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

NICE guideline

Second consultation, January 2004

If you wish to comment on the recommendations, please make your comments on the full version of the draft guideline.
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Key priorities for implementation

1. **Respect, understanding and choice**

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

2. **Staff training**

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

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 health professionals who may assess or treat people who have self-harmed.

3. **Planning of services**

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

4. **Activated charcoal**

Primary care, 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: healthcare staff should be able to offer activated charcoal appropriately, at the earliest opportunity, and within the first 2 hours following ingestion of poison.

5. **Triage**
Consideration should be given to introducing the Australian Mental Health Triage Scale adapted for use in England and Wales as an adjunct to existing triage systems.

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.

6. Psychological, psychosocial and pharmacological interventions

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

7. Assessment of need

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 intent and hopelessness, as well as a full mental health and social needs assessment.

8. Assessment of risk

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

1 Guidance

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

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

1.1 Issues for all services and professionals

1.1.1 Users’ experience of services

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

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

1.1.1.2 Providing treatment and care for people following an act of self-harm is emotionally demanding and requires a high level of communication skills and regular clinical supervision in which the emotional impact upon staff members can be discussed and understood. [GPP]

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

1.1.1.4 When assessing people who self-harm, staff should ask service users to explain their feelings and understanding of the self-harm in their own words. [GPP]

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

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

When relatives or carers are present

1.1.1.7 People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment, although for the initial psychosocial
assessment the interview should take place with the service user alone to maintain confidentiality. [GPP]

1.1.1.8 Provide emotional support and help if necessary to the relatives/carers of people who have self-harmed as they may also be experiencing high levels of distress and anxiety. [GPP]

Specific issues regarding treatment and care

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

1.1.1.10 Adequate anaesthesia should be offered to people throughout the process of suturing or other painful treatments. [GPP]

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

1.1.2 Staff training and service planning

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

Staff training

1.1.2.1 Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed. [C]
1.1.2.2 People who self-harm should be involved in the planning and delivery of training for staff. [GPP]

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

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

Planning of services

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

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

1.1.2.7 In jointly planning an integrated emergency department service for people who self-harm, service managers should consider integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department. [GPP]
1.1.2.8 In addition, emergency department and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day. [GPP]

1.1.2.9 Emergency departments catering for children and young people under 16 years of age, PCTs and local children’s mental health services, in conjunction with local carers and service users wherever possible, should jointly plan the configuration and delivery of integrated physical and mental health care services within emergency departments for children and young people who self-harm. [C]

1.1.3 Activated charcoal

For the majority of drugs taken in overdose, taking activated charcoal as early as possible and within 2 hours of ingestion can prevent or reduce absorption of the drug. Activated charcoal should be immediately available for rapid and appropriate use.

1.1.3.1 Primary care, 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: healthcare staff should be able to offer activated charcoal appropriately, at the earliest opportunity, and within the first 2 hours following ingestion of poison. [B]

1.1.3.2 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; for which poisons activated charcoal should and should not be used; the potential dangers and contraindications of giving activated charcoal; and the need to encourage and support service users when offering activated charcoal. [B]
1.1.4 Consent to care

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

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

1.1.4.2 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. Staff should attempt to obtain relevant information from relatives, friends, carers and other key people to inform the assessment. [GPP]

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

1.1.4.4 Staff should give full information 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 procedure (for example, taking the person to hospital by ambulance) or treatment is initiated. [GPP]

1.1.4.5 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, detaining to allow assessment and treating against the person’s stated wishes. [GPP]

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

1.1.4.7 Staff working with those who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm. [GPP]

1.2 The management of self-harm in primary care

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm, and their relatives, could also help in prevention.

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

1.2.1.2 All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features, and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user. [C]

1.2.1.3 In the assessment and management of self-injury in primary care, healthcare workers should refer service users for urgent treatment in an emergency department if assessment suggests there is a significant risk to the individual who has self-injured. [GPP]

1.2.1.4 In the majority of circumstances, people who have self-poisoned and present to primary care should be urgently referred to the nearest emergency department, especially in view of the fact that
the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned. [GPP]

1.2.1.5 Primary healthcare staff should offer activated charcoal to any person who has self-poisoned within the last 2 hours, unless this is contraindicated, if the person is fully conscious and able to protect his or her own airway. The sooner activated charcoal is administered the greater the likelihood of reducing or preventing absorption of the ingested poison. Service users should be encouraged to take activated charcoal and warned that it is not at all pleasant to consume. Transportation to the emergency department should not be delayed, and ambulance staff informed of the intervention so as to monitor for possible vomiting. [A]

1.2.1.6 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-injury and self-poisoning in the primary care setting, following discussion with the nearest emergency department consultant, taking samples to test for paracetamol and other drugs as necessary. [GPP].

1.2.1.7 If there is any doubt about the seriousness of an episode of self-harm the general practitioner should discuss the case with the emergency consultant as management in secondary care may be necessary. [GPP]

1.2.1.8 Consideration should be given to the patient’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 harm or reluctance to attend other care centres or the service user is very distressed. [GPP]

When urgent referral to the emergency department is not necessary

1.2.1.9 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 identify the need for urgent referral to secondary mental health services. [GPP]

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

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

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

**Service users at risk of self-poisoning in primary care**

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

1.2.1.14 Consideration should be given to preventing or reducing the prescription of co-proxamol, especially for people who are at risk of self-harm. [GPP]

1.2.1.15 When prescribing medication to relatives who live with a person who is considered at risk of self-harm by poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in
overdose, and consider prescribing fewer tablets at any one time, as relatives’ medication is often used in self-poisoning. [GPP]

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

Ambulance staff have an increasingly important role in the assessment and early treatment of self-harm, a role which could be better supported by more collaborative working with other professional groups.

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

1.3.1.2 Ambulance staff should be trained in the assessment and early management of self-harm. Training should particularly address the different methods of self-harm and the appropriate treatments, the likely effects if untreated, and issues of consent and mental capacity. [GPP]

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

1.3.1.4 Ambulance Trusts, the emergency department and Community Mental Health Trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to an emergency department, for people who have self-harmed, where this is appropriate and does not increase the risks to the service user. [GPP]
1.3.1.5 In cases of self-poisoning, ambulance staff should obtain all substances and/or medications found at the scene of an emergency call, whether thought to be involved in the overdose or not, and hand these over upon arrival at the emergency department. [GPP]

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

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

1.3.1.8 Ambulance staff should offer activated charcoal to any person who has self-poisoned within the last 2 hours, unless this is contraindicated, if the person is fully conscious and able to protect his or her own airway. The sooner activated charcoal is administered the greater the likelihood of reducing or preventing absorption of the ingested poison. Service users should be encouraged to take activated charcoal and warned that it is not at all pleasant to consume, and the possibility of vomiting anticipated and monitored. [A]

1.3.1.9 In the emergency treatment of opioid overdose with IV 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, as the effects of naloxone are short-lived in comparison with the effects of most opioids and patients frequently relapse once the effect of naloxone has worn off. All people who have overdosed with opioids should be conveyed to hospital, even if the initial response to naloxone has been good. [GPP]

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

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

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

1.3.1.13 Ambulance Trusts should regularly update ambulance staff of any change in the local arrangements for services available for the emergency treatment of people who have self-harmed. [GPP]
1.3.1.14 Ambulance Trusts should routinely audit incidents of overdose to ensure that interventions are being used consistently and effectively. [GPP]

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

The emergency department provides the main services for people who self-harm. The further integration of physical and the early psychosocial components of healthcare, for people who self-harm, is needed.

1.4.1 Triage

1.4.1.1 Staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment. [GPP]

1.4.1.2 Consideration should be given to introducing the Australian Mental Health Triage Scale adapted for use in England and Wales as an adjunct to existing triage systems. [C]

1.4.1.3 Triage nurses working in emergency departments should be trained in the use of mental health triage systems. [C]

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

1.4.2 For people waiting for physical treatments

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

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

1.4.2.3 If a person has to wait for treatment, he or she should be offered an environment which is safe, supportive and minimises their distress. For many patients, this may be a separate quiet room with supervision and contact to ensure safety. [GPP]

1.4.3 For people who wish to leave before assessment and/or treatment

1.4.3.1 For people who have self-harmed and present to services and wish 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. The assessment should be clearly recorded in his or her notes. [C]

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

1.5 Medical and surgical management of self-harm

Self-poisoning can be treated by reducing absorption, increasing elimination and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with glue, and more complicated injuries will need surgical assessment and possible exploration.
1.5.1 General treatment for ingestion

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

1.5.1.2 Emergency department staff should offer activated charcoal to any person who has self-poisoned within the last 2 hours, unless this is contraindicated, if the person is fully conscious and able to protect his or her own airway. The sooner activated charcoal is administered the greater the likelihood of reducing or preventing absorption of the ingested poison. Service users should be encouraged to take activated charcoal and warned that it is not at all pleasant to consume. [A]

1.5.1.3 Activated Charcoal (AC) given via a nasogastric tube in conjunction with endotracheal intubation, may also be considered for serious and life threatening overdoses when consciousness is impaired and the patient is unable to adequately protect their own airway. AC should be given at the earliest opportunity and within two hours of ingestion. The increased risk of aspiration pneumonitis should be taken into account before undertaking this intervention. [C]

1.5.1.4 Multiple doses of activated charcoal should not be given to people who self harm to reduce the absorption or to promote elimination of poisons unless specifically recommended by TOXBASE or following consultation with NPIS. [B]

1.5.1.5 Emetics, including ipecac, should not be used in the management of self-harm by poisoning. [B]

1.5.1.6 Cathartics as a specific treatment should not be used in the management of self-harm by poisoning. [C]
1.5.1.7 Gastric lavage should only be used in the management of self-harm by poisoning following consultation with NPIS or a poisons treatment centre. [B]

Collecting samples and interpreting results

1.5.1.8 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 even gastric contents may be indicated following discussion with the NPIS. If possible, samples of the suspected poison should also be collected. [GPP]

1.5.1.9 Toxicology laboratory staff should provide regular updates for emergency department staff about which toxicology tests are available, both locally and at the nearest specialised toxicology laboratory, and of the correct methods of collecting, handling and storing samples, and of how they should be transferred to the laboratory. [GPP]

1.5.1.10 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 local toxicology laboratory or the NPIS. [GPP]

1.5.1.11 When emergency department staff are unsure about the interpretation of assay results, advice should be sought from the local laboratory or NPIS. [GPP]

Information and laboratory services available to clinicians treating self-poisoning

Emergency department staff should have easy access to TOXBASE, and be fully trained in its use, and know how and when to contact the National Poisons Information Service.
1.5.1.12  TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. Accessing TOXBASE should be the first point of call for poisons information. [GPP]

1.5.1.13  The NPIS telephone number should be permanently and easily available to clinical staff involved in the emergency treatment of self-poisoning. NPIS should only be contacted directly after clinicians have accessed TOXBASE. [GPP]

1.5.1.14  Clinical staff involved in the emergency treatment of self-poisoning should be given training to better understand human toxicology, and in order to make best use of TOXBASE and the NPIS telephone service. The emergency department, in conjunction with local, regional or national toxicology units (including NPIS), should ensure all staff receive regular training. [GPP]

1.5.1.15  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 its poisons database. [GPP]

1.5.1.16  For the specific management and treatment of overdose with substances not covered in this guideline, clinicians should consult with TOXBASE or discuss the individual case with the National Poisons Information Service (NPIS). [GPP]

**Paracetamol screening**

1.5.1.17  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. [C]
1.5.2 Management of paracetamol overdose

1.5.2.1 Emergency department staff should offer activated charcoal to any person who has self-poisoned with paracetamol within the last two hours, if the person is fully conscious and able to protect his or her own airway. The sooner activated charcoal is administered the greater the likelihood of reducing or preventing absorption. Service users should be encouraged to take activated charcoal and warned that it is not at all pleasant to consume. [A]

1.5.2.2 TOXBASE should be used to guide the further management of paracetamol poisoning. This should be easily available to all clinicians treating paracetamol poisoning. [C]

1.5.2.3 Intravenous N-acetylcysteine should be considered as the treatment of choice in the treatment of paracetamol overdose (although the optimum dose is unknown). If NAC cannot be used, for example, in patients who report previous proper anaphylactic reactions following administration of NAC, for people who abuse intravenous drugs where intravenous access may be difficult, or people with needle phobia, then TOXBASE should be consulted. [C]

1.5.2.4 In the event of an anaphylactoid reaction following administration of intravenous NAC, procedures outlined in TOXBASE should be followed. [GPP]

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

1.5.3 Flumazenil in benzodiazepine overdose

If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help establish the diagnosis and assist in treatment to restore adequate respiration and improve consciousness if this is a clinical priority.
1.5.3.1 In patients who are unconscious or showing marked impairment of consciousness with evidence of respiratory depression in which self-poisoning with a benzodiazepine is suspected, flumazenil should be considered as a diagnostic tool in preparation for the possible therapeutic use of flumazenil. To avoid the more serious adverse reactions only small doses should be employed. [A]

1.5.3.2 Flumazenil should be used in the diagnosis or treatment of benzodiazepine overdose only when full resuscitation equipment is immediately available. [GPP]

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

1.5.3.4 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. [GPP]

1.5.3.5 In unconscious patients in whom self-poisoning with a benzodiazepine is suspected, and the concomitant ingestion of significant amounts of tricyclic antidepressants has been excluded, flumazenil should be considered as a therapeutic option for patients for whom an improved level of consciousness is considered as a clinical priority, such as those who also have consumed other central nervous system depressants, including alcohol, and are showing signs of respiratory depression. [A]

1.5.3.6 When the decision to administer flumazenil has been taken, the clinical team should specifically monitor and document the side effects known to occur with flumazenil, especially physical reactions such as convulsions. [A]
1.5.4 Treatment and management of poisoning with salicylates

Early cases of salicylate poisoning should be treated with activated charcoal and monitored for the need for further treatment, as outlined in TOXBASE.

1.5.4.1 Emergency department staff should offer activated charcoal to any person who has self-poisoned with salicylates within the last two hours, if the person is fully conscious and able to protect his or her own airway. The sooner activated charcoal is administered the greater the likelihood of reducing or preventing absorption. Service users should be encouraged to take activated charcoal and warned that it is not at all pleasant to consume. [A]

1.5.4.2 The further treatment of self-poisoning with salicylates should follow the current guidance outlined in TOXBASE on the emergency treatment of poisoning with aspirin. [C]

1.5.5 Treatment of opioid overdose

Naloxone should be used for opioid overdose.

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

1.5.5.2 A minimum safe dose of naloxone should be used to reverse respiratory depression caused by opioids but which prevents the patient becoming agitated. This is especially important in people who are dependent upon opioids. [C]

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

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

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

1.5.6 Advice for people who repeatedly self-poison

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

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

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

1.5.7 General treatment for self injury

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

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

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

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

**Superficial wound closure**

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

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

**Support and advice for people who self-injure repeatedly**

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.

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

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

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

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

1.6 Psychosocial assessment

Everyone who has self-harmed should have a comprehensive assessment of needs and risk. Referral, treatment and discharge following self-harm should be based on the overall assessment of risk and needs.

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

1.6.2 Assessment of need (specialist mental health professionals)

1.6.2.1 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 intent and hopelessness, as well as a full mental health and social needs assessment. [C]

1.6.2.2 The comprehensive assessment of need should be written clearly in the service user’s notes. [C]

1.6.2.3 To encourage joint clinical decision making, service users and the assessor should both read through the written assessment of need, wherever possible, to mutually agree the assessment. Their agreement should be written into the notes. Where there is
significant disagreement, the service user should be offered the opportunity to write his or her disagreement in the notes. [GPP]

1.6.3 Assessment of risk (specialist mental health professionals)

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

1.6.3.2 The assessment of risk should be written clearly in the service user’s notes. [GPP]

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

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

1.6.3.5 Consideration should be given to combining assessment of needs and risks as a single integrated psychosocial assessment process. [GPP]

1.6.4 Referral and discharge following self-harm

1.6.4.1 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 worker wherever 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 the notes. [GPP]
1.6.4.2 Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. [C]

1.6.4.3 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 risks. [C]

1.6.4.4 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, as many such people may have a range of other social and personal problems that may later increase risk, problems that may be amenable to therapeutic and/or social interventions. [GPP]

1.6.4.5 Overnight admission should be considered following an act of self-harm, especially for people who are very distressed, for those in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication and for those people who may be returning to an unsafe or potentially harmful environment. [GPP]

1.6.5 Training

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

1.6.6 Special issues for children

Children and young people who self-harm have a number of special needs given their vulnerability. Physical treatments will follow similar principles as for adults.
1.6.6.1 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 paediatric doctors in a separate children’s area of the Emergency Department. [GPP]

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

1.6.6.3 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. [C]

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

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

1.6.6.6 Following admission of a child or young person after self-harm, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person. [C]

1.6.6.7 Staff who have emergency contact with children and young people who have self-harmed must understand how issues of capacity and consent apply to this group. [GPP]
1.6.6.8  In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person’s consent, (including Gillick Competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act. [GPP]

1.6.6.9  During admission to a paediatric ward following self-harm, the child and adolescent mental team should undertake assessment and provide consultation for the young person, their family, the paediatric team and social services and education staff as appropriate. [C]

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

1.6.6.11 Child and adolescent mental health practitioners involved in the assessment and treatment of children and young people who have self-harmed should: be trained specifically to work with young people and their families after self-harm; be skilled in the assessment of risk; have regular supervision; and have access to consultation with senior colleagues. [C]

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

1.6.6.13 For young people who have self-harmed several times, consideration may be given to offering developmental group psychotherapy with other adolescents who have repeatedly self-harmed. This should include at least six sessions. Extending the group therapy may also be offered, the precise length of which should be decided jointly by the clinician and the service user. [B]
1.6.7 Special issues for older people

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

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

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

1.6.7.3 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 to give time to monitor changes in mental state and levels of risk. [GPP]

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

1.7 Psychological, psychosocial and pharmacological interventions

Referral for further assessment and/or treatment should be based upon a comprehensive psychosocial assessment. Treatments suggested should be directed towards a person’s underlying problems or particular diagnosis rather than because they have self-harmed, 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.

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

1.7.1.2 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 be also be provided for all service users. [GPP]

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

1.7.1.4 For people who have self-harmed and are deemed to be at risk of repetition, consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow greater access to a therapist than good standard care, and outreach should include following up the service user when an appointment has been missed. The therapeutic intervention plus outreach should continue for at least 3 months. [C]

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

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

This guideline is relevant to people aged 8 years and older and to all healthcare professionals involved in the help, treatment and care of people who self-harm and their carers. These include the following.

- Professional groups who are involved in the care and treatment of people who have self-harmed, including A&E staff, paramedical and ambulance staff, general practitioners, psychiatrists, prison health staff, clinical psychologists mental health nurses, community psychiatric nurses, social workers practice nurses and others
- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those who have self-harmed. These may include, occupational therapists, art therapists, pharmacists, and the police and professionals who work in the criminal justice and education sectors
- Those with responsibility for planning services for people who self-harm and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

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

3 Implementation in the NHS

3.1 In general

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

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

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

3.2 Audit

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

4 Research recommendations

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

- Research, using appropriate survey and rigorous qualitative methods, should be conducted about the meaning of self-harm to people from different ethnic and cultural groups. This should include the exploration of issues of intentionality.
- Epidemiological research should be conducted to determine the prevalence of self-harm in refugees and asylum seekers.
- 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, should be undertaken to establish morbidity and mortality rates for specific drug ingestions used in self-harm.

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

- Qualitative research methods, such as Q sort (Stainton Rogers, 1995) and Interpretive Phenomenological Analysis (Smith et al., 1999), should be used to better understand staff attitudes to self-harm and their psychological and social origins.

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

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

- Research designed to determine the best methods for keeping people who self-harm in contact with services, including evaluating the longer-term consequences of being lost from services.

- An adequately powered national multi-centre RCT, reporting all relevant clinical outcomes, 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 and the ingestion of other substances.

- An appropriately designed and adequately powered study should be undertaken to clarify the optimum dose level at which NAC should be used (for both oral and intravenous administration), reporting relevant outcomes, 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.

- An adequately powered RCT reporting all relevant outcomes should be undertaken to assess the relative efficacy and tolerability of methionine compared with NAC in the treatment of paracetamol overdose.

- 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.

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

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline *Self-Harm: short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care* will be published by the National Collaborating Centre for Mental Health; it will be available from its website, the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk). [This will be the case once the guideline has been published]

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.
The booklet *The Guideline Development Process – Information for the Public and the NHS* has more information about the Institute’s guideline development process. It is available from the Institute’s website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0038).

### 6 Review date

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

A version of this guideline for people who self harm, their families and carers and the public is available from the NICE website ([www.nice.org.uk](http://www.nice.org.uk)) or from NHS Response Line (telephone 0870 1555 455 and quote reference number N0XXX for an English version and N0XXX for a version in English and Welsh).
Appendix A: Grading scheme

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

Box 1 Hierarchy of evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of evidence</th>
<th>Grade</th>
<th>Evidence</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</td>
<td>A</td>
<td>At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level 1) without extrapolation</td>
</tr>
<tr>
<td>IIa</td>
<td>Evidence obtained from at least one well-designed controlled study without randomisation</td>
<td>B</td>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels 2 or 3); or extrapolated from level 1 evidence</td>
</tr>
<tr>
<td>IIb</td>
<td>Evidence obtained from at least one other well-designed quasi-experimental study</td>
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<tr>
<td>III</td>
<td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies</td>
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</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities</td>
<td>C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available</td>
</tr>
<tr>
<td>GPP</td>
<td></td>
<td></td>
<td>Recommended good practice based on the clinical experience of the GDG</td>
</tr>
<tr>
<td>NICE</td>
<td>Evidence from NICE guideline or health technology appraisal</td>
<td>NICE</td>
<td>Evidence from NICE guideline or health technology appraisal (not used in this guideline)</td>
</tr>
</tbody>
</table>
Appendix B: The Guideline Development Group

Professor Paul Lelliott
Director, College Research Unit, Royal College of Psychiatrists
Chair, Guideline Development Group

Dr Tim Kendall
Co-Director, National Collaborative Centre for Mental Health;
Deputy Director, Royal College of Psychiatrists Research Unit, and
Medical Director and Consultant Psychiatrist, Community Health Sheffield
NHS Trust
Facilitator, Guideline Development Group

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Chief Executive, Samaritans

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

Ms Pamela Blackwood
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Greenwich Social Services, currently Caller Services Manager, Samaritans
Lead, Topic Group on User Experience

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Health Economist
Appendix C: The Guideline Review Panel

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

<table>
<thead>
<tr>
<th>Member</th>
<th>Area of expertise/experience</th>
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<tbody>
<tr>
<td>Dr Chaand Nagpaul</td>
<td>Clinical practice</td>
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<tr>
<td>GP Stanmore</td>
<td></td>
</tr>
<tr>
<td>Mr John Seddon</td>
<td>Patient and carer issues</td>
</tr>
<tr>
<td>Patient representative</td>
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</tr>
<tr>
<td>Professor Kenneth Wilson</td>
<td>Methodology</td>
</tr>
<tr>
<td>Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust</td>
<td></td>
</tr>
<tr>
<td>Professor Shirley Reynolds</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Professor of Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich</td>
<td></td>
</tr>
<tr>
<td>Dr Roger Paxton</td>
<td>Implementation</td>
</tr>
<tr>
<td>R&amp;D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust</td>
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</tbody>
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Appendix D: Technical detail on the criteria for audit

Objectives for the audit

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

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

Individuals to be included in an audit

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

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

Measures that could be used as a basis for an audit

See table below.

<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
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</thead>
<tbody>
<tr>
<td>1. Staff show care and respect to people who self-harm and present to A&amp;E</td>
<td>1.1 Those who self-harm and present to A&amp;E report that they:</td>
<td>Survey of a consecutive series of people attending A&amp;E after self-harm</td>
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<tr>
<td></td>
<td>• are treated respectfully</td>
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<td></td>
<td>• are given full information about their treatment and care</td>
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<tr>
<td></td>
<td>• are fully involved in decisions about their treatment and care</td>
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<td></td>
<td>• are provided with written information about relevant local services</td>
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<tr>
<td>2. Trust training departments provide appropriate training for health care staff who have contact with people who self-harm</td>
<td>2.1 Training includes:</td>
<td>A. Review of trusts’ training records</td>
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<tr>
<td></td>
<td>• the problems faced by people who self-harm when they have contact with services</td>
<td>B. Survey of staff perceptions of the quality of training</td>
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<td>• the meaning of and motives for self-harm</td>
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<td>• capacity and consent in relation to self-harm</td>
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<td>• assessment of people who self-harm</td>
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<tr>
<td>STANDARDS</td>
<td>CRITERIA</td>
<td>AUDIT METHODS</td>
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<td>5. Health care staff who have first contact with people who self-harm conduct an adequate initial assessment</td>
<td>5.1 Ambulance staff who attend a person who has self-harmed record: • information about home environment • social and family support network • history leading to self-harm • patient’s emotional state and level of distress</td>
<td>Review of written ambulance staff/triage nurse assessments of consecutive series of patients who attend emergency department having self-harmed</td>
</tr>
<tr>
<td>4. Health care professionals give activated charcoal within ten minutes of attending a person who has self-poisoned within the past two hours (unless contraindicated).</td>
<td>4.1 Ambulance crews give activated charcoal within ten minutes of attending a person who has self-poisoned within the past two hours</td>
<td>Review of Ambulance staff/emergency department records of consecutive series of patients assessed by ambulance/emergency department staff</td>
</tr>
<tr>
<td>3. Planners involve those who have experienced self-harm in the planning of services for people who self-harm</td>
<td>3.1 Strategic Health Authorities involve service users in commissioning, planning and evaluation of services for people who self-harm</td>
<td>Review of documents relating to commissioning, planning and evaluation of services for people who self-harm</td>
</tr>
<tr>
<td>2.2 Trusts train the following groups of staff: • ambulance crews • emergency department doctors and nurses • mental health professionals who assess people who self-harm as part of their duty commitment</td>
<td>2.3 Trusts involve people who have self-harmed in planning and delivering the training</td>
<td></td>
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<tr>
<td>1. early management, including the use of activated charcoal • the content of the NICE guideline</td>
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</table>

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| 5.2 | Ambulance staff collect all substances and medications found at the scene |
| 5.3 | The triage assessment in the emergency department includes:  
- capacity and willingness to stay and accept treatment  
- needs for physical care  
- need for urgent psychosocial and/or psychiatric assessment (the use of a standardised mental health triage system would fulfil this criterion)  
| 5.4 | The triage assessment takes account of information provided by the ambulance staff if they were involved in conveying the person to hospital |

| 6. | A health care professional conducts and records a comprehensive assessment of psychosocial needs for every person who self-harms and presents to the health service |
| 6.1 | The needs assessment includes:  
- social situation (living arrangements, work, debt)  
- personal relationships  
- recent life events and current difficulties  
- psychiatric history (including previous self-harm, drug/alcohol use)  
- mental state examination  
- enduring psychological characteristics associated with self-harm  
- motivation for the act  
| Review of emergency department/mental health records of consecutive series of patients assessed following an episode of self-harm |

| 7. | A health care professional conducts and records a comprehensive assessment of risk for every person who self-harms and presents to the health service |
| 7.1 | The risk assessment includes:  
- characteristics of the act of self-harm (intent, medical seriousness, use of violent methods, evidence of planning, precautions taken to prevent rescue)  
- characteristics of the person (hopelessness, criminality, future suicidal intent,)  
- circumstances of the person (social class, physical illness, recent bereavement, social isolation)  
| Review of emergency department/mental health records of consecutive series of patients assessed following an episode of self-harm |
8. Services provide assessment, treatment and care promptly for people who self-harm

<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
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<tbody>
<tr>
<td>8. Services provide assessment, treatment and care promptly for people who self-harm</td>
<td>8.1 When the patient’s condition indicates that there is an immediate threat to life, an ambulance arrives within 8 minutes of being called to attend a person who has self-harmed, otherwise an ambulance arrives within 14 minutes in urban areas or 19 minutes in rural areas when activated through the 999 system.</td>
<td>A. Process audit of response times for a consecutive series of patients, who have self-harmed, attended by the ambulance service</td>
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<td>8.2 Emergency department staff conduct a triage assessment, within ** minutes, of a person who has self-harmed arriving **to be completed</td>
<td>B. Process audit of response times for a consecutive series of patients, who have self-harmed, who attend an emergency department</td>
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<td>8.3 Mental health staff called to make a psychosocial assessment, in an emergency department, of a person who has self-harmed, attends within 30 minutes in an urban area and 90 minutes in a rural area</td>
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<td>8.4 People who have self-harmed and attend an emergency department depart the emergency department within four hours</td>
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<td>9. Emergency departments have appropriate facilities for the care of people who have self-harmed</td>
<td>9.1 Emergency departments offer people who have self-harmed the option of waiting for treatment in an environment that is safe, supportive and which minimises distress</td>
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</tbody>
</table>

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

**Appendix E: The algorithms**

*[Included as a separate document]*
Appendix F: Glossary

**Activated Charcoal:** A substance which, when taken orally, can bind many poisons in the stomach thereby reducing their absorption into the body.

**Advance directives:** Written instructions agreed between a patient and healthcare professional in which the patient specifies in advance of treatment his or her preferred treatments and identifies the treatments he or she do not wish to receive. These are used to guide clinicians in the event that the patient becomes unable to make decisions for him or herself. Advance directives allow people, for instance, to state their wishes with regard to electroconvulsive therapy, or drugs they know give them bad side effects. The patient should understand the nature of the condition for which treatment may be required, the need for treatment, the expected benefits of the proposed treatment, and the possible adverse consequences. Advance directives cannot be used to refuse treatment altogether when a person is subject to the Mental Health Act.

**Behavioural therapy:** A therapeutic approach based on the belief that all behaviour, normal and abnormal, is learned and that the objective is to teach people new ways of behaving.

**Borderline Personality Disorder:** DSM-IV diagnosis where the individual displays a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

**Cathartics:** Substances such as laxatives that produce an evacuation of the bowels.

**Clinical significance:** An effect size may be statistically significant, but it is only clinically important if it is assessed as having clinical significance. That is that the size of the effect is large enough to make a clinical difference – for example, a reduction in the relative risk of 20% or more of experiencing an ‘event’ such as repetition of self harm is considered clinically significant.

**Cognitive behavioural therapy (CBT):** A discrete, time-limited, structured psychological intervention, derived from the cognitive-behavioural model of affective disorders in which the patient:

- works collaboratively with a therapist to identify the types and effects of thoughts, beliefs and interpretations on current symptoms, feelings states and/or problem areas
- develops skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms/problems; and
learns a repertoire of coping skills appropriate to the target thoughts, beliefs and/or problem areas.

**Cohort study** (also known as follow-up, incidence, longitudinal, or prospective study): An observational study in which a defined group of people (the cohort) is followed over time and outcomes are compared in subsets of the cohort who were exposed or not exposed, or exposed at different levels, to an intervention or other factor of interest. Cohorts can be assembled in the present and followed into the future (a ‘concurrent cohort study’), or identified from past records and followed forward from that time up to the present (a ‘historical cohort study’). Because random allocation is not used, matching or statistical adjustment must be used to ensure that the comparison groups are as similar as possible.

**Dialectical behaviour therapy:** A multifaceted and intensive psychological treatment designed for patients with borderline personality disorder.

**Electroconvulsive therapy (ECT):** A therapeutic procedure in which an electric current is briefly applied to the brain to produce a seizure. This is used for treatment of severe depression symptoms or to ease depression that is not responding well to other forms of treatment. Sometimes called convulsive therapy, electroshock therapy or shock therapy.

**Emesis:** Vomiting – the expulsion of the stomach contents through the mouth.

**Endotracheal intubation:** Insertion of a rubber or plastic tube through the nose or mouth into the trachea allowing the supply of oxygen or anaesthetic gases to the lungs.

**Entero-hepatic elimination:** The removal of a drug from the intestine or liver.

**Family therapy:** Family sessions with a treatment function based on systemic, cognitive behavioural or psychoanalytic principles, which may include psychoeducational, problem solving and crisis management work and specific interventions with the identified patient.

**Gastric lavage:** A method of gastric decontamination used in the treatment of poisoning. Lavage involves the passage of a lubricated tube via the mouth and oesophagus into the stomach. Patients are positioned on their side with the head lower than the feet. A small quantity of fluid is passed into the stomach and the contents drained out (by gravity) by lowering the end of the tube. This is repeated until the solution is clear of particulate matter. This procedure should only be done by an experienced health professional.

**Gastrointestinal perforation:** An opening in the gastrointestinal tract (the passage along which food usually passes).

**Haemodiafiltration:** A technique similar to haemodialysis, where blood is dialysed using ultrafiltration through a membrane permeable to water and small molecules.
**Haemodialysis:** A method of removing waste products or poisons from the circulating blood.

**Haemoperfusion:** The transfer of blood through tissue.

**Health Technology Appraisal (HTA):** The process of determining the clinical and cost effectiveness of a health technology in order to develop recommendations on the use of new and existing medicines and other treatments within the NHS in England and Wales.

**Hepatotoxic:** Something that poisons the liver.

**Histrionic Personality Disorder:** The guideline uses the DSM-IV definition which states that the individual displays a pattern of excessive emotionality and attention seeking.

**Hydrocarbons:** An organic molecule that consists only of carbon and hydrogen atoms, and no other elements.

**Inpatient behavioural therapy:** The patient requires a stay in hospital and receives behavioural therapy.

**Insight-oriented therapy:** Therapies designed to give people a better awareness and understanding of previously unconscious feelings, motivations and actions and how they influence present feelings and behaviours.

**Intubation:** A simple operation consisting of the introduction, through the mouth into the larynx, of a tube designed to keep the air passage open at this point.

**Ipecac:** (Ipecacuanha), a substance that produces vomiting when brought into contact with the interior of the stomach.

**Osmotic cathartic:** Substances that produce an evacuation of the bowel by an osmotic action (drawing fluid into the bowel).

**Patient:** The term ‘service user’ is preferred to refer to people who have self-harmed in this guideline. The term ‘patient’ is used under the following conditions: the care or treatment of a doctor as in: (1) a person under the care of a doctor in reports of research or recommendations in which care by doctors is a crucial element, (e.g. ‘Recent surveys suggest that about 10%–15% of patients are managed solely in primary care …’), (2) generic and typical usages, such as ‘NICE programmes for patients’, ‘Patient Bill of Rights’, (3) NICE recommendations which are required to be quoted verbatim; (4) frequently used noun compounds, (e.g. ‘drug-naïve patients’ ‘patient sample’).

**Problem-solving therapy:** A discrete, time limited, structured psychological intervention that focuses on learning to cope with specific problems areas and where the therapist and patient work collaboratively to identify and prioritise key problem areas, break problems down into specific manageable tasks, solve problems, and develop appropriate coping behaviours for problems.
Psychodynamic psychotherapy: Psychological interventions, derived from a psychodynamic/psychoanalytic model in which:

- therapist and patient explore and gain insight into conflicts and how these are represented in current situations and relationships including the therapy relationship (such as transference and counter-transference)
- patients are given an opportunity to explore feelings, and conscious and unconscious conflicts, originating in the past, and the technical focus is on interpreting and working through conflicts
- therapy is non-directive and patients are not taught specific skills such as thought monitoring, re-evaluation or problem-solving.

Psychosocial assessment: An assessment that includes several components, the most important of which are the assessment of needs and the assessment of risks. The assessment of needs is designed to identify those personal (psychological) and environmental (social) factors that might explain an act of self-harm; this assessment should lead to a formulation, based upon which a management plan can be developed.

Risk assessment: An assessment of the likelihood of an individual repeating self-harm and in particular, of attempting suicide.

Salicylates: A group of drugs to which aspirin belongs.

Standard care: ‘Standard care’ is the normal care given to those suffering from acute psychiatric episodes in the area concerned; this involved hospital-based treatment for all studies included.

Suicidal ideation: Thoughts about committing suicide.

TOXBASE: The National Information Poison Service’s computerised database, which is available via the Internet to healthcare professionals. This database is the primary toxicology information source in the UK for the management of poisoning.

Vasodilatation: A state of increased calibre of the blood vessels.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AC</td>
<td>Activated Charcoal</td>
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<tr>
<td>ACB</td>
<td>Association of Clinical Biochemists</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and emergency</td>
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<tr>
<td>AGREE</td>
<td>Appraisal of Guidelines Research and Evaluation</td>
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<td>AHA</td>
<td>American Hospital Association</td>
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<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<tr>
<td>BAAEM</td>
<td>British Association of Accident and Emergency Medicine</td>
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<td>BDZs</td>
<td>Benzodiazepines</td>
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<td>BNF</td>
<td>British National Formulary</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<td>BT</td>
<td>Behaviour Therapy</td>
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<td>CBT</td>
<td>Cognitive behavioural therapy</td>
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<tr>
<td>CEBMH</td>
<td>Centre for Evidence-Based Mental Health, University of Oxford</td>
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<td>CEFAHP</td>
<td>Clinical Effectiveness Forum for the Allied Health Professionals</td>
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<td>CEMH</td>
<td>Centre for Economics in Mental Health</td>
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<td>CHAI</td>
<td>Commission for Health Care, Audit and Improvement</td>
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<td>CI</td>
<td>Confidence interval</td>
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<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
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<td>CM</td>
<td>Case management</td>
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<tr>
<td>CNS</td>
<td>Central nervous system</td>
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<td>CORE</td>
<td>Centre for Outcomes Research and Effectiveness, British Psychological Society</td>
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<tr>
<td>CRU</td>
<td>College Research Unit, Royal College of Psychiatrists</td>
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<tr>
<td>DHSS</td>
<td>Department of Health and Social Services</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of the American Psychiatric Association</td>
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<tr>
<td>ECT</td>
<td>Electroconvulsive therapy</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>EMBASE</td>
<td>Excerpta Medica Database</td>
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<td>ES</td>
<td>Effect size</td>
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<td>FAEM</td>
<td>Faculty of Emergency Medicine</td>
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<td>GABA</td>
<td>Gamma-aminobutyric acid</td>
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<td>GCS</td>
<td>Glasgow Coma Scale</td>
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<td>GDG</td>
<td>Guideline development group</td>
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<td>GI</td>
<td>Gastro-intestinal</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<td>GPP</td>
<td>Good practice point</td>
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<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
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<td>HMO</td>
<td>Health Maintenance Organisation</td>
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<td>HRSD</td>
<td>Hamilton Rating Scale for Depression</td>
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<td>HTA</td>
<td>Health Technology Appraisal</td>
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<td>ICD10</td>
<td>International Classification of Disease</td>
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<td>ICERs</td>
<td>Incremental cost-effectiveness ratios</td>
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</tbody>
</table>
ICU  Intensive Care Unit
IoP  Institute of Psychiatry
IPT  Interpersonal Psychotherapy
IV  Intravenous

MEDLINE  Compiled by the U.S. National Library of Medicine (NLM) and published on the Web by Community of Science, MEDLINE is a source of life sciences and biomedical bibliographic information.

N  Number of studies
n  Number of participants
NAC  N-acetylcysteine
NCCMH  National Collaborating Centre for Mental Health
NHS  National Health Service
NICE  National Institute for Clinical Excellence
NIMH  National Institute of Mental Health
NISW  National Institute for Social Work
NNT  Numbers needed to treat
NPIS  National poison Information Service
NSF  National Service Framework (for mental health)

PCT  Primary Care Trust
PsycINFO  An abstract (not full-text) database of psychological literature from the 1800s–present.
PubMed  A service of the National Library of Medicine, includes over 14 million citations for biomedical articles back to the 1950's. These citations are from MEDLINE and additional life science journals.

QI  Quality Improvement

RCGP  Royal College of General Practioners
RCN  Royal College of Nursing
RCT  Randomised controlled trial
RCPsych  Royal College of Psychiatrists
RPS  Royal Pharamaceutical Society
RR  Relative risk (risk ratio)

SCIE  Social Care Institute of Excellence
SIB  Self injurious behaviour
SMD  Standardised mean difference
SSRIs  Selective serotonin reuptake inhibitors

TCAs  Tricyclic antidepressants

WHO  World Health Organisation
WMD  Weighted mean difference