Surveillance report 2016 – Self-harm in over 8s (NICE guidelines CG16 and CG133)

National Institute for Health and Care Excellence

Surveillance programme

Surveillance proposal consultation document

Self-harm in over 8s: short-term management and prevention of recurrence NICE guideline CG16 – 12-year surveillance review

Self-harm in over 8s: long term management NICE guideline CG133 – 4-year surveillance review

# Background information

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| Self-harm in over 8s: short-term management and prevention of recurrence (NICE guideline CG16) Guideline issue date: July 2004  Review decision - transferred onto the static list (2014).  7-year surveillance review: no update (2012).  2-year surveillance review: no update (2006). |  | Self-harm in over 8s: long term management (NICE guideline CG133) Guideline issue date: November 2011  2-year surveillance review: no update (2014). |

We reviewed NICE guidelines CG16 and CG133 together.

# Surveillance proposal for consultation

## Self-harm in over 8s: short-term management and prevention of recurrence NICE guideline CG16

We will not update the guideline at this time. NICE guideline CG16 will remain in the static list because:

* No evidence was identified that would impact on the current guidance and no major ongoing studies or research have been identified as due to be published in the near future (that is, within the next 3-5 years).

## Self-harm in over 8s: long term management NICE guideline CG133

We will not update the guideline at this time.

We also propose to remove the following NICE research recommendations from the NICE version of the NICE guideline CG133 and the NICE research recommendations database:

* For healthcare professionals who work with people who self-harm, does the provision of training in assessment and management improve outcomes compared with no additional specialist training?
* For people who self-harm (including young people), does the provision of psychosocial assessment with a validated risk scale, compared with psychosocial assessment alone, improve outcomes?
* For people who have self-harmed, does the provision of a psychological therapy with problem-solving elements, compared with treatment as usual, improve outcomes? What is the differential effect for people with a past history of self-harm, compared with people who self-harm for the first time?
* What are the different approaches to harm reduction following self-harm in NHS settings?

## Reason for the proposal

### Self-harm in over 8s: short-term management and prevention of recurrence NICE guideline CG16

#### New evidence

We found 10 new studies in a search for systematic reviews and randomised controlled trials published between 19 September 2011 and 26 April 2016. We also considered 2 additional studies identified by members of the guideline committee who originally worked on this guideline. From all sources, 12 studies were considered to be relevant to the guideline.

Evidence identified in previous surveillance 7 years after publication of the guideline was also considered. This included 36 studies identified by search and 1 study identified in comments received during consultation on the 7-year surveillance decision.

This included new evidence that supports current recommendations on:

* Issues for all services and healthcare professionals (users' experience of services, staff training and service planning)
* Medical and surgical management of self-harm (general treatment for ingestion, management of paracetamol overdose, flumazenil in benzodiazepine overdose, treatment of opioid overdose)
* Support and advice for people who repeatedly self-harm
* Psychosocial assessment
* Special issues for children and young people (under 16 years)
* Psychological, psychosocial and pharmacological interventions.

We asked topic experts whether this new evidence would affect current recommendations NICE guideline CG16. Generally, the topic experts thought that an update was not needed.

We did not find any new evidence on:

* Issues for all services and healthcare professionals (consent to care, activated charcoal)
* The management of self-harm in primary care
* The assessment and initial management of self-harm by ambulance services
* The treatment and management of self-harm in emergency departments
* Medical and surgical management of self-harm (paracetamol screening, treatment and management of poisoning with salicylates, general treatment for self-injury)
* Referral, admission and discharge following self-harm
* Special issues for older people (older than 65 years).

None of the new evidence considered in surveillance of this guideline was thought to have an effect on current recommendations.

Additionally, we did not identify any relevant ongoing research that is expected to publish results in the next 3–5 years.

No equalities issues were identified during the surveillance process.

### Self-harm in over 8s: long term management NICE guideline CG133

#### New evidence

We found 15 new studies in a search for systematic reviews and randomised controlled trials published between 25 October 2012 and 26 April 2016. We also considered 5 additional studies identified by members of the guideline committee who originally worked on this guideline. From all sources, 20 studies were considered to be relevant to the guideline.

Evidence identified in previous surveillance 2 years after publication of the guideline was also considered. This included 13 studies identified by search.

This included new evidence that supports current recommendations on:

* Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks
* Longer-term treatment and management of self-harm (interventions for self-harm).

We asked topic experts whether this new evidence would affect current recommendations in NICE guideline CG133. Generally, the topic experts thought that an update was not needed.

We did not find any new evidence on:

* General principles of care
* Primary care
* Longer-term treatment and management of self-harm (provision of care, care plans, risk management plans, provision of information about the treatment and management of self-harm, harm reduction)
* Treating associated mental health conditions.

None of the new evidence considered in surveillance of this guideline was thought to have an effect on current recommendations.

Additionally, we identified relevant ongoing research that is expected to publish results in the next 3–5 years.

No equalities issues were identified during the surveillance process.

#### Research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. See the [research recommendations](#_Research_recommendations) section for further information.

For the surveillance review of NICE guideline CG133 we assessed 5 prioritised research recommendations, and proposed that 4 should be removed from the NICE version of guideline and NICE research recommendations database. The research recommendations will remain in the full version of the NICE guideline CG133.

### Overall decision

After considering all the new evidence and views of topic experts, we decided not to update NICE guidelines CG16 and CG133, and leave NICE guideline CG16 on the static list.

We also propose removing 4 prioritised research recommendations from the NICE version of the CG133 guideline and the NICE research recommendations database.

## Further information

See the summary of new evidence for NICE guidelines CG16 (Appendix A1) and CG133 (Appendix A2) below for further information.

For details of the process and update decisions that are available, see [ensuring that published guidelines are current and accurate](http://www.nice.org.uk/article/pmg20/chapter/13-ensuring-that-published-guidelines-are-current-and-accurate) in ‘Developing NICE guidelines: the manual’.

# Appendix A1: summary of new evidence from surveillance

## Self-harm in over 8s: short-term management and prevention of recurrence (NICE guideline CG16)

## [Issues for all services and healthcare professionals](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#issues-for-all-services-and-healthcare-professionals)

### Preamble to the recommendations in this section of the guideline

#### 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.

1. What is the experience of services of people who self-harm, and does this affect outcomes?

Recommendations derived from this question

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

A systematic review 1 was identified which evaluated patients’ attitudes towards clinical services following an episode of self-harm in order to improve service design. The review concluded that poor communication between patients and staff and perceived lack of staff knowledge of self-harm were common themes.

12-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

A topic expert mentioned that the Children's and adolescents' mental health and Child and Adolescent Mental Health Services (CAMHS) Third Report of Session 2014-15 from the House of Commons Health Committee highlighted the importance of intensive services provided in the community to act as a bridge between inpatient services and community services, with the aim of preventing the need for an admission, or facilitating a more swift discharge back to the community. The Inquiry concluded that the experience of care reported by children and young people (CYP) suffering a mental health crisis remains extremely negative due to inadequate crisis support.

Impact statement

At the 7-year surveillance review, the new evidence was considered unlikely to impact on guideline recommendations. Current guidance already recognises that the experience of care for people who self-harm is often unacceptable and that 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. No new evidence was identified during the 12-year surveillance review to change this conclusion.

New evidence is unlikely to change guideline recommendations.

## [Staff training and service planning](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#issues-for-all-services-and-healthcare-professionals)

### Preamble to the recommendations in this section of the guideline

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.

1. Does training of staff in the recognition, assessment and management of people who self-harm, or aimed at improving attitudes to self-harm, have an impact on outcomes, including rates of detection?

Recommendations derived from this question

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.

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

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.

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.

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.

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

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.

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.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

One randomised controlled trial (RCT) 2 was identified which assessed the impact of clinical education on the attitudes of health clinicians towards working with deliberate self-harm behaviours in patients with borderline personality disorder. Some improvement in attitude ratings were found for both emergency medicine clinicians and mental health clinicians in working with deliberate self-harm behaviours in borderline personality disorder, following attendance at the education programme.

12-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

At the 7-year surveillance review, the new evidence was considered unlikely to impact on guideline recommendations. No new evidence was identified during the 12-year surveillance review to change this conclusion.

New evidence is unlikely to change guideline recommendations.

## [Consent to care](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#issues-for-all-services-and-healthcare-professionals)

### Preamble to the recommendations in this section of the guideline

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. In trauma patients who have arrived at an emergency department unconscious and for whom there is no clear explanation of their trauma, does a psychosocial assessment improve detection and outcome of self-harm?

Recommendations derived from this question

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.

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.

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.

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.

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [The management of self-harm in primary care](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance#the-management-of-self-harm-in-primary-care)

### Preamble to the recommendations in this section of the guideline

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. Are there models of GP care that improve patient outcomes and reduce the need for specialist care?

Recommendations derived from this question

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [The assessment and initial management of self-harm by ambulance services](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#the-assessment-and-initial-management-of-self-harm-by-ambulance-services)

### Preamble to the recommendations in this section of the guideline

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. In patients who self-harm, has the current surveillance system improved outcomes compared with that in place 10 years ago?

Recommendations derived from this question

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.

Surveillance decision

No new information was identified at any surveillance review.

## [The treatment and management of self-harm in emergency departments](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance#the-treatment-and-management-of-self-harm-in-emergency-departments)

### Preamble to the recommendations in this section of the guideline

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. What is the impact of different triage systems on outcomes?

Recommendations derived from this question

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.

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.

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.

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

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [Triage](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#the-treatment-and-management-of-self-harm-in-emergency-departments)

1. For those people who self-harm and attend an emergency department does a psychosocial assessment lead to a different outcome compared with no psychosocial assessment?

Recommendations derived from this question

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.

Surveillance decision

No new information was identified at any surveillance review.

## [People who wish to leave before assessment and/or treatment](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance" \l "the-treatment-and-management-of-self-harm-in-emergency-departments)

1. What proportion of people who have self-harmed and attend an emergency department leave after being triaged but before having a psychosocial assessment and what are the consequences? Are certain groups more likely to leave than others?

Recommendations derived from this question

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [Medical and surgical management of self-harm](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance" \l "medical-and-surgical-management-of-self-harm)

### Preamble to the recommendations in this section of the guideline

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. In patients who self-poison does any form of gastric emptying/decontamination as opposed to no intervention influence outcome a) after 1 hour of ingestion b) between >60 minutes and < 4 hr c) greater than 4 hr?

Recommendations derived from this question

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.

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:

* 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.

1.3.1.5 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.

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.

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.

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.

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.

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.

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.

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.

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).

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

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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.

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.

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

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.

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.

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

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.

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.

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.

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.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

Activated charcoal

The benefits and harms of interventions for paracetamol overdose were assessed in a systematic review3. The review concluded that activated charcoal appears to be the best choice for reducing absorption of paracetamol. An additional systematic review 4 concluded that activated charcoal has been associated with few clinically significant adverse effects in the treatment of poisoned patients.

An RCT5 of activated charcoal for the routine management of oral drug overdose was identified which concluded that routine administration of activated charcoal following oral overdose did not significantly influence length of stay or other patient outcomes compared with no decontamination.

One study6 was identified with the aim of determining the frequency of complications associated with the use of multiple dose activated charcoal. The study considered clinically significant complications associated with the use of multiple dose activated charcoal to occur infrequently.

A prospective cross-over trial7 was identified which aimed to determine the effect of a novel charcoal cookie formulation compared with a standard aqueous charcoal product on the absorption of orally administered cimetidine. Both charcoal products effectively adsorbed cimetidine leading to decreased absorption of most of the cimetidine dose. The charcoal cookie was found to be more palatable compared with the aqueous charcoal product.

Activated charcoal for paracetamol overdose

A randomised cross-over study8 was identified which aimed to determine whether activated charcoal is more effective following acetaminophen overdose when used alongside a drug with anticholinergic activity (atropine). Activated charcoal was found to be more effective in the presence of anticholinergic activity one hour after drug ingestion.

One RCT9 was identified which investigated the dose dependent adsorptive capacity of activated charcoal for decontamination of a simulated paracetamol overdose. The study concluded that an activated charcoal-drug ratio of 10:1 is recommended.

A randomised cross-over study10 was identified which compared the adsorption capabilities of an activated-charcoal-yoghurt mixture versus activated-charcoal-water slurry following a simulated paracetamol overdose. The results of the study indicated that the two activated-charcoal preparations exhibited similar absorption reduction of paracetamol.

Two studies were identified which evaluated the timing of activated charcoal administration following overdose of paracetamol. The results of one study11 indicated that the effect of activated charcoal rapidly declines between 1hr and 3hr after combined oral overdose of paracetamol and oxycodone. The results of the second study12 suggested that there may be some benefit in administering activated charcoal 3hr after an overdose of paracetamol compared with no treatment.

Activated charcoal for carbamazepine overdose

One RCT13 evaluated the effect of multiple-dose activated charcoal versus a simple dose of 1g/kg for carbamazepine poisoning. The results of the study indicated that multiple dose charcoal led to a shorter duration of coma and reduced length of stay compared with the simple dose.

Activated charcoal for citalopram overdose

One study14 was identified which examined Bayesian methodology for population pharmacokinetic analysis of data that arose from deliberate self-poisoning with citalopram. The study findings suggested that charcoal administration is potentially beneficial after citalopram overdose although the dose-exposure relationship needs to be further explored.

Activated charcoal for moxifloxacin overdose

A randomised cross-over study15 was identified which evaluated the effect of activated charcoal on the pharmacokinetics of oral and intravenous administration of moxifloxacin. The study concluded that activated charcoal may be useful in treating moxifloxacin overdose by preventing its absorption.

Activated charcoal for antiepileptic medication overdose

The effect of single and repeated doses of oral activated charcoal on the absorption and elimination of antiepileptic drugs was assessed in a study16. The results of the study indicated that oral activated charcoal reduced gastrointestinal absorption of the antiepileptic drugs tested.

Naloxone

An RCT17 was identified which compared the effectiveness of concentrated intranasal naloxone with intramuscular naloxone for suspected opiate overdose. The results of the study indicated that intranasal naloxone reversed heroin overdose in 82% of patients with the time to adequate response being similar for both intranasal and intramuscular routes.

Flumazenil

A systematic review18 was identified which examined whether flumazenil, a benzodiazepine antagonist, should be used in patients with coma due to suspected drug poisoning. The systematic review concluded that, compared with placebo, flumazenil may be effective in the reversal of coma in patients with suspected drug poisoning.

This new evidence identified at the 7-year surveillance review was considered unlikely to impact on guideline recommendations.

12-year surveillance summary

Acetylcysteine for paracetamol overdose

An RCT19 (n=222 patients) compared standard intravenous acetylcysteine regimen (duration 20.25 hours) with a shorter modified regimen (duration 12 hours), with antiemetic pre-treatment (intravenous ondansetron 4 mg) or placebo in patients with acute paracetamol overdose. The primary outcome was vomiting, retching, or need for rescue antiemetic treatment at 2 hours which could be assessed in 217 patients (108 allocate to the shorter modified regimen and 109 allocated to the standard acetylcysteine regimen). There was a lower risk of vomiting, retching, or need for rescue antiemetic treatment at 2 hours in patients allocated to the shorter modified regimen compared to patients in the standard acetylcysteine regimen and in patients receiving ondansetron compared to placebo. It was concluded that the sample size was not large enough to detect non-inferiority of the shorter modified regimen compared to the standard acetylcysteine regimen.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

Through surveillance, a range of studies were identified evaluating treatments including naloxone, flumazenil, activated charcoal for overdose of five different medication (paracetamol, carbamazepine, citalopram, moxifloxacin, and antiepileptic medication), and acetylcysteine for paracetamol overdose. In general, it was concluded that activated charcoal was effective and safe to treat people who have self-harmed by poisoning. Intranasal and intramuscular naloxone was effective to reverse heroin overdose. Flumazenil was effective to reverse coma in people with drug poisoning. The findings about acetylcysteine for paracetamol overdose were inconclusive due to insufficient sample size. This evidence is generally consistent with current recommendations. Activated charcoal is already recommended for the majority of drugs taken in overdose (recommendations [1.1.4.1 – 1.1.4.2](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#issues-for-all-services-and-healthcare-professionals)). Naloxone is suggested for the treatment of opioid overdose (recommendations [1.3.1.10](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#the-assessment-and-initial-management-of-self-harm-by-ambulance-services) and [1.5.5.1 – 1.5.5.5](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#medical-and-surgical-management-of-self-harm)). Flumazenil is suggested for the treatment of benzodiazepine overdose (recommendations [1.5.3.1 – 1.5.3.7](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#medical-and-surgical-management-of-self-harm)) and acetylcysteine is suggested for the treatment of paracetamol overdose (recommendations [1.5.2.2 – 1.5.2.3](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#medical-and-surgical-management-of-self-harm)). Acetylcysteine is licensed for 21 hour infusion schedule.

New evidence is unlikely to change guideline recommendations.

## [Paracetamol screening](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#medical-and-surgical-management-of-self-harm)

1. In unconscious trauma patients where there is evidence of self-harm, does a routine paracetamol screen lead to improved outcomes compared with not screening?

Recommendations derived from this question

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.

Surveillance decision

No new information was identified at any surveillance review.

1. In patients who self-harm by poisoning, does routine paracetamol levels estimation improve outcome compared with no routine estimation?

Recommendations derived from this question

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.

Surveillance decision

No new information was identified at any surveillance review.

## [General treatment for self-injury](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#medical-and-surgical-management-of-self-harm)

### Preamble to the recommendations in this section of the guideline

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. In persons who self-harm by cutting, is there any evidence that a specific type of wound closure significantly influences rates of infections, scarring, etc.?

Recommendations derived from this question

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.

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [Support and advice for people who repeatedly self-harm](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance#support-and-advice-for-people-who-repeatedly-self-harm)

### Preamble to the recommendations in this section of the guideline

#### 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.

#### 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. For people who have had a psychosocial assessment after an episode of self-harm, which ‘non-statutory’ or ‘user-defined’ interventions improve outcomes compared with no treatment or treatment as usual (e.g. self-help, voluntary counselling, peer advocacy, harm minimisation, etc.)?

Recommendations derived from this question

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.

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.

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.

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.

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.

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.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

Adults

Postcard interventions

One RCT20 was identified which aimed to determine whether a postcard intervention reduces self-harm in individuals presenting to the emergency department. The results of this study indicated that the postcard intervention did not reduce further self-harm 12 months following the initial presentation.

Two additional RCTs21,22 evaluating postcards compared with TAU for repetition of self-poisoning concluded that there was no significant reduction in the proportion of people repeating self-poisoning in the intervention group compared with the control group.

Self-help interventions

An RCT23 was identified which evaluated the impact of a brief intervention plus a health information leaflet among people who misuse alcohol presenting to services following deliberate self-harm. The primary outcome was recurrent self-harm during the subsequent six months. The results of the study indicated that repeat self-harm was not influenced by treatment allocation.

Adolescents

Clinical interventions

A systematic review24 was identified which assessed the evidence for the effectiveness of clinical interventions designed to reduce the repetition of deliberate self-harm in adolescents and young adults. The review highlighted that group therapy was the only specific programme which led to a significant reduction in rates of repetition of self-harm. As such, the review concluded that the evidence base in this area is limited.

The effectiveness of interventions for paediatric patients with suicidal-related emergency department visits was evaluated in a systematic review25. The review concluded that transition interventions (3 trials) were most promising for reducing suicide-related outcomes and improving post-emergency department treatment adherence. Transition interventions included a brief emergency department intervention and post-discharge contact, follow-up by interim psychiatric care, and attendance of outpatient sessions with a parent.

12-year surveillance summary

An RCT26 included suicidal youths from 2 emergency departments (aged 10 to 18, n=181) and compared 2 strategies for improving rates of follow-up treatment: 1) enhanced mental health intervention, 2) usual emergency department care enhanced by provider education. There was a higher rate of participants attending outpatient treatment and psychotherapy as well as a higher rate of combined psychotherapy and medication in the group allocated to the enhanced mental health intervention compared to the group allocated to usual care.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

Through surveillance, a range of studies were identified evaluating the following interventions: postcards, self-help, group therapy, transition interventions, and an intervention to increase motivation for follow-up treatment. Postcard and self-help interventions did not reduced repetition of self-harm in adults. Group therapy seemed to reduce repetition of self-harm in adolescents but the evidence was limited. Transition interventions might reduce suicide-related outcomes. The enhanced mental health intervention seemed to increase rates of follow-up treatment. This evidence is generally consistent with current recommendations about referral for further treatment including psychological and psychosocial interventions (recommendations [1.11.1.1 to 1.11.1.3](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#psychological-psychosocial-and-pharmacological-interventions-2)).

New evidence is unlikely to change guideline recommendations.

1. In a patient who self-harms does restricting the pack size reduce the incidence and/or severity of the non-accidental overdose?

Recommendations derived from this question

No recommendation made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

1. In patients who self-harm does labelling, product information or verbal information influence the selection of pharmaceuticals taken as a means of self-harm?

Recommendations derived from this question

No recommendation made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

## [Psychosocial assessment](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance#psychosocial-assessment)

### Preamble to the recommendations in this section of the guideline

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

1. Are there factors related to the individual (either characteristics of the individual or of the act of self-harm) that predict outcome (including suicide, non-fatal repetition, other psychosocial outcomes)? How strong are these predictors either singly or in combination and what are their positive and negative predictive power?

Recommendations derived from this question

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.

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.

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.

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

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.

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.

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.

1.7.3.3 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)).

1.7.3.4 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)).

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.

Surveillance decision

No new information was identified at any surveillance review.

1. For any factors associated with self-harm that have an effect on outcome (see question 16 – 16), Which of these factors can and should be assessed in the emergency department?

Recommendations derived from this question

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.

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.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

A systematic review 27 was identified which assessed the roles of traits in suicidal behaviours concluding that hopelessness, neuroticism and extroversion held the most promise for risk screening. In addition, a case-control study 28 was identified which aimed to identify risk factors associated with attempted suicide among people who had attempted suicide and were admitted to hospital and matched controls. Factors associated with increased risk of suicide attempt were unemployment, lack of formal education and the presence of stressful life events in the last six months. Lastly, an additional systematic review 29 aimed to quantify the ability of the Beck Hopelessness Scale (BHS) to predict suicide and nonfatal self-harm. The study concluded that the standard cut-off point on the BHS identifies a high-risk group for potential suicide. The standard cut-off point is also capable of identifying those who are at risk of future self-harm, but the low specificity rate means it is unlikely to be of use in targeting treatment designed to lower the rate of repetition.

12-year surveillance summary

The following were found to be associated with suicide attempt and completed suicide:

* Alcohol use disorder in a meta-analysis of observational studies30 (31 studies; n=420,732).
* Five or less years of unemployment in a systematic review of observational studies31 (16 studies).
* Lower serum total cholesterol level in a meta-analysis of epidemiological studies32 (65 studies; n=510,392).

The following were found to be associated with suicide attempts:

* Childhood sexual abuse in a meta-analysis of longitudinal studies33 (7 longitudinal studies and 2 twin studies; n=8,733).
* Child physical abuse, emotional abuse, and neglect in a systematic review of observational studies34 (124 studies).

The following were found to be associated with suicide behaviours but it was unclear whether suicidal behaviours included both suicide attempt and completed suicide from the abstract:

* Psychiatric disorders with comorbid sleep disturbances and specific psychiatric conditions (such as depression, post-traumatic stress disorder, panic disorder and schizophrenia) in a systematic review of observational studies35 (19 studies).
* Smoking in patients with psychosis in a meta-analysis of observational studies36 (13 studies; n=6,813 adult patients).

A systematic review of observational studies37 (19 studies) found that the association between non-psychotropic medications and risk of suicide or attempted suicide remains unknown because the included studies differed in study design, outcome, type of medication, and control for confounding factors. Meta-analysis was considered inappropriate due to the differences between studies (heterogeneity).

It was unclear whether the population in these systematic reviews and meta-analyses were people who had previously self-harmed.

During the 12-year surveillance review, there was evidence of risk factors associated with suicide attempt or completed suicide such as alcohol use disorder, childhood sexual abuse, psychiatric disorders with comorbid sleep disturbances, five or less years of unemployment, child physical abuse, child emotional abuse, child neglect, smoking in patients with psychosis, and lower serum total cholesterol level. The association between non-psychotropic medications and risk of suicide or attempted suicide remains unknown.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

During the 7-year surveillance review, there was evidence of traits that could be used for risk screening of suicidal behaviours such as hopelessness, neuroticism and extroversion. There was also evidence of risk factors associated with attempted suicide such as unemployment, lack of formal education and the presence of stressful life events in the last six months. There was evidence about the utility of the BHS in predicting suicide and self-harm. Risk assessment is part of recommendation 1.7.3.1 of NICE guideline CG16 but recommendations about risk assessment scales from NICE guideline CG16 (1.7.3.3 and 1.7.3.4) have been replaced with recommendations of CG133 for the long-term management of self-harm (1.3.11-1.3.13). New recommendations of NICE guideline CG133 (1.3.11-1.3.13) suggest that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm or to determine who should and should not be offered treatment or who should be discharged. However, risk assessment tools may be considered to help structure risk assessments.

Through surveillance, a range of studies were identified evaluating risk factors for self-harm and suicide. This evidence is generally consistent with recommendation [1.7.3.1](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#psychosocial-assessment) which states that all people who have self-harmed should be assessed for risk and 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.

New evidence is unlikely to change guideline recommendations.

1. For any factors associated with self-harm that have an effect on outcome (see question 16 – 16), What is the effect of applying an intervention for these factors?

Recommendations derived from this question

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.

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.

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.

1.11.1.4 For the further management of people who have self-harmed, see 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

Surveillance decision

No new information was identified at any surveillance review.

## [Assessment of risk (specialist mental health professionals)](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance" \l "psychosocial-assessment)

1. In services which have specialist teams to make psychosocial assessments of people who self-harm, are there better rates of detection of people who self-harm, better engagement with services and improved outcomes?

Recommendations derived from this question

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.

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.

1.7.3.3 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

1.7.3.4 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

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.

Surveillance decision

No new information was identified at any surveillance review.

1. For people who have harmed themselves, or expressed intent, does formal risk assessment, compared with a non-standardised assessment, alter decision making, change engagement or affect outcomes?

Recommendations derived from this question

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.

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.

1.7.3.3 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

1.7.3.4 See recommendations 1.3.11, 1.3.12 and 1.3.13 in 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

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.

Surveillance decision

No new information was identified at any surveillance review.

1. [Referral, admission and discharge following self-harm](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#referral-admission-and-discharge-following-self-harm)

Recommendations derived from this area (no questions made in guideline)

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.

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

1. [Special issues for children and young people (under 16 years)](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#special-issues-for-children-and-young-people-under-16-years)

Recommendations derived from this area (no questions made in guideline)

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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:

* 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.

1.9.1.13 For the further management of young people who have self-harmed, see 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

Surveillance decision

This review question should be updated.

7-year surveillance summary

No relevant evidence was identified.

12-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

A topic expert highlighted that recommendation 1.9.1.3 of CG16 had been based on a report from the Royal College of Psychiatrics (CR64 ‘Managing deliberate self-harm in young people’, March 1998) which has subsequently been updated. The topic expert mentioned that the Royal College of Psychiatrics (RCPsych) position remains the same for under 16 year olds, but recommends that routine admission to a paediatric ward is not expected for 16 and 17 year olds.

The report previously stated: ‘Admission to a paediatric, adolescent or medical ward or to a designated unit is usually desirable. Generally, this is indicated regardless of the toxicological state of the young person in order that adequate further physical and psychosocial assessments can occur and management/crisis intervention be planned and initiated.’

The updated report RCPsych (Self-harm, suicide and risk: helping people who self-harm, final report of a working group CR158, June 2010) states: ‘A significant issue raised was the importance of admitting children and young people under 16 years of age to the paediatric ward after self-harm.’

Impact statement

The evidence identified through the 12-year surveillance review was considered unlikely to have an impact on current recommendations. The evidence was considered in the context of the guideline and current recommendations. However, recommendation 1.9.1.3 already covers this issue in the sentence below:

‘Alternative placements may be required, depending upon the age of the child.’

New evidence is unlikely to change guideline recommendations.

1. [Special issues for older people (older than 65 years)](https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#special-issues-for-older-people-older-than-65-years)

Recommendations derived from this area (no questions made in guideline)

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.

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.

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.

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.

Surveillance decision

No new information was identified at any surveillance review.

## [Psychological, psychosocial and pharmacological interventions](https://www.nice.org.uk/guidance/CG16/chapter/1-Guidance#psychological-psychosocial-and-pharmacological-interventions-2)

### Preamble to the recommendations in this section of the guideline

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. For people who have had a psychosocial assessment after an episode of self-harm, which pharmacological interventions improve outcomes compared with no treatment or treatment as usual (e.g. antidepressants, neuroleptics, ECT, lithium, carbamazepine, etc.)?

Recommendations derived from this question

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.

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.

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.

1.11.1.4 For the further management of people who have self-harmed, see 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

Surveillance decision

This review question should not be updated.

7-year surveillance summary

Adults

Fatty acid supplementation

A small-scale RCT38 was identified which evaluated the efficacy of omega-3 fatty acid supplementation versus placebo in improving psychological wellbeing in patients with recurrent self-harm. The results of the study indicated that supplementation led to reductions in surrogate markers of suicidal behaviour.

12-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

During the 7-year surveillance review, it was concluded that fatty acid supplementation undertaken after an episode of self-harm may improve outcomes compared with placebo. However, the evidence was not considered enough to impact on current recommendations because it was from a small RCT. No new evidence was identified at the 12-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

1. For people who have had a psychosocial assessment after an episode of self-harm, which specific psychosocial interventions improve outcomes compared with no treatment or treatment as usual (e.g. DBT, problem-solving, interpersonal therapy, CBT, counselling, etc.)?

Recommendations derived from this question

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.

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.

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.

1.11.1.4 For the further management of people who have self-harmed, see 'Self-harm: longer-term management' ([NICE clinical guideline 133](https://www.nice.org.uk/guidance/cg133)).

Surveillance decision

This review question should not be updated.

7-year surveillance summary

Adults

Psychosocial interventions

A systematic review39 evaluated whether additional psychosocial interventions following an episode of self-harm reduce the incidence of subsequent suicide. The review concluded that there is no evidence that additional psychosocial interventions following self-harm have a marked effect on the incidence of subsequent suicide.

Cognitive behavioural therapy approaches

The effectiveness of a 10-session cognitive therapy intervention in preventing repeat suicide attempts in adults who had recently attempted suicide was evaluated in an RCT40. Participants in the cognitive therapy group had a lower reattempt rate and were 50% less likely to reattempt suicide than participants in the usual care group.

One large-scale RCT41 compared a brief form of cognitive therapy, manual-assisted cognitive behaviour therapy (MACT) versus treatment as usual (TAU) for deliberate self-harm. The study concluded that MACT had value in preventing self-harm and was cost-effective although this appeared to be confined mainly to those who do not have borderline personality disorder.

An RCT42 was identified which compared brief psychodynamic-interpersonal therapy (PIT) with usual care on repetition of self-harm in patients presenting to an emergency department with deliberate self-poisoning. The results of the study indicated that PIT for deliberate self-poisoning is effective in reducing suicidal ideation.

One controlled trial43 was identified whereby adults presenting to Accident and Emergency departments following self-harm were allocated to a personal construct psychotherapy or treatment as usual. The study concluded that there is some evidence suggestive of a lower frequency of repetition of self-harm in the intervention group compared with control.

Children and adolescents

A systematic review24 was identified which assessed the evidence for the effectiveness of clinical interventions designed to reduce the repetition of deliberate self-harm in adolescents and young adults. The review highlighted that group therapy was the only specific programme which led to a significant reduction in rates of repetition of self-harm. As such, the review concluded that the evidence base in this area is limited.

The effectiveness of interventions for paediatric patients with suicidal-related emergency department visits was evaluated in a systematic review25. The review concluded that transition interventions were most promising for reducing suicide-related outcomes and improving post-emergency department treatment adherence.

12-year surveillance summary

A systematic review and meta-analysis44 included 5 RCTs and examined the efficacy of dialectical behaviour therapy (DBT) in adults with borderline personality disorder. DBT was beneficial in terms of suicide and parasuicidal behaviour compared to treatment as usual.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

Evidence identified through surveillance indicated that psychosocial interventions undertaken after an episode of self-harm may improve outcomes compared with no treatment or treatment as usual. These interventions included CBT approaches and DBT. However, a guideline was developed on the longer-term management of self-harm (NICE guideline CG133 published November 2011) and recommendations 1.9.1.13 and 1.11.1.4 of NICE guideline CG16 were replaced within the section on the further management of people who have self-harmed of NICE guideline CG133. Recommendation 1.11.1.5 of NICE guideline CG16 was deleted following publication of NICE guideline CG133.

New evidence is unlikely to change guideline recommendations.

1. For people who have had a psychosocial assessment after an episode of self-harm, which social interventions improve outcomes compared with no treatment or treatment as usual (e.g. rehousing, crisis intervention, respite, debt counselling, networking, befriending, etc.)?

Recommendations derived from this question

No recommendation made in the guideline.

Surveillance decision

This review question should not be updated.

7-year surveillance summary

Adults

Educational interventions in adults

One RCT45 compared a brief educational intervention and periodic follow-up contacts with treatment as usual (TAU) for suicide attempters attending the emergency department. The results of the study demonstrated that at 18 months post-discharge, the proportion of subjects with repeated suicide attempts was not significantly different between the two groups.

A similar RCT46 was identified which compared TAU plus patient education and follow-up compared with TAU alone in reducing subsequent suicide among suicide attempters. The results of the study indicated that there were significantly fewer deaths from suicide in the intervention group compared with control.

Adolescents

Skills-based treatment interventions

The efficacy of a skills-based treatment protocol compared with supportive relationship therapy for adolescents after a suicide attempt was evaluated in an RCT47. Decreases in suicidal ideation at three-and six-months follow-up were obtained but there were no differences between treatment groups.

12-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No topic expert feedback was relevant to this evidence.

Impact statement

The evidence identified through the 7-year surveillance review was considered unlikely to have an impact on current recommendations. No new evidence was identified through the 12-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

# Research recommendations

1. 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.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Epidemiological research should be conducted to determine the prevalence of self-harm in refugees and asylum seekers.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Appropriate multi-methodology research on self-harm as a response to child sexual and other abuse should be carried out, to include a review of the substantial service user literature, and to examine the range of interventions that service users believe to be supportive and helpful, including survivor organisations and networks and other voluntary organisations for women who self-harm.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An adequately powered epidemiological study, reporting all relevant outcomes, including quality of life, occupational status and potential, income, physical well-being and quality of relationship status, should be undertaken to establish the morbidity and mortality rates for specific drug ingestions used in self-harm.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

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

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. 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.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Comparative pilot studies should be undertaken to evaluate different approaches to introducing and using advance directives for people who self-harm repeatedly. Studies should address ethical, legal and practical implications and consequences, as well as acceptability to service users and healthcare practitioners. Service users should be included in the design and evaluation of each pilot.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. A large-scale audit, reporting all relevant outcomes, of the use of activated charcoal in cases of poisoning in pre-hospital settings should be undertaken.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. A national programme should be developed to coordinate the surveillance by NPIS and other agencies of health risks in self-poisoning so that the combined data can be used to inform and guide recommendations on treatment and prevention.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. 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.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. A well-designed, prospective multicentre study of screening for plasma paracetamol concentrations, including health economic analyses, is required in order to develop detailed guidelines on the selection criteria, clinical value and cost-effectiveness of screening for paracetamol.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An RCT, recording all relevant biochemical and clinical outcomes, is needed to determine the relative efficacy of activated charcoal given to patients presenting between 1 and 2 hours following ingestion of poison, as compared with giving no activated charcoal, in the treatment of overdose, particularly when used in paracetamol overdose. Particular attention should be paid to the differences with different ingested poisons and to the incidence of side effects.

New evidence was found about activated charcoal used in paracetamol and other drugs overdose. This evidence was included under clinical question [16 – 09](#_Medical_and_surgical).

A randomised cross-over study8 aimed to determine whether activated charcoal was more effective following acetaminophen overdose when used alongside a drug with anticholinergic activity (atropine).

One RCT9 investigated the dose dependent adsorptive capacity of activated charcoal for decontamination of a simulated paracetamol overdose.

A randomised cross-over study10 compared the adsorption capabilities of an activated-charcoal-yoghurt mixture versus activated-charcoal-water slurry following a simulated paracetamol overdose.

One RCT13 evaluated the effect of multiple-dose activated charcoal versus a simple dose of 1g/kg for carbamazepine poisoning.

A randomised cross-over study15 was identified which evaluated the effect of activated charcoal on the pharmacokinetics of oral and intravenous administration of moxifloxacin.

From an assessment of the abstracts, it seemed that none of these studies reported the time when active charcoal was provided following ingestion of poison. It was also unclear which comparison interventions or controls were used in some of the studies. There was not a comparison of the differences between different ingested poisons. The incidence of side effects was not reported. This research recommendation will be considered again at the next surveillance point.

1. 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.

A randomised controlled trial 19 was undertaken about the use of acetylcysteine for the treatment of paracetamol overdose which was included under clinical question [16 – 09](#_Medical_and_surgical). However, the study was not about the optimum dose level of acetylcysteine, it did not include oral administration, or biochemical outcomes and it was unclear from abstract whether patient characteristics were analysed. This research recommendation will be considered again at the next surveillance point.

1. An adequately powered national multi-centre RCT, reporting all relevant clinical outcomes, is required to evaluate the therapeutic use of flumazenil in unconscious patients in whom self-poisoning with benzodiazepines is suspected. Particular attention should be paid to the incidence of serious physical adverse events, dose, the rate of administration of flumazenil, the ingestion of other substances, and patient characteristics that may predict good and poor outcomes is required.

A systematic review of RCTs18 was identified which examined whether flumazenil should be used in patients with coma due to suspected drug poisoning of unclear cause. The systematic review concluded that, compared with placebo, flumazenil may be effective in the reversal of coma in patients with suspected drug poisoning with similar major side effects to placebo. However, the systematic review did not report dose and rate of administration of flumazenil, the ingestion of other substances, and patient characteristics that may predict good and poor outcomes. This evidence was included under clinical question [16 – 09](#_Medical_and_surgical). This research recommendation will be considered again at the next surveillance point.

1. An adequately powered diagnostic trial to evaluate different methods of detecting the presence of tricyclic antidepressants in the emergency setting should be undertaken.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Adequately powered RCTs, reporting all relevant short-, medium- and long-term outcomes, including the experience of care and the acceptability of treatments, are needed to evaluate methods of wound closure for people who have self-harmed through cutting. For superficial wounds this should include trials comparing skin closure strips and tissue adhesives, and head-to-head trials of the cost and clinical effectiveness of different types of tissue adhesive.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Appropriately designed studies to evaluate the place of self-management of wound closure for people who recurrently self-harm by cutting, identifying people for whom this approach would be most suited, should be undertaken.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. Multi-centre monitoring of the number of people who self-harm, including whether each act is a repetition of previous self-harm, taking into account cross-flow in and out of each catchment area, should be undertaken to assess local differences in self-harm presentations and to enable observational studies to be carried out to evaluate the impact of different styles of mental health service provision.

An observational study48 (32 hospitals in England, n=6,442 people with 7,689 episodes of self-harm during a 3 month period) was referred by a topic expert. This study reported on hospital service variations regarding psychological assessment by a mental health professional (ranging from 22% to 88%), self-harm episodes with admissions to general hospitals (ranging from 22% to 85%), referral for specialist mental health follow-up (ranging from 11% to 64%), referral to non-statutory services (ranging from 4% to 62%), and self-harm episodes with psychiatric admissions (ranging from 4% to 62%). There were also variations about specialist assessment rate depending on self-harm method: the median rate was 45% for self-cutting and 58% for self-poisoning.

An observational study49 (31 hospitals in England, n=6,347 people with 7,599 episodes of self-harm during a 3 month period) was referred by a topic expert. This study reported that clinical management of self-harm at hospital level and repetition rate of self-harm were associated but the association was small. Service quality was not correlated to repetition of self-harm.

Both these observational studies partially address research recommendation 18. More observational studies are needed to evaluate the impact of other mental health services for self-harm other than hospital services. This research recommendation will be considered again at the next surveillance point.

1. An appropriately designed study reporting all relevant outcomes should be undertaken to assess the impact of changes in local health policy upon the management of self-harm in difference services (for example, in emergency departments), including outcomes for service users.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An appropriately designed study should be undertaken to discover more about self-injury, particularly the similarities and differences compared with self-poisoning, such as whether repetition rates and fatal suicide attempts are different.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An appropriately designed study should be undertaken to assess the impact on services of involving service users in service planning and delivery, especially in emergency departments, focusing particularly on outcomes, including satisfaction and loss from the service, for people with repeated presentations.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An appropriately designed study, reporting all relevant outcomes including user satisfaction with services and the numbers lost from services, repetition rates and suicide, should be undertaken to pilot and evaluate integrated needs and risk assessment, compared with both ‘standard assessment practice’ and a separate assessment of needs and risk.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. 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.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. User-led, qualitative research into the experience and views of people who self-harm is required firstly examining the benefits and adverse consequences of the services they receive and the treatments they have undertaken, and secondly investigating the benefits and adverse consequences of self-help groups and service user support groups.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. A multi-centre RCT is required reporting all relevant outcomes including quality of life, occupational status, satisfaction with services and self-harm repetition rates, addressing the clinical and cost effectiveness of emergency card services for people who have self-harmed and presented to services for the first time.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. An adequately powered RCT reporting all relevant outcomes should be undertaken to determine the relative effectiveness of group therapy for young people who self-harm. The study should address patient characteristics (such as gender, diagnosis, frequency and method of self-harm, past history of abuse) and family characteristics (such as parental disharmony and divorce, family size, socio-economic status, mental health problems in the parents and siblings). Outcomes should include loss from services, admission rates, satisfaction, repetition of self-harm, quality of life, educational attainment and employment status. Consideration should also be given to investigating the effectiveness of this type of therapy for adults.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. 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.

No new evidence was identified that would affect this research recommendation. This research recommendation will be considered again at the next surveillance point.

# Appendix A2: summary of new evidence from surveillance

## Self-harm in over 8s: long term management (NICE guideline CG133)

133 – 01 [General principles of care](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#general-principles-of-care)

Recommendations derived from this area (no questions made in guideline)

Working with people who self-harm

1.1.1 Health and social care professionals working with people who self-harm should:

* aim to develop a trusting, supportive and engaging relationship with them
* be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
* ensure that people are fully involved in decision-making about their treatment and care
* aim to foster people's autonomy and independence wherever possible
* maintain continuity of therapeutic relationships wherever possible
* ensure that information about episodes of self-harm is communicated sensitively to other team members.

1.1.2 Health and social care professionals who work with people who self-harm should be:

* familiar with local and national resources, as well as organisations and websites that offer information and/or support for people who self-harm, and
* able to discuss and provide advice about access to these resources.

Access to services

1.1.3 Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS).

1.1.4 Ensure that children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate.

1.1.5 When language is a barrier to accessing or engaging with services for people who self-harm, provide them with:

* information in their preferred language and in an accessible format
* psychological or other interventions, where needed, in their preferred language
* independent interpreters.

Self-harm and learning disabilities

1.1.6 People with a mild learning disability who self-harm should have access to the same age-appropriate services as other people covered by this guideline.

1.1.7 When self-harm in people with a mild learning disability is managed jointly by mental health and learning disability services, use the Care Programme Approach (CPA).

1.1.8 People with a moderate or severe learning disability and a history of self-harm should be referred as a priority for assessment and treatment conducted by a specialist in learning disabilities services.

Consent and confidentiality

1.1.12 Health and social care professionals who work with people who self-harm should be trained to:

* understand and apply the principles of the Mental Capacity Act (2005) and Mental Health Act (1983; amended 1995 and 2007)
* assess mental capacity, and
* make decisions about when treatment and care can be given without consent.

1.1.13 Be familiar with the principles of confidentiality with regard to information about a person's treatment and care, and be aware of the circumstances in which disclosure of confidential information may be appropriate and necessary.

1.1.14 Offer full written and verbal information about the treatment options for self-harm, and make all efforts necessary to ensure that the person is able, and has the opportunity, to give meaningful and informed consent.

1.1.15 Take into account that a person's capacity to make informed decisions may change over time, and that sometimes this can happen rapidly in the context of self-harm and suicidal behaviour.

1.1.16 Understand when and how the Mental Health Act (1983; amended 1995 and 2007) can be used to treat the physical consequences of self-harm.

1.1.17 Health and social care professionals who work with people who self-harm should have easy access to legal advice about issues relating to capacity and consent.

1.1.18 Health and social care professionals who have contact with children and young people who self-harm should be trained to:

* understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm
* understand how issues of capacity and consent apply to different age groups
* assess mental capacity in children and young people of different ages.

They should also have access at all times to specialist advice about capacity and consent.

Safeguarding

1.1.19 CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local [safeguarding procedures](http://safeguardingchildren.org.uk/).

1.1.20 If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:

* use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
* consider using the [Common Assessment Framework](http://www.cwdcouncil.org.uk/caf/)\*; advice on this can be sought from the local named lead for safeguarding children.

If serious concerns are identified, develop a child protection plan.

1.1.21 When working with people who self-harm, consider the risk of domestic or other violence or exploitation and consider local safeguarding procedures for vulnerable adults and children in their care. Advice on this can be obtained from the local named lead on safeguarding adults.

Families, carers and significant others\*\*

1.1.22 Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate.

1.1.23 When families, carers or significant others are involved in supporting a person who self-harms:

* offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
* offer contact numbers and information about what to do and whom to contact in a crisis
* offer information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers or significant others to access these
* inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.

1.1.24 CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with perceived risks and the responsibilities and views of parents or carers.

Managing endings and supporting transitions

1.1.25 Anticipate that the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm, and:

* Plan in advance these changes with the person who self-harms and provide additional support, if needed, with clear contingency plans should crises occur.
* Record plans for transition to another service and share them with other health and social care professionals involved.
* Give copies to the service user and their family, carers or significant others if this is agreed with the service user.

1.1.26 CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services.

* Time the transfer to suit the young person, even if it takes place after they reach the age of 18 years.
* Continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.

1.1.27 Mental health trusts should work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services, as described in this guideline.

\* It should be noted that the Common Assessment Framework is not applicable in Wales.

\*\* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

No new information was identified at any surveillance review.

## [Training and supervision for health and social care professionals](https://www.nice.org.uk/guidance/CG133/chapter/1-Guidance#general-principles-of-care)

133 – 02 Does the provision of staff training (knowledge, skills based) improve outcomes (for example, staff attitudes, user satisfaction, user engagement with services)? (Note: Impact of setting and content of training to be taken into account if data are available).

Recommendations derived from this question

1.1.9 Health and social care professionals who work with people who self-harm (including children and young people) should be:

* trained in the assessment, treatment and management of self-harm, and
* educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes.

1.1.10 Health and social care professionals who provide training about self-harm should:

* involve people who self-harm in the planning and delivery of training
* ensure that training specifically aims to improve the quality and experience of care for people who self-harm
* assess the effectiveness of training using service-user feedback as an outcome measure.

1.1.11 Routine access to senior colleagues for supervision, consultation and support should be provided for health and social care professionals who work with people who self-harm. Consideration should be given of the emotional impact of self-harm on the professional and their capacity to practice competently and empathically.

Surveillance decision

No new information was identified at any surveillance review.

133 – 03 [Primary care](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#primary-care)

Recommendations derived from this area (no questions made in guideline)

1.2.1 If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:

* levels of distress are rising, high or sustained
* the risk of self-harm is increasing or unresponsive to attempts to help
* the person requests further help from specialist services
* levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

1.2.2 If a person who self-harms is receiving treatment or care in primary care as well as secondary care, primary and secondary health and social care professionals should ensure they work cooperatively, routinely sharing up-to-date care and risk management plans. In these circumstances, primary health and social care professionals should attend CPA meetings.

1.2.3 Primary care professionals should monitor the physical health of people who self-harm. Pay attention to the physical consequences of self-harm as well as other physical healthcare needs.

Surveillance decision

No new information was identified at any surveillance review.

## [Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks](https://www.nice.org.uk/guidance/CG133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)

133 – 04 For people who self-harm, does formal risk assessment, needs assessment and psychosocial assessment improve outcomes? (Note: Impact of setting/organisational context and content of assessment to be taken into account if data are available).

Recommendations derived from this question

1.3.1 Offer an integrated and comprehensive psychosocial assessment of needs (see [recommendations 1.3.2–1.3.5](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)) and risks (see [recommendations 1.3.6–1.3.8](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)) to understand and engage people who self-harm and to initiate a therapeutic relationship.

1.3.2 Assessment of needs should include:

* skills, strengths and assets
* coping strategies
* mental health problems or disorders
* physical health problems or disorders
* social circumstances and problems
* psychosocial and occupational functioning, and vulnerabilities
* recent and current life difficulties, including personal and financial problems
* the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
* the needs of any dependent children.

1.3.3 All people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for working-age adults (see [recommendations 1.3.1 and 1.3.2](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)). In addition:

* pay particular attention to the potential presence of depression, cognitive impairment and physical ill health
* include a full assessment of the person's social and home situation, including any role they have as a carer, and
* take into account the higher risks of suicide following self-harm in older people.

1.3.4 Follow the same principles as for adults when assessing children and young people who self-harm (see [recommendations 1.3.1 and 1.3.2](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)), but also include a full assessment of the person's family, social situation, and child protection issues.

1.3.5 During assessment, explore the meaning of self-harm for the person and take into account that:

* each person who self-harms does so for individual reasons, and
* each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.

Risk assessment

A risk assessment is a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm.

1.3.6 When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

* methods and frequency of current and past self-harm
* current and past suicidal intent
* depressive symptoms and their relationship to self-harm
* any psychiatric illness and its relationship to self-harm
* the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
* specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
* coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
* significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
* immediate and longer-term risks.

1.3.7 Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking.

1.3.8 When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others'\* medications.

1.3.9 In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person.

1.3.10 Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

Risk assessment tools and scales

Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

1.3.11 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

1.3.12 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

1.3.13 Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in [recommendation 1.3.6](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health).

1.3.14 Summarise the key areas of needs and risks identified in the assessment (see [recommendations 1.3.1–1.3.8](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)) and use these to develop a care plan (see [recommendations 1.4.2 and 1.4.3](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm)) and a risk management plan (see [recommendations 1.4.4 and 1.4.5](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm)) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP.

1.3.15 If there is disagreement between health and social care professionals and the person who self-harms about their needs or risks, consider offering the person the opportunity to write this in their notes.

\* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

This review question should not be updated.

2-year evidence update summary

A prospective cohort study50 in Manchester, UK evaluated the predictive ability of risk assessments by psychiatrists (n=865) compared with mental health nurses (n=2626) following hospital presentation of self-harm in people aged 16 years or over. Repetition rate of self-harm was similar between those assessed by mental health nurses and psychiatrists. Mental health nurses identified more participants as high risk compared with psychiatrists, but sensitivity in terms of correct identification of repeaters as high risk at initial assessment was not significantly different between groups.

A retrospective cohort study51 from Philadelphia, USA examined predictors of suicide in participants followed up in 2005 who had been hospitalised for suicide ideation (n=207) or suicide attempt (n=499) between 1970 and 1975. People who took active precautions against being discovered during their index suicide attempt were significantly more likely to die by subsequent suicide compared with those people who did not. The risk of suicide for participants aged over 30 years were significantly less than for those aged under 30 years. African-American participants were less likely to die by suicide than white people.

The importance of comprehensive assessments was reinforced by a cohort study 52, which concluded that life expectancy and physical health appeared to be severely compromised in individuals who had self-harmed.

A prospective cohort study53 (n=4019) evaluated the ability of the SAD PERSONS scale and the modified SAD PERSONS scale to predict suicide attempts in people presented to emergency psychiatric services. High-risk scores on both scales had a low sensitivity (namely greater chance of a false negative result) for identifying current suicide attempts and for predicting future suicide attempts compared with low-risk scores.

During 2-year evidence update, it was concluded that this evidence was unlikely to have implications for NICE guideline CG133. The guideline already recommended that current and past suicidal intent should be assessed and that risk assessment scales should not be used to predict future suicide.

4-year surveillance summary

A systematic review of scales for self-harm risk assessment54 (8 publications of cohort studies in adults) found that the included scales did not seem to accurately detect adults with risk of self-harm. Although there were scales with high sensitivity (namely greater chance of correctly identifying a true positive result), their positive predictive value was low (namely the proportion of people with a positive test who actually have risk of self-harm).

Topic expert feedback

A systematic review of prospective cohort studies55 (12 studies on risk factors and 7 studies on risk scales) was noted by topic experts which found that three risk scales were evaluated Beck Hopelessness Scale (BHS), Suicide Intent Scale (SIS) and Scale for Suicide Ideation (SSI) with low positive predictive values and did not seem to accurately detect the risk of suicide.

Impact statement

During the 2-year evidence update, there was new evidence about the assessment of current and past suicidal intent. Through surveillance, new evidence was found about risk scales but these scales did not seem to accurately detect the risk of suicide. This evidence is generally consistent with current recommendations, which suggest that current and past suicidal intent should be assessed and that risk assessment scales should not be used to predict future suicide.

New evidence is unlikely to change guideline recommendations.

## [Risk assessment](https://www.nice.org.uk/guidance/CG133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)

### Preamble to the recommendations in this section of the guideline

Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

133 – 05 What are the risk and protective factors (internal and external) amongst people who self-harm that predict outcomes (for example, suicide, non-fatal repetition, other psychological outcomes)?

Recommendations derived from this question

A risk assessment is a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm.

1.3.6 When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

* methods and frequency of current and past self-harm
* current and past suicidal intent
* depressive symptoms and their relationship to self-harm
* any psychiatric illness and its relationship to self-harm
* the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
* specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
* coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
* significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
* immediate and longer-term risks.

1.3.7 Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking.

1.3.8 When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others'\* medications.

1.3.9 In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person.

1.3.10 Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

\* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

This review question should not be updated.

2-year evidence update summary

A multicentre, single-blind, randomised controlled trial (RCT; n=443 people aged over 18 years registered at 4 GPs) in London, UK reported by Crawford et al. (2011)56 assessed whether asking about suicide (including direct questions about suicidal ideation) could itself affect mental health. Participants were randomised to questions about suicidal ideation or to questions on health and lifestyle. There were no differences between the suicidal ideation questions group and the health and lifestyle questions group in terms of the proportion of participants reporting that: their life was not worth living, they wished they were dead, or they had thought of taking their life.

During 2-year evidence update, it was concluded that questions about suicidal ideation in people who had signs of depression did not appear to increase feelings that life was not worth living. The evidence was considered to be consistent with NICE guideline CG133 and suggested that asking about suicidal ideas is not harmful.

4-year surveillance summary

A systematic review of longitudinal studies57 (172 studies) found that a history of self-injurious thoughts and behaviours predicted suicide attempts and death by suicide but the prediction was considered weak because most of the odds ratios were lower than 2.0.

Topic expert feedback

A systematic review of prospective cohort studies55 (12 studies on risk factors and 7 studies on risk scales) was noted by topic experts which found four risk factors predicting suicide following self-harm: previous episodes of self-harm, suicidal intent, physical health problems and male gender.

Impact statement

During the 2-year evidence update, there was evidence that asking questions of suicidal ideation in people who had signs of depression did not appear to increase feelings that life was not worth living. During the 4-year surveillance, there was weak evidence that a history of self-injurious thoughts and behaviours predicted suicide attempts and death by suicide. There was also evidence on risk factors predicting suicide following self-harm such as previous episodes of self-harm, suicidal intent, physical health problems and male gender. This evidence is generally consistent with current recommendations, which suggest performing a risk assessment in people who self-harm. Risk assessment is recommended as part of the psychosocial assessment in community mental health services and other specialist mental health settings. The risk assessment is defined as a detailed clinical assessment including the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual (recommendations [1.3.6 – 1.3.10](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health))

New evidence is unlikely to impact on the guideline.

133 – 06 [Longer-term treatment and management of self-harm](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm)

Recommendations derived from this area (no questions made in guideline)

Provision of care

1.4.1 Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see [section 1.3](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#psychosocial-assessment-in-community-mental-health-services-and-other-specialist-mental-health)) and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS\*.

Care plans

1.4.2 Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:

* prevent escalation of self-harm
* reduce harm arising from self-harm or reduce or stop self-harm
* reduce or stop other risk-related behaviour
* improve social or occupational functioning
* improve quality of life
* improve any associated mental health conditions.

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.

1.4.3 Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others\*\*. Care plans should:

* identify realistic and optimistic long-term goals, including education, employment and occupation
* identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
* identify the roles and responsibilities of any team members and the person who self-harms
* include a jointly prepared risk management plan (see below)
* be shared with the person's GP.

Risk management plans

1.4.4 A risk management plan should be a clearly identifiable part of the care plan and should:

* address each of the long-term and more immediate risks identified in the risk assessment
* address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
* include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
* ensure that the risk management plan is consistent with the long-term treatment strategy.

Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.

1.4.5 Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.

Provision of information about the treatment and management of self-harm

1.4.6 Offer the person who self-harms relevant written and verbal information about, and give time to discuss with them, the following:

* the dangers and long-term outcomes associated with self-harm
* the available interventions and possible strategies available to help reduce self-harm and/or its consequences (see recommendations [1.1.1](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#general-principles-of-care) and [1.4.10](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm))
* treatment of any associated mental health conditions (see section [1.5](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#treating-associated-mental-health-conditions)).

1.4.7 Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to [information for the public](https://www.nice.org.uk/guidance/cg133/ifp/chapter/about-this-information) that NICE has produced for [this guideline](https://www.nice.org.uk/guidance/cg133/ifp/chapter/about-this-information) and for the [short-term management of self-harm](https://www.nice.org.uk/guidance/cg16/informationforpublic) (NICE clinical guideline 16).

\* Tier 2 CAMHS: primary care; Tier 3 CAMHS: community child and adolescent mental health teams.

\*\* 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Surveillance decision

No new information was identified at any surveillance review.

## [Interventions for self-harm](https://www.nice.org.uk/guidance/CG133/chapter/1-Guidance" \l "longer-term-treatment-and-management-of-self-harm)

133 – 07 For people who self-harm, do psychological and psychosocial interventions (compared with no treatment or other interventions) improve outcomes?

Subquestion

What are the associated adverse effects?

* Interventions: problem-solving, interpersonal therapy, CBT, peer support groups, self-help, computer-based interventions, DBT, counselling, psychodynamic interventions, family interventions, group therapy, postcards, assertive outreach, multi-systemic therapy, respite care, crisis management (refer to Borderline Personality Disorder guideline)

Recommendations derived from this question

1.4.8 Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:

* The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
* Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
* Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Surveillance decision

This review question should not be updated.

2-year evidence update summary

Assertive outreach

A parallel group superiority RCT58 (n=243) in Copenhagen, Denmark evaluated whether an assertive outreach intervention after a suicide attempt reduced future suicide attempts in people aged 12 years or older. Participants included people with severe personality disorders, alcohol misuse, or with no offer of subacute treatment meeting the need for suicide prevention. Participants were admitted to intensive care, paediatric, or emergency units after a suicide attempt in the last 14 days. They were randomised to standard treatment or to the ‘assertive intervention for deliberate self-harm’ (AID) intervention. In both study groups, drug treatment was continued or prescribed as relevant, and participants who were not abusing substances and not receiving other ongoing treatments were also offered 6 to 8 therapy sessions by the Copenhagen Centre of Excellence in Suicide Prevention. During 1-year follow-up, there was no difference in the number of suicide attempts between the AID and the standard care groups based on either hospital records, or self-reported data.

Problem-solving therapy

A Zelen RCT59 (Zelen RCTs perform randomisation before informed consent is given) from New Zealand evaluated the effect of problem-solving therapy in people aged over 16 years presenting to hospital with self-harm. Participants were randomised to problem-solving therapy plus usual care (n=522, of whom 253 consented), or usual care alone (n=572, of whom 299 consented). Among patients whose index episode was their first presentation for self-harm, there was no significant difference in the proportion of repeat self-harm between the groups. However, for those initially presenting with repeat self-harm, problem-solving therapy was associated with significantly less re-presentation at 12 months. Among this sub-group, there was also a significantly shorter time to repetition of self-harm than usual care.

An outreach, problem solving, adherence, and continuity intervention

A single-blind RCT60 from Copenhagen, Denmark compared an outreach, problem solving, adherence, and continuity intervention (OPAC; n=69) with treatment as usual (TAU, n=64) in preventing repeated suicide attempts in people aged 12 years or over who presented with attempted suicide at the emergency room or clinical departments of a single hospital. Significantly fewer participants receiving OPAC repeated a suicidal act compared with TAU. There were 2 suicides in the OPAC group (including 1 drop-out) and 1 suicide in the TAU group. Previous suicidal behaviour was significantly associated with suicide attempts, but OPAC retained a significant effect when controlling for this.

Postcard intervention

An RCT61 (n=2300) in Tehran, Iran examined whether a postcard intervention reduced suicidal behaviour in participants aged 12 years or over admitted to a specialist poisons hospital with self-poisoning (which was not recreational, habitual misuse, accidental, or caused by medical treatment). Participants were randomised to the postcard intervention plus TAU (standard follow-up for self-poisoning) or TAU only. In the intervention, postcards (in the form of a 4-page greeting card, each with a different message) were mailed at 1, 2, 3, 4, 6, 8, 10, and 12 months after discharge, and also on the participant’s birthday. The first postcard enclosed a return envelope to make contact, change contact details, or withdraw from the study. Participants received replies to any questions or requests in the subsequent postcard. There was a significant reduction among the postcard group compared with TAU in the proportion of those with suicidal ideation, proportion of suicide attempts, and number of suicide attempts per person. There was no significant reduction in self-cutting, or self-cutting events per person.

General interventions for self-harm and suicide

Two reviews examined interventions for self-harm and suicide among adolescents.

A systematic review of 14 RCTs62 (n=2036) evaluated the effectiveness of interventions in reducing self-harm repetition in adolescents presenting with self-harm. The RCTs examined: developmental group psychotherapy, youth nominated support teams; problem-solving, cognitive behavioural therapy (CBT), home-based family therapy, cognitive analytic therapy, attachment-based family therapy, therapeutic assessment for self-harm, emotion regulation group training, issuing tokens allowing readmission, and family intervention for suicide prevention. No significant reduction in self-harm repetition compared with TAU was seen in any of the included trials except for 1 RCT of developmental group therapy which was shown to reduce the likelihood of 2 or more episodes of self-harm versus standard care. However, these findings were not replicated in 2 further trials of group therapy. The full version of NICE CG133 also discussed the same 3 trials and drew the same conclusions.

A second systematic review of 15 RCTs63 (n=1853) evaluated interventions for adolescents and young adults who presented to a clinical setting with suicidal ideation, suicidal attempts, or deliberate self-harm. The RCTs assessed: individual-based psychological therapies, group-based psychological therapies, youth nominated support teams, effects of medication and psychotherapy, emergency access card, home-based family intervention, compliance enhancement intervention, and attachment-based family therapy. No statistical difference was found between group therapy and standard care. In 1 RCT, CBT (versus TAU) was associated with significantly fewer self-harm incidents and significantly reduced suicidal ideation on the Suicide Cognition Scale. There was also 1 RCT of people with borderline personality disorder, with results suggesting that compared with client-centred therapy, dialectical behaviour therapy led to fewer suicide attempts. None of the other included studies showed any significant effects in terms of the outcomes of interest.

A cohort study64 concluded that self-harming behaviour in adolescents may resolve spontaneously, which could be an additional consideration in the management of self-harm in this population.

Mentalisation-based treatment

A double-blind RCT65 (n=80) in London, UK evaluated mentalisation-based treatment for adolescents (MBT-A) compared with TAU in reducing self-harm among adolescents aged 12 to 17 years presenting to community mental health services or hospital emergency departments with intentional self-harm. Participants were randomised to MBT-A or TAU. Participants who were severely depressed were also likely to be offered antidepressants. For the primary outcome of self-harm (assessed by self-report on the self-harm scale of the Risk-Taking and Self-Harm Inventory, and confirmed via interview), both TAU and MBT-A reduced the levels of self-harm behaviour however, self-harm scores were significantly lower for the MBT-A group. Reporting at least 1 incident of self-harm in the past 3 months was also significantly reduced for the MBT-A group compared with the TAU group at 12 months.

During 2-year evidence update, it was concluded that some of the evidence was consistent with current recommendations (such as the focus on continuity of care and psychological supervision of professionals as well as the inclusion of problem solving interventions). Regarding postcard interventions, the data suggested that a postcard intervention may reduce suicidal ideation and suicide attempts compared with TAU but the limitations of the study (particularly differences between the Iranian setting and the UK) meant that the evidence was considered unlikely to have an impact on current recommendations. It should be noted that studies of postcard interventions from Australia and New Zealand were examined during guideline development concluding that there was insufficient evidence to determine clinical effects between interventions and routine care. Evidence also suggested that a year-long MBT-A programme may be more effective than TAU in reducing self-harm among adolescents at 12 months, but further research is needed to confirm findings (particularly cost-effectiveness analysis, because the length and intensive nature of the intervention may involve high costs). In general, this evidence was considered unlikely to have an impact on current recommendations.

4-year surveillance summary

Parents and carers intervention

An RCT66 (n=147 parents and full-time carers) evaluated an eight-session group programme (SPACE) for parents and carers of young people with deliberate self-harm in comparison to a waiting-list control group. There was a greater improvement in parents and carers well-being in the intervention group compared to the control group.

Postcard intervention

An RCT67 evaluated the efficacy of an intervention on people who self-harmed by poisoning after 5 years. People were randomised to a postcard intervention (8 in 12 months) plus TAU or to TAU. There were no differences between the groups for any repeat-episode self-poisoning admission or any psychiatric admission but there was a significant reduction in event rates for both self-poisoning and psychiatric admissions in the intervention group.

Problem-solving skills training

An RCT68 (n=433 adults) found no differences in rates of repeated self-harm between a structured group problem-solving skills training programme plus TAU intervention and a TAU control group.

Brief therapy

An RCT69 (n=30 patients) found included 30 patients admitted to a level 1 trauma centre for suicide attempt who were randomised to a brief intervention plus usual care or to usual care. There was a greater improvement in readiness to change and reasons for living in patients receiving the brief intervention compared to patients under usual care.

An RCT70 (n=120 patients) allocated patients who had recently attempted suicide to the Attempted Suicide Short Intervention Program (ASSIP) plus TAU or to TAU. At 24-month follow-up, there was a greater reduction of suicide attempts in the ASSIP group compared to the control group.

Dialectical behaviour therapy

An RCT71 (n=80 participants) assessed the effectiveness and cost-effectiveness of dialectical behaviour therapy (DBT) compared to TAU in reducing self-harm in patients with personality disorder. There was a greater reduction of self-harm in the DBT group compared to the TAU group. DBT had a higher cost compared to TAU but the difference was not significant.

An RCT72 (n=99 women) compared three DBT interventions in women with borderline personality disorder and suicide attempts and/or non-suicidal self-injury (NSSI) acts. The interventions were standard DBT (skills training and individual therapy), DBT-S (skills training plus case management) and DBT-I (individual therapy plus activities group). Standard DBT and DBT-S (both including skills training) showed a greater improvement in the frequency of non-suicidal self-injury compared to DBT-I.

An RCT73,74 (n=77 adolescents) allocated adolescents with recent and repetitive self-harm to either DBT for adolescents (DBT-A) or enhanced usual care (EUC). At the end of trial period (19 weeks)73, there was a higher reduction of self-harm, suicidal ideation and depressive symptoms in adolescents receiving DBT-A compared to adolescents receiving EUC. At 1-year follow-up74 (n=75 adolescents), the reduction of self-harm continued higher with DBT-A compared to EUC. However, differences between the groups were no longer observed in other outcomes such as suicidal ideation, hopelessness, depressive or borderline symptoms and global level of functioning.

Therapeutic assessment

Two-year follow-up of an RCT 75 (n=69 adolescents) compared a therapeutic assessment (psychosocial assessment and therapeutic intervention) and a standard psychosocial assessment in adolescents presenting with self-harm. There were no differences between the groups in the frequency of accidental and emergency presentations for self-harm. The therapeutic assessment group showed higher treatment engagement compared to the group receiving assessment as usual.

Psychosocial interventions

A systematic review of randomised controlled trials was included during guideline development and updated in 2015.76 This update included randomised controlled trials of psychosocial interventions for self-harm in children and adolescents (11 trials; n=1,126 participants) compared to TAU or placebo. There were no trials of pharmacological interventions. Meta-analysis was only possible for dialectical behaviour therapy and group-based therapy. The following interventions did not have an impact on repetition of self-harm: therapeutic assessment, dialectical behaviour therapy for adolescents (DBT-A), group-based therapy, compliance enhancement, cognitive behavioural therapy (CBT), home-based family intervention, and provision of an emergency card. There was an association between mentalisation therapy and decrease number of adolescents reporting repetition of self-harm with the Risk-Taking and Self-Harm Inventory. Adverse effects were not reported.

A meta-analysis of randomised controlled trials77 (24 trials: 11 active contact and follow-up, 9 psychotherapy, 1 pharmacotherapy, and three miscellaneous therapy) found that active contact and follow-up interventions were effective in preventing repetition of suicidal behaviour at 12 months but not at 24 months. It was unclear whether psychotherapy, pharmacotherapy, and miscellaneous therapy had an effect on preventing repetition of suicidal behaviour.

A systematic review of randomised controlled trials78 (19 studies; n=2,176 adolescents) found that there was a lower proportion of adolescents who self-harm in the group of therapeutic interventions (psychological and social interventions) compared to the control groups (TAU and placebo). Three therapeutic interventions were considered to have the largest effect size: dialectical behaviour therapy, cognitive-behavioural therapy, and mentalisation-based therapy.

During the 4-year surveillance review, the following interventions reported benefits on self-harm outcomes: parents and carers intervention, brief interventions, and mentalisation-based therapy. Other interventions reported mixed evidence on self-harm outcomes: postcard intervention, active contact and follow-up interventions, dialectical behaviour therapy, cognitive-behavioural therapy, and therapeutic assessment. Some interventions reported no impact on self-harm outcomes: problem-solving skills training programme, group-based therapy, compliance enhancement, home-based family intervention, and provision of an emergency card.

Topic expert feedback

Topic experts highlighted several relevant studies which may help to strengthen recommendations on providing psychological interventions following self-harm:

A systematic review of randomised trials79 (14 trials) found that brief contact interventions (telephone contacts, emergency or crisis cards, and postcard or letter contacts) may reduce subsequent episodes of self-harm or suicide attempt as well as the risk of suicide compared to control interventions. However, the reduction was not significant and not all trials were included in the meta-analysis.

A systematic review of randomised controlled trials was included during guideline development and updated in 2016.80 This update included randomised controlled trials of psychosocial interventions for self-harm in adults (55 trials n=17,699 participants) compared to TAU or alternative treatments. The following psychosocial interventions had an effect on the reduction of repetition of self-harm compared to TAU: cognitive behavioural based psychotherapy (CBT), group based emotion regulation psychotherapy and mentalisation. Dialectical behaviour therapy (DBT) also reduced repetition of self-harm compared to an alternative form of psychological therapy. DBT reduced more the frequency of self-harm compared to TAU. Repetition of self-harm was not reduced by the following psychological interventions: DBT compared to TAU, case management compared to either TAU or enhanced usual care, and continuity of care by the same therapist compared to a different therapist. Cognitive behavioural based psychotherapy did not reduce the frequency of self-harm compared to TAU. Remote contact interventions (including adherence enhancement, mixed multimodal interventions, postcards, emergency cards, general practitioner's letter, telephone contact, and mobile telephone-based psychological therapy) were not associated with reduction of repetition of self-harm compared to TAU. Mixed interventions compared to alternative forms of psychological therapy or TAU did not reduce repetition of self-harm. Mixed interventions included interpersonal problem-solving skills training, behaviour therapy, home-based problem-solving therapy, long-term psychotherapy, provision of information and support, treatment for alcohol misuse, intensive inpatient and community treatment, general hospital admission, or intensive outpatient treatment. Adverse effects were not reported.

Impact statement

Through surveillance reviews, there was mixed evidence regarding psychosocial interventions for the management of self-harm with some evidence reporting benefits (such as parents and carers intervention, brief interventions, and mentalisation-based therapy), other reporting mixed results (such as postcard intervention, active contact and follow-up interventions, dialectical behaviour therapy, cognitive-behavioural therapy, and therapeutic assessment), and other reporting no impact (such as problem-solving skills training programme, group-based therapy, compliance enhancement, home-based family intervention, and provision of an emergency card). In general, this evidence was unlikely to have an impact on current recommendations. This evidence is generally consistent with current recommendations, which suggest considering psychological interventions which have been specifically structured for people who self-harm such interventions could include cognitive-behavioural, psychodynamic or problem solving elements (recommendation [1.4.8](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm)).

New evidence is unlikely to impact on the guideline.

133 – 08 For people who self-harm, do pharmacological interventions (compared with no treatment or other interventions) improve outcomes? What are the associated adverse effects?

Subquestion

What are the associated adverse effects?

* Interventions: Antidepressants, antipsychotics, lithium, anticonvulsants (for example, valproate, carbamazepine, lamotrigine), benzodiazepines, analgesics.

Recommendations derived from this question

1.4.9 Do not offer drug treatment as a specific intervention to reduce self-harm.

Surveillance decision

This review question should not be updated.

2-year evidence update summary

No relevant evidence was identified.

4-year surveillance summary

A systematic review of randomised controlled trials81 (5 trials; n=50 adults) found 4 trials comparing naltrexone to placebo and one trial comparing clomipramine to placebo in the treatment of self-injurious behaviour in adults with intellectual disability. Meta-analysis was not considered to be appropriate. It was concluded that naltrexone and clomipramine showed weak evidence of clinical effectiveness on self-injurious behaviour in adults with intellectual disability.

A systematic review of randomised controlled trials was included during guideline development and updated in 201582. This update included randomised controlled trials of pharmacological interventions or natural products for self-harm in adults (7 trials; n=546 participants) compared to placebo/alternative pharmacological treatment. Meta-analysis was only possible for antidepressants showing non-significant effects on repetition of self-harm including newer generation antidepressants, low-dose fluphenazine, mood stabilisers, or natural products. The antipsychotic flupenthixol showed a significant reduction in self-harm but this finding was from a small trial (n=30).

Topic expert feedback

It was highlighted that the systematic review82 updated in 2015 specifically referred to nomifensine, mianserin and paroxetine as ‘newer generation antidepressants’. However, nomifensine has been withdrawn from the UK. Mianserin is rarely prescribed in England (4,400 items last year, compared with 6.5 million for fluoxetine [Prozac]). Paroxetine may not be the antidepressant of choice for people who self-harm due to concerns over withdrawal effects. In summary, it was concluded that newer antidepressants are not relevant to current practice in the UK.

Impact statement

During the 4-year surveillance, new evidence was identified about pharmacological interventions in adults who self-harm but it was considered to be weak. This evidence is generally consistent with current recommendations, which suggest not to offer drug treatment as a specific intervention to reduce self-harm (recommendation [1.4.9](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#longer-term-treatment-and-management-of-self-harm)).

New evidence is unlikely to impact on the guideline.

## [Harm reduction](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance" \l "longer-term-treatment-and-management-of-self-harm)

133 – 09 For people who self-harm, does the provision of self-management and/or harm minimisation strategies, compared with no treatment or treatment as usual, improve outcomes? Interventions include: replacement therapy, positive emotion technique.

Recommendations derived from this question

1.4.10 If stopping self-harm is unrealistic in the short term:

* consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
* consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
* advise the service user that there is no safe way to self-poison.

Surveillance decision

No new information was identified at any surveillance review.

133 – 10 For people who self-harm, do psychological and psychosocial interventions in combination with pharmacological interventions (compared with psychosocial or pharmacological interventions alone) improve outcomes?

Subquestion

What are the associated adverse effects?

Recommendations derived from this question

No recommendation made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

133 – 11 For people who self-harm, what are the key principles underlying safer prescribing?

Subquestion

Consider:

* prescribing frequency (weekly, monthly)
* toxicity of drug.

Recommendations derived from this question

No recommendation made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

133 – 12 [Treating associated mental health conditions](https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance#treating-associated-mental-health-conditions)

Recommendations derived from this area (no questions made in guideline)

1.5.1 Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:

* [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](https://www.nice.org.uk/guidance/cg115) (NICE clinical guideline 115).
* [Depression](https://www.nice.org.uk/guidance/cg90) (NICE clinical guideline 90).
* [Schizophrenia](https://www.nice.org.uk/guidance/cg82) (NICE clinical guideline 82).
* [Borderline personality disorder](https://www.nice.org.uk/guidance/cg78) (NICE clinical guideline 78).
* Drug misuse ([psychosocial interventions](https://www.nice.org.uk/guidance/cg51) or [opioid detoxification](https://www.nice.org.uk/guidance/cg52)) (NICE clinical guidelines 51 and 52).
* [Bipolar disorder](https://www.nice.org.uk/guidance/cg38) (NICE clinical guideline 38).

1.5.2 When prescribing drugs for associated mental health conditions to people who self-harm, take into account the toxicity of the prescribed drugs in overdose. For example, when considering antidepressants, selective serotonin reuptake inhibitors (SSRIs) may be preferred because they are less toxic than other classes of antidepressants. In particular, do not use tricyclic antidepressants, such as dosulepin, because they are more toxic.

Surveillance decision

No new information was identified at any surveillance review.

# Research recommendations

Prioritised research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. We may then propose to remove research recommendations from the NICE version of the guideline and the [NICE database for research recommendations](https://www.nice.org.uk/about/what-we-do/science-policy-research/research-recommendations). The research recommendations will remain in the full version of the guideline. See NICE’s [research recommendations process and methods guide 2015](https://www.nice.org.uk/Media/Default/About/what-we-do/Research-and-development/Research-Recommendation-Process-and-Methods-Guide-2015.pdf) for more information.

These research recommendations were deemed priority areas for research by the guideline committee. At this 4-year surveillance review time point for NICE guideline CG133 a decision will be taken on whether to retain the research recommendations or stand them down.

We applied the following approach:

* New evidence relevant to the research recommendation was found and an update of the related review question is planned.
  + The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database. If needed, a new research recommendation may be made as part of the update process.
* New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.
  + The research recommendation will be retained because there is evidence of research activity in this area.
* New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.
  + The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database because further research is unlikely to impact on the guideline.
* Ongoing research relevant to the research recommendation was found.
  + The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.
* No new evidence relevant to the research recommendation was found and no ongoing studies were identified.
  + The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.
* The research recommendation would be answered by a study design that was not included in the search (usually systematic reviews or randomised controlled trials).
  + The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.
* The new research recommendation was made during a recent update of the guideline.
  + The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

1. For healthcare professionals who work with people who self-harm, does the provision of training in assessment and management improve outcomes compared with no additional specialist training?

No new relevant evidence has been found since the research recommendation was first made. Therefore it is proposed to remove this research recommendation from the NICE research recommendations database.

1. For people who self-harm (including young people), does the provision of psychosocial assessment with a validated risk scale, compared with psychosocial assessment alone, improve outcomes?

No new relevant evidence has been found since the research recommendation was first made. Therefore it is proposed to remove this research recommendation from the NICE research recommendations database.

1. For people who have self-harmed, does the provision of a psychological therapy with problem-solving elements, compared with treatment as usual, improve outcomes? What is the differential effect for people with a past history of self-harm, compared with people who self-harm for the first time?

No new relevant evidence has been found since the research recommendation was first made. Therefore it is proposed to remove this research recommendation from the NICE research recommendations database.

1. For people who self-harm, does the provision of potentially cheap low-intensity/brief psychosocial interventions, compared with treatment as usual, improve outcomes?

Two RCTs evaluated brief interventions 69,70 showing effects on outcomes in people who self-harm. Both trials are discussed under clinical question 133 – 07. However, none of these trials reported an economic evaluation providing evidence on the cost of the interventions.

As new evidence was found that partially answered the research recommendation it could be useful to wait for additional evidence. Therefore it is proposed to keep this research recommendation. This research recommendation will be considered again at the next surveillance point.

1. What are the different approaches to harm reduction following self-harm in NHS settings?

No new relevant evidence has been found since the research recommendation was first made. Therefore it is proposed to remove this research recommendation from the NICE research recommendations database.

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