NHS

National Institute for Clinical Excellence

Self-harm

The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

Clinical Guideline 16

July 2004

Developed by the National Collaborating Centre for Mental Health

Clinical Guideline 16
Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

Issue date: July 2004

This document, which contains the Institute's full guidance on self-harm, is available from the NICE website (www.nice.org.uk/CG016NICEguideline).

An abridged version of this guidance (a 'quick reference guide') is also available from the NICE website (www.nice.org.uk/CG016quickrefguide). Printed copies of the quick reference guide can be obtained from the NHS Response Line (telephone 0870 1555 455 and quote reference number N0625).

Information for the Public is available from the NICE website or from the NHS Response Line (quote reference number N0626 for a version in English and N0627 for a version in English and Welsh).

The quick reference guide for this guideline has been distributed to the following:

- NHS Trust chief executives in England and Wales
- Primary Care Trust (PCT) chief executives
- Local Heath Group general managers
- Local Health Board (LHB) chief executives
- Strategic Health Authority chief executives in England and Wales
- Medical and nursing directors in England and Wales
- Clinical governance leads in England and Wales
- Audit leads in England and Wales
- NHS trust, PCT and LHT libraries in England and Wales
- Patient advice and liaison co-ordinators in England and Wales
- Community Health Councils in Wales
- Consultant psychiatrists in England and Wales
- Consultant psychologists in England and Wales
- Consultants in Emergency Medicine in England and Wales
- Consultant paediatricians in England and Wales
- GPs in England and Wales
- Directors of health and social care
- NHS Director Wales
- Chief Executive of the NHS in England
- Chief Medical, Nursing and Pharmaceutical Officers in England and Wales
- Medical Director & Head of NHS Quality – Welsh Assembly Government
- NHS Clinical Governance Support Team
- Patient advocacy groups
- Representative bodies for health services, professional organisations and statutory bodies, and the Royal Colleges
- Mental health nurse consultants
- Senior pharmacists and pharmaceutical advisors in England and Wales
- Directors of directorates of health and social care
- Community psychiatric nurses

This guidance is written in the following context:
This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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Key priorities for implementation

Respect, understanding and choice

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated charcoal

- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.

- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

Assessment of needs

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

- Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

The following guidance is evidence-based. The grading scheme used for the recommendations (A, B, C and good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

1 Guidance

This guideline makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed. For the purpose of this guideline, the term self-harm is defined as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself.

In the first part, the guideline makes recommendations that apply across the whole health community, wherever people who self-harm present for help, including good practice points to improve the integration of the different services involved. In the second part of the guideline, the recommendations directly address the care offered to people who self-harm presenting in primary care, in the community, or in secondary care. Throughout the guideline, the need to treat people who self-harm with compassion and understanding is emphasised.

The guideline is relevant to all people aged 8 years of age and older who have self-harmed. Where it refers to children and young people, this applies to all people who are between 8 and 16 years of age inclusive. However, it should be borne in mind that local services vary the upper age limit depending upon whether a young person is in full-time education or not.

1.1 Issues for all services and healthcare professionals

1.1.1 Users' experience of services

The experience of care for people who self-harm is often unacceptable. All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses this as a priority.

Respect, understanding and choice

1.1.1.1 People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm. **GPP**

1.1.1.2 Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood. **GPP**

1.1.1.3 Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes. **GPP**

1.1.1.4 When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words. **GPP**

1.1.1.5 When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right. **GPP**

1.1.1.6 Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide people who self-harm with full information about the different treatment options available. **GPP**

When relatives or carers are present

1.1.1.7 People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality and to allow discussion about issues that may relate to the relationship between the service user and carers. **GPP**

1.1.1.8 Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety. **GPP**

Specific issues regarding treatment and care

1.1.1.9 People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment. **GPP**

1.1.1.10 Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments. **GPP**

1.1.1.11 When physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance. **GPP**

1.1.2 Staff training and service planning

Self-harm is poorly understood by many NHS staff. All staff that come into contact with people who self-harm need dedicated training to improve both their understanding of self-harm and the treatment and care they provide. Effective collaboration of all local health organisations will be essential to develop properly integrated services.

Staff training

1.1.2.1 Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed. **C**

1.1.2.2 People who self-harm should be involved in the planning and delivery of training for staff. **GPP**

1.1.2.3 Emergency departments should make training available in the assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment. **C**

1.1.2.4 Mental health services and emergency department services should jointly develop regular training programmes in the psychosocial assessment and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed. **C**

Planning of services

1.1.2.5 Strategic Health Authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm. **GPP**

1.1.2.6 Emergency departments, PCTs and local mental health services, in conjunction with local service users and carers wherever possible, should jointly plan the configuration and delivery of integrated physical and mental healthcare services within emergency departments for people who self-harm. **C**

1.1.2.7 Emergency departments catering for children and young people under 16 years of age, PCTs and local children's mental health services, in conjunction with local carers and service users, should jointly plan the configuration and delivery of integrated physical and mental healthcare services within emergency departments for children and young people who self-harm. **C**

1.1.2.8 In jointly planning an integrated emergency department service for people who self-harm, service managers should consider integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department. **GPP**

1.1.2.9 Emergency department and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day. **GPP**

1.1.3 Consent to care

Issues of consent, mental capacity and mental ill health in the assessment and treatment of people who self-harm should be understood and addressed by all healthcare professionals involved in the care of this group of people.

1.1.3.1 All healthcare professionals who have contact, in the emergency situation, with people who have self-harmed should be adequately trained to assess mental capacity and to make decisions about when treatment and care can be given without consent. **GPP**

1.1.3.2 Primary healthcare practitioners, ambulance staff, triage nurses and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed. Within the bounds of patient confidentiality, and subject to the patient's consent, staff should attempt to obtain relevant information from relatives, friends, carers and other key people, to inform the assessment. **GPP**

1.1.3.3 In the assessment and treatment of people who have self-harmed, mental capacity should be assumed unless there is evidence to the contrary. **GPP**

1.1.3.4 Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated. **GPP**

1.1.3.5 If a person is assessed as being mentally incapable, staff have a responsibility, under common law, to act in that person's best interests. If necessary, this can include taking the person to hospital, and detaining them to allow assessment and treatment against the person's stated wishes. **GPP**

1.1.3.6 Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to explain each new treatment or procedure and obtain consent before it is initiated. **GPP**

1.1.3.7 Staff working with people who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm. **GPP**

1.1.3.8 Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times. **GPP**

1.1.4 Activated charcoal

For the majority of drugs taken in overdose, taking activated charcoal as early as possible, preferably within 1 hour of ingestion, can prevent or reduce absorption of the drug. Activated charcoal should be immediately available for rapid and appropriate use.

1.1.4.1 Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times. **B**

1.1.4.2 All healthcare professionals who are able to offer activated charcoal to people who have self-poisoned should ensure that they know how and when this should be administered. This should include: **B**

- knowing for which poisons activated charcoal should and should not be used
- the potential dangers and contraindications of giving activated charcoal
- the need to encourage and support service users when offering activated charcoal.

1.2 The management of self-harm in primary care

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm, and their relatives, could also help in prevention. In remote areas, access to TOXBASE (the national database of the National Poisons Information Service [NPIS]) may be necessary.

1.2.1.1 When an individual presents in primary care following an episode of self-harm, healthcare professionals should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding. **GPP**

1.2.1.2	All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user.	C
1.2.1.3	In the assessment and management of self-injury in primary care, healthcare professionals should refer service users for urgent treatment in an emergency department, if assessment suggests there is a significant risk to the individual who has self-injured.	GPP
1.2.1.4	In most circumstances, people who have self-poisoned and present to primary care should be urgently referred to the nearest emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned, making accurate risk assessment difficult.	GPP
1.2.1.5	If there is any doubt about the seriousness of an episode of self-harm, the general practitioner should discuss the case with the nearest emergency department consultant, as management in secondary care may be necessary.	GPP
1.2.1.6	Consideration should be given to the service user's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate person where there is a risk of further self-harm or reluctance to attend other care centres, or the service user is very distressed.	GPP
1.2.1.7	In remote areas at considerable distance from an emergency department or where access is likely to be delayed, consideration should be given to initiating assessment and treatment of self-harm in the primary care setting, following discussion with the nearest emergency department consultant. This should include taking samples to test for paracetamol and other drugs, as indicated in TOXBASE.	GPP

When urgent referral to an emergency department is not necessary

1.2.1.8 If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services. **GPP**

1.2.1.9 Assessment of the service user's needs should be comprehensive and should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment. **C**

1.2.1.10 Following assessment and treatment of self-harm in primary care, the outcome of the risk and needs assessment, and full details of the treatment provided, should be forwarded to the appropriate secondary mental health team at the earliest opportunity. **GPP**

1.2.1.11 Healthcare professionals who may have to assess and/or treat people who have self-harmed should ensure that they are properly trained and competent to undertake assessment and treatment as necessary. **GPP**

Service users at risk of self-poisoning in primary care

1.2.1.12 In service users who are considered at risk of self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose, and should consider prescribing fewer tablets at any one time. **GPP**

1.2.1.13 Consideration should be given to preventing or reducing the prescription of co-proxamol, especially for people who are at risk of self-poisoning. **GPP**

1.2.1.14 As medication intended for relatives is often used in self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose when prescribing medication to relatives who live with a person who is considered at risk of self-poisoning. They should also consider prescribing fewer tablets at any one time. Care must be taken, however, to preserve confidentiality appropriately. **GPP**

1.3 The assessment and initial management of self-harm by ambulance services

Ambulance staff have an increasingly important role in the assessment and early treatment of self-harm, a role that needs to be well supported through effective collaboration with other professional groups.

1.3.1.1 When ambulance staff attend a person who has self-harmed, they should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding. **GPP**

1.3.1.2 Ambulance staff should be trained in the assessment and early management of self-harm. Training should particularly address the different methods of self-harm and the appropriate treatments, the likely effects if untreated, and issues of consent and mental capacity, as these apply both to adults, and to children and young people. **GPP**

1.3.1.3 In cases where, following an act of self-injury, the service user does not require emergency treatment in the emergency department, ambulance staff should consider, having taken full account of the service user's preferences, taking the service user to an alternative appropriate service, such as a specialist mental health service. The decision to do so should be taken jointly between the ambulance staff, the service user and the receiving service. **GPP**

1.3.1.4 Ambulance Trusts, the emergency department and Mental Health Trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self-harmed, where this is appropriate and does not increase the risks to the service user. **GPP**

1.3.1.5 In cases of self-poisoning, ambulance staff should obtain all substances and/or medications found at the scene of an emergency call, whether thought to be involved in the overdose or not, and pass these to staff upon arrival at the emergency department. **GPP**

1.3.1.6 Unless the service user's clinical condition requires urgent treatment that should not be delayed, ambulance staff should record relevant information about the service user's home environment, social and family support network, and history leading to self-harm, as well as the service user's initial emotional state and level of distress. This information should be passed to emergency department staff. **GPP**

1.3.1.7 When transporting people who have self-harmed to an emergency department, wherever possible, ambulance staff should take into account the service user's preferences when more than one emergency department facility exists within a reasonable distance, unless doing so significantly increases the risk to the service user, or when one department has specialised in the treatment of people who have self-harmed. **GPP**

1.3.1.8 When a person who has self-poisoned presents to the ambulance service within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, ambulance staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm. **B**

1.3.1.9 Activated charcoal may also be considered between 1 and 2 hours after ingestion as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm. **C**

1.3.1.10 In the emergency treatment of opioid overdose when using intravenous naloxone, ambulance staff should adhere to the guidelines established by the Joint Royal Colleges Ambulance Liaison Committee. Particular attention should be given to the possible need for repeated doses of naloxone and frequent monitoring of vital signs, because the effects of naloxone are short-lived in comparison with the effects of most opioids and service users frequently relapse once the effect of naloxone has worn off. All people who have overdosed with opioids should be conveyed to hospital, even if the initial response to naloxone has been good. **GPP**

1.3.1.11 The ambulance services should ensure that there is rapid access to TOXBASE and the NPIS so that their crew can gain additional information on substances and/or drugs ingested in cases of self-poisoning in order to assist in decisions regarding urgent treatment and the transfer of patients to the most appropriate facilities. **GPP**

1.3.1.12 When people who have self-harmed are considering refusing further treatment, ambulance staff should assess mental capacity and provide information about the potential consequences of not receiving treatment when attempting to gain valid consent. When consent is withheld, the guidance on consent and capacity in this guideline should be followed. **GPP**

1.3.1.13 PCTs, in conjunction with acute and mental health trusts, should consider the level of support needed for the delivery of an adequate pre-hospital care system for self-harm. Specific consideration should be given to the provision of telephone advice to ambulance staff from crisis resolution teams, approved social workers and Section 12 approved doctors, regarding the assessment of mental capacity and the possible use of the Mental Health Act in the urgent assessment of people who have self-harmed. **GPP**

1.3.1.14 Ambulance Trusts should regularly update ambulance staff about any change in local arrangements for services available for the emergency treatment of people who have self-harmed. **GPP**

1.3.1.15 Ambulance Trusts should routinely audit incidents of overdose, both to ensure that interventions are being used consistently and effectively, and to monitor adverse incidents. **GPP**

1.4 The treatment and management of self-harm in emergency departments

The emergency department provides the main services for people who self-harm. Emergency department staff should assess risk and emotional, mental and physical state quickly, and try to encourage people to stay to organise psychosocial assessment.

1.4.1 Triage

1.4.1.1 When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding. **GPP**

1.4.1.2 Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment. **GPP**

1.4.1.3 Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner. **C**

1.4.1.4 Triage nurses working in emergency departments should be trained in the use of mental health triage systems. **C**

1.4.1.5 All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness. **C**

1.4.2 People waiting for physical treatments

1.4.2.1 A psychosocial assessment should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed, or the patient is unconscious or otherwise incapable of being assessed. **GPP**

1.4.2.2 People who have self-harmed should be provided with clear and understandable information about the care process, both verbally and as written material in a language they understand. **C**

1.4.2.3 If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety. **GPP**

1.4.3 People who wish to leave before assessment and/or treatment

1.4.3.1 For a person who has self-harmed and presents to services, but wishes to leave before psychosocial assessment has been undertaken, assessment of mental capacity and the presence of mental illness should be undertaken before the person leaves the service. This assessment should be clearly recorded in his or her notes. The assessment should be passed on to the person's GP and to the relevant mental health services as soon as possible to enable rapid follow-up. **C**

1.4.3.2 People who have self-harmed and present to services and wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental illness is established, should be referred for urgent mental health assessment. Appropriate measures should also be taken to prevent the person leaving the service. **C**

1.5 Medical and surgical management of self-harm

Self-poisoning can be treated by reducing absorption, increasing elimination and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with tissue adhesive, whilst more complicated injuries will need surgical assessment and possibly exploration.

1.5.1 General treatment for ingestion

1.5.1.1 Gastrointestinal decontamination should be considered only for people who have self-harmed by poisoning who present early, are fully conscious with a protected airway, and are at risk of significant harm as a result of poisoning. **B**

1.5.1.2 When a person who has self-poisoned presents to the emergency department within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, emergency department staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm. **B**

1.5.1.3 When a person who has self-poisoned is fully conscious and able to protect his or her own airway, activated charcoal may also be considered between 1 and 2 hours after ingestion, as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm. **C**

1.5.1.4 Multiple doses of activated charcoal should not be used in the management of self-poisoning to reduce absorption, or to promote elimination of poisons, unless specifically recommended by TOXBASE or following consultation with the National Poisons Information Service (NPIS). **B**

1.5.1.5 Emetics, including ipecac (ipecacuanha), should not be used in the management of self-poisoning. **B**

1.5.1.6 Cathartics as a specific treatment should not be used in the management of self-poisoning. **C**

1.5.1.7 Gastric lavage should not be used in the management of self-poisoning unless specifically recommended by TOXBASE or following consultation with the NPIS. **B**

1.5.1.8 Whole bowel irrigation should not be used in the management of self-poisoning, unless specifically recommended by TOXBASE or following consultation with the NPIS. **C**

Collecting samples and interpreting results

1.5.1.9 Staff involved in the emergency treatment of self-poisoning should collect appropriate samples for analysis; usually this will be a sample of blood, although samples of urine, vomit or sometimes gastric contents may be indicated following discussion with the NPIS. If possible, samples of the suspected poison should also be collected. **GPP**

1.5.1.10 Hospital laboratory staff should provide emergency department staff with regular updates about which toxicology tests are available, both locally and at the nearest specialised toxicology laboratory. These should include information on the correct methods of collecting, handling and storing samples, and how samples should be transferred to the laboratory. **GPP**

1.5.1.11 Where emergency department staff are unsure about the value of undertaking a toxicology assay or about whether an assay is available locally, advice should be sought from TOXBASE, the local hospital laboratory, a specialised toxicology laboratory or the NPIS. **GPP**

1.5.1.12 When emergency department staff are unsure about the interpretation of assay results, advice should be sought from the local hospital laboratory, specialised toxicology laboratory or the NPIS. **GPP**

Information and laboratory services available to clinicians treating self-poisoning

Emergency department staff should have easy access to TOXBASE, be fully trained in its use, and know how and when to contact the NPIS.

1.5.1.13 TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. TOXBASE should be the first point of call for poisons information. **GPP**

1.5.1.14 The NPIS telephone number should be permanently and easily available to clinical staff involved in the emergency treatment of self-poisoning. The NPIS should normally be contacted only directly after clinicians have accessed TOXBASE or if there is concern about the severity of poisoning in a particular case. **GPP**

1.5.1.15 Clinical staff involved in the emergency treatment of self-poisoning should be given training to better understand human toxicology, in order to make best use of TOXBASE and the NPIS telephone service. Emergency departments, in conjunction with local hospital laboratories or regional toxicology units, or NPIS units, should ensure all staff receive regular training. **GPP**

1.5.1.16 In cases where the suspected poison is a substance for which little toxicology data exists, clinical and laboratory data about exposure and absorption should be passed to the NPIS to help in the development of TOXBASE and other poisons information databases. **GPP**

1.5.1.17 For further information about the management of overdose with substances covered by this guideline and for the specific management and treatment of overdose with substances not covered in this guideline, clinicians should consult TOXBASE or discuss the individual case with the NPIS. **GPP**

Paracetamol screening

1.5.1.18 Plasma paracetamol concentrations should be measured in all conscious patients with a history of paracetamol overdose, or suspected paracetamol overdose, as recommended by TOXBASE. They should also be taken in patients with a presentation consistent with opioid poisoning, and in unconscious patients with a history of collapse where drug overdose is a possible diagnosis. Plasma paracetamol levels should be measured for risk assessment no earlier than 4 hours and no later than 15 hours after ingestion, as results are not reliable outside this time period. **C**

1.5.2 Management of paracetamol overdose

1.5.2.1 Following gut decontamination with activated charcoal as recommended in this guideline, TOXBASE should be used to guide the further management of paracetamol poisoning. TOXBASE should be easily available to all clinicians treating paracetamol poisoning. **C**

1.5.2.2 Intravenous acetylcysteine should be considered as the treatment of choice for paracetamol overdose (although the optimum dose is unknown). If acetylcysteine is not available or cannot be used, for example in people who abuse intravenous drugs where intravenous access may be difficult, or for people with needle phobia, then TOXBASE should be consulted. **C**

1.5.2.3 In the event of an anaphylactoid reaction following administration of intravenous acetylcysteine, procedures outlined in TOXBASE should be followed. **GPP**

1.5.2.4 In cases of staggered ingestion of paracetamol, the procedures outlined in TOXBASE should be followed in conjunction with discussion with the NPIS. **GPP**

1.5.3 Flumazenil in benzodiazepine overdose

If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help reduce the need for admission to intensive care. Although widely used, flumazenil is not currently licensed for the treatment of benzodiazepine overdose in the UK.

1.5.3.1 When a positive diagnosis of self-poisoning with a benzodiazepine has been made, the possibility of mixed overdose should be considered, and investigated if necessary, at the earliest opportunity, especially if the patient's clinical progress suggests that he or she may later require admission to intensive care. **GPP**

1.5.3.2 In patients who are unconscious or showing marked impairment of consciousness, with evidence of respiratory depression likely to lead to admission to intensive care with endotracheal intubation, and in whom self-poisoning with a benzodiazepine is suspected, flumazenil should be considered as a therapeutic option to avoid intubation and artificial ventilation. The decision to administer flumazenil should be based upon a comprehensive assessment including a full clinical and biochemical assessment of the patient's respiratory status, and his or her ability to protect his or her own airway. Clinicians should, however, avoid the use of flumazenil in: patients who may have ingested proconvulsants, including tricyclic antidepressants; those who have a history of epilepsy; and patients who are dependent upon benzodiazepines. **B**

1.5.3.3 When using flumazenil in the treatment of benzodiazepine poisoning, clinicians should use small doses, comparable to those used in other contexts, and administer slowly, to avoid the emergence of the more serious adverse reactions associated with the use of flumazenil. **GPP**

1.5.3.4 Given the relatively high incidence of adverse psychological events experienced by patients following administration of flumazenil, the minimum effective dose should be used and only for as long as it is clinically necessary. **B**

1.5.3.5 When using flumazenil in the treatment of benzodiazepine poisoning, care should be taken to ensure that patients who become agitated should be closely monitored and warned of the risk of re-sedation, especially if the patient expresses the desire to leave the treatment setting. **C**

1.5.3.6 Flumazenil should be used in the treatment of benzodiazepine overdose only when full resuscitation equipment is immediately available. **GPP**

1.5.3.7 Only clinicians who have been explicitly trained in the use of flumazenil for the treatment of benzodiazepine poisoning, as described in this guideline, should undertake to administer flumazenil in this context. **GPP**

1.5.4 Treatment and management of poisoning with salicylates

1.5.4.1 Following gut decontamination with activated charcoal, where this is indicated by this guideline, the further treatment of self-poisoning with salicylates should follow the current guidance outlined in TOXBASE. **C**

1.5.5 Treatment of opioid overdose

1.5.5.1 Naloxone should be used in the diagnosis and treatment of opioid overdose associated with impaired consciousness and/or respiratory depression. **B**

1.5.5.2 The minimum effective dose of naloxone should be used to reverse respiratory depression caused by opioids without causing the patient to become agitated. This is especially important in people who are dependent upon opioids. **C**

1.5.5.3 When reversing the effects of opioids, especially long-acting opioids such as methadone, the use of an intravenous infusion of naloxone should be considered. **C**

1.5.5.4 When reversing the effects of opioid overdose using naloxone in people who are dependent upon opioids, naloxone should be given slowly. Preparations should be made to deal with possible withdrawal effects, especially agitation, aggression and violence. **GPP**

1.5.5.5 When using naloxone in the treatment of opioid poisoning, regular monitoring of vital signs (including the monitoring of oxygen saturation) should be undertaken routinely until the patient is able to remain conscious with adequate spontaneous respiration unaided by the further administration of naloxone. **GPP**

1.5.6 General treatment for self-injury

The treatment of self-injury should be the same as for any other injury, although the level of distress should be taken into account, and therefore delays should be avoided. Tissue adhesive is effective and simple to use for small superficial wounds.

1.5.6.1 In the treatment and management of injuries caused by self-cutting, appropriate physical treatments should be provided without unnecessary delay irrespective of the cause of the injury. **GPP**

1.5.6.2 In the treatment and management of people with self-inflicted injuries, clinicians should take full account of the distress and emotional disturbance experienced by people who self-harm additional to the injury itself, in particular, immediately following injury and at presentation for treatment. **GPP**

1.5.6.3 In the treatment and management of superficial uncomplicated injuries of greater than 5 cm in length, or deeper injuries of any length, wound assessment and exploration, in conjunction with a full discussion of preferences with the service user, should determine the appropriate physical treatment provided. **GPP**

Superficial wound closure

1.5.6.4 In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, the use of tissue adhesive should be offered as a first-line treatment option. **A**

1.5.6.5 In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, if the service user expresses a preference for the use of skin closure strips, this should be offered as an effective alternative to tissue adhesive. **B**

1.6 Support and advice for people who repeatedly self-harm

1.6.1 Advice for people who repeatedly self-poison

Service users who repeatedly self-poison, and their carers where appropriate, may need advice about the risks of self-poisoning.

1.6.1.1 Harm minimisation strategies should not be offered for people who have self-harmed by poisoning. There are no safe limits in self-poisoning. **GPP**

1.6.1.2 Where service users are likely to repeat self-poisoning, clinical staff (including pharmacists) may consider discussing the risks of self-poisoning with service users, and carers where appropriate. **GPP**

1.6.2 Advice for people who repeatedly self-injure

Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure.

1.6.2.1 For people presenting for treatment who have a history of self-harm, clinicians may consider offering advice and instructions for the self-management of superficial injuries, including the provision of tissue adhesive. Discussion with a mental health worker may assist in the decision about which service users should be offered this treatment option. **GPP**

1.6.2.2 Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss harm minimisation issues/techniques. Suitable material is available from many voluntary organisations. **GPP**

1.6.2.3 Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss appropriate alternative coping strategies. Suitable material is available from many voluntary organisations. **GPP**

1.6.2.4 Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue. **GPP**

1.7 Psychosocial assessment

Everyone who has self-harmed should have a comprehensive assessment of needs and risk; engaging the service user is a prerequisite.

1.7.1 Engaging the service user

1.7.1.1 Healthcare workers should undertake the assessment of needs and risk for people who have self-harmed as part of a therapeutic process to understand and engage the service user. **GPP**

1.7.2 Assessment of needs (specialist mental health professionals)

1.7.2.1 All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment. **C**

1.7.2.2 The comprehensive assessment of needs should be written clearly in the service user's notes. **C**

1.7.2.3 To encourage joint clinical decision making, service users and the assessor should both read through the written assessment of needs, wherever possible, to mutually agree the assessment. Agreement should be written into the service user's notes. Where there is significant disagreement, the service user should be offered the opportunity to write his or her disagreement in the notes. The assessment should be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up. **GPP**

1.7.3 Assessment of risk (specialist mental health professionals)

1.7.3.1 All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent. **C**

1.7.3.2 The assessment of risk should be written clearly in the service user's notes. The assessment should also be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up. **GPP**

1.7.3.3 If a standardised risk assessment scale is used to assess risk, this should be used only to aid in the identification of people at high risk of repetition of self-harm or suicide. **C**

1.7.3.4 Standardised risk-assessment scales should not be used as a means of identifying service users at supposedly low risk who are not then offered services. **C**

1.7.3.5 Consideration should be given to combining the assessment of risks into a needs assessment framework to produce a single integrated psychosocial assessment process. **GPP**

1.7.4 Training

1.7.4.1 All health professionals, including junior psychiatrists, social workers and psychiatric nurses, who undertake psychosocial assessment for people who have self-harmed should be properly trained and supervised to undertake assessment of needs and risk specifically for people who self-harm. **C**

1.8 Referral, admission and discharge following self-harm

Referral, treatment and discharge following self-harm should be based on the overall assessment of needs and risk.

1.8.1.1 The decision to refer for further assessment and/or treatment or to discharge the service user should be taken jointly by the service user and the healthcare professional whenever this is possible. When this is not possible, either as a result of diminished mental capacity or the presence of significant mental illness, this should be explained to the service user and written in their notes. **GPP**

1.8.1.2 Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto the service user's GP and to any relevant mental health services as soon as possible to enable follow-up. **C**

1.8.1.3 The decision to discharge a person without follow-up following an act of self-harm should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto their GP and to any relevant mental health services. **C**

1.8.1.4 In particular, the decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions. **GPP**

1.8.1.5 Temporary admission, which may need to be overnight, should be considered following an act of self-harm, especially for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity thereafter. **GPP**

1.9 Special issues for children and young people (under 16 years)

Children and young people who self-harm have a number of special needs, given their vulnerability. Physical treatments will follow similar principles as for adults.

1.9.1.1 Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department. **GPP**

1.9.1.2 Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed. **GPP**

1.9.1.3 All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary. **C**

1.9.1.4 For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person. **C**

1.9.1.5 A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm. **C**

1.9.1.6 Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person. **C**

1.9.1.7 Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues. **GPP**

1.9.1.8 In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act. **GPP**

1.9.1.9 During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team and social services and education staff as appropriate. **C**

1.9.1.10 All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues. **GPP**

1.9.1.11 Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should: **C**

- be trained specifically to work with children and young people, and their families, after self-harm
- be skilled in the assessment of risk
- have regular supervision
- have access to consultation with senior colleagues.

1.9.1.12 Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed. **GPP**

1.9.1.13 For young people who have self-harmed several times, consideration may be given to offering developmental group psychotherapy with other young people who have repeatedly self-harmed. This should include at least six sessions. Extension of the group therapy may also be offered; the precise length of this should be decided jointly by the clinician and the service user. **B**

1.10 Special issues for older people (older than 65 years)

When older people self-harm, treatments will be much the same as for younger adults, but the risk of further self-harm and suicide are substantially higher and must be taken into account.

1.10.1.1 All people older than 65 years of age who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to the potential presence of depression, cognitive impairment and physical ill health, and should include a full assessment of their social and home situation. **GPP**

1.10.1.2 All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults. **GPP**

1.10.1.3 Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and levels of risk. **GPP**

1.10.1.4 In all other respects, the assessment and treatment of older adults who have self-harmed should follow the recommendations given for adults. **GPP**

1.11 Psychological, psychosocial and pharmacological interventions

Referral for further assessment and/or treatment should be based upon a comprehensive psychosocial assessment, and should be aimed at treating a person's underlying problems or particular diagnosis rather than simply treating self-harming behaviour, although intensive therapeutic help with outreach may reduce the risk of repetition. Whatever the treatment plan, primary care and mental health services should be informed.

1.11.1.1 Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed. **C**

1.11.1.2 Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, including the likely benefits and disadvantages, in a spirit of collaboration, before treatments are offered. The provision of relevant written material with time to talk over preferences should also be provided for all service users. **GPP**

1.11.1.3 The mental health professional making the assessment should inform both mental health services (if they are involved already) and the service user's GP, in writing, of the treatment plan. **GPP**

1.11.1.4 For people who have self-harmed and are deemed to be at risk of repetition, consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow frequent access to a therapist, when needed, home treatment when necessary, and telephone contact; and outreach should include following up the service user actively when an appointment has been missed to ensure that the service user is not lost from the service. The therapeutic intervention plus outreach should continue for at least 3 months. **C**

1.11.1.5 For people who self-harm and have a diagnosis of borderline personality disorder, consideration may be given to the use of dialectical behaviour therapy. However, this should not preclude other psychological treatments with evidence of effectiveness for people with this diagnosis, but not reviewed for this guideline. **C**

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/Docref.asp?d=32018

This guideline is relevant to people aged 8 years and older who have carried out acts of self-harm, regardless of whether accompanied by mental illness, and to all healthcare professionals involved in the help, treatment and care of people who self-harm, and their carers. The guideline makes recommendations that cover the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm. The professional groups that this guideline will be relevant to include the following.

- Professional groups who are involved in the care and treatment of people who have self-harmed, including emergency department staff, paramedical and ambulance staff, general practitioners, counsellors, paediatricians, paediatric nurses, psychiatrists, prison health staff, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses and others.

- Professionals in other health and non-health sectors who may have direct contact with, or are involved in the provision of health and other public services for, people who have self-harmed. These may include occupational therapists, art therapists, pharmacists, and the police and professionals who work in the criminal justice and education sectors.

- Those with responsibility for planning services for people who self-harm and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guideline will cover the acute care of self-harm in people with learning disabilities, but not repetitive self-injurious behaviour, such as head banging.

3 Implementation in the NHS

3.1 In general

The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

Local health communities should review their existing practice for self-harm against this guideline as they develop their Local Delivery Plans. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of service users that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.doh.gov.uk/nsf/mentalhealth.htm

3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. The Guideline Development Group's full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Mental Health (see Section 5).

- Research, using appropriate survey and rigorous qualitative methods, should be conducted about the meaning of self-harm to people from different ethnic and cultural groups. This should include the exploration of issues of intentionality.

- A study using an appropriate and rigorously applied qualitative methodology should be undertaken to explore user experiences of services.

- Qualitative research methods, such as Q sort and Interpretive Phenomenological Analysis, should be used to better understand staff attitudes to self-harm and their psychological and social origins.

- A study of appropriate design reporting all relevant patient outcomes (mortality, morbidity, numbers lost to the service, patient satisfaction) should be undertaken to assess the impact of the introduction of the Mental Health Triage Scale.

- Further research into treatments specific to people who self-harm should evaluate the differential responses of different patient subgroups, using a broad range of outcomes, especially those relevant to service users, such as quality of life.

- An adequately powered RCT reporting all relevant outcomes should be undertaken to determine the clinical and cost effectiveness of intensive interventions combined with assertive outreach for people who self-harm. The study should address patient characteristics (such as age, gender, diagnosis, frequency and method of self-harm, past history of abuse) and therapists' characteristics (such as age, gender, training, professional discipline, parental status). Outcomes should include loss from services, admission rates, satisfaction, repetition of self-harm, quality of life, and employment status.

- An appropriately designed and adequately powered study should be undertaken to clarify the optimum dose level at which acetylcysteine should be used (for both oral and intravenous administration) in the treatment of paracetamol poisoning, reporting all relevant biochemical and clinical outcomes, including liver function, liver failure and adverse reactions. Consideration should be given to patient characteristics such as co-ingested substances, including alcohol.

5 Other versions of this guideline

Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline *Self-harm: the short-term*

physical and psychological management and secondary prevention of self-harm in primary and secondary care will be published by the National Collaborating Centre for Mental Health; it will be available from its website (www.rcpsych.ac.uk/cru/nccmh.htm), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The Guideline Development Process – An Overview for Stakeholders, the Public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

Information for the public

A version of this guideline for people who self-harm, their advocates and carers, and for the public (including information for children and young people) is available from the NICE website (www.nice.org.uk/CG016publicinfo) or from the NHS Response Line (0870 1555 455; quote reference number N0626 for an English version and N0627 for an English and Welsh version). This is a good starting point for explaining to patients the kind of care they can expect.

Quick reference guide

A quick reference guide for healthcare professionals is also available from the NICE website (www.nice.org.uk/CG016quickrefguide) or from the NHS Response Line (0870 1555 455; quote reference number N0625).

6 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C on the basis of the level of associated evidence or noted as a GPP recommendation (see Box 1) – this grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

Box 1: Hierarchy of evidence and recommendations grading scheme

Level	Type of evidence	Grade	Evidence
I	Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials	**A**	At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation
IIa **IIb** **III**	Evidence obtained from at least one well-designed controlled study without randomisation Evidence obtained from at least one other well-designed quasi-experimental study Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies	**B**	Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	**C**	Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available
		GPP	Recommended good practice based on the clinical experience of the Guideline Development Group

Adapted from Eccles, M and Mason, J (2001). How to develop cost-conscious guidelines. *Health Technology Assessment* **5**: 16; NHS Executive. Clinical Guidelines: *Using Clinical Guidelines to Improve Patient Care Within the NHS*. London: 1996.

Appendix B: The Guideline Development Group

Professor Paul Lelliott (Chair)
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Consultant Psychiatrist, Oxleas Mental Heath NHS Trust

Dr Tim Kendall (Facilitator)
Co-Director, National Collaborative Centre for Mental Health
Deputy Director, Royal College of Psychiatrists Research Unit
Medical Director and Consultant Psychiatrist, Sheffield Care Trust

Mr Simon Armson
Chief Executive, Samaritans (until July 2004)
Psychotherapist and Mental Health Act Commissioner

Mr Simon Baston
Charge Nurse, Emergency Nurse Practitioner, A&E Department, Sheffield Teaching Hospitals

Ms Pamela Blackwood
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Rachel Burbeck
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Richard Jenkins
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Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

Dr Chaand Nagpaul (Chair)
General practitioner, Stanmore

Mr John Seddon
Patient representative

Professor Kenneth Wilson
Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust

Professor Shirley Reynolds
Professor of Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich

Dr Roger Paxton
R&D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

Appendix D: Technical detail on the criteria for audit

Objectives for the audit

One or more audits can be carried out in different care settings to ensure that:

- individuals who self-harm are involved in their care
- treatment options are appropriately offered and provided for individuals who self-harm.

Individuals to be included in an audit

A single audit could include all individuals who self-harm. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people who self-poison or self-injure
- a sample of people from particular populations in primary care.

Measures that could be used as a basis for an audit

See table on pages 43–48.

STANDARDS	CRITERIA	AUDIT METHODS
1. Staff show respect and understanding to people who self-harm and present to an emergency department	1.1 People who self-harm and present to an emergency department report that they: • are treated respectfully • are given full information about their treatment and care • are fully involved in decisions about their treatment and care • are provided with written information about relevant local services	Survey of a consecutive series of people attending an emergency department after self-harm
2. Trusts provide appropriate training for healthcare staff who have contact with people who self-harm	2.1 Training includes: • the problems faced by people who self-harm when they have contact with services • an exploration of some of the meanings of and motives for self-harm • capacity and consent in relation to self-harm • assessment of people who self-harm • early management, including the use of activated charcoal • the content of the NICE guideline 2.2 Trusts train the following groups of staff: • ambulance crews • emergency department medical staff • mental health professionals who assess people who self-harm as part of their duty commitment	A. Review of trusts' training records B. Survey of staff perceptions of the quality of training

STANDARDS	CRITERIA	AUDIT METHODS
3. Activated charcoal should be immediately available to ambulance and emergency department staff involved in the care of people who have self-harmed by poisoning at all times	3.1 Ambulance crews give activated charcoal at the earliest opportunity and within 1 hour following ingestion to a person who has self-poisoned 3.2 Emergency department staff give activated charcoal at the earliest opportunity and within 1 hour following ingestion to a person who has self-poisoned (unless administered previously) 3.3 Emergency department staff give activated charcoal between 1 and 2 hours of ingestion to people who have self-poisoned and are at risk of significant harm	Review of Ambulance staff/emergency department records of consecutive series of patients assessed by ambulance/emergency department staff

STANDARDS	CRITERIA	AUDIT METHODS
4. Healthcare staff who have first contact with people who self-harm conduct an adequate initial assessment	4.1 Ambulance staff who attend a person who has self-harmed record: • information about home environment • social and family support network • history leading to self-harm • patient's emotional state and level of distress 4.2 Ambulance staff collect all substances and medications found at the scene 4.3 The triage assessment in the emergency department includes: • capacity and willingness to stay and accept treatment • needs for physical care • need for urgent psychosocial and/or psychiatric assessment (the use of a standardised mental health triage system such as the Australian Mental Health Triage Scale would fulfil this criterion) 4.4 The triage assessment takes account of information provided by the ambulance staff if they were involved in conveying the person to hospital	Review of written ambulance staff/triage nurse assessments of consecutive series of patients who attend emergency department having self-harmed

STANDARDS	CRITERIA	AUDIT METHODS
5. Emergency departments have appropriate facilities for the care of people who have self-harmed	5.1 Emergency departments offer people who have self-harmed the option of waiting for treatment in an environment that is safe, supportive and that minimises distress. This must include regular contact with a named member of staff	Survey of a consecutive series of people attending an emergency department after self-harm
6. Healthcare staff offer treatment for the physical consequences of self-harm, regardless of the patient's willingness to accept psychosocial assessment or psychiatric treatment	6.1 Physical treatment includes: • wound assessment • adequate anaesthesia and/or analgesia, to be reassessed throughout treatment • tissue adhesive • sedation	Survey of a consecutive series of people attending an emergency department after self-injury
7. Healthcare professionals offer full information about the treatment options	7.1 Healthcare staff who attend a person who has self-harmed make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure or treatment is initiated	Survey of a consecutive series of people attending an emergency department after self-harm

STANDARDS	CRITERIA	AUDIT METHODS
8. A healthcare professional conducts and records a comprehensive assessment of psychosocial needs for every person who self-harms and presents to the health service	8.1 The needs assessment includes: • social situation (living arrangements, work, debt) • personal relationships • recent life events and current difficulties • psychiatric history (including previous self-harm, drug/alcohol use) • mental state examination • enduring psychological characteristics associated with self-harm • motivation for the act 8.2 Decision about referral for further management should be based upon a combined needs and risk assessment	Review of emergency department/mental health records of consecutive series of patients assessed following an episode of self-harm

STANDARDS	CRITERIA	AUDIT METHODS
9. A healthcare professional conducts and records a comprehensive assessment of risk for every person who self-harms and presents to the health service	9.1 The risk assessment includes: • characteristics of the act of self-harm (intent, medical seriousness, use of violent methods, evidence of planning, precautions taken to prevent rescue) • characteristics of the person (hopelessness, forensic history, future suicidal intent) • circumstances of the person (social class, physical illness, recent bereavement, social isolation) 9.2 Decision about referral for further management should be based upon a combined needs and risk assessment	Review of emergency department/mental health records of consecutive series of patients assessed following an episode of self-harm

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.

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