4-year surveillance audit document (2016)

Self-harm in over 8s: long term management (2011) NICE guideline CG133

Appendix A.2: Summary of new evidence from surveillance

133 – 01 **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.

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*; 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

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

This review question should not be updated.

2-year evidence update summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Topic experts referred to a cluster randomised trial[1] evaluating the effect of mental health professionals training in suicide guidelines. This trial included 45 psychiatric departments (n=566 patients with suicide ideation). The intervention was an e-learning supported train-the-trainer programme which did not have a treatment effect on suicide ideation in the whole sample. Suicide ideation was significantly decreased in patients with depression (n=154).

Impact statement

There was evidence from a cluster randomised trial that staff training in suicide guidelines might have an effect on suicide ideation but this effect was limited in people with depression. This evidence is consistent with current recommendations, which suggest that 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 (recommendation 1.1.9).

New evidence is unlikely to change guideline recommendations.

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133 – 03 **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

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) and risks (see recommendations 1.3.6–1.3.8) 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). 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), 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.

Surveillance decision

This review question should not be updated.

2-year evidence update summary

A retrospective cohort study[2] 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 [3], which concluded that life expectancy and physical health appeared to be severely compromised in individuals who had self-harmed.

During 2-year evidence update, it was concluded that this evidence was unlikely to have implications for NICE guideline CG133.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

A systematic review of prospective cohort studies[4] (12 studies on risk factors and 7 studies on risk scales) was noted by topic experts which found that three risk scales including the Beck Hopelessness Scale (BHS), Suicide Intent Scale (SIS) and Scale for Suicide Ideation (SSI) had 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. This evidence is generally consistent with current recommendations, which suggest that current and past suicidal intent should be assessed.

New evidence is unlikely to change guideline recommendations.

Risk assessment

Preamble to the recommendations in this section of the guideline

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.

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

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.

1.3.14 Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8) and use these to develop a care plan (see recommendations 1.4.2 and 1.4.3) and a risk management plan (see recommendations 1.4.4 and 1.4.5) 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 study[5] 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 prospective cohort study[6] (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. 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)[7] 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 and that risk scales did not seem to accurately detect the risk of suicide attempts and self-harm. The evidence was considered to be consistent with NICE guideline CG133 which suggested that asking about suicidal ideas is not harmful. Furthermore, the guideline already recommends that risk assessment scales should not be used to predict future suicide attempts.

4-year surveillance summary

A systematic review of longitudinal studies[8] (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. Another systematic review[9] of observational studies (16 studies) reported that five or less years of unemployment was related to greater risk of suicide in a meta-analysis of 6 cohort studies.

A systematic review of scales for self-harm risk assessment[10] (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 studies[4] (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, male gender, and unemployment. Through surveillance, there was evidence that risk scales did not seem to accurately detect the risk of suicide attempts and self-harm. 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). The guideline already recommended that risk assessment scales should not be used to predict future suicide or repetition of self-harm.

New evidence is unlikely to impact on the guideline.

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133 – 06 **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) 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 and 1.4.10)
- treatment of any associated mental health conditions (see section 1.5).

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 that NICE has produced for this guideline and for the short-term management of self-harm (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

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 RCT[11] (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 RCT[12] (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 RCT[13] 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 RCT[14] (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 RCTs[15] (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 RCTs[16] (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 study[17] 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 RCT[18] (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

Postcard intervention

A randomised controlled trial[19] 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

A randomised controlled trial[20] (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

A randomised controlled trial[21] (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.

A randomised controlled trial[22] (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

A randomised controlled trial[23] (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.

A randomised controlled trial[24] (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.

A randomised controlled trial[25,26] (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)[25], 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-up [26] (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 a randomised controlled trial[27] (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.[28] 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, DBT-A, group-based therapy, compliance enhancement, 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 trials[29] (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 trials[30] (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 recommendation on providing psychological interventions following self-harm:

A systematic review of randomised trials[31] (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.[32] 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: CBT, group based emotion regulation psychotherapy and mentalisation. 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), others reporting mixed results (such as postcard intervention, active contact and follow-up interventions, dialectical behaviour therapy, cognitive-behavioural therapy, and therapeutic assessment), and others 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 considered 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).

New evidence is unlikely to impact on the guideline.

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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 trials[33] (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 2015[34]. 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 review[34] 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).

New evidence is unlikely to impact on the guideline.

Harm reduction

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.

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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 recommendations made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

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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 recommendations made in the guideline.

Surveillance decision

No new information was identified at any surveillance review.

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133 – 12 **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 (NICE clinical guideline 115).
- Depression (NICE clinical guideline 90).
- Schizophrenia (NICE clinical guideline 82).
- Borderline personality disorder (NICE clinical guideline 78).
- Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
- Bipolar disorder (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. The research recommendations will remain in the full versions of the guideline. See NICE's research recommendations process and methods guide 2015 for more information.

These research recommendations were deemed priority areas for research by the Guideline Committee; therefore, at this 4-year surveillance review time point 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.

RR – 01 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 evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

It was proposed to remove the research recommendation from the NICE version of the guideline and the NICE research recommendations database because there is no evidence of research activity in this area. We considered the views of stakeholders through consultation. It was decided to retain this research recommendation based on the feedback from stakeholder consultation.

RR – 02 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 evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

We considered the views of stakeholders through consultation. Most stakeholders agreed with our proposal. This research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database.

RR – 03 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 evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

It was proposed to remove the research recommendation from the NICE version of the guideline and the NICE research recommendations database because there is no evidence of research activity in this area. We considered the views of stakeholders through consultation. It was decided to retain this research recommendation based on the feedback from stakeholder consultation.

RR – 04 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 [21,22] 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.

Surveillance decision

This research recommendation should be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 05 What are the different approaches to harm reduction following self-harm in NHS settings?

No new evidence relevant to the research recommendation was found and no ongoing studies were identified.

Surveillance decision

It was proposed to remove the research recommendation from the NICE version of the guideline and the NICE research recommendations database because there is no evidence of research activity in this area. We considered the views of stakeholders through consultation. It was decided to retain this research recommendation based on the feedback from stakeholder consultation.

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