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 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 person act in ways that may reduce rather than potentiate their 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 person's immediate needs, such as:
specialist mental health services that can offer intensive support to 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 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 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 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 person and discussion of 'reasons for living'
more active containment strategies (such as alerting a person's social support network, arranging follow-up, liaising with primary care, signposting and safety planning)
high containment strategies (such as taking a 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 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, and/or 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 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 to a person justifies breaching confidentiality
- An ability to help a 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 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 family, carers and friends 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 person’s use of websites that show means of completing suicide, or which promote suicide directly
  - directing a person to appropriate suicide prevention websites or forums (i.e. those which have been endorsed by national or local agencies)

An ability to work with a 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 the people's needs of people 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 people 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 person over a period of time:
  - continuity of staff responsible for a person's care is desirable
  - changes in the staff responsible for the person's care should be signalled openly and their potential impact discussed with the person

Active outreach

- An ability to actively promote a person's engagement with the service (and the service with the 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 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 the person

An ability to act as a case manager and to advocate on a 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 to understand and overcome barriers to engaging with psychiatric, psychological and practical support offered (e.g. anxieties or previous adverse experiences)
helping them in their contacts with organisations with which they are involved (e.g. health and social care services, housing services and the benefits system)
helping them arrange appointments with other services, and helping them prepare for and attend meetings with these services
coordinating with others involved in supporting them (e.g. family, carers, significant others and 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 person 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 person has accessed urgent help
An ability to draw on knowledge that a 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 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 person
coping strategies that a person can employ to distract themselves from (or reduce) the suicidal crisis or impulses to self-harm
people who can be contacted to help distract a person from (or reduce) suicidal urges or impulses to self-harm
supportive contacts (both professional and non-professional) who can help to resolve the crisis
professionals who can help to resolve the crisis
reducing access to means of harm prior to suicidal crises or episodes of self-harm
An ability to help a person understand the step-by-step nature of the safety plan
An ability to help a person describe/write each step in their own words
An ability to help a 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, carers and significant others)
An ability to help a 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 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 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 person's resilience and resources

Coping strategies people can employ

An ability to draw on knowledge that a 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 person may not be able to seek support from others
An ability to help a 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-harming behaviour)
An ability to help a person 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, significant others or friends (without explicitly informing them of their suicidal state/self-harming behaviour) may help to distract a person from their problems and/or their thoughts about self-harm or suicide
An ability to help a 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 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 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 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 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 person 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 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

People who self-harm 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

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 and 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 person's physical health needs are fully assessed and are being met before initiating 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 person's willingness to complete psychological assessment)
An ability to promote an atmosphere of respect, understanding and choice by:	
	providing privacy
	talking to a person in a way that is consistently empathetic, calm, compassionate and non-judgemental
	allowing time to listen to a person, even if the contact is only brief
	taking a person's likely distress into account even if this is not immediately apparent
	inviting a person to explain their feelings and their understanding of their self-harm in their own words
	involving the person in all discussions and decision-making about their treatment and subsequent care
An ability to engage a person's family, carers or significant others 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 the person at that point
	involving them in decisions about treatment and care, with the person's agreement
	providing them with relevant information and support

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 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 person's willingness to wait and identify strategies to achieve this
An ability to take into account a person's likely distress even if this is not immediately apparent (e.g. by talking to them in an empathetic, non-judgemental way, or by having discussions in a private space)
An ability to establish whether the 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 a person (and where appropriate their family or carers) about the risks of self-harm, 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 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' people to further information and support from relevant organisations

Documentation

An ability to document the assessment in a 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 person's care

Comprehensive assessment and initial intervention for self-harm

- An ability to draw on knowledge that a person may have many motivations for self-harming other than suicide, including relieving distress and preserving life
- An ability to draw on knowledge that a 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 only 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 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 and 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. acute financial difficulties)
  - 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, or exposure to unnecessary physical risks)
- 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 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 person
  - 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 attempts)
    - 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 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 whether further intervention is required or whether a person can be safely discharged from care
where there is a decision not to follow up a person, an ability to ensure that this is based on a holistic appraisal of their situation and not solely on a judgement that they are 'low-risk' or do not have a mental health problem (given that social and personal problems may increase risk over time, and are amenable to a range of interventions)
An ability to discuss decisions about further intervention with a person 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 may be helpful following an act of self-harm, especially for:
people who are very distressed
people for whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication
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 the further treatment should be based upon the combined assessment of needs and risk, and not just the fact that a person has self-harmed
An ability to draw on knowledge that any treatment will be aimed at addressing a person's underlying problems rather than simply treating self-harming behaviour

Working with older adults

An ability to draw on knowledge that self-harm in adults over 65 years is associated with much higher rates of suicide intent and subsequent suicide than in other populations, and so this group may require specialist assessment from professionals experienced in recognising depression in older adults
An ability to draw on knowledge that any assessment of self-harm in adults over the age of 65 years needs to include:
particular attention to the potential presence of depression, cognitive impairment and physical ill health
a full assessment of a person's family, social and home situation, including any role they have as a carer
an assessment for risk of suicide

Support for staff

An ability for organisations to recognise that providing care for 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 on 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 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 person's needs in order 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)
    - focussing 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 a person (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 that a person encountered
- 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

Collaborative Assessment and Management of Suicidality (CAMS)[1]

Knowledge of basic principles and rationale for CAMS

An ability to draw on knowledge that the CAMS framework is a structured but flexible clinical support tool intended for workers from a variety of professional backgrounds and levels of skill intended to be used to both assess and manage suicidal risk
An ability to draw on knowledge that CAMS sessions are guided by a structured 'suicide status form'
An ability to draw on knowledge that each session should include both assessment and intervention along with a treatment plan update
An ability to draw on knowledge that CAMS is based upon a core philosophy of care including:
explicitly demonstrating empathy for the high level of distress experienced by people who are suicidal
a highly interactive style of collaboration in the assessment and treatment process
honesty and transparency in all aspects of communication
An ability to draw on knowledge that the primary focus of CAMS is on the prevention of suicidal behaviour (rather than addressing suicidality as a symptom of another mental health problem and so making the latter the primary focus)
An ability to draw on knowledge that a person in a CAMS framework is engaged as a key partner in therapy by focusing on the person-defined problems ('suicidal drivers') that lead to suicidal thoughts, feelings, and behaviours
An ability to draw on knowledge that CAMS is oriented towards keeping a person who is suicidal out of an inpatient setting (wherever this is possible and appropriate)

Ability to maintain a collaborative focus

An ability to maintain a highly collaborative focus throughout the treatment by:
setting out the practitioner's role as a coach, guide or collaborator in the process
building up a shared understanding of the suicide risk as defined by both parties
prioritising discussion of the person's point of view (in terms of key drivers of the suicidal state)
co-constructing plans that address risk with, rather than for, the person
adopting a seating position in the room, which physically enables the person and therapist to work together when co-constructing written summaries during assessment and treatment planning

[1] Source: Jobes DA. Managing Suicidal Risk: A Collaborative Approach. Second Edition. New York: Guilford Press; 2016.

Ability to conduct a risk assessment using CAMS

An ability to pace and structure an assessment appropriately (e.g. introducing the topic of suicidal risk early in the session while engaging a person sensitively)
An ability to help a person identify, discuss and rate core risk and warning factors that may relate to their suicidality, such as:
acute states such as hurt, anguish or misery
feelings of being pressurised or overwhelmed
agitation (a sense of emotional urgency or need to take action)
thoughts such as hopelessness or self-hatred
guilt or shame
An ability to help a person rate the degree to which being suicidal relates to thoughts and feelings about themselves or other people
An ability to help a person rate their overall likelihood of acting upon suicidal thoughts
An ability to help a person identify ‘reasons for living’ and ‘reasons for dying’
An ability to help a person identify the relative relationship between their wish to live and their wish to die
An ability to help a person to begin prioritising the key issues that are contributing to their suicidal behaviour
An ability to assess empirically-based risk factors and warning signs in collaboration with the person in a non-judgemental matter including:
suicidal ideation (its frequency and duration)
suicide planning, preparation and rehearsal
history of suicidal behaviours (single or multiple attempts)
a history of impulsivity (as indicated by the person’s perceptions of their own behaviour)
substance use
significant losses that may be acting as precipitants (either single or cumulative)
relationship problems
a strong sense of being a burden to others
significant and/or enduring health problems
sleep problems
major legal/financial issues
shame

Ability to co-construct a treatment plan

Orientation

An ability to foster collaboration and individual choice through discussion of a person’s options, including the choice to end their life, while maintaining an orientation towards helping them commit to treatment
An ability to create a 'stabilisation plan’ that helps a person to identify actions they can take (such as reducing access to lethal means, alternative coping behaviours and sources of social support they can call upon) when they are feeling suicidal
An ability to use motivational techniques to capitalise on people’s ambivalence about suicide and create an intention to choose to live, at least for a finite time period
An ability to strike a balance between communicating empathy for a person’s suicidal wish and helping them consider other, more effective, ways to have their needs met
An ability to negotiate a mutually agreed period of time during which a person agrees to put the choice to end their life to one side and follow their suicide-specific treatment plan

	ensuring that this is an adequate period of time for the intervention to be effective (typically about 3 months/6 to 8 sessions)
	making it clear that this is a critical condition to embarking on treatment
An ability to convey in an honest and straightforward manner the clinician's duty and responsibility to act on clinical judgement if the person is in clear and imminent danger, and to arrange hospitalisation or intensive home treatment if necessary	

Intervention

An ability to draw on knowledge that a CAMS treatment plan should contain no more than three problems (one of which should focus on a person's potential for self-harm), and also include the goals of any intervention and the methods that will be used,	
An ability to ensure that the first step in stabilisation planning is an empathic discussion that focuses on removing a person's access to lethal means of harming themselves	
An ability to construct a 'coping hierarchy' with the person that consists of a number of steps that they can use to manage suicidal thoughts and feelings, redirecting behaviour and moving attention away from a narrowing focus on suicide, including:	
	restriction of access to means
	self-soothing activities
	distracting activities
	pleasurable or absorbing activities
	using their social network effectively
An ability to help the person overcome obstacles in constructing the hierarchy, such as lack of ideas and/or hopelessness	
An ability to help the person identify people they can contact in an emergency, including family, carers and friends, professionals and crisis lines, if coping strategies fail to work	
An ability to help the person begin prioritising the key problems that are driving suicidality by identifying two focal problems for the remaining part of the intervention	
An ability to target and treat the problems driving suicidality, which may be:	
	direct (those problems that cause a person to want to end their life in an urgent and pressing way)
	indirect (those issues, problems or concerns that make a person vulnerable to suicidal states but do not directly cause them to become acutely suicidal, for example homelessness, isolation, insomnia, trauma history)
An ability to make use of appropriate treatment strategies or onward referrals to assist a person in tackling their suicidal drivers, aiming to get to the root of why these issues compel them to consider suicide	
An ability to make use of the CAMS approach in a flexible way in subsequent sessions, moving from a focus on assessment to an emphasis on increasing a person's coping skills and targeting the focal problems identified by the assessment	

Ending therapy

An ability to identify when it is safe and appropriate to end the CAMS intervention, usually on the basis of consistent feedback from the person (over a period such as 3 to 4 weeks) that indicates that they are at very low overall risk of ending their life, for example:	
	they have been able to manage their thoughts and feelings
	they have not engaged in any self-harm, or made any behavioural preparations for suicide
	they have increased their knowledge and use of a range of coping strategies
Towards the end of successful CAMS-guided care, an ability to focus on reasons for living and a life worth living with purpose and meaning	
An ability to judge whether continuation of therapy is appropriate and to discuss the options open to the person, for example:	
	if therapy will continue with the same therapist, negotiating a new treatment contract so that the work can shift towards addressing the ongoing direct and indirect drivers identified in the initial assessment
	if therapy will continue with a new agency or therapist, supporting this transition by identifying how and when this will be done
Where end of treatment has been mutually agreed as the most appropriate course of action, an ability to support the person by offering occasional ‘booster’ sessions	

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 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 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
An ability to draw on knowledge that all medications have benefits and risks

Knowledge of psychopharmacology for staff with prescribing rights

An ability to draw on knowledge of national guidance for the treatment of 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 follow guidance around safe prescribing of medications and where guidance is not followed, to give a clear rationale as to why

Working with people who self-harm and/or are suicidal

An ability to discuss with people and (where appropriate) their family, carers or significant others:	
	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 (or discontinue) medication, employing the knowledge and skills identified as underpinning this activity by the relevant professional body
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