NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

SCOPE

1 Guideline title

Self-harm: the longer term management of self-harm

1.1 Short title

Self-harm (longer term management)

2 The remit

This guideline follows on from Clinical Guideline 16 (2004): 'Self harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care'. The Department of Health has asked NICE: ‘To prepare a clinical guideline on the management of self-harm (intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act) to include the role of mental health professionals in ensuring service users who have self-harmed receive appropriate treatment for underlying problems that may have led to the act of self-harm.’ It will cover the longer term management of self-harm in a variety of settings.

3 Clinical need for the guideline

3.1 Epidemiology

a) The prevalence of self-harm is difficult to estimate. A national interview survey in 1999 suggested between 4.6% and 6.6% of people in the UK have self-harmed. A more recent international survey of 15-16-year-olds found the prevalence of self–harm (in the past year) in the UK was 3.2% in boys and 11.1% in girls. The lifetime prevalence in the UK for self-harm was 4.8% in boys and 16.7% in girls.

b) A survey of general hospitals in Oxford, Manchester and Leeds found 7344 people presented with a total of 10,498 episodes of self-harm. Most episodes (80%) were due to self-poisoning and the rest to self-injury (mainly self-cutting). Although most research to date has been hospital-based, it is likely that many self-harm episodes do not come to the attention of health services.

c) A recent systematic review found that there was a higher prevalence of self-harm in South Asian women than in South Asian men and white women in the UK.

3.2 Current practice

a) Self-harm is most commonly managed in secondary care. This includes both hospital medical care and mental health services. About half of the people who present to an accident and emergency (A&E) department after self-harming are assessed by a mental health professional. Treatments include psychosocial interventions, pharmacological interventions and harm minimisation.

b) People who self-harm often also have contact with primary care. About half of the people who attend an emergency department following self-harm will have visited their GP in the previous month. A similar proportion will visit their GP within 2 months of attending an A&E department following self-harm.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, ‘Further information’).

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) All people aged 8 years or older who self-harm.

4.1.2 Groups that will not be covered

a) Children younger than 8 years.

b) People with a neurodevelopmental disorder with repetitive stereotypical self-injurious behaviour (SIB), for example head-banging in people with a significant learning disability.

4.2 Healthcare setting

a) Care received in primary, secondary and community healthcare settings from healthcare professionals who have direct contact with people who self-harm, and who make decisions about risk and needs assessment, treatment and management of care for people who self-harm.

b) The guideline will not provide specific recommendations for A&E departments, paramedic services, prison medical services, the police and those who work in the criminal justice, social care and education sectors, but the guideline will be relevant to their work.

4.3 Clinical management

4.3.1 Key clinical issues that will be covered

a) Longer term care management of people who self-harm.

b) Ongoing psychosocial assessment for the longer term management of people who have self-harmed. This will include an assessment of need and risk and how these are integrated.

c) Psychosocial interventions compared with control groups, or other active interventions, for the specific treatment of self-harming behaviour. For example, but not exclusively, self-help, problem-solving therapy, mentalisation-based treatment, cognitive behavioural therapy, dialectical behaviour therapy, psychodynamic psychotherapy and family therapy.

d) Pharmacological interventions for the specific treatment of self-harm compared with control groups, other pharmacological interventions, or psychological interventions for the treatment of self-harm. For example, antidepressants, anxiolytics and antipsychotics for the specific treatment of self-harm.

e) Safe prescribing for people with a history of self-harm.

f) Treatment of groups who may have specific care needs. For example, those from black and minority ethnic groups, people who self-cut, young people and older adults.

g) Harm minimisation and other strategies aimed at reducing the risks and / or harm associated with self-harming behaviour. For example, advice on safer cutting, distraction techniques and exploring alternatives to self-harm.

h) Referral to other guidelines for the treatment and management of any accompanying or underlying mental health problems.

i) Possible adverse effects associated with the provision of treatment following self-harm.

4.3.2 Clinical issues that will not be covered

a) The treatment and management of any mental health problem or substance use disorder that may accompany, underlie or be associated with self-harming behaviour. However, the guideline will refer to other relevant NICE guidance.

b) The longer term management of the physical consequences of self-harm, such as reconstructive surgery, pain management and infection arising from injuries.

c) Acute physical, psychiatric and psychological care of people who have just self-harmed. For the immediate care of those that have self harmed, please see Clinical Guideline 16 (2004): 'Self harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care'.

4.4 Main outcomes

a) Self-harm and self-harm repetition (for example, self-poisoning or self-cutting).

b) Suicide.

c) Quality of life.

d) Service user determined outcomes.

We will also consider secondary outcomes such as social and psychological functioning, other causes of mortality, and resource use.

4.5 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually only be from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see 'Further information').

4.6 Status

4.6.1 Scope

This is the consultation draft of the scope. The consultation dates are 7 August 2009 to 4 September 2009.

4.6.2 Timing

The development of the guideline recommendations will begin in November 2009.

5 Related NICE guidance

5.1 Published guidance

5.1.1 NICE guidance to be updated

When reviewing the evidence for this guideline a need maybe identified to update section of CG16 on Psychological, pharmacological and psychosocial interventions for the management of self-harm

5.1.2 Other related NICE guidance

- Schizophrenia (update). NICE clinical guideline 82 (2009). Available from www.nice.org.uk/CG82
- Borderline personality disorder. NICE clinical guideline 78 (2009). Available from www.nice.org.uk/CG78
- Antisocial personality disorder. NICE clinical guideline 77 (2009). Available from www.nice.org.uk/CG77
- Bipolar disorder. NICE clinical guideline 38 (2006). Available from www.nice.org.uk/CG38
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005). www.nice.org.uk/CG26
- Violence. NICE clinical guideline 25 (2005). Available from www.nice.org.uk/CG25

- Depression (amended): the management of depression in primary and secondary care. NICE clinical guideline 23 (2007). Available from www.nice.org.uk/CG23
- Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2007). Available from www.nice.org.uk/CG22
- Self-harm. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG16

5.2 Guidance under development

NICE is currently developing the following related guidance (details available from the NICE website).

- Depression in adults with a chronic physical health problems. NICE clinical guideline. Publication expected October 2009.
- Depression in adults (update). NICE clinical guideline. Publication expected October 2009.

6 Further information

Information on the guideline development process is provided in:

- 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS'
- 'The guidelines manual'.

These are available from the NICE website (www.nice.org.uk/guidelinesmanual). Information on the progress of the guideline will also be available from the NICE website (www.nice.org.uk).