Crisis intervention

Knowledge

An ability to draw on knowledge that a suicidal crisis arises when a person experiences intense thoughts about suicide, combined with a powerful sense:	
	of unease and dissatisfaction with life
	of being overwhelmed by their emotions
	that they may act upon their suicidal thoughts
An ability to draw on knowledge that a crisis intervention has the immediate aim of reducing the intensity and frequency of self-harm and suicidal thoughts and behaviour and/or increasing a person's ability to cope with them in the short-term (so that their desire to act is overcome)	
An ability to draw on knowledge that a crisis intervention should focus on:	
	acknowledging and validating distress
	helping a child or young person begin to understand (and so think about) thoughts and feelings in relation to the difficulties that have led them to their current way of thinking
	helping a child or young person act in ways that may reduce rather than potentiate negative feelings
	gaining an understanding of what support is available to them in the here and now
If the suggested strategies are ineffective, an ability to access a level of support appropriate to a child's or young person's immediate needs, such as:	
	specialist mental health services that can offer intensive support in the community or home environment
	inpatient services, if support in the community is untenable (e.g. because intensive monitoring is required and is not available)
An ability to draw on knowledge of the need to arrange for follow-up care aimed at addressing the problems and vulnerabilities that led to the suicidal crisis, even if a child or young person is no longer actively intent on acting on their suicidal thoughts	

Intervention

An ability to discuss issues empathically, but also to move the situation forward by working with a child or young person to develop a concrete plan that aims to defuse and contain the current crisis	
An ability to match the extent and intensity of a crisis intervention to the degree of risk and need represented by a child or young person, and so introduce strategies that are appropriately responsive to the need to contain the crisis, such as:	
	low containment strategies, such as direction to agencies offering relevant support (e.g. Citizens Advice or debt management), discussion of issues that are affecting the child or young person and discussion of 'reasons for living'
	more active containment strategies (such as alerting a child or young person's social support network, arranging follow-up, liaising with primary care, signposting and safety planning)
	high containment strategies (such as taking a child or young person to an emergency department for further assessment and intervention, arranging intensive support from mental health teams, considering pharmacological interventions for coexisting mental health problems if appropriate)

- An ability to draw on knowledge that the priority of a basic crisis intervention is to help a child or young person at risk of suicide access appropriate care and facilitate further intervention, through a two-stage approach:
  - establishing rapport by listening and using empathetic communication such as:
    - asking their name (if not known) and sharing your own name with them
    - relating to them as an individual, in an open and direct way
    - showing a willingness to discuss suicide directly (and doing so)
    - directly acknowledging and validating their pain and distress
    - taking the time to listen to them carefully and showing understanding (e.g. by offering summaries of what they have said)
    - holding off making any attempt to convince them to change their mind (as this may increase their resistance until sufficient rapport has been established)
  - only once rapport is established, moving to advocating for delaying suicide, for example by:
    - gently challenging and potentially exploring the idea that others would be better off if they were dead (taking care not to imply that they should desist from suicide out of guilt about the reaction of others to their death)
    - advocating for delaying suicide because of its finality
    - considering possibilities for ongoing contact with services or support networks, tailored to their needs and circumstances (as a way of instilling hope for the future)
    - considering the possibility of supportive medication to treat underlying diagnoses such as depression
- An ability to advise on restricting and removing access to lethal means:
  - giving a clear rationale for the importance of limiting access to means
  - giving the means to the professional, or agreeing for the means to be handed over to others
    - gaining consent from a child or young person to make direct contact with the individual who has agreed to secure the lethal means
      - an ability to judge when the risk of harm justifies breaching confidentiality
- An ability to help a child or young person mobilise their social support networks by:
  - engaging them empathetically in discussions about the social support available to them, and their use of it
  - helping them discuss (and ideally overcome) their apprehension about a lack of interest or willingness in those around them to step in to prevent them from acting on their suicidal thoughts
  - helping them generate ideas about the types of requests they might make (e.g. being able to check in regularly by phone call, text message or in person, making plans to engage in meaningful activities)
  - (with their permission) contacting their family or carers to advise on appropriate support and provide information about warning signs, and to check whether they themselves need support
- An ability to identify and manage online activities that may be promoting suicidal thoughts and intent, by:
  - discussing a child or young person’s use of websites that show means of completing suicide or promote suicide directly
  - directing a child or young person to appropriate suicide prevention websites or forums (i.e. those endorsed by national or local agencies)

An ability to work with a child or young person to develop a written crisis plan that aims to manage suicidal ideation by helping them:
identify and so draw on times they have managed to cope with difficulties in the past
identify short-term goals that can realistically be achieved by someone in an acutely dysphoric or hopeless state (and record them in a way that they can follow)
generate or choose from a list of activities that may help to reduce negative feelings and distract from suicidal thinking (especially activities that will foster a sense of connection to others)
make decisions about when to access emergency care
draw up a written statement that explicitly specifies a safety plan (strategies and activities that a person agrees to engage in to try to manage their distress, with specific instructions for accessing a crisis line or emergency care if this does not alleviate the crisis)

Clinical management

Clinical management aims to identify people's needs and to promote active and meaningful contact with relevant services.

It is not (in itself) a therapeutic intervention, but it does represent good clinical practice, and is intended to increase the likelihood that individuals will receive appropriate care and support (making it an initial step and subsequently part of the process, rather than a stand-alone intervention).

Knowledge

- An ability to draw on knowledge of mental health problems and their relevance to self-harm and suicide*
- An ability to draw on knowledge of self-harm and suicide*
- An ability to draw on knowledge that clinical management usually involves:
  - assessment (including assessment of safety and risk) and care planning*
  - active outreach
  - support to make the best use of available services
  - continuity of staff contact
- An ability to draw on knowledge that clinical management usually involves liaison within and across services and teams

* Competences relevant to these areas are identified in the relevant sections of this framework

- An ability to draw on knowledge that because effective outreach involves building a trusting relationship with a child or young person over time:
  - continuity of professionals responsible for their care is desirable
  - changes in the professional responsible for their care should be communicated openly and the potential impact discussed with them

Active outreach

- An ability to actively promote a child's or young person's engagement with the service (and the service with a child or young person), for example by:
  - building rapport
  - tailoring contact to them, based on an understanding of their needs and preferred communication style
  - providing a rapid response to their needs
  - being flexible about channels of communication (e.g. email, text, telephone)
  - being flexible about the venues for meeting (where possible)

An ability to help a child or young person identify and overcome obstacles to accessing appropriate support (both within the service, with other teams and in their support network), for example:
working with them to identify any practical, psychological or social obstacles
helping them to problem solve potential ways around any obstacles
discussing their concerns or negative perceptions of sources of support in a collaborative manner that validates their experience but also encourages reflection (rather than automatically acting on these perceptions)

Advocating for a child or young person

An ability to act as a case manager and to advocate on a child's or young person's behalf by:
working to deliver coordinated care (e.g. within or across multi-disciplinary teams)
facilitating within- and across-team referrals for relevant services
working with them, and their family or carers, to understand and overcome barriers to engaging with psychiatric, psychological and practical support offered (e.g. anxieties or previous adverse experiences)
helping them, and their family or carers, prepare for and attend meetings with these services
coordinating with others involved in supporting them (e.g. family, carers, friends) to make sure that the right level of information is shared with the right people

Safety planning

Basic principles of safety planning

An ability to draw on knowledge that a safety plan is:	
	a ‘stepped’ sequence of potential coping strategies and sources of support that a child or young person at risk can use during or before a suicidal crisis or an episode of self-harm
	intended to be worked through step by step until the suicidal crisis or episode of self-harm has resolved, or a child or young person has accessed urgent help
An ability to draw on knowledge that a child or young person should have ‘ownership’ of the safety plan, and that this should be developed with them	
An ability to draw on knowledge that a safety plan should be expressed in a child or young person’s own words	
An ability to draw on knowledge that a safety plan should be developed in the context of the shared understanding of risk that emerges from a comprehensive assessment	

Constructing a safety plan

An ability to draw on knowledge that safety plans should address the following steps:	
	warning signs and external triggers of a suicidal crisis or an imminent episode of self-harm that are specific to the child or young person
	coping strategies that a child or young person can employ to distract themselves from the suicidal crisis or impulses to self-harm
	people who can be contacted to help distract a child or young person from (or reduce) suicidal urges or impulses to self-harm
	supportive contacts (both professionals and non-professionals) who can help to resolve the crisis
	professionals who can help to resolve the crisis
	reducing access to means of harm
An ability to help a child or young person understand the step-by-step nature of the safety plan	
An ability to help a child or young person describe/write each step in their own words	
An ability to help a child or young person identify a limited number of entries per step (usually no more than three) so as to keep strategies focused and specific	
An ability to agree a strategy to ensure that the safety plan can be easily located or accessed and shared (e.g. with family and carers)	
An ability to help a child or young person review and amend the safety plan (to make it more likely that it will be used and be effective at times of crisis)	

Warning signs

An ability to help a child or young person identify warning signs of a suicidal crisis and/or episode of self-harm:	
	situations or circumstances that may act as ‘triggers’
	thoughts
	images
	thinking styles (e.g. rumination, thinking biases (such as catastrophising, or ‘all or nothing’ thinking)
	mood
	experience of shame or guilt
	changes in habits or behaviours (e.g. sleeping poorly or arguing more with family)
	escalating frequency and/or severity of impulses to self-harm
An ability to help a child or young person recognise the significance of their warning signs so that they can use them as indicators of a need to initiate the safety plan	

Constructing the steps of a safety plan

An ability to undertake safety planning collaboratively, and in a manner that aims to engage a child or young person’s resilience and resources

Coping strategies children and young people can employ

An ability to draw on knowledge that a child or young person needs some effective strategies that they can implement alone (even for brief periods) as help may not always be immediately available from others or a child or young person may not be able to seek support from others	
An ability to help a child or young person identify activities they can use to distract themselves from their thoughts of self-harm and/or suicide, such as:	
	emotional regulating or self-soothing techniques learned through prior or concurrent therapeutic interventions
	going for a walk, listening to music, exercising, engaging in a hobby, reading, praying (if religious)
	using harm reduction strategies (substitutes for self-harm)
An ability to help a child or young identify potential barriers to participating in a planned distracting activity	

Contacting others as a distraction from suicidal impulses

An ability to draw on knowledge that contact with family members, carers or friends (without explicitly informing them of their suicidal state/self-harming behaviour) may help to distract a child or young person from their problems and/or their thoughts about self-harm or suicide
An ability to help a child or young person identify key social settings and people in their natural social environment who may help to refocus their attention and so distract them from self-harming or suicidal thoughts and urges
An ability to ensure that relevant information contained within the safety plan includes:
specific details of the service or people who can be contacted, including addresses and phone numbers
consideration of any factors that may place a child or young person at increased risk (e.g. access to alcohol and drugs)

Seeking support from others to help to resolve the crisis

An ability to draw on knowledge that this step is distinguished from contacting others as a distraction in that a child or young person explicitly identifies that they are in a suicidal crisis or are at risk of self-harm and need support and help
An ability to help a child or young person identify and engage with supportive individuals who:
they feel able to tell that they are experiencing thoughts of self-harm or suicide
are likely to respond in a compassionate and helpful manner
are able to engage explicitly with the safety planning process
An ability to help a child or young person indicate what support they would like from the supportive contacts, and how they will help when contacted

Seeking support from professionals to help to resolve a suicidal crisis

An ability to help a child or young person and their family or carers identify health or social care or other professionals who will provide appropriate, accessible professional help in a suicidal crisis
An ability to ensure the relevant information is contained within the safety plan and includes:
specific details of the service or people who can be contacted, including addresses and phone numbers
adequate consideration of service remit and opening times, to ensure that contacts for both daytime and out-of-hours are included

Increasing safety by reducing access to means of harm

An ability to draw on knowledge that because most suicidal acts are impulsive, a plan to reduce access to potentially lethal means of harm can reduce the risk of suicide
An ability to help a child or young person identify lethal means of harm to which they would have access in a suicidal crisis, and to help them place those means out of reach (possibly involving one of the people named in the safety plan)

Assessment and initial management of self-harm

Children and young people who have self-harmed may initially present in contexts (such as emergency departments) where the usual response will be a rapid assessment and onward referral or signposting. This assessment may be carried out by a non-specialist; if so a more comprehensive assessment and intervention should usually follow, carried out by a specialist mental health worker.

This section identifies the competences associated with both approaches (which in some settings may be conducted by the same person).

Undertaking a rapid assessment and identifying an immediate action plan

Working with children and young people

An ability to draw on knowledge of legal guidance relevant to working with children and young people, including:
procedures for assessing capacity/competence
procedures for gaining consent from a child or young person and their family or carers
use of the Mental Health Act with children and young people
confidentiality (and its limits)
the Children Act
safeguarding

Promoting engagement

An ability to draw on knowledge of the importance of the experience of care at the first point of contact, given the:
high proportion of people who self-harm who do not seek help
increased risk of death by suicide in this group
close association between negative experiences of stigma and discrimination and subsequent disengagement with services leading to poor outcomes for this group
An ability to ensure that a child's or person's physical health needs are fully assessed and are being met before starting a psychological assessment, and that:
effective measures are in place to minimise pain and discomfort
medical treatment for the self-injury or self-poisoning is initiated in a respectful and timely way (regardless of the cause of the self-harm and/or a child's or young person's willingness to complete psychological assessment)

An ability to promote an atmosphere of respect, understanding and choice by:	
	providing privacy
	talking to a child or young person in a way that is consistently empathic, calm, compassionate and non-judgemental
	allowing time to listen to a child or young person, even if the contact is only brief
	taking a child or young person's likely distress into account even if this is not immediately apparent
	inviting a child or young person to explain their feelings and their understanding of their self-harm in their own words
	involving a child or young person in all discussions and decision-making about their treatment and subsequent care
An ability to engage a child or young person's family or carers wherever possible and appropriate*, for example	
	acknowledging that they may be angry or upset and judging whether they are best placed to offer support to a child or young person at that point
	involving them in decisions about treatment and care, with the agreement of the child or young person where appropriate
	providing them with relevant information and support

* With respect to considerations of capacity and consent for under 16s and over 16s

Triage

An ability to make a rapid assessment of cognitive function and mental capacity at the outset, to establish whether a reliable assessment is possible	
	an ability to draw on knowledge that an assessment should not be undertaken if a child or young person is intoxicated or under the influence of illicit drugs
When assessments are conducted in settings such as an emergency department (where the initial triage may be followed by long delays), an ability to establish a child or young person's willingness to wait and identify strategies to achieve this	
An ability to take into account a child's or young person's likely distress even if this is not immediately apparent (e.g. by talking to them in an empathic, non-judgemental way, or by having discussions in a private space)	
An ability to establish whether a child or young person is willing or able to attend further assessment and possible treatment	
An ability to provide clear information about the process of assessment and medical treatment for self-harm and any further medical or psychological treatment options available	

Offering advice about self-harm

- An ability to offer non-judgemental advice to children and young people (and where appropriate their family or carers) about the risks of self-poisoning or self-injury including:
  - that there is no safe way to self-poison
  - discussing strategies aimed at harm reduction (e.g. reinforcing existing helpful coping strategies and developing new strategies that might act as an alternative to self-harm)
  - where stopping self-harm is unrealistic in the short-term, discussing less destructive or harmful methods of self-harm with a child or young person (and their family or carers where this has been agreed) such as:
    - using less invasive or safer means that mimic the functions associated with self-harm (e.g. freezing the skin with ice cubes to feel pain without damaging tissue)
    - removing medication or storing it safely (to reduce impulsivity)
    - having a first-aid kit available so as to manage injuries more safely
    - identifying ways to delay self-harm
    - recognising when medical attention is essential

Signposting

- An ability to 'signpost' children and young people, and their families and carers, to further information and support from relevant organisations

Documentation

- An ability to document assessments in a child or young person's notes, including making a note of key information that will be relevant to maintaining their safety
- An ability to ensure that the findings of the assessment are disseminated and available to other staff and other services who are (or will be) involved in the care of the child or young person

Comprehensive assessment and initial intervention for self-harm

- An ability to draw on knowledge that a child or young person may have many motivations for self-harm other than suicide, including relieving distress and preserving life
- An ability to draw on knowledge that a child or young person who self-harms repeatedly may not always do so for the same reasons each time
- An ability to draw on knowledge that standardised checklists may be used alongside a 'narrative' interview but not as the sole means of risk assessment (because they may obscure the specific reasons for self-harm, and are poor predictors of suicide)
- An ability to assess each act of self-harm separately and in full, with the aim of understanding a child's or young person's intent, including, for example:
  - methods and frequency of current and past self-harm
  - current and past suicidal intent
  - current psychological difficulties and their relationship to self-harm
  - personal, social and occupational functioning
  - factors that immediately preceded self-harm (e.g. extreme affective states or emotions or relationship breakdown)
  - immediate consequences of self-harm
  - coping strategies that they have used to limit or avert self-harm or to contain the impact of factors that have preceded episodes of self-harm
  - significant adverse life events (e.g. bereavement or trauma)
  - influence of significant relationships on the level of risk (i.e. whether these are supportive or whether they contribute to risk)
  - coexisting risk-taking or self-destructive behaviours (such as excessive alcohol of drug misuse)
- An ability to draw together information from the assessment into a formulation that:
  - describes the antecedents of the episode of self-harm including:
    - long-term vulnerability factors (such as a history of abuse or enduring psychological difficulties)
    - short-term vulnerability factors (such as difficulties in relationships or drug or alcohol misuse)
    - precipitating factors (likely to be stressors experienced immediately prior to self-harm), such as financial crises, relationship issues, deaths or other losses)
  - identifies the main motivations for self-harm

Developing a collaborative care plan

- An ability to draw on knowledge that a care plan should include both a risk management or safety plan and a longer-term plan that addresses underlying and/or long-standing issues that lead to self-harm
- An ability to work with a child or young person to develop a collaborative written care plan that identifies:
  - realistic (and optimistic) goals and the steps to achieve them
  - the roles and responsibilities of professionals and the child or young person and their family or carers
  - the services that will be involved
  - a risk management plan that is collaborative and congruent with the long-term treatment strategy, and which:
    - addresses the risks identified in the assessment
    - addresses the specific factors (psychological, pharmacological, social and relational) that are associated with increased risk (aiming to reduce the risk of repetition of self-harm and/or suicide)
    - includes a safety plan that identifies self-management strategies and the procedure for accessing services if self-management strategies fail
- An ability to identify any concerns a child or young person has about sharing the care plan with relevant individuals and services, and to discuss the rationale for information-sharing as well as the limits of confidentiality
  - an ability to indicate to whom the care plan will be disseminated
  - an ability to share information in a timely manner

Referral for further assessment or treatment

- Based on the assessment of needs and risk, an ability to identify what further intervention is required
- An ability to discuss decisions about further intervention with a child or young person, and (where appropriate) their family or carers, and document any instances where this is not possible (e.g. as a result of diminished capacity)
- An ability to draw on knowledge that temporary admission is good practice following an act of self-harm, especially for:
  - children and young people who are very distressed
  - children and young people for whom psychosocial assessment proves too difficult because of drug and/or alcohol intoxication
  - children and young people who may be returning to an unsafe or potentially harmful environment (making treatment in the community an inappropriate option)
- An ability to draw on knowledge that further treatment should be based on the combined assessment of needs and risk, and not solely the fact that a child or young person has self-harmed
- An ability to draw on knowledge that any treatment will be aimed at addressing underlying problems rather than simply treating self-harming behaviour

Support for staff

An ability for organisations to recognise that providing care for children and young people who have self-harmed can be emotionally demanding, and that staff undertaking this work should have access to regular support and supervision in which:
the emotional impact upon staff members can be recognised, discussed and understood
personal feelings about the work can be discussed (so as to ensure they do not interfere with the quality of care)

Interventions for self-harm

- An ability to implement an individualised brief intervention for a child or young person who has self-harmed, based on therapeutic strategies of known effectiveness (e.g. motivational interviewing, cognitive behavioural therapy, interpersonal therapy, problem-solving)
- An ability to draw on the formulation of a child's or young person's needs to determine the appropriate components of a brief intervention, which would usually include:
  - engaging them and exploring their motivation and readiness to talk about change, for example:
    - discussing issues in a way that does not assume readiness to change
    - exploring ambivalence about self-harm and other concerning behaviours (e.g. drug and alcohol use)
    - helping them to access personally relevant reasons for change
    - being aware of ways in which their prior experiences and expectations can lead to difficulties in the interaction (e.g. appearing to be disinterested or angry because of negative experiences of seeking help)
  - providing information about self-harm in a way that is destigmatising
  - developing a shared formulation of the factors relevant to the triggering incident, based on:
    - identifying and understanding the triggers for self-harm (starting with the most recent incident)
    - focusing on highly specific details about thoughts, emotions, behaviours, interactions and the consequences of each of these in the chain of events
  - identifying potential targets for change
    - using the formulation to pinpoint key links in the chain of events leading up to an episode of self-harm, which could be:
      - identifying relevant behaviours (e.g. drinking, drug taking, avoiding people or situations, searching the internet for pro-suicide sites)
      - identifying relevant cognitions (e.g. spiralling negative thoughts about self/others/the future)
      - identifying negative interaction patterns (e.g. confrontations or difficulties in communicating needs and distress)
  - helping them (and their family or carers) explore different perspectives on triggering problems (rather than reacting to them impulsively) and identifying alternative ways of construing these through:
    - cognitive strategies (e.g. differentiating between situations, emotions and thoughts, exploring the evidence for and against an interpretation, recognising thinking biases)
    - interpersonal strategies (e.g. developing awareness of their own feelings, recognising how feelings affect communication and responses, exploring others' points of view)
  - helping them (and their family or carers) to use a range of therapeutic strategies to identify and plan alternative actions they could take when they encounter problem situations in the future, such as:
    - identifying alternative behavioural responses to distressing emotions (e.g. using distraction and self-soothing techniques)
    - implementing problem-solving strategies
    - challenging negative thoughts
    - identifying and implementing more effective communication skills
    - in-session practice of new skills
  - planning between-session practice of alternative coping strategies, including:

discussing difficulties that they anticipate may arise when trying out alternative coping strategies
planning how possible obstacles could be managed
systematically reviewing between-session practice in the next session to identify learning points and any areas of difficulty
enhancing their (and family or carers') awareness of their strengths and resources (e.g. by identifying times when they have demonstrated effective coping, by identifying positive qualities that they possess in areas unrelated to their difficulties)
developing a co-constructed written account of the intervention that reviews the events leading to self-harm, identifies what has been learned, and specifies the strategies that can be used to deal with similar situations in the future

Knowledge of pharmacological interventions

Knowledge of pharmacological interventions required by all healthcare workers

An ability to draw on knowledge on the use of pharmacological interventions for coexisting mental health problems in young people who self-harm and/or are suicidal
An ability to draw on knowledge that there is no clear evidence for the benefit of pharmacological interventions specifically for self-harm and suicidal behaviour in children and young people in the absence of a coexisting mental health problem
An ability to identify, refer to or liaise with a psychiatrist or other medical practitioner when there are concerns that relate to psychotropic medication(s) that are currently being prescribed or being considered for the management of self-harm or suicidal behaviour in young people
An ability to draw on knowledge of the prescription of psychotropic medication for young people, while retaining a balanced view of the utility of psychopharmacology for these age groups, for example the need to weigh benefits against risks in both the short and long term

Knowledge of psychopharmacology for staff with prescribing rights

An ability to draw on knowledge of national guidance for the treatment of children and young people who self-harm and/or are suicidal that include recommendations regarding the role of medication (e.g. NICE or SIGN guidelines)
An ability to draw on knowledge of presenting conditions where medication potentially forms part of the intervention
An ability to draw on knowledge of interactions between prescribed and non-prescribed medications
An ability to draw on knowledge of the potential adverse effects of antidepressant medication (possible increase in suicidal thoughts and behaviours), especially when initiating treatment
An ability for the prescriber to recognise that in children and young people, medication for coexisting mental health problems should be started by professionals in specialist services

Working with children and young people

An ability to discuss with children and young people and (where appropriate) their family or carers:	
	the potential role of medication in their treatment regimen
	the potential side effects of medications and their risks and benefits
	their understanding of, and any concerns about, the medication
An ability to recognise significant side effects and to take appropriate action	

Specialist skills

An ability (for appropriately qualified practitioners) to provide specialist assessment, which includes the detection and diagnosis of those conditions and circumstances where medication may be indicated
An ability to prescribe and discontinue medication, employing the knowledge and skills identified as underpinning this activity by the relevant professional body (i.e. medicines optimisation)
An ability to review medication plans at appropriate intervals
An ability for GPs, psychiatrists and appropriately qualified practitioners within a team to act as a resource to their colleagues (e.g. providing advice or consultation, or offering relevant training in psychopharmacology)
An ability to recognise that professionals involved in prescribing psychotropic medication require ongoing training, professional development and supervision