**NICE Clinical Guideline**

**Self Harm Scoping Workshop Notes – 28th July 09**

**Group A**

1. **Title. Which is most appropriate:**
   **a) Self harm: management of self harm in primary, secondary and community care (update)**
   **OR**
   **b) Self harm: the longer term management of self harm in primary, secondary and community care**
   **OR**
   **c) Self harm: the management of self harm after the first 48 hours**
   *The group preferred the title "Self harm: the longer term management of self harm" as the term 'update' is confusing.*

2. **Suggested guideline development group composition – Are all the suggested members appropriate and important? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?**
   *The group felt that there should be a psychiatrist with experience of working with older people on the GDG, and more than one representative from the voluntary sector. It was also suggested that each profession should have a representative from each healthcare setting, possibly as sub-groups.*

3. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and the relative importance of improving clinical care for those who self harm?**
   *Overall, the group felt the scope was on the right track, with some amendments (see below). The group did raise concerns over the types of evidence that will be used to develop the guideline and stressed that RCTs should not be the only types of evidence used, particularly in this field.*

4. **Do the topics listed in the scope (section 4.3.1) cover the areas of care for people who self harm that are considered to be most important? Are there any omissions or any topics on the list that should be deleted?**
   *The group felt the following amendments should be made to section 4.3.1:*
   a) *"Longer term care for people. . ." should be amended to "longer term care and support for people. . ."*
   *b) No changes were suggested*
   *c) No changes were suggested*
   *d) No changes were suggested*
   *e) Additional groups that should be considered are: older people; those with dementia; those with physical health problems; those with learning difficulties and those with communication problems – language, cultural, physical or emotional.*
   *f) Distraction strategies (e.g. counting, knitting etc) should also be looked at. The use of harm minimisation strategies may be helpful*

*in the short term but unsure how helpful they are in the long term and should only be suggested by trained professionals. It was also suggested that long term wound management, pain and infection management, and reconstructive surgery should be explored.*

*g) No changes suggested.*

*h) No changes suggested.*

*4.3.2 – the group felt that prisons, and the transition from prison, should not be excluded from the scope.*

5.

**a) How big will the cost impact be?**

*It was highlighted that the cost effectiveness should not be judged over a short amount of time as it may take service users 8-10 years of treatment before any benefits were truly realised. The group also raised the issue of direct payments and the effects this may have on cost effectiveness.*

**b) How appropriate are the populations and settings?**

*The group felt the age should be lowered to 5 yrs or over.*
*The group felt that people with learning disabilities who display repetitive self injurious behaviour (SIB) should be included within the scope. It was asserted that this is a form of self harm and is likely to be due to underlying causes, and not 'part of the learning disability' as often assumed.*
*Reference to the original self harm guideline should be included in 4.1.2 c).*
*The group agreed with the settings listed, but felt that prisons should also be included.*

**c) What are the key outcomes to be considered (see also section 4.4 of the draft scope)?**

*The service users' own perception of recovery, self efficacy/control and personalisation were suggested as additional outcomes.*

**d) What are the group's views about the available evidence base?**

*The group felt it unlikely that there will be a great deal of evidence for this topic, particularly RCTs.*

**6. Equalities – how do inequalities impact on the management of people who self harm? Should any particular subgroups of the population be considered within the guideline?**

*See 4 e)*

**<u>Group B</u>**

**1. Title. Which is most appropriate:**

**a) Self harm: management of self harm in primary, secondary and community care (update)**
**OR**
**b) Self harm: the longer term management of self harm in primary, secondary and community care**
**OR**

**c) Self harm: the management of self harm after the first 48 hours**
*The group preferred the option b). They felt the relationship between this guideline and the original guideline on self harm needs to be clearly defined as it is currently confusing. There was discussion about whether the terms 'broader' or' wider' should be used to clarify the greater scope of the current guideline compared to the previous guidance.*

2. **Suggested guideline development group composition – Are all the suggested members appropriate and important? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?**
*The group felt that counsellors and psychotherapists should be included within the GDG constituency as there needs to be a more diverse knowledge of various therapies. There was some discussion about how this might be most appropriately worded. It was also asserted that non-statutory service delivery representatives are very important.*

3. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and the relative importance of improving clinical care for those who self harm?**
*The group were concerned about the types of evidence that will be looked at in this guideline.*
*It is important to look at the impact self harm has on relationships and how to support carers.*
*There was some discussion about the term 'carer'*
*The group also felt that the relationship between self harm and drug use should be looked at.*

4. **Do the topics listed in the scope (section 4.3.1) cover the areas of care for people who self harm that are considered to be most important? Are there any omissions or any topics on the list that should be deleted?**
*The group felt the following amendments should be made to section 4.3.1:*
   a) *No changes were suggested*
   b) *Mentalisation based therapy should also be looked at. Concerned that the therapies listed are all psychological – needs to be more varied. Self help groups should be looked at to see if they help or aggravate the situation.*
   c) *No changes were suggested*
   d) *No changes were suggested*
   e) *Additional groups that should be considered are: children and young people; south Asian women; gender differences, those from LGBT groups*
   f) *Concern about possible adverse effects of treatment e.g. is there a possibility that if service users are stopped from self harming they may use drugs instead? Alternative coping strategies should be explored.*
   g) *No changes suggested.*
   h) *No changes suggested.*

*The tension between self harm and suicide should be fully explored.*

5.
   a) **How big will the cost impact be?**

*No changes were suggested.*

b) **How appropriate are the populations and settings?**
*The group felt that people with learning disabilities should not be excluded, just the repetitive SIB.*

c) **What are the key outcomes to be considered (see also section 4.4 of the draft scope)?**
*The main suggestion was to include a measure of quality of life. The group suggested additional outcomes could include: repetition of self harm; suicide; drug use; service user views; tools to measure outcomes; and how these outcomes interact with each other.*

d) **What are the group's views about the available evidence base?**
*The group felt it unlikely that there will be a great deal of evidence for this topic, particularly RCTs. There was discussion about the degree to which non-RCT evidence would be reviewed and whether there was scope for primary data collection.*

6. **Equalities – how do inequalities impact on the management of people who self harm? Should any particular subgroups of the population be considered within the guideline?**
*See 4 e)*

**Group C**

1. **Title. Which is most appropriate:**
**a) Self harm: management of self harm in primary, secondary and community care (update)**
**OR**
**b) Self harm: the longer term management of self harm in primary, secondary and community care**
**OR**
**c) Self harm: the management of self harm after the first 48 hours**
*The group felt the title for the guideline should be: "Self harm: the medium and long term management after an acute episode (in primary, secondary or community care)".*

2. **Suggested guideline development group composition – Are all the suggested members appropriate and important? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?**
*The group felt that the group also needed an occupational therapist, a substance use expert, an expert in epidemiology of self harm and a member with experience of safeguarding/child protection.*

3. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and the relative importance of improving clinical care for those who self harm?**
*The group felt it should be made clearer that this guideline will follow the original self harm guideline and that section 5.5 of the scope should state*

*that this guideline will only be updating chapter 9 of the previous one. Section 3.2 is currently too focused on adults.*

4. **Do the topics listed in the scope (section 4.3.1) cover the areas of care for people who self harm that are considered to be most important? Are there any omissions or any topics on the list that should be deleted?**
   *The group felt the following amendments should be made to section 4.3.1:*
   a) *No changes were suggested*
   b) *No changes were suggested*
   c) *Need to ensure the therapies looked at are for beyond the acute phase.*
   d) *Need to ensure the medication looked at is for beyond the acute phase.*
   e) *Additional groups that should be considered are older people with co-morbidities and the terminally ill. Need to express the different needs of different age groups.*
   f) *Need to include safe prescribing*
   g) *No changes suggested.*
   h) *No changes suggested.*

5.
   a) **How big will the cost impact be?**
      *No changes were suggested.*

   b) **How appropriate are the populations and settings?**
      *People with learning disabilities should not be excluded, just the repetitive SIB.*
      *The group questioned if secure psychiatric settings also be looked at.*

   c) **What are the key outcomes to be considered (see also section 4.4 of the draft scope)?**
      *The group felt that social functioning that is relevant to the age group should be included, e.g. if looking at children, are they attending school?*
      *Suicide needs to be defined.*
      *Hospitalisation also needs to be added.*

   d) **What are the group's views about the available evidence base?**
      *None given*

6. **Equalities – how do inequalities impact on the management of people who self harm? Should any particular subgroups of the population be considered within the guideline?**
   *See 4 e)*

**<u>Group D</u>**

1. **Title. Which is most appropriate:**
   **a) Self harm: management of self harm in primary, secondary and community care (update)**
   **OR**

**b) Self harm: the longer term management of self harm in primary, secondary and community care**
**OR**
**c) Self harm: the management of self harm after the first 48 hours**
*The group preferred option c).*

2. **Suggested guideline development group composition – Are all the suggested members appropriate and important? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?**
*The group felt that the GDG also needed an expert in complex trauma and a member with experience of safeguarding children.*

3. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and the relative importance of improving clinical care for those who self harm?**
*The guideline needs clear signposting to the original self harm guideline. Partnership working also needs to be explored.*

4. **Do the topics listed in the scope (section 4.3.1) cover the areas of care for people who self harm that are considered to be most important? Are there any omissions or any topics on the list that should be deleted?**
*The group felt the following amendments should be made to section 4.3.1:*
   a) *No changes were suggested.*
   b) *No changes were suggested.*
   c) *Add mentalisation based therapy, self help, peer support, psychodynamic (individual and group), emotional freedom techniques and embodiment therapy.*
   d) *Add anxiolytics and SSRIs.*
   e) *Additional groups that should be considered are homeless people and travellers.*
   f) *Harm minimisation needs to be defined.*
   g) *Referral needs to be clearly defined.*
   h) *Add 'minimise harm done to service users by services.'*

5.
   a) **How big will the cost impact be?**
   *No changes were suggested.*

   b) **How appropriate are the populations and settings?**
   *No changes were suggested.*

   c) **What are the key outcomes to be considered (see also section 4.4 of the draft scope)?**
   *The group felt that absenteeism; employment and carer outcomes should be added.*

   d) **What are the group's views about the available evidence base?**
   *None given.*

6. **Equalities – how do inequalities impact on the management of people who self harm? Should any particular subgroups of the population be considered within the guideline?**

*See 4 e)*