Self-harm and Suicide Prevention Competence Framework

Community and public health

National Collaborating Centre for Mental Health

Self-harm and Suicide Prevention Competence Framework: Community and public health

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Authorship Statement

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1. About the competence framework

There is an increasing focus on addressing the needs of people who [self-harm](#) and/or are [suicidal](#). This framework aims to ensure that these people are supported in line with best practice when they come into contact with a broad range of individuals who can help. These could be mental health specialists or other specialist professionals who can undertake preventive interventions. Others will come from a wider workforce (e.g. teachers, youth workers, police officers, volunteers). While these individuals are highly experienced in their own area, they will not be expected to be able to deliver advanced mental health interventions. However, they do have an important role to play in self-harm and suicide prevention, particularly around signposting and providing support.

This document describes a competence framework for self-harm and suicide prevention for people of all ages living in the community. It brings together the evidence of 'what works' in this area across these diverse settings. It identifies the knowledge and skills needed by both individuals and organisations in the wider workforce to prevent self-harm and suicide. It is intended to support training and enhance practice.

1.1. Competence and competence frameworks

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

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

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

1.2. Self-harm and suicide prevention competence frameworks

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

This document focuses on the competences relevant to self-harm and suicide prevention in the community, for people of all ages. An overview of the relevant areas of competence will be provided here.

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

A further background document has been written for people who might receive support for self-harm or suicidal thoughts. This aims to inform people of the help they can expect from different individuals or professionals when talking about their self-harm, suicidal thoughts or distress. This document can be downloaded from https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework.

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

Amanda Tuffrey
Expert by Experience, 2018

2.   Background

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

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

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

The frameworks have a range of applications, supporting:

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

2.1. Scope of the frameworks and relationships between them

Three frameworks have been developed. The first two focus on children and young people aged 8–18 and adults aged 18 and upwards, and the competences they describe will be most relevant to health and social care professionals, some of whom will have mental health

expertise. However, professionals working with the public across all spheres of civic life, including health and social care, education, the voluntary and community sector and more, may also encounter people at risk of self-harm and/or suicide. These professionals may not have knowledge of mental health and their responsibility for helping a person may be limited to immediate support rather than long-term care. This separate competence framework has been developed, therefore, with a focus on working with the wider public. Although there is considerable overlap across the three frameworks in terms of their structure, they address different contexts and audiences, and so their content has been adapted to the needs of their target audience.

2.1.1. The current framework

The current framework is aimed at the broad range of individuals working with the community and in public health contexts, who may come into contact with people who self-harm and/or are suicidal. These individuals include teachers, police, transport workers, employers, staff and many others. The framework will also apply to those who have a designated suicide prevention role within an organisation. They may not be specialists in mental health, but they do have responsibility for the identification, prevention and management of self-harm and suicide.

Although most of the competences in the framework describe the work of individual professionals, other parts identify what an organisation needs to do in order to support people and ensure that they can work effectively. This is particularly important for the framework for working with the community and public health, where organisational support is fundamental in identifying which aspects of the framework are relevant and acknowledging what will be done to implement it.

2.1.2. Population and specialist public health frameworks

This competence framework is aimed at professionals who work with individuals in need. It is not aimed at specialist public health or population health professionals. The Public Mental Health Content Guide[5] published by HEE outlines the broader skills and knowledge that might be required for public health specialists.

3. How the competences were identified

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

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

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

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

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

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[a] The National Institute for Health and Care Excellence (NICE) provide national evidence-based guidance and advice for health, public health and social care professionals on how to improve health, public health and social care services, as well as quality standards for people who commission these services.

4. Scope of the work

4.1. Audience

This competence framework is intended for, and may be used by, all people who work within the community, as well as the organisations in which they work. Individuals and organisations may wish to use the competences to inform their current approaches and practice around working with people who self-harm and/or are suicidal, or to develop training around self-harm and suicide prevention. Not all competences will be relevant to all staff, so staff, employers and wider organisations should pay attention to the competences that are most relevant to them.

Domains	Constituents include
Frontline non-clinical staff and volunteers who work with people at risk of self-harm and suicide	Staff, organisations and providers in: • Transport services, particularly rail • The police, including British Transport Police • Welfare settings, including homeless shelters, supported housing, housing associations and care homes • Voluntary and community sector services
Other non-clinical staff and organisations involved in self-harm and suicide prevention	• Head teachers, teachers and support staff in primary, secondary, further and higher education • Employers, senior managers and human resource teams of high-risk organisations • Organisations working with at-risk populations (this includes voluntary and voluntary and community sector organisations) • Organisations that develop and deliver self-harm and suicide prevention and intervention training
Other/public	• Local authorities implementing their own suicide prevention plans • People who currently harm, or have previously harmed, themselves • People who currently feel, or have previously felt, suicidal • The families, carers and support networks of people who self-harm and/or are suicidal • People bereaved by suicide, including family, carers, significant others, friends and colleagues • The public

This framework is largely relevant for professionals who may come into contact with a person who has self-harmed or is suicidal within the wider community. This means these professionals or individuals are likely to be the first points of contact for these people. This framework identifies the skills and knowledge required to support people in the community, however it does not contain the more specialist competences that health and social care professionals, including primary care practitioners, might require to care for a person or keep them safe in the long-term. These sets of competences can be found in the framework for

working with adults and older adults, and the framework for working with children and young people.

4.2. Populations

This competence framework is applicable across a wide age range and is relevant to individuals who work with children and young people, as well as adults and older adults.

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

4.2.1. Advancing mental health equality

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

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

Additionally, it was noted that some people may find it difficult to access services or engage with interventions because of the social determinants of their distress, such as socioeconomic status, employment status, housing status, financial problems and many other social issues. All professionals should work collaboratively with the relevant agencies to address social issues that contribute to distress. This will also help to ensure that the person can engage with the support and care that is available to them.

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

Further information about advancing mental health equality through practice can be found in the Professional competences for individual workers section of this document and in the competence framework itself.

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[b] An Equalities Impact Assessment is a process that is carried out to ensure that the project or piece of work being completed does not discriminate against people who are already disadvantaged or vulnerable.

5. The competence framework for self-harm and suicide prevention in the community

5.1. Issues relevant to supporting people who have self-harmed and/or are suicidal

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

5.1.1. Working collaboratively with the person

All work with people who self-harm and/or are suicidal should be undertaken collaboratively. This means developing trusting working relationships from the outset that enable people to make choices and share decision-making around the way they wish to be supported, empowering individuals and helping them feel that they have control over their life and any decisions that are made about them.

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

Stella Branthonne-Foster
Expert by Experience, 2018

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

If assessments and intervention plans are a part of a professional's role, these should reflect a collaborative process between the professional, the person and (according to the person's wishes) their family, carers or significant others. This collaborative relationship should be reflected in the development of a shared language that accurately reflects the way the person understands their own problems and care. Without a collaborative approach, people can feel that interventions are imposed on them, which then increases the risk of disengagement.[6]

5.1.2. Person-centred rather than protocol-centred

People who have self-harmed and/or are suicidal can sometimes experience their support or care from professionals as being 'protocol driven' rather than personalised (for example, being taken through a standardised set of questions or checklists that the organisation uses to assess risk). Negative attitudes of staff or the public towards self-harm may also contribute to this experience.[7][8] This can be alienating and distressing for the person, which may lead to them disengaging from any form of support.

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

Stella Branthonne-Foster
Expert by Experience, 2018

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

5.1.3. Sharing information with families, carers and significant others

Families, carers and significant others who have been bereaved by the suicide of a loved one commonly report that health and social care professionals often seem reluctant to share information about a person's risk of suicide. If professionals who work in the community have longer term contact with a person, they may also need to make decisions about whether to share information with a person's family, carers and significant others. If a person has capacity to make decisions and does not pose a risk to themselves or others, then professionals have a duty to maintain confidentiality. However, when supporting a person at risk of suicide, there will be circumstances and situations where professionals may need to engage a person's family, carers or significant others in order to help keep the person safe. Although initially developed with health and social care professionals in mind, the [Consensus statement on information sharing and suicide prevention](#),[9] developed by the Department of Health with a number of medical colleges and professional bodies, sets out best practice that can be applied by all professionals. This includes routinely discussing with the person whether they would like their family, carers or significant others to be involved, how they might like them to be involved, and whether this

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

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

has changed over time. In the absence of these advance discussions, a professional judgement must be made based on the person's understanding, mental capacity, their previously expressed wishes and what is in their best interests. Professional judgement should then guide what information is disclosed, along with the urgency of the disclosure.

For children and young people under the age of 18, the position on information sharing is clearer than for adults. Professionals still have the same duties of confidentiality as with adults when sharing information, but information can be shared if this will protect a child or young person from risk of death or serious harm. In these cases, professionals can disclose information to an appropriate person or authority and will make a judgement on whether to share this information with the family, carers or significant others (which would usually be the case).

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

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

> *Although a patient's right to confidentiality is paramount, there are instances where professionals sharing information – with consent – with a person's trusted family or friends could save their life. Stronger action needs to be taken to raise awareness of the Consensus statement, to train staff in this area (including training on how to seek consent), and to engender a culture shift away from the current presumption that suicidal patients will not want their family or friends to be involved in their recovery.*
>
> Suicide Prevention: Interim Report. House of Commons Health Committee (2016)

5.1.4. Managing transitions between services

Transitions in care may represent periods of risk for people who self-harm and/or are suicidal. For a person who is being supported in the community or the wider public by individuals or an organisation that is not healthcare focused, this may happen when a professional refers them to a statutory health service for further support, care and treatment. Given that discontinuation of care can often happen during transitions, a person can be lost within the system unless transitions are anticipated and well-planned.. This is particularly true for transitions from children and young people's organisations, such as schools or colleges, into adult health care services if the young person is of a certain age,[10][11] but it may also be seen in a person's transitions between statutory services and voluntary and community sector services, or community organisations.

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

with the receiving service, support the person in whichever ways are appropriate, and monitor the success of the transition.

It should be noted that if a young person is going through a transition from a children and young people's health service into an adult health service, it is likely that this transition will coincide with other transitions in the young person's life, for example moving away to university and other challenges associated with early adulthood. During these times, a young person should be supported as much as possible by the people within their community to access help where they need it, especially as such lifestyle changes may mean moving to a new geographical area and, subsequently, a new and unfamiliar network of support. This might require additional support from university staff or other community groups as a person settles into their new lifestyle.

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

Amanda Tuffrey
Expert by Experience, 2018

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

5.1.5. Relationship between self-harm and suicide

The relationship between self-harm and suicide is complicated. Although people who self-harm are significantly more likely to die by suicide or to harm themselves using more serious methods than the general population who do not self-harm, people have many motivations for self-harm and are not always intent on dying.[12] Suicidal intent may not be evident early on, but often emerges over time.[13]

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

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

5.1.6. Risk assessment

When working with people who have self-harmed or who experience suicidal thoughts, it may seem clear that the person's current level of risk to themselves or others should be assessed. However, while there are many factors associated with risk, evidence indicates that our ability to accurately predict risk is limited.[14] [15] This means that, if professionals are

involved in assessing risk, it is possible both to over-estimate and also to under-estimate the actual risk of suicide in a person at a given moment in time. Research suggests that if attempting to predict risk, professionals should move away from prediction to focusing on the needs of the person and seeing assessment as a way of informing management rather than as a stand-alone activity.[16]

In many settings, including those where professionals may work with the public, risk classification scales and risk assessment tools are widely used when assessing risk. Using these in addition to discussions may make sense, as they can provide a helpful structure and prompt the person who is completing the assessment to ask about current feelings and motivations. However, using tools and scales in isolation from a broader discussion with the person about their life as a whole can be both misleading and possibly unhelpful. As well as the evidence suggesting that risk assessment tools and scales do not have predictive value,[14][15] their use can also cause the person to disengage from support. One reason for this is that these tools tend to be in a checklist format, which means that people may be asked about matters that are not relevant to them, and may not be given the opportunity to raise matters of personal significance. This can contribute to feelings of not being listened to or not having an open space in which to discuss concerns.

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

In this framework, the emphasis is on a collaborative assessment of risk, needs and strengths, which engages a person in a meaningful dialogue that helps them to consider their difficulties, the context in which these difficulties arise and the resources available to help keep them safe. As indicated by the structure of the competence framework map (see Figure 1), assessment of risk, needs and strengths is not a stand-alone activity. To be most helpful, it should be combined with some structured support. This can include, for example, a safety plan, sharing plans with others, reducing access to lethal means and supporting them to access the best available evidence-based treatment to meet the needs of that person.

5.1.7. Postvention

'Postvention' refers to interventions aimed at supporting people who have been directly affected by a death by suicide. These interventions should take the form of individualised support for those who have been affected by a person's death. This includes any interventions or signposting offered within an organisation, such as a workplace, school or university, where groups of individuals are offered support and the opportunity to express their feelings regarding the death of a colleague or fellow student. As with exposure to any traumatic event, many individuals may be able to draw on their own strengths and support

networks, but some will have significant mental health needs that would benefit from organised support. This is particularly important in contexts where the occurrence of a suicide may lead to more people dying by suicide among those who knew the person.[17 18]

Public Health England has published guidance aimed at helping local authorities develop high-quality suicide bereavement services (Support after suicide: a guide to providing local services),[19] and Business in the Community have worked together with Public Health England to develop a postvention toolkit for employers (Crisis management in the event of a suicide: a postvention toolkit for employers).[20]

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

After a death by suicide, it is standard practice for many organisations to conduct an independent investigation into the circumstances that led to the death and to identify any changes that are needed to prevent further deaths or serious incidents. These are often carried out by an independent team of skilled investigators who have the training, relevant professional experience and knowledge to conduct a serious incident investigation. The investigation may require organisations and individuals in the community to be involved or to provide evidence.
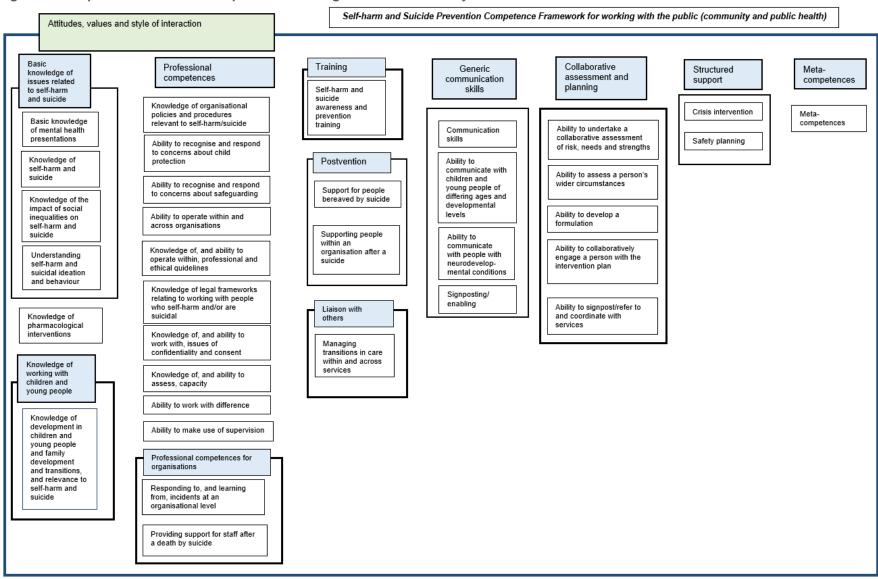
The terms of reference for the scope of the investigation, as well as the timescale for reporting, should be set out before the investigation begins. The dissemination of any learning that comes out of these investigations should be timely.

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

5.1.9. Reflective practice

Reflective practice is the process by which professionals reflect on their own actions, learn from their experience and consider how to make improvements in their practice. This is part of continuous self-learning and it requires professionals to be self-aware and appropriately self-critical. There is strong evidence to suggest that this is beneficial in medical professions,[21 22 23] therefore it may be inferred that other professional groups could also find reflective practice helpful.

Figure 1: Competence framework map for the working with the community

5.2. Using the competence framework map

All competences discussed here are mapped on Figure 1. Within the map, there are several activities that contribute to individual competences. This document provides an overview of each of the activity areas outlined on the map and their related competences, while the specific detail of the competences can be found on https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework.

The framework for community and public health is intended to be relevant to professionals in these settings and whose work brings them into contact both with people who may self-harm and/or are suicidal and with people who are impacted by these behaviours (such as family members, carers, significant others or work colleagues).

Some professionals will have basic training in mental health, others none or very little; some will be in a position where they take statutory responsibility for supporting distressed individuals, others will have a minimal role or no formal role at all. The framework is intended to encompass all these levels of input. For example, some parts of the framework describe basic competences (such as communication skills) that will be helpful whatever the role; other areas will require more by way of background knowledge and training.

A key message is that there is no expectation that the whole framework will be relevant to (or required of) all professionals. It is more a matter of identifying the sets of competence that relate to the role being undertaken, so that professionals have the knowledge and skills that they need to offer effective help.

5.3. Competences

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

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

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

I want those looking after me, including my teachers and first responders, to be compassionate and non-judgemental.

Stella Branthonne-Foster
Expert by Experience, 2018

Working with people who have self-harmed and/or are suicidal should be grounded in compassion and respect. For this reason, the whole framework is underpinned by the competences within 'Attitudes, values and style of interaction'. This should be the same level of compassion and respect that would be received by, or given to, anyone else, regardless of whether or not they self-harm or have suicidal thoughts.

Professionals should be able to:

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

5.3.2. Core knowledge and skills

Basic knowledge of issues related to self-harm and suicide

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

The competences within 'Knowledge of self-harm and suicide' set out the knowledge that a professional who comes into contact with people who self-harm and/or are suicidal would be expected to have. This includes knowledge on prevalence of self-harm and suicide and commonly used terminology. These competences also explore the associations between self-harm and suicide, look at the connections between mental health, physical health and social and psychological factors, and describe the impact of self-harm and suicide on others.

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

The final set of competences in this part of the framework, 'Understanding self-harm and suicidal ideation and behaviour', describes the factors thought to contribute to the emergence of self-harm as well as suicidal thoughts and feelings. It also describes the factors that might contribute to a person going from thinking about suicide to actively trying to end their life.

Although this framework is intended for professionals without specialist mental health knowledge, 'Knowledge of pharmacological interventions' might be required because medication has a part to play in the treatment regimen of people who self-harm and/or are suicidal, most commonly for coexisting mental health problems.

There is also a dedicated part of the framework related to knowledge about working with children and young people. 'Knowledge of development in children and young people and family development and transitions, and relevance to self-harm and suicide' sets out areas of development common to all children and young people, along with the transitions arising during adolescence that can be challenging for some and that may exacerbate distress, self-harm and suicidal thoughts.

Professional competences

This part of the framework focuses on professional competences, some of which are applicable to individual workers who work in community and public settings and some to organisations within the community.

Professional competences for individual workers

The first set of competences, applicable to all individual workers, includes 'Knowledge of organisational policies and procedures relevant to self-harm and suicide' as they relate to the support of people who have self-harmed and/or are suicidal. Additionally, all workers should ideally have the 'Ability to recognise and respond to concerns about child protection'. This involves knowing about relevant legislation and the principles that inform child protection procedures, how to recognise the signs of neglect and abuse, and the actions that need to be taken when there is a concern about harm. Linked to this are the competences regarding the 'Ability to recognise and respond to concerns about safeguarding'. Safeguarding refers to the protection of individuals who are at risk of harm from various forms of abuse or neglect. These harms can be experienced by people of any age, therefore competences around safeguarding are broader than those for child protection.

The 'Ability to operate within and across organisations' is an important skill to hold as it requires knowledge of the roles and responsibilities of each professional or individual who might be involved in the support of the person, regardless of which organisation they belong to. It is also important for individuals to know their own organisational policies and procedures. For support to be delivered seamlessly across multiple services in the community, individuals also need to understand local pathways of support, care and treatment. This knowledge will help to ensure that the person can be supported by the most appropriate services and their experience of accessing them will be smooth and consistent.

All professions and regulatory bodies set out ethical standards that professionals are expected to know and apply in their practice. The competences within 'Knowledge of, and

ability to operate within, professional and ethical guidelines' draw attention to the application of these principles in areas such as autonomy, consent, confidentiality and the minimisation of harm.

'Knowledge of legal frameworks relating to working with people who self-harm and/or are suicidal' is key to working in this area, as knowledge of critical issues such as consent and capacity may be required. It is particularly important for professionals to be familiar with the legislation that is relevant to their discipline or that may apply in other related settings. Knowledge of mental health law would also be desirable for those who work closely to support people who have self-harmed and/or are suicidal. Other critical areas of legislative knowledge include data protection, equality, parental rights and responsibilities, shared decision-making, child protection and human rights. Linked to this is 'Knowledge of, and ability to work with, issues of confidentiality and consent', a potentially complex area which often requires careful judgement about instances in which it is in the person's best interests to maintain or to breach confidentiality, and to whom information is appropriately passed or withheld from. Related to this is 'Knowledge of, and ability to assess, capacity', a skill that might be relevant to some professionals who work in this area. Individual workers who need to assess capacity should be able to make adjustments to their communication style so that they can make themselves understood; this will reduce the chance of workers making an incorrect capacity judgement (communication skills are discussed in more detail on page 22). It should also be remembered that capacity refers to a specific issue at a specific time and that any observations of capacity or lack of capacity can be temporary or can fluctuate. Detailed descriptions on assessing capacity can be found in the 'Professional competences' part of the framework.

Respecting diversity, promoting equality of opportunity for people receiving support and challenging inequalities and discrimination are all important parts of any practice, regardless of what that practice is or who is being supported. The 'Ability to work with difference' includes the ability to take account of the ways in which people differ, along with how a person's defining characteristics can influence the way they experience life, the way they present to services and what kind of support they receive. All workers should be able to support people from all backgrounds and with protected characteristics (as set out in the Equality Act 2010[24]), or additional characteristics that might be relevant, such as socioeconomic status. People who are societally disadvantaged in any way may experience additional challenges, with discrimination and stigma not only making them more vulnerable, but also making it harder for them to access support. Wherever professionals do identify inequalities in support, they should begin to take necessary steps to overcome these.

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

Professional competences for organisations

A final group of professional competences within the framework relate to the response of an organisation to a suicide. The first set of competences reflects the importance of

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

Training, postvention and liaising with others

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

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

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

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

Generic communication skills

The part of the framework titled 'Generic communication skills' applies to all professionals who work with people who have self-harmed and/or are suicidal.

'Communication skills' are fundamental to working with people who have self-harmed and/or are suicidal, and this section of the

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

Rachel Rowan
Expert by Experience, 2017

framework identifies the techniques that can be used to encourage open and collaborative discussion. When communicating with a person in such circumstances, professionals should be able to draw on basic communication skills so that people feel that they are:

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

There is also a set of specific competences around communicating with children and young people in 'Ability to communicate with children and young people of differing ages and developmental levels'. All professionals should keep these in mind when interacting with children and young people and attempt to align their style of interaction to the child's or young person's level of understanding, adapting it to follow patterns of engagement most natural for the child or young person.

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

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

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

Finally, the role of 'Signposting/enabling' is outlined, setting out the competences needed to direct people to resources and sources of support. There is the need not only to identify these sources of support, but also to facilitate their uptake by the person.

Collaborative assessment and planning

Some professionals who work in the public may need to complete an assessment of risk, strength and needs with the person who has self-harmed or is feeling suicidal. It is less likely that professionals will need to complete a formulation, however some may find this to be a part of their professional role. This part of the framework focuses on assessment and formulation and starts with 'Ability to undertake a collaborative assessment of risk, needs and strengths'. This might be a key area within the framework for some professionals and as such, it is important to recognise the limitations of assessment. Through research and practice, a large number of factors have been identified as associated with risk, but these

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

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

The 'Ability to develop a formulation' might be a step for some professionals during the assessment process, as this is the point at which information is gathered together into a coherent account that helps to understand the determinants of self-harm and/or suicidal thoughts and the factors that maintain it. If completing a formulation is part of a professional's role, this is an exercise that should be shared with the person to test its accuracy and to confirm the person's sense of its relevance. The 'Ability to collaboratively engage a person with the intervention plan' that is developed as a result of the formulation is the next part of the process. An intervention plan should not be imposed on a person. Rather, professionals should engage the person (and their family, carers or significant others) throughout the decision-making process to give them the ability to explore support, care or treatment options and understand each other fully. Together with the professionals' guidance, they can develop an intervention plan that all parties agree with and understand. If the person feels a lack of control over decisions about themselves, there is a risk they will disengage, so this is an important part of ongoing support with the person. Commonly, the intervention plan will involve professionals from a wide range of agencies, so the 'Ability to signpost/refer to and coordinate with services' may be a key part of this planning process.

Structured support

Although most professionals who work in the community or in the wider general public will not be undertaking specific interventions, they may contribute to some form of 'Structured support'. This support should be tailored to individual need, be specifically adapted for people who have self-harmed and/or are suicidal, and focus on the management of self-harm and/or suicidal thoughts or behaviour either in the immediate sense or in the form of longer-term support within the community. Two components are included here, 'Crisis intervention' and 'Safety planning'. Although there is some overlap in these areas, each is part of a process, applicable at different points in a person's presentation. Although these may not be the only approaches that work in this context, they have been used in practice and if delivered proactively have been found to contribute to keeping a person safe. These forms of support can be offered by any professional who may be supporting a person who has self-harmed and/or is suicidal. The competences within this part of the framework should enable non-clinicians to feel confident to offer this support and intervention to anyone who might need it.

5.3.3. Meta-competences

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

6. Applications of the competence framework

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

6.1. Curricula

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

6.2. Training

Effective training is vital to ensuring that the approach in which someone might be supported is compassionate, consistent and effective. The framework can support this by providing:

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

6.3. Organisational structuring

Organisations can use this framework to ensure that the organisational structures and the training programmes that they provide meet the competences. This framework can be used to evaluate an organisation's current practice and processes to ensure that professionals are able to meet all that is set out in the framework. This may include creating safer environments for people and staff and ensuring that processes are in place to allow staff to offer appropriate help and intervene when needed. This will mean that professionals can help those who require support effectively.

6.4. Clinical governance

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

6.5. Supervision

The competences described in the framework can be used in supervision by both the person receiving supervision and the supervisor. The person receiving supervision can use the

competences in their reflective practice, considering the areas where they could improve their practice in line with the framework. Similarly, the supervisor can use the framework as a tool to guide discussion on reflective practice, identifying areas for growth and learning. This can then be addressed through additional training and support during future supervision.

6.6. Research

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

7. Definitions

7.1. Suicide, self-harm and prevention

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

Prevention

'Interventions designed to reduce the occurrences of new cases', after the US National Academy of Medicine (formerly the Institute of Medicine).[25]

Self-harm

We use the National Institute for Health and Care Excellence's (NICE's) definition of self-harm: [26,27 28]

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

Suicide

Suicides are defined as 'deaths by intentional self-harm and deaths of undetermined intent by individuals aged 10 and over', following the 2017 report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).[29]

Suicide attempt

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

7.2. Other terms used in the framework

Assessment

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

Formulation

A collaborative process between a person and one or more professional(s) to understand the person's needs. During a formulation the professional will draw on any knowledge of mental health as well as social, environmental and biological factors to develop some working theories about the person's mental health, and develop an understanding of need.

Intersectionality

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

Meta-competences

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

Postvention

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

Protected characteristics

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

Risk assessment

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

Safety plan

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

Supervision

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

Transitions

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

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Appendix B: NICE guideline evidence search

To ensure that this work was developed in line with the evidence-based recommendations published by NICE, NICE guidelines were reviewed to identify quality statements and recommendations relevant to self-harm and suicide prevention. The following guidelines were considered:

- Antenatal and postnatal mental health: clinical management and service guidance
- Bipolar disorder: assessment and management
- Borderline personality disorder: recognition and management
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- Child maltreatment: when to suspect maltreatment in under 18s
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings
- Coexisting severe mental illness and substance misuse: community health and social care services
- Depression in adults with a chronic physical health problem: recognition and management
- Depression in adults: recognition and management
- Depression in children and young people: identification and management
- Eating disorders: recognition and management
- Generalised anxiety disorder and panic disorder in adults: management
- Looked-after children and young people
- Obsessive-compulsive disorder and body dysmorphic disorder: treatment
- Post-traumatic stress disorder: management
- Preventing suicide in community and custodial settings
- Self-harm in over 8s: long-term management
- Self-harm in over 8s: short-term management and prevention of recurrence
- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
- Transition between inpatient mental health settings and community or care home settings

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

- Depression in children and young people
- Self-harm
- Service user experience in adult mental health services
- Transition between inpatient mental health settings and community or care home settings

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

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

NICE quality statement	NICE quality standard
People using mental health services who may be at risk of crisis are offered a crisis plan.	QS14 - Service user experience in adult mental health services, quality statement 9
People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.	QS14 - Service user experience in adult mental health services, quality statement 10
People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.	QS34 - Self-harm, quality statement 1
People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.	QS34 - Self-harm, quality statement 2
People who have self-harmed receive a comprehensive psychosocial assessment.	QS34 - Self-harm, quality statement 3
People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.	QS34 - Self-harm, quality statement 4
People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.	QS34 - Self-harm, quality statement 5
People receiving continuing support for self-harm have a collaboratively developed risk management plan.	QS34 - Self-harm, quality statement 6
People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.	QS34 - Self-harm, quality statement 7
People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.	QS34 - Self-harm, quality statement 8
Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS (Child and Adolescent Mental Health Services) professionals within a maximum of 24 hours of referral. If necessary, children and young people are provided with a safe place while waiting for the assessment.	QS48 - Depression in children and young people
People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged.	QS159 - Transition between inpatient mental health settings and community or care home settings, quality statement 4