u> 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).</p> <p><u>Settings:</u> EDs</p> <p><u>Interventions:</u> Included brief mental</p>	<p>Cognitive abandonment psychotherapy</p> <p>Cognitive behaviour therapy (CBT)</p> <p>Attempted Suicide Short Intervention Program (ASSIP)</p> <p>Brief Intervention and Contact (BIC)</p> <p>Telephone follow-up contacts</p> <p>Safety Assessment and Follow-up Telephone Intervention (SAFTI)</p> <p>Case management</p> <p>Safety Planning Intervention+ (SPI+)</p>	<p>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</p>

			<p>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.</p> <p><u>Outcomes:</u> 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.</p> <p><u>Comparators:</u> Not specified</p>		<p>the intervention. They also called for more consistent reporting of adverse events.</p>
Reen et al. (2020)	To describe and categorize all	Inpatient	<p><u>Searched:</u> Academic databases and Google Scholar</p>	<p>Bradford Refocusing Model Constant observation</p>	<p>This review examined interventions aimed at improving the quality and safety of constant</p>

<p><u>Title:</u> Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards</p> <p>Systematic review</p> <p>(16 included studies)</p>	<p>interventions relevant to constant observations and integrate learning from these interventions to improve this widespread practice and to minimize its restrictive use on psychiatric wards.</p>		<p><u>Designs:</u> 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.</p> <p><u>Populations:</u> Adult psychiatric inpatient populations</p> <p><u>Settings:</u> Inpatient psychiatric wards, including acute, intensive and forensic psychiatric wards. Excluded physical health settings or services other than adult inpatient psychiatric wards.</p> <p><u>Intervention:</u> 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</p>	<p>Intermittent observation</p>	<p>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.</p> <p>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.</p>
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			<p>interventions addressing only general observation practice or intermittent observation.</p> <p><u>Outcomes:</u> No restrictions on included outcome measures (so included both self-harm and suicide-related outcomes)</p> <p><u>Comparators:</u> None specified</p>		
<p>Thibaut et al. (2019)</p> <p><u>Title:</u> Patient safety in inpatient mental health settings: a systematic review</p> <p>Systematic review</p> <p>(364 included studies)</p>	<p>Identify and synthesise the literature on patient safety within inpatient mental health settings.</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases, Google Scholar</p> <p><u>Designs:</u> 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.</p> <p><u>Population:</u> Included mental health inpatients. Excluded centres on physical healthcare patients.</p> <p><u>Settings:</u> Inpatient settings. Excluded amalgamation of data</p>	<p>DBT informed skills training for self-harm – 'Living through distress'</p> <p>Peer support and DBT strategies</p> <p>Special observations</p> <p>Collaborative Management and Assessment of Suicide</p>	<p>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.</p>

			<p>from inpatient and outpatient settings (where inpatient sample cannot be separated out), primary care, outpatient mental health services, community or social care</p> <p><u>Outcomes:</u> Patient safety outcomes (including self-harm and suicidal behaviour). Excluded studies where patient safety was not the central research question or outcome.</p> <p><u>Interventions:</u> Excluded interventions where patient safety was not the central aim</p>		
<p>Timberlake et al. (2020)</p> <p><u>Title:</u> Nonsuicidal Self-Injury: Management on the Inpatient Psychiatric Unit</p> <p>Non-systematic review</p> <p>(9 included papers)</p>	<p>To review the latest research on treatment and management of non-suicidal self-injury specific for the acute inpatient psychiatric population.</p>	Inpatient	<p><u>Searched:</u> Academic databases only</p> <p><u>Designs:</u> Included peer-reviewed articles. Excluded abstract only/poster presentations</p> <p><u>Population:</u> 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.</p> <p><u>Settings:</u> Included inpatient settings.</p> <p><u>Outcomes:</u> Deliberate self-harm. Excluded studies not focusing on self-harm or that did not distinguish</p>	<p>Special observation</p> <p>Safety contracts</p> <p>Combined DBT and mentalisation-based group therapies</p> <p>Safewards</p> <p>Collaborative problem-solving nursing approach</p>	<p>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.</p>

			between non-suicidal self-harm or suicidal acts. <u>Interventions:</u> Any		
Virk et al. (2022) <u>Title:</u> 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	<u>Searched:</u> Academic databases <u>Designs:</u> Included RCTs with any comparator published after January 2010. Excluded non-randomised controlled trials. <u>Population:</u> CYP aged 6-19 years old. At least 25% needed to be recruited from a paediatric emergency department. <u>Settings:</u> Paediatric emergency departments. <u>Outcomes:</u> Suicidal ideation, engagement with outpatient services, incidence of depressive symptoms, hopelessness, family empowerment, hospital admission and feasibility of interventions. <u>Interventions:</u> 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.
Ward-Stockham et al. (2022)	To evaluate the effect of Safewards on conflict and	Inpatient	<u>Searched:</u> Academic databases, and unpublished and grey literature repositories	Safewards	This review evaluated the effect of the Safewards model on conflict (including self-harm and suicide attempts, amongst other conflict events) and

<p><u>Title:</u> Effect of Safewards on reducing conflict and containment and the experiences of staff and consumers: A mixed-methods systematic review</p> <p>Systematic review</p> <p>(14 included studies)</p>	<p>containment events in inpatient units and the perceptions of staff and consumers</p>		<p><u>Designs:</u> Quantitative, qualitative or mixed methods studies</p> <p><u>Populations:</u> Healthcare staff and inpatient consumers</p> <p><u>Settings:</u> Any inpatient setting globally</p> <p><u>Outcomes:</u> Rates of conflict (including self-harm and suicide attempts), rates of containment, or staff or consumer experience of safety or perspectives of Safewards</p> <p><u>Interventions:</u> Safewards</p> <p><u>Comparators:</u> No restrictions stated</p>		<p>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.</p>
<p>Yiu et al. (2021)</p> <p><u>Title:</u> A systematic review and meta-analysis of psychosocial interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients</p> <p>Systematic review and meta-analysis</p>	<p>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).</p>	<p>Inpatient</p>	<p><u>Searched:</u> Academic databases and ISRCTN Registry (trial registry)</p> <p><u>Designs:</u> Only included RCTs</p> <p><u>Population:</u> Included adult inpatients</p> <p><u>Settings:</u> Inpatient mental health settings</p> <p><u>Outcomes:</u> Self-harm and suicide were primary outcomes</p> <p><u>Interventions:</u> Included psychosocial interventions (non-pharmacological</p>	<p>CBT</p> <p>DBT</p> <p>Peer support and DBT strategies</p> <p>City nurses</p>	<p>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.</p>

(10 included papers)			intervention targeting psychological or social factors that can reduce self-harm and suicide in people with mental health problems)		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.
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A&E = Accident and Emergency; BPD = Borderline Personality Disorder; CBT = Cognitive Behaviour 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; RCT = Randomised Controlled Trial.

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
<i>Dialectical behaviour therapy-based approaches</i>					
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
<i>Cognitive behaviour therapy-based approaches</i>					
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
Liberian & Eckman (1981)*	RCT	Behavioural therapy	Adults	Not measured	Positive
Patsiokas & Clum (1985)*	RCT	Cognitive restructuring	Not reported	Not measured	Not significant
		Problem-solving therapy (PST)		Not measured	Not significant
<i>Other psychological approaches</i>					

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
Lieberman & 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
Stewart & 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 & Bowles (2001)	Pre-post without controls	Bradford Refocusing model	Adults	No significance testing	No significance testing
Fletcher & 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); Motto & 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) (Yiu et al., 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.

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 (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 (IISPT)	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
<i>On demand access to crisis support</i>					
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
<i>Follow-up contacts only</i>					
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); Cebrià 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 & 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
<i>Other approaches</i>					
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

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Figure 1. PRISMA flow diagram

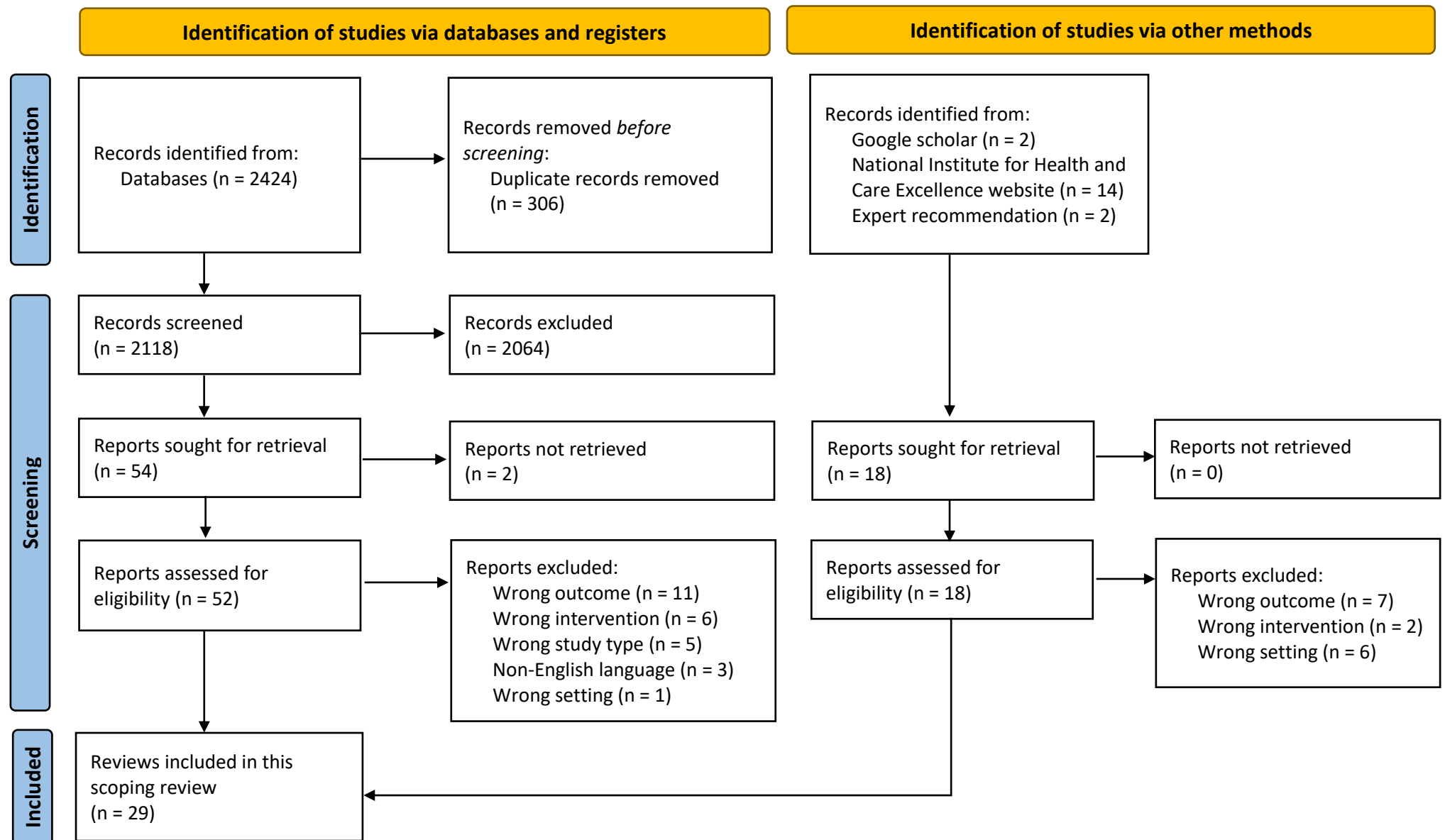


Figure captions

Figure 1. PRISMA flow diagram.