

Relational care: building trust to reduce self-harm and suicide in inpatient mental health and emergency department settings

Presentation by: Alan Simpson (Professor of Mental Health Nursing at KCL, Co-Director of the NIHR MHPRU) and Jessica Griffiths (Research Associate at the MHPRU)



Acknowledgment

This presentation reports independent research commissioned and funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme, conducted by the NIHR Policy Research Unit in Mental Health (MHPRU).

The views expressed are those of the authors and not necessarily those of the NIHR, the Department of Health and Social Care or its arm's length bodies, or other government departments.

Introduction

- Suicidality and self-harm remain key reasons for inpatient admissions in both acute and mental health hospitals.
- A key purpose of inpatient mental health services and emergency departments (EDs) is to provide a safe environment for people presenting with, and at-risk of, self-harm and/or suicide.
- Despite this, people admitted to hospital are still dying by suicide and engaging in self-harm within these settings.
- Given the prevalence of self-harm and suicidality in inpatient mental health and ED settings, these patient groups have been identified as a priority within national suicide prevention strategies (DHSC, 2023).

Alternatives to structured risk assessments

- **Over-reliance** on using **structured risk assessments** and **risk stratification** to assess self-harm and suicide risk.
 - Despite research consistently demonstrating the **ineffectiveness of risk assessment checklists** for predicting self-harm and suicide risk.
- **Reliance on restrictive practices** (e.g. physical restraint, seclusion, rapid tranquillisation, and special observations) to manage risk.
 - Despite their potential to **undermine therapeutic relationships** and cause **physical and psychological harm** to patients and staff.
- Therefore, there's a growing need for **alternative approaches** to assessing and managing self-harm and suicide risk in inpatient mental health and ED settings.

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

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

Scan this QR code to
read the paper:



Full citation:

Griffiths, J. L., Foye, U., Stuart, R., Jarvis, R., Chipp, B., Griffiths, R., ... Simpson, A. (2025). Quantitative Evidence for Relational Care Approaches to Assessing and Managing Self-Harm and Suicide Risk in Inpatient Mental Health and Emergency Department Settings: A Scoping Review. *Issues in Mental Health Nursing*, 46(6), 529–565. <https://doi.org/10.1080/01612840.2025.2488335>

Co-produced definition of ‘relational care’

“Relational care can be practised at **individual, group, organisational or systemic levels**. It prioritises **interpersonal relationships** grounded in **values** such as respect, trust, humility, compassion, and shared humanity, and involves **personalised and holistic care**, addressing **power imbalances**, and promoting effective **collaboration** between staff, patients and their social networks.” (Griffiths et al., 2025)

Method

- **Review question:** What is the quantitative evidence for the impact of ‘relational care’ in non-forensic inpatient mental health and emergency department settings on self-harm and suicide-related outcomes?
- Conducted a scoping review in accordance with **PRISMA-Sc guidelines**.
- Searched **three academic databases** (Medline, PsycINFO and CINAHL) and **grey literature** for relevant reviews.

Eligibility criteria

	Included	Excluded
Population	Mental health patients of any age	Reviews only including staff or family/carers
Intervention	Approaches to assessing and managing self-harm and/or suicide risk including a focus on interpersonal relationships and at least some of the values and/or principles outlined in our definition of ‘relational care’.	• Pharmacological interventions • Surveillance technologies • Restrictive interventions • Structured risk assessment checklists and risk stratification • Interventions only focused on the physical environment
Outcomes	• Self-harm (e.g. frequency, severity), • Suicide (e.g. suicidal ideation, suicide attempt frequency, completed suicides)	• Risk to others • Risk from others • Other patient, staff or carer outcomes

Eligibility criteria (continued)

	Included	Excluded
Setting	- Non-forensic inpatient mental health settings (including acute and longer-term services) - Emergency departments	- Forensic inpatient services - Services specifically for autistic people or people with intellectual disabilities - Non-psychiatric medical wards - Services for people living with dementia - Neurorehabilitation wards - Community-based services
Study type	- Reviews (including systematic, scoping, rapid, and narrative reviews) - Published in English - Published in any country, any date - Included peer-reviewed and non-peer-reviewed literature	- Primary research studies - Books - Editorials, commentaries, opinion pieces - PhD/MSc/BSc theses - Blog posts and social media content - Non-English language papers

Results

- We identified **29 relevant reviews**.
- Including **62 relational care approaches**, reported in **87 primary papers**.
 - 30 approaches evaluated in inpatient mental health settings
 - 32 evaluated in emergency department settings
- Many of these were psychological interventions delivered at **individual or group levels**.
- Some **ward- and organisation-level approaches** were also identified.
- Primary studies **varied in design**, from RCTs and controlled studies, to pre-post and cross-sectional studies.

Approaches with supporting evidence in inpatient settings

Individual- and group-level approaches	Ward- and organisation-level approaches
Adapted Dialectical Behaviour Therapy (10/11)*	Safewards (2/2)*
CBT-based approaches (2/8)*	City nurses (1/2)
Combined DBT and MBT group therapies (1/1)*	Intermittent observations (3/3)
Collaborative Assessment and Management of Suicidality (CAMS) (2/2)*	Collaborative problem-solving training for nurses (1/1)
Psychodynamic-oriented crisis assessment and treatment (1/1)*	Twilight nursing shifts and evening activity programme (1/1)
Brief admission crisis intervention program (1/1)*	
Insight-oriented psychotherapy (1/1)*	
Steps to Enhance Positivity (STEPS) therapy (1/1)	
Caring letters (1/2)*	
Wellness and lifestyle discussion group (1/1)*	

Approaches with supporting evidence in emergency departments

Approaches started in the ED and continued after discharge	Approaches started <u>after</u> ED discharge
Brief Intervention and Contact (1/2)*	Telephone follow-up contacts (4/6)*
Safety Assessment and Follow-Up Telephone Intervention (SAFTI) (1/1)*	CBT-based approaches (2/4)*
Safety Planning Intervention with follow-up (SPI+) (1/1)*	The Attempted Suicide Short Intervention Program (ASSIP) (1/1)*
Rapid response outpatient team (1/1)*	Attachment-Based Family Therapy (1/1)*
Assertive case management (1/1)*	Abandonment psychotherapy (1/1)*
	Brief psychodynamic interpersonal therapy (1/1)*
	Non-directive supportive relationship treatment (1/1)*
	Case management (1/1)

Overall conclusions of the reviews

- Identified **some approaches with some supporting evidence** for a **positive impact** on self-harm or suicide-related outcomes.
- A **lack of high-quality evidence** overall.
- **Poor descriptions of some interventions**, their underlying theoretical assumptions, and mechanisms of change.
- A **lack of consistency** in methods and outcomes measured across studies.
- A **lack of lived experience involvement** in the research.

Considerations

- Absence of evidence is not evidence of a lack of value in certain approaches.

Challenges implementing relational care:

- **Dynamic** environments with a **mix** of patients, staff, and visitors
- **High turnover** of patients in ED settings
- **Variability** between services, wards, teams, individual staff
- **Inconsistent** shift patterns, staffing **shortages**, reliance on **bank and agency staff**
- Lack of **staff training** and **supervisory support**
- **Power imbalances** between patients and staff
- **Significant risk** – getting it wrong has severe consequences

Challenges researching relational care:

- Difficulties **defining** ‘relational care’
- Difficulties measuring **fidelity** to relational care values and principles
- Difficulties **measuring** self-harm and suicide
 - Relatively rare events and nature, reasons and methods are vast, variable and changeable
 - Can be hard to **distinguish** suicidal and non-suicidal self-harm
 - Rating **severity** can be problematic
 - Self-harm often ‘**private**’

Conclusions

This scoping review proposes a **co-produced definition** of 'relational care'.

Identifies **supporting evidence for some relational care approaches** to assessing and managing self-harm and suicide risk in inpatient mental health and ED settings.

This includes a variety of **individual-, group- and organisation-level** approaches.

Implications for policy, research, and practice



Co-produced research is needed to clarify the **definition**, **core components**, and develop a **framework** for applying and evaluating 'relational care'.



Further **high-quality research**, including larger-scale RCTs, is required to evaluate effectiveness and **long-term impact** (including other important outcomes).



Future studies should explore **barriers and facilitators** to implementing relational care and use qualitative methods to capture perspectives of **patients, staff, and family/carers**.



Realist approaches could explore what works for whom, in what circumstances, and how.

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

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

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

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

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

Thank you for listening!

Any questions?

Email: jessica.griffiths@kcl.ac.uk

or alan.simpson@kcl.ac.uk



Scan this QR code to
read the full paper:



NIHR | Policy Research Unit
Mental health

FUNDED BY
NIHR | National Institute for
Health and Care Research