NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Self-harm: assessment, management and preventing recurrence

Draft for consultation, January 2022

This guideline covers assessment, management and preventing recurrence for all people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability.

This guideline will update NICE guideline CG16 (published July 2004) and NICE guideline CG133 (published November 2011).

Who is it for?

- Healthcare professionals and social care practitioners, commissioners and providers
- Third sector organisations
- The criminal justice system
- People using self-harm services, their families and carers

What does it include?

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect services
- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Information and support

1.1.1 Provide information and support for people who have self-harmed. Share information with family members or carers (as appropriate). Topics to discuss include:

- what self-harm is
- why people self-harm and, where possible, the specific circumstances of the person
- support and treatments available
- how to manage scars or injuries
- care plans and safety plans, and what they involve
- the impact of encountering stigma around self-harm
- who will be involved in their care and how to get in touch with them
- where appointments will take place
- what to do if they have any concerns, and what do to in an emergency
- local services and how to get in touch with them, including out-of-hours
- local support groups, online forums, local and national charities, and how to get in touch with them.

1.1.2 Provide information and support for the family members or carers (as appropriate) of the person who has self-harmed. Topics to discuss include:

- the emotional impact on the person and their family members or carers
- advice on how to cope when supporting someone who self-harms
- what to do if the person self-harms again
- how to seek help for the physical consequences of self-harm
- how to assist and support the person
- how to recognise signs that the person may be at risk of self-harm
- steps to reduce the risk of self-harm
- support for families and carers and how to access it
- the impact of encountering stigma around self-harm
- local services and how to get in touch with them, including out-of-hours
- local peer support groups, online forums, local and national charities, and how to get in touch with them
- their right to a formal assessment of their own needs including their physical and mental health (known as a 'carer's assessment'), and how to access this (see the NICE guideline on supporting adult carers).

1.1.3 Information for people who have self-harmed and their family members or carers should be:

- tailored to their individual needs and circumstances, for example, first presentation or repeat self-harm, severity of self-harm, type of self-harm, underlying conditions
- provided throughout their care
- sensitive and empathetic
- supportive and respectful
- consistent with their care plan, if there is one in place
- conveyed in the spirit of hope and an expectation of recovery.

For more guidance on communication, providing information (including different formats) and shared decision making, see the NICE guidelines on shared decision making, service user experience in adult NHS mental health, patient experience in adult NHS services and babies, children and young people's experience of healthcare.

1.1.4 Recognise that support and information may need to be adapted for people who may be subject to other forms of discrimination, for example, people with physical disabilities, disadvantaged groups, people from Black, Asian and minority ethnic backgrounds, and people who are LGBT+.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on information and support.

Full details of the evidence and the committee's discussion are in:

- evidence review A: information and support needs
- evidence review B: information and support needs (family and carers)
- evidence review F: psychosocial assessment.

1.2 Consent and confidentiality

1.2.1 All health and social care professionals who have contact with people who self-harm should be able to:

- understand when and how to apply the principles of the Mental Capacity Act 2005 and its Code of Practice, Mental Health Act 2007 and its Code of Practice, and the Care Act 2014 and the Care Act 2014 statutory guidance
- assess mental capacity
- make decisions about when treatment and care can be given without consent
- understand when and how to seek further guidance about consent to care
- direct people to independent mental capacity advocates (IMCAs).

Also see the NICE guidelines on decision making and mental capacity and service user experience in adult mental health.

1.2.2 All health and social care professionals who have contact with children and young people who self-harm should be able to:

- understand how to apply the principles of the Children Act 1989 and Children and Families Act 2014 in relation to competence, capacity and confidentiality and the scope of parental responsibility
- understand how to apply the principles of the Mental Health Act 2007 to young people
- understand how issues of capacity and competence to consent apply to children and young people of different ages
- assess the young person's capacity to consent (including Gillick competence).

1.2.3 Staff working with people who self-harm should have access at all times to specialist advice (for example, liaison psychiatry) and legal advice about issues relating to capacity and consent.

1.2.4 Staff working with people who self-harm should be familiar with the limits of confidentiality with regard to information about a person's treatment and care.

1.2.5 Staff working with people who self-harm should be aware of the benefits of involving the person's family and carers and sharing information, and should recognise the need to seek consent from the person as early as possible.

1.2.6 Staff working with people who self-harm should recognise that if it is necessary to breach confidentiality, they should ensure that the person who has self-harmed is still involved in decisions about their care.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on consent and confidentiality.

Full details of the evidence and the committee's discussion are in evidence review C: consent, confidentiality and safeguarding.

1.3 Safeguarding

1.3.1 All healthcare professionals who have contact with people who self-harm should:

- understand when and how to apply the safeguarding principles of the Care Act 2014, the Children Act 1989, and the Children and Families Act 2014
- ask about safeguarding concerns, for example, domestic abuse, violence or exploitation at the earliest opportunity and, if appropriate, when the person is alone
- explore whether the person's needs should be assessed and documented according to local safeguarding procedures
- be aware of local safeguarding procedures for vulnerable adults and children in their care, and seek advice from the local named lead on safeguarding if needed.

Also see the NICE guidelines on domestic violence and abuse, child abuse and neglect and child maltreatment.

1.3.2 If people who self-harm are referred to local health and social care services under local safeguarding procedures, use a multi-agency approach, including education and/or third sector services, to ensure that different areas of the person's life are taken into account when assessing and planning for their needs.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on safeguarding.

Full details of the evidence and the committee's discussion are in evidence review C: consent, confidentiality and safeguarding.

1.4 Involving family members and carers

1.4.1 Ask the person who has self-harmed whether and how they would like their family or carers to be involved in their care, taking into account the

factors in recommendation 1.4.2, and review this regularly. If the person agrees, share information with family members or carers (as appropriate), and encourage them to be involved.

1.4.2 When thinking about involving family members or carers in supporting a person who has self-harmed, take into account issues such as:

- whether the person has consented for information to be shared and, if so, if the consent is limited to certain aspects of their care
- any safeguarding concerns
- the person's mental capacity, age and competence to make decisions
- the person's right to confidentiality and autonomy in decision making
- the balance between autonomy (in young people, their developing independence and maturity) and the need to involve family members or carers
- the balance between the possible benefits and risks of involving family members of carers and the rights of the person.

1.4.3 When involving family members or carers in supporting a person who has self-harmed:

- encourage a collaborative approach to:
  - support the person who has self-harmed
  - minimise the person's self-harm behaviours **and**
  - prevent recurrence
- give them opportunities to be involved in decision making, care planning and developing safety plans to support the person beyond the initial self-harm episode, and through their care pathway
- ensure that there is ongoing and timely communication with the family or carers
- regularly review whether the person who has self-harmed still wants their family or carers to be involved in their care, and ensure that they know they can withdraw consent to share information at any time.

1.4.4 Be aware that even if the person has not consented to involving their family or carers in their care, family members or carers can still provide information about the person.

1.4.5 Support the person and their family members or carers (as appropriate) in trying alternative methods of communication (such as non-verbal language, letters, wellbeing passports or emojis) if the person who has self-harmed finds it difficult to vocalise their distress when they are in need of care.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on involving family members and carers.

Full details of the evidence and the committee's discussion are in evidence review D: involving family and carers.

1.5 Psychosocial assessment, risk assessment and care by specialist mental health professionals

1.5.1 At the earliest opportunity after an episode of self-harm, a specialist mental health professional should carry out a psychosocial assessment to:

- develop a collaborative therapeutic relationship with the person
- begin to develop a shared understanding of why the person has self-harmed
- ensure that the person receives the care they need
- give the person and their family members or carers (as appropriate) information about their condition and diagnosis.

1.5.2 Do not delay the psychosocial assessment until after medical treatment is completed.

1.5.3 If the person who has self-harmed is intoxicated by drug or alcohol use, agree with the person and colleagues what immediate assistance is

needed, for example, support and advice about medical assessment and treatment.

1.5.4 Do not use breath or blood alcohol levels to delay the psychosocial assessment.

1.5.5 If the person is not able to participate in the psychosocial assessment, ensure that they have regular reviews, and complete a psychosocial assessment as soon as possible.

1.5.6 If the person who has self-harmed has agreed a care plan, check this with them and follow it as much as possible.

1.5.7 Carry out the psychosocial assessment in a private, designated area where it is possible to speak in confidence without being overheard.

1.5.8 Take into account the preferences of the person who has self-harmed as much as possible when carrying out the psychosocial assessment, for example, by:

- making appropriate adjustments for any physical, mental health or neurodevelopmental conditions the person may have **and**
- providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment.

1.5.9 During the psychosocial assessment, explore the meaning of self-harm for the person. Take into account:

- the need for psychological interventions, social care and support, or occupational or vocational rehabilitation
- the person's values, wishes and what matters to them
- the person’s treatment preferences
- that each person who self-harms does so for their own reasons
- that 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
- whether it is appropriate to involve their family and carers; see the section on involving family members and carers.

1.5.10 During the psychosocial assessment, explore the following to identify the person's risk factors and needs:

- historic factors, including:
  - vulnerabilities, including those related to age, gender identity, sexual orientation and cultural factors
  - past self-harm and/or suicidal behaviours
  - adverse childhood events
  - history of trauma, if the person feels able to discuss this in the acute context
  - family history of suicide
  - any mental health and/or neurodevelopmental condition and its relationship to self-harm
  - treatments
- changeable and current factors, including:
  - recent and current life difficulties
  - recent or ongoing trauma
  - ability to engage in work or educational activities
  - methods and frequency of current self-harm, including their ongoing access to methods of self-harm
  - prescribed medicines
  - current suicidal thoughts and behaviours
  - significant relationships and changes to them
  - threats of abuse or harm; see the section on safeguarding
  - the needs of any dependents and any safeguarding issues
  - harmful or hazardous use of alcohol or recreational drugs
  - any personal, financial, social or other factors preceding self-harm, such as emotional distress
  - the benefits and harms of social media and internet resources
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors, including:
  - coping strategies (social, psychological, pharmacological) that the person has used to:

- ◊ limit or avert self-harm **or**
- ◊ minimise the impact of personal, social or other factors preceding episodes of self-harm

– supportive personal and family relationships

– support from statutory or third sector services

– the person's and their family and carers' (as appropriate) perspective about their ability to manage their distress.

1.5.11 For children and young people who have self-harmed, in addition to the topics in recommendations 1.5.9 and 1.5.10, also ask about their social, peer group and home situation, and identify any child protection or safeguarding issues (also see the section on safeguarding).

1.5.12 For people over 65 years who have self-harmed, ensure that a specialist mental health professional experienced in assessing older people who self-harm carries out the psychosocial assessment. In addition to the topics in recommendations 1.5.9 and 1.5.10, they should also:

- pay particular attention to the potential presence of depression, cognitive impairment and physical ill health
- include an assessment of the person's social and home situation, including any role they have as a carer
- recognise the increased potential for loneliness and isolation
- recognise that people over 65 have a higher risk of suicide after an episode of self-harm.

1.5.13 If a person has self-harmed and presents to services but wants to leave before a full psychosocial assessment has taken place, assess the immediate risks, the person's mental capacity and any mental health problems before they leave.

1.5.14 Conduct a risk formulation as part of every psychosocial assessment. Include the identified risk factors, situations in which the risk of self-harm or suicide might increase, and proposed actions to reduce these risks.

1.5.15 Together with the person who self-harms and their family and carers (if appropriate), develop a care plan using the key areas of needs and risks identified in the psychosocial assessment (see recommendations 1.5.8 to 1.5.14).

1.5.16 Give the person a copy of their care plan, and share them as soon as possible with the healthcare professionals involved in the person's care.

1.5.17 If a person presents with frequent episodes of self-harm or if treatment has not been effective, carry out a multidisciplinary review with the person and those involved in their care to agree a joint plan and approach. This should involve:

- identifying an appropriate healthcare professional to coordinate the person's care and act as a point of contact
- reviewing the person's existing care and support, and arranging referral to any necessary services
- developing a care plan
- developing a safety plan for future episodes of self-harm, which should be written with and agreed by the person who self-harms.

Risk assessment tools and scales

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

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

1.5.20 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.

1.5.21 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on psychosocial assessment, risk assessment and care by specialist mental health professionals.

Full details of the evidence and the committee's discussion are in:

- evidence review F: specialist psychosocial assessment
- evidence review G: risk assessment.

1.6 Assessment and care by health and social care professionals

Principles for assessment and care by health and social care professionals

1.6.1 When a person presents to a health or social care professional following an episode of self-harm, the professional should:

- treat the person with respect, dignity and kindness
- establish the means of self-harm and, if accessible to the person, discuss removing this with therapeutic collaboration or negotiation, or limit the potential of immediate risk
- assess whether there are concerns about capacity, competence, consent or duty of care, and seek advice from a senior colleague or appropriate clinical support if necessary
- seek consent to liaise with those involved in the person's care (including family members and carers, as appropriate) to gather information to understand the context of and reasons for the self-harm
- discuss with the person their current support network, any safety plan or coping strategies.

1.6.2 Carry out concurrent medical healthcare and the psychosocial assessment as soon as possible after a self-harm episode.

1.6.3 For immediate first aid for self-poisoning, see the BNF's guidance on poisoning, emergency treatment, TOXBASE and the UK National Poisons Information Service.

1.6.4 Do not use aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes.

Assessment and care in primary care

1.6.5 When a person presents in primary care after an episode of self-harm, consider referring them to mental health or social care services for a psychosocial assessment or informing their existing mental health team, with agreement from the person and their family members or carers (as appropriate).

1.6.6 Make referral to mental health services a priority when:

- the person's levels of distress are rising, high or sustained
- the frequency or degree of self-harm or suicidal intent is increasing
- the physical consequences of self-harm cannot be safely managed in primary care
- the person asks for further support from mental health services
- levels of distress in parents or carers of children and young people are rising, high or sustained, despite attempts to help.

1.6.7 If the person who has self-harmed is being supported and given care in primary care, their GP should ensure that the person has:

- regular follow-up appointments with their GP
- regular reviews of self-harm behaviour
- a medicines review
- information, social care, voluntary and non-NHS sector support and self-help resources

- care for any coexisting mental health problems, including referral to mental health services as appropriate.

Assessment and care by ambulance staff and paramedics

1.6.8 When attending a person who has self-harmed but who does not need urgent physical care, ambulance staff and paramedics should:

- discuss with the person the best way that the ambulance service can help them
- follow the person's care plan and safety plan if available
- record relevant information about the following, and pass this information to emergency department staff if the person is conveyed, or share it with other relevant people involved in the person's ongoing care if the person is not being conveyed:
  - home environment
  - social and family support network
  - history leading to self-harm
  - initial emotional state and level of distress
  - any medicines found at their home.

1.6.9 When attending a person who has self-harmed but who does not need urgent physical care, ambulance staff and paramedics should discuss with the person (and any relevant services) if it is possible for the person to be assessed or treated by an appropriate alternative service, such as a specialist mental health service or their GP.

Assessment and care by non-mental health emergency department professionals

1.6.10 When a person attends the emergency department or minor injury unit following an episode of self-harm, emergency department staff responsible for initial assessment or triage should establish the following as soon as possible:

- the severity of the injury and how urgently medical treatment is needed
- the person's emotional and mental state, and level of distress

- whether the person is at immediate risk of further self-harm or suicide
- whether there are any safeguarding concerns
- the person's willingness to accept medical treatment and mental healthcare
- the appropriate nursing observation level
- whether the person has a care plan.

1.6.11 When a person attends the emergency department or minor injury unit following an episode of self-harm, offer referral to liaison psychiatry services (or an equivalent specialist mental health service or a suitably skilled mental health professional) as soon as possible after arrival, for a psychosocial assessment (see the section on psychosocial and risk assessment), and support and assistance alongside medical care.

1.6.12 A liaison psychiatry professional or a suitably skilled mental health professional should see and speak to the person at every attendance after an episode of self-harm.

1.6.13 Ensure that the emergency department has a private, designated area for psychosocial assessments to take place, where it is possible to speak in confidence without being overheard.

1.6.14 Ensure that the waiting area in the emergency department for people who have self-harmed is close to appropriate staff who can provide care, support and observation.

1.6.15 Ensure that appropriate joint governance arrangements are in place so that medical care and mental healthcare can be delivered together in emergency departments. This should include:

- access to electronic record systems for both mental health services and medical treatment at the point of care
- jointly agreed referral pathways for concurrent mental health and medical care
- jointly agreed approaches to initial assessment and triage
- monitoring of the use of mental health law and mental capacity law

- joint safeguarding procedures
- jointly agreed nursing observation policies
- referral pathways to appropriate community services.

1.6.16 Ensure that procedures are in place for people who have self-harmed who wish to leave, or have left, the emergency department before medical care and mental health assessment and care is complete.

1.6.17 Ensure that procedures are in place to identify people who frequently attend the emergency department or minor injury unit following an episode of self-harm so that a multidisciplinary review can be arranged in collaboration with mental health services (see recommendation 1.5.17).

Assessment and care in general hospital settings

1.6.18 When a person is admitted to hospital following an episode of self-harm, offer referral to liaison psychiatry services (or an equivalent specialist mental health service or a suitably skilled mental health professional) as soon as possible after admission for a psychosocial assessment (see the section on psychosocial and risk assessment), and support and assistance alongside medical care.

1.6.19 A liaison psychiatry professional or a suitably skilled mental health professional should see and speak to the person at every admission after an episode of self-harm.

1.6.20 Mental health and acute ward staff should jointly decide the need for close observation on a case-by-case basis, taking into account the person's views and ensuring that observation is:

- by appropriately skilled and trained healthcare staff
- with the informed consent of the person or within an appropriate legal framework
- reviewed regularly.

1.6.21 Children and young people who have been admitted to a paediatric ward following an episode of self-harm should have:

- access to child and adolescent mental health service (CAHMS) or age-appropriate liaison psychiatry 24 hours a day
- a joint daily review by both the paediatric team and mental health team
- regular multidisciplinary meetings between the general paediatric team and mental health services.

Assessment and care in social care

1.6.22 When working with people who have self-harmed, social care professionals should foster a collaborative approach with all agencies involved in the care of the person, as well as their family members and carers, as appropriate.

1.6.23 Do not withhold a social care assessment or social care services if a person has been referred to mental health services following an episode of self-harm.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on assessment and care by health and social care professionals.

Full details of the evidence and the committee's discussion are in:

- evidence review E: non-specialist assessment
- evidence review T: models of care.

1.7 Assessment and care by non-health and social care professionals

Principles for assessment and care by non-health and social care professionals

1.7.1 When a person who has self-harmed presents to a non-health professional, for example, a teacher or member of staff in the criminal justice system, the non-health professional should:

- treat the person with respect, dignity and kindness
- address any immediate physical health needs resulting from the self-harm, in line with locally agreed policies; if necessary, call 111 or 999 or other external medical support
- seek advice from a health or social care professional, which may include referral to a healthcare or mental health service
- ensure that the person is aware of sources of support such as local NHS urgent mental health helplines, local authority social care services, Samaritans, NHS111 and Childline, and that people know how to seek help promptly
- address any safeguarding issues.

Assessment in schools and educational settings

1.7.2 Educational settings should have guidance for staff to support students who self-harm. This should include:

- how to identify self-harm behaviours
- how to assess the needs of students
- what do to if they suspect a student is self-harming
- how to support the student's close friends and peer group.

1.7.3 Educational settings should have a designated lead responsible for:

- ensuring that self-harm guidance is implemented
- ensuring that self-harm guidance is regularly reviewed and kept up-to-date in line with current professional guidance
- ensuring that staff are aware of the guidance and understand how to implement it
- supporting staff with implementation if there are any uncertainties.

1.7.4 All educational staff should:

- be aware of the guidance for identifying and assessing the needs of students who self-harm

- know how to implement the guidance within their roles and responsibilities
- know who to go to for support and supervision.

1.7.5 For students who have self-harmed, the designated lead should seek the advice of mental health professionals to develop a support plan with the student and their family members and carers (as appropriate) for when they are in the educational setting. This should include guidance from other agencies involved in the person's care, as appropriate.

1.7.6 Educational staff should take into account how the student's self-harm may affect their close friends and peer groups, and provide appropriate support to reduce distress to them and the person.

Assessment and care in the criminal justice system and other secure settings

1.7.7 Staff in criminal justice settings and other secure settings such as immigration detention centres should be aware that those in their care have a high risk of self-harm.

1.7.8 Staff in criminal justice settings and other secure settings such as immigration detention centres should be aware of arrangements for:

- transferring people to a healthcare setting when necessary
- in reach or onsite support.

1.7.9 Staff in criminal justice settings and other secure settings such as immigration detention centres should follow local guidance on assessing people who have self-harmed, as well as the NICE guideline on mental health of adults in contact with the criminal justice system.

1.7.10 Staff in criminal justice settings and other secure settings such as immigration detention centres should ensure that people who have self-harmed have a safe location to await assessment or treatment following an episode of self-harm.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on assessment and care by non-health and social care professionals.

Full details of the evidence and the committee's discussion are in:

- evidence review B: information and support needs (family and carers)
- evidence review E: non-specialist assessment.

1.8 Admission to and discharge from hospital

1.8.1 Consider admission to a general hospital after an episode of self-harm if:

- there are concerns about the safety of the person
- the person is unable to engage in a psychosocial assessment (for example, because they are too distressed or intoxicated)
- the assessment needs to be done at a more appropriate time.

1.8.2 If a 16- or 17-year-old is admitted to a general hospital, ensure that it is to a ward that can meet the needs of young people.

1.8.3 For arrangements for initial aftercare for people who have been admitted to a general hospital after they have self-harmed, see the section on initial aftercare after an episode of self-harm.

1.8.4 Do not delay carrying out a psychosocial assessment or offering mental health treatment if the person is admitted to hospital or needs treatment for physical injuries.

1.8.5 If a person self-harms during a hospital admission, follow the local hospital policy for investigating untoward incidents and undertake a full investigation.

1.8.6 Before discharging a person who has self-harmed from a general hospital, ensure that:

- a psychosocial assessment has taken place

- a care plan has been drawn up
- a discharge planning meeting with all appropriate agencies and people has taken place **and**
- arrangements for aftercare have been specified.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on admission to and discharge from hospital.

Full details of the evidence and the committee's discussion are in evidence review H: admission to hospital.

1.9 Initial aftercare after an episode of self-harm

1.9.1 After an episode of self-harm, discuss and agree with the person, and their family members and carers (as appropriate), the format and frequency of initial aftercare and which services will be involved in their care. Record this in the person's care plan and ensure that the person and their family members and carers have a copy of the plan and contact details for the team providing the aftercare.

1.9.2 Within 48 hours of the psychosocial assessment after an episode of self-harm, provide initial aftercare from the mental health team, GP or team who carried out the psychosocial assessment.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on initial aftercare after an episode of self-harm.

Full details of the evidence and the committee's discussion are in:

- evidence review I: initial aftercare
- evidence review T: models of care.

1.10 Interventions for self-harm

1.10.1 Plan treatment for self-harm taking into account the psychosocial assessment and any associated coexisting conditions (see recommendation 1.10.9).

1.10.2 Offer a cognitive behavioural therapy (CBT)-based psychological intervention that is specifically structured for adults who self-harm. Ensure that the intervention:

- starts as soon as possible
- is typically between 4 and 10 sessions
- is tailored to the person's needs and preferences.

1.10.3 For children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm, consider dialectical behaviour therapy adapted for adolescents (DBT-A).

1.10.4 Work collaboratively with the person, using a strengths-based approach to identify solutions to reduce their distress that leads to self-harm.

1.10.5 Consider developing a safety plan in partnership with people who have self-harmed. Safety plans should be used to:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify coping strategies, including troubleshooting
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

1.10.6 The safety plan should:

- be developed collaboratively and compassionately between the person who has self-harmed and the professional involved in their care using shared decision making (see the NICE guideline on shared decision making)
- be developed in collaboration with family and carers, as appropriate
- use a problem-solving approach
- be held by the person
- be shared with the family, carers and relevant health and social care professionals as decided by the person
- be accessible to the person and the professionals involved in their care at times of crisis.

1.10.7 Do not use diagnosis, age, substance misuse or coexisting conditions as reasons to withhold psychological interventions for self-harm.

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

1.10.9 For guidance on how to treat coexisting conditions that may be related to self-harm, also see the NICE guidelines on:

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence
- Autism spectrum disorder in adults: diagnosis and management
- Autism spectrum disorder in under 19s: recognition, referral and diagnosis
- Bipolar disorder
- Borderline personality disorder
- Depression in adults
- Depression in children and young people
- Drug misuse in over 16s: opioid detoxification
- Drug misuse in over 16s: psychosocial interventions
- Eating disorders
- Generalised anxiety disorder and panic disorder in adults: management

- Obsessive-compulsive disorder and body dysmorphic disorder: treatment
- Psychosis and schizophrenia in adults
- Post-traumatic stress disorder.

Harm minimisation

1.10.10 If a person is engaged in ongoing care and treatment but is not yet in a position to resist the urge to self-cut, only consider harm minimisation strategies:

- in the spirit of hope and the expectation of recovery, and to reduce the severity and/or recurrence of injury
- as part of an overall approach to the person's ongoing recovery-focused care and support, and not as a standalone intervention **and**
- after being discussed and agreed in a collaborative way with the person and their family members or carers (as appropriate), and the wider multidisciplinary team.

1.10.11 Discuss harm minimisation strategies with the person that could help to prevent further episodes of self-harm, for example:

- distraction techniques or coping strategies
- approaches to self-care
- the impact of alcohol and recreational drugs on the urge to self-harm.

1.10.12 Be aware that harm minimisation strategies may not be appropriate for many forms of self-harm.

Therapeutic risk taking

1.10.13 Therapeutic risk taking should only be used after a psychosocial assessment (see the section on psychosocial assessment, risk assessment and care by specialist mental health professionals), and should:

- use shared decision making, to ensure the person is able to make an informed choice, and include family and carers, where appropriate

- draw on the person's strengths and coping strategies
- focus on positive outcomes
- be part of an ongoing assessment to revisit the decision
- be concurrent with psychiatric care if necessary.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on interventions for self-harm.

Full details of the evidence and the committee's discussion are in:

- evidence review J: psychosocial interventions
- evidence review K: pharmacological interventions
- evidence review L: harm minimisation
- evidence review M: therapeutic risk-taking
- evidence review D: involving family and carers
- evidence review P: skills in specialist settings
- evidence review R: skills in non-specialist settings.

1.11 Supporting people to be safe after self-harm

1.11.1 Ensure continuity of care, wherever possible, in the staff caring for people who have self-harmed by minimising the number of different staff they see.

1.11.2 For guidance on ensuring continuity of care, see the section on continuity of care and relationships in the NICE guideline on patient experience in adult NHS services and the section on continuity and coordination of care in the NICE guideline on babies, children and young people's experience of healthcare.

1.11.3 Do not use staff who are untrained in clinical observation (for example, security staff or medical students) to undertake such observations in a person who has self-harmed.

1.11.4 Ensure that the care plans of people who have self-harmed can be accessed by primary and secondary care and other professionals involved in their care.

1.11.5 Ensure that staff working with people who have self-harmed are always visible and accessible to the people they are caring for, to encourage interaction, particularly during handovers and busy periods.

1.11.6 Assess the safety of the environment, balancing the need for restrictions against respect for autonomy, and remove items that may be used to self-harm.

1.11.7 At the earliest opportunity, help people who have self-harmed to become familiar with the clinical setting in which they are being cared for, and tell them how to get support.

1.11.8 Staff should know how to raise concerns without delay about a person who has self-harmed.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on supporting people to be safe after self-harm.

Full details of the evidence and the committee's discussion are in evidence review N: supporting people to be safe.

1.12 Safer prescribing and dispensing

1.12.1 When prescribing medicines to someone who has previously self-harmed and remains at risk of self-harm, healthcare professionals should take into account:

- the toxicity of the prescribed medicines for people at risk of overdose (for example, opiate-containing painkillers and tricyclic antidepressants)
- their recreational drug and alcohol consumption, and the risk of misuse
- the person's access to the prescribed medicines when assessing their risk of suicide or self-harm.

Also see NICE's key therapeutic topic on suicide prevention: optimising medicines and reducing access to medicines as a means of suicide.

1.12.2 Use shared decision making to discuss limiting the quantity of medicines supplied to people with a history of self-harm, and ask them to return unwanted medicines for safe disposal. Also see the NICE guideline on shared decision making.

1.12.3 Consider carrying out a medicines review after an episode of self-harm. Take into account the pharmacokinetic properties of medicines, for example, half-life, risk of toxicity and the concurrent use of medicines such as benzodiazepines and opiates. If necessary, contact the National Poisons Information Service for further advice. Also see the NICE guideline on medicines optimisation.

1.12.4 Community pharmacy staff should be aware of warning signs relating to self-harm, such as identifying people who are buying large amounts of over-the-counter medicines or who have access to large amounts of medicines.

1.12.5 Healthcare professionals, including GPs and community pharmacy staff should use consultations and medicines reviews as an opportunity to assess self-harm if appropriate, for example, asking about thoughts of self-harm or suicide, actual self-harm, and access to substances that might be taken in overdose (including prescribed, over-the-counter medicines, herbal remedies and recreational drugs).

For a short explanation of why the committee made these recommendations, see the rationale and impact section on safer prescribing and dispensing.

Full details of the evidence and the committee's discussion are in evidence review O: safer prescribing.

1.13 Training

1.13.1 Training for all staff who work with people of any age who self-harm should:

- involve people who self-harm and their families or carers (where appropriate), and staff in the planning, delivery and evaluation of training
- be available in a range of formats, including interactive role play, online, face-to-face and through provision of resources
- explore staff attitudes, values, beliefs and biases
- be appropriate to the level of responsibility of the staff member
- be provided on a regular and ongoing basis.

1.13.2 All staff who work with people of any age who self-harm should have training specific to their role so that they can provide care and treatment outlined in this guideline. Training should cover:

- treating and managing episodes of self-harm, including de-escalation using the least restrictive measures
- discussing self-harm with the person in an open way to explore the reasons for each episode of self-harm
- involving people who self-harm in all discussions and allowing sufficient time for decision making about their treatment and subsequent care
- communicating compassionately and facilitating engagement with people who have self-harmed, including using active listening skills
- being culturally competent through respecting and appreciating the cultural contexts of people's lives
- education about the underlying factors or triggers that may lead people to self-harm
- education about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes
- recognising the impact of other diagnoses and comorbidities, and how they interact with self-harm

- balancing patient autonomy and safety when providing care for people who have self-harmed
- risk assessment of people who have self-harmed, relevant to their role and environment
- the formal processes involved in treatment after self-harm, including:
  - treatment and referral options
  - relevant care pathways
  - relevant legislation
  - procedures specific to the setting, including layout, policies and protocols.

1.13.3 In addition to the training in recommendation 1.13.2, mental health professionals who work with people of any age who self-harm should have training on conducting psychosocial and risk assessments, including early detection.

1.13.4 Staff undertaking observation of people who have self-harmed should also be trained in therapeutic observation methods, including engagement and rapport building.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on training.

Full details of the evidence and the committee's discussion are in:

- evidence review P: skills in specialist settings
- evidence review R: skills in non-specialist settings
- evidence review N: supporting people to be safe.

1.14 Supervision

1.14.1 All staff who work with people of any age who self-harm should receive regular, high-quality formal supervision from senior staff with relevant skills, training and experience. Supervision should:

- take into account the emotional impact of self-harm on staff and how this affects their ability to deliver compassionate care
- focus on ongoing skill development
- include reflective practice
- promote confidence and competence in staff working with people who have self-harmed.

1.14.2 Ensure that all staff working with people who self-harm have easily accessible ongoing support from senior staff with relevant skills, training and experience. Support should include:

- clear lines of responsibility around decision making, particularly for situations where there are challenges around the balance between autonomy and safety for a person who has self-harmed
- emotional support or signposting to emotional support services, as preferred by the member of staff.

For a short explanation of why the committee made these recommendations, see the rationale and impact section on supervision.

Full details of the evidence and the committee's discussion are in:

- evidence review Q: supervision in specialist settings
- evidence review S: supervision in non-specialist settings.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline.

Care plan

The plan of treatment or healthcare to be provided to the service user. It typically documents risks, the needs of the service user, the interventions that will support their recovery, as well as the key professional involved in their care.

CBT-based psychological intervention

Cognitive behavioural therapy (CBT)-based psychotherapy helps people identify and critically evaluate their thoughts about emotional experiences and events, and aims to help them change the ways in which they deal with problems. The Cochrane review that NICE drew on to evaluate research evidence for this guideline used a broad conceptualisation that included treatments focused on modifying thoughts, behaviours, and problem-solving skills.

Dialectic behavioural therapy for adolescents (DBT-A)

Dialectic behavioural therapy for adolescents (DBT-A) is a manualised, typically 16-week behavioural treatment, comprising weekly concurrent individual therapy, a multifamily skills training group, between-session skills coaching for young people and their families, family therapy as needed and a peer-supervision group for therapists. DBT-A aims to equip young people with the skills to reduce or stop self-harm and suicidal behaviours, effectively manage their emotions and improve their relationships.

Designated lead

A senior member of staff within an educational setting who takes lead responsibility for the mental health and wellbeing of students who is given appropriate resources such as funding, time and training to do so. Their role is to provide advice and support to other members of staff, participate in the assessment of students and take part in the development of strategies and policies within the education setting for the care of students with mental health problems, including self-harm. The designated lead liaises with external agencies and parents to work collaboratively in supporting students' needs with an awareness of local provisions.

Risk formulation

A collaborative process between the person who has self-harmed and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

Harm minimisation

Harm minimisation is an approach to self-harm that accepts the person's need to self-harm while aiming to keep long-term damage and frequency of injury to a minimum. It can include suggesting distraction techniques, advice on alternatives to self-harm (for example, use of ice cubes on the skin, drawing on a limb with red marker pens), or even discussing safer ways to self-harm.

Psychosocial assessment

A comprehensive assessment including an evaluation of the person's needs and risks that is designed to identify those personal psychological and environmental (social) factors that might explain an act of self-harm.

Safety plan

A written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods.

Observation

A therapeutic intervention most commonly used in inpatient settings, which allows staff to monitor and assess the mental and physical health of people who are at risk of harm towards themselves and/or others. It should be seen as an opportunity for active engagement as well as sensitive supervision.

Therapeutic risk taking

A process that aims to empower people who self-harm to make decisions about their own safety and to take risks to enable recovery. Key principles include joint decision making, clear information sharing, drawing on existing strengths, collaborative planning, and an understanding that risk taking may result in positive as well as negative outcomes.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Models of care

What is the effectiveness of different models of care for children and young people who self-harm?

> For a short explanation of why the committee made this research recommendation, see the rationale section on assessment and care by health and social care professionals.
>
> Full details of the evidence and the committee's discussion are in evidence review T: models of care.

2 Assessment in non-specialist settings

What are the most effective approaches to assessment in non-specialist settings including primary care, the criminal justice system and immigration service?

> For a short explanation of why the committee made this research recommendation, see the rationale section on assessment and care by health and social care professionals and the rationale section on assessment and care by non-health and social care professionals.
>
> Full details of the evidence and the committee's discussion are in evidence review E: non-specialist assessment.

3 Routine admission to hospital

Is routine or automatic admission effective for young people or older adults who have self-harmed?

For a short explanation of why the committee made this research recommendation, see the rationale section on admission to and discharge from hospital.

Full details of the evidence and the committee's discussion are in evidence review H: admission to hospital.

4 Psychological interventions

What is the effectiveness of specific psychological interventions including digital compared with face-to-face (technology use) in different populations and settings?

For a short explanation of why the committee made this research recommendation, see the rationale section on interventions for self-harm.

Full details of the evidence and the committee's discussion are in evidence review J: psychosocial interventions.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect services.

Information and support

Recommendations 1.1.1 to 1.1.4

Why the committee made the recommendations

There was evidence on the information that people who had self-harmed and their family members and carers want to receive, and how they want to receive it. The committee based the recommendations on the evidence, their knowledge and experience, and the NICE guidelines on patient experience in adult NHS mental health services, and patient experience in adult NHS services.

Much of the evidence on the information needs of people who had self-harmed was consistent with that of family and carers, who want information about self-harm to be shared with them. However, there was conflicting evidence about whether people want information to be shared with family members. The committee agreed that information should be available to the person's family and carers where appropriate and in agreement with the person.

There was evidence that family members and carers have additional information and support needs specific to their experience that are often unmet. The committee agreed that further information and support should be provided to family members and carers as appropriate.

There was evidence that people who had self-harmed and their family and carers perceived support (or a lack of it) based on how they had been communicated with, and that they value support from a range of sources. There was also evidence that people who had self-harmed value information that is specific to their circumstances, and the committee agreed that information should be tailored to the individual. The evidence also suggested that people and their family and carers find it difficult to get the information or support they need.

The committee discussed existing NICE guidelines that have important information about how to appropriately provide information and support to people and agreed that the guidelines are relevant for people who have self-harmed.

The recommendation that people from protected groups should have additional support was based on the committee's experience and knowledge that forms of discrimination are often causal factors for self-harm.

How the recommendations might affect practice

The recommendations should make it easier for people who have self-harmed and their family members and carers to get support and information after an episode of self-harm, and reduce the variation in the information provided. It should also lead to a higher quality of care.

The impact for providers will vary according to what information and support they currently offer. The recommendations may mean that providers need to change the information they give, but the cost should be minimal and will result in people who self-harm and their family and carers being better informed about self-harm and their care options. The recommendations may mean that family members seek further care for themselves more frequently than they currently do, but it is difficult to estimate the effect this will have on practice.

Return to recommendations

Consent and confidentiality

Recommendations 1.2.1 to 1.2.6

Why the committee made the recommendations

There was no evidence so the committee based the recommendations on their knowledge of current best practice as well as existing guidance and protocols. Without evidence, the committee could not be more specific about how consent and confidentiality should be considered specifically for people who have self-harmed.

The committee agreed that existing guidance covers any issues that might arise about consent and assessing capacity to consent in children and young people of different ages. Staff should be aware of these principles while still feeling

empowered to seek additional advice, to feel confident in situations when consent to care may not be given. The committee also agreed that access to independent mental capacity advocates (IMCAs) would allow the person who has self-harmed to feel confident about decisions about their care.

The committee discussed the risk of legal repercussions for staff either when making decisions about a person's care without their consent or when breaching confidentiality. They recommended that staff have access to experienced colleagues and formal legal advice to allow them to provide care with confidence.

The recommendation about the limitations of confidentiality was based on the consensus statement from the National Suicide Prevention Strategy Advisory Group, which states that confidentiality can often be a barrier to information sharing, to the detriment of other staff members and family members and carers. The committee agreed that confidentiality could also limit collaboration between staff across different clinical settings.

The committee agreed that sharing information about a person's care with family members and carers has multiple benefits that often improve outcomes, such as allowing the person to receive appropriate care outside of clinical settings. The committee discussed the risks attached to information sharing and agreed it is still necessary to seek consent from the person, especially before sharing information with family members and carers. This was supported by qualitative evidence from review for involving family members and carers, that family members and carers want to be more involved in the management of self-harm, whereas people who have self-harmed find information sharing without their consent to be a breach of trust.

The committee discussed the risks of breaching confidentiality and agreed that it can lead to feelings of disempowerment and further distress for the person who has self-harmed. The committee therefore agreed that the person should still be included in decisions after confidentiality has been breached to promote autonomy.

How the recommendations might affect practice

These recommendations are in line with existing recommended practice, and should result in easier access to legal advice and better awareness of the benefits of information sharing.

Return to recommendations

Safeguarding

Recommendations 1.3.1 and 1.3.2

Why the committee made the recommendations

The recommendations are based on the committee's knowledge of current best practice, as well as existing guidance on safeguarding in healthcare. The committee agreed that staff should always consider whether such concerns exist for children and adults who have self-harmed, and be prepared to follow safeguarding procedures when necessary. This will enable staff to intervene in situations where safeguarding is a concern to reduce the risk of further harm to the person.

The committee agree that a multi-agency approach to safeguarding would promote collaborative working between different sectors, allowing for information sharing and therefore improving the service provided to the person.

How the recommendations might affect practice

These recommendations are in line with existing recommended practice, but may also enable better communication and transitions across services through multi-agency approaches.

Return to recommendations

Involving family members and carers

Recommendations 1.4.1 to 1.4.5

Why the committee made the recommendations

There was conflicting evidence on if and how family members and carers should be involved in the support and treatment of people who have self-harmed. The evidence

showed both potential risks and benefits, so the committee based the recommendations on the evidence and their own knowledge and experience.

There was good evidence that involving family members and carers can have a positive effect on care and that a collaborative approach to care is helpful as long as the person continues to consent to their family and carers' involvement. The committee recognised that there may be circumstances where involving family members or carers is not appropriate, so agreed that involvement should be encouraged and accommodated where appropriate, after taking into account the person's preferences, capacity and the risks and benefits.

There was also evidence that family members, school staff and healthcare professionals value two-way communication to enable information sharing about any changes in the life or treatment of the person who has self-harmed.

The committee highlighted if the person has not given consent, family and carers can still share information with healthcare professionals, which can provide helpful insights to make a holistic assessment of, and base their professional judgements on, the needs of the person who has self-harmed.

There was evidence that people who had self-harmed and their family and carers value being able to communicate using non-verbal means. The committee agreed that this can encourage positive communication because it can often be difficult for the person to express their needs when they are very distressed. The use of non-verbal forms of communication can reduce the need for the person to explain how they are feeling, and help to build the initial therapeutic rapport and understanding of the person's needs.

How the recommendations might affect practice

These recommendations should make it easier for healthcare professionals to recognise when it is appropriate to involve family members and carers in the care of people who have self-harmed, and allow people who have self-harmed to make decisions about the involvement of family and carers. They should also enable family members and carers to be involved in care in a way that is collaborative and helpful for the person who has self-harmed.

Providers may need to change how they involve family members and carers, but the costs will be minimal and will result in a higher quality of care for people who self-harm.

Return to recommendations

Psychosocial assessment, risk assessment and care by specialist mental health professionals

Recommendations 1.5.1 to 1.5.17

Why the committee made the recommendations

The recommendations are based on the available evidence, but because of concerns over the quality and scarcity of evidence, most are based on the committee's knowledge and experience.

The committee agreed that risk assessment is a part of psychosocial assessment and that risk should not be used to determine care management in isolation of other factors.

There was evidence that an assessment model incorporating therapeutic elements such as identification of the target problem has a positive effect on satisfaction. The committee agreed the factors to take into account in the psychosocial assessment, and what it should include.

The committee agreed that delaying a psychosocial assessment could result in the person receiving inappropriate treatment. They discussed that if the person is not able to engage in the assessment, they should be regularly reviewed so that it can take place as soon as appropriate, and that any care plan should always be followed to optimise the psychosocial assessment.

The committee agreed that breathalysers and blood alcohol tests do not accurately assess the ability of a person to meaningfully engage with an assessment, and could be used to wrongly deny someone an assessment.

There was evidence that people value privacy and having a safe and trusted environment when discussing self-harm.

The committee agreed the self-harm triggers and risk factors to explore, and that risk formulation should inform the care plan. The committee agreed that this would allow comorbidities to be taken into account and enable specialist staff to provide a higher quality of care. The committee also agreed that using the psychosocial and risk assessment to develop a care plan could have a positive impact on the person's engagement with follow-up. Qualitative evidence was consistent with the committee's agreement that including family and carers in the person's care has a positive impact.

The committee agreed that there are additional factors to include for children, young people and older adults, and agreed that providing the person with a copy of their care plan would increase transparency and improve trust. Additionally, the committee agreed that providing any other relevant healthcare professionals with the care plan would ensure that all staff are up-to-date about the person's preferences, improving the quality of their care and their transition between services.

The committee discussed that briefly assessing the person if they chose to leave before a full assessment had taken place could prevent repeat self-harm or attempted suicide.

There was insufficient evidence for the committee to define how frequent attendance for self-harm would have to be to trigger a multidisciplinary review. However, the committee agreed that this recommendation was still important based on their knowledge that the individual circumstances of the person, including whether they are continuing to self-harm, should be assessed to evaluate whether a multidisciplinary review is necessary. The committee agreed that a multidisciplinary review should enable staff to reconsider current care, finding the most suitable care approach for the person and therefore preventing further repeat self-harm.

Risk assessment tools and scales

Recommendations 1.5.18 to 1.5.21

The committee agreed that risk assessment tools and scales cannot accurately predict risk of self-harm or suicide, and that determining access to treatment or

hospital admission based on inaccurate risk assessment tools could lead to repeat self-harm, distress and lower patient satisfaction.

The committee agreed that the potential harms of risk stratification, including the implication that risk is static instead of dynamic, outweigh any benefits it has as a clinical communication tool or an adjunct to clinical assessment, so agreed that risk stratification should not be used.

How the recommendations might affect practice

The recommendations should change how psychosocial assessments are conducted to include the assessment of risk, reduce the potential for distress during assessment and improve the person's satisfaction and engagement with services. The recommendations should also allow for more involvement of family members and carers when appropriate, which could result in a better quality of care.

Most of the recommendations are based on existing recommended practice with some additional considerations that should have a minimal effect on costs, depending on how services currently assess people who have self-harmed.

Return to recommendations

Assessment and care by health and social care professionals

Recommendations 1.6.1 to 1.6.23

Why the committee made the recommendations

There was no evidence, so the committee made recommendations mostly based on their knowledge and experience, supplemented by qualitative evidence from the reviews on information and support needs, and staff skills. They agreed it is important to give advice about assessment and care in different settings, but the lack of evidence meant they were unable to be more specific.

The committee made a research recommendation on the most effective approaches to assessment in non-specialist settings to better inform future guideline development. Because of a lack of evidence, the committee also made a research recommendation on models of care for children and young people who self-harm.

Principles for assessment and care by health and social care professionals

Recommendations 1.6.1 to 1.6.4

The committee agreed that assessment for people who have self-harmed should be collaborative and prioritise preserving the person's dignity to minimise distress, while maintaining physical safety. Evidence showed that people who had self-harmed value positive, compassionate support after an episode of self-harm. The committee agreed that the person carrying out the assessment should gather information from other sources, such as professionals and family members, in order for the assessment to be as accurate as possible, and ask about potential coping strategies to inform any future safety plan.

The committee agreed that physical healthcare and mental healthcare should always be delivered concurrently so neither is prioritised at the expense of the other, and to prevent treatment delays. Non-specialist health and social care professionals should seek appropriate advice about care for people who have self-poisoned.

The committee agreed that punitive or aversive approaches should not be used, based on their knowledge that such approaches are considered malpractice and often have harmful effects on people who have self-harmed, potentially leading to increased distress and risk of repeat self-harm or suicide.

Assessment and care in primary care

Recommendations 1.6.5 to 1.6.7

The committee agreed that referring people to mental health services would be reassuring and ensure that people are in the most appropriate setting.

The committee agreed that if people are being cared for in primary care following an episode of self-harm, there should be continuity of care and regular reviews of factors relating to their self-harm to ensure that the person who has self-harmed feels supported and engaged with services.

Assessment and care by ambulance staff and paramedics

Recommendations 1.6.8 and 1.6.9

The committee agreed that information about the person's situation should be recorded because it is invaluable for mental health staff when they carry out the psychosocial assessment. The committee agreed that collaboration between ambulance staff and the person who has self-harmed about their care would allow these preferences to be accommodated by ambulance staff and in other settings.

The committee agreed that ambulance staff should discuss whether assessment should be carried out by alternative services based on qualitative evidence from the review on skills for non-specialist staff. This showed that ambulance staff often felt that the emergency department was not the preferred place that the person who had self-harmed wanted to be taken. They agreed that referral to alternative services could facilitate the person’s engagement with services.

Assessment and care by non-mental health emergency department professionals

Recommendations 1.6.10 to 1.6.17

The committee agreed that an initial rapid assessment of the person’s mental and physical care needs is important to quickly establish the best course of action, accommodate the person’s needs and prevent risk of any further harm.

The recommendations about liaison psychiatry are based on the committee's knowledge that such services have a positive influence on care. The recommendations are also based on evidence from the review on models of care, which showed that specialist psychosocial assessment by mental health staff has an important benefit in terms of self-harm repetition over 12 months.

Evidence from the qualitative review on the information and support needs of people who have self-harmed showed that people value privacy and a safe and trusted environment when discussing self-harm.

The committee agreed that people who have self-harmed may feel neglected when asked to wait in isolated areas of the emergency department, and that people who have self-harmed may need support during a time of potential distress.

The committee based the governance recommendations on the Healthcare Safety Information Branch (HSIB) report on investigation into the provision of mental health care to patients presenting at the emergency department (2018), which found that clarity about service pathways and good communication between teams can result in successful safeguarding, de-escalation of mental health crises, and prevent immediate repeat self-harm or suicide.

The HSIB report also informed the recommendation that there should be an agreed procedure in place for people who wish to leave before treatment is complete. The committee agreed this would ensure that people who leave and who are at risk of repeat self-harm or suicide are identified so appropriate follow-up contact can be made.

The committee agreed that procedures for identifying people who frequently self-harm would allow non-specialist staff in emergency departments to facilitate a multidisciplinary review to ensure that people get the right treatment and support.

Assessment and care in general hospital settings

Recommendations 1.6.18 to 1.6.21

The recommendations about liaison psychiatry are based on the committee's knowledge that such services have a positive influence on care. The recommendations are also based on evidence from the review on models of care, which showed that specialist psychosocial assessment by mental health staff had an important benefit in terms of self-harm repetition over 12 months.

The recommendation about observation was based on the committee's experience that observation can be intimidating and unnecessary, especially when carried out by security guards. The committee agreed that observation should be discussed with people to reduce distress, and carried out by healthcare staff.

The committee agreed that children and young people in hospital have specific needs and should therefore have access to age-appropriate specialist care.

Assessment and care in social care

Recommendations 1.6.22 and 1.6.23

The committee agreed that a shared approach between health and social care professionals is important to promote holistic care for people who self-harm to ensure that different areas of the person's life are taken into account. The committee discussed their experience that social care services can be withdrawn from people after an episode of self-harm, and agreed that this practice should be strongly discouraged despite the lack of evidence, based on their knowledge that this often results in people not receiving the care that they need, potentially leading to repeat self-harm and suicide.

How the recommendations might affect practice

The recommendations should change the way in which assessments are conducted in a range of settings, to reduce the potential for distress after self-harm and improve the person's satisfaction and engagement with services.

Most of the recommendations are based on existing best practice with some additional considerations that should have a minimal effect on costs, depending on how services currently assess people who have self-harmed. The recommendation that people who have self-harmed should have access to liaison psychiatry in emergency departments and general hospital settings should not have a cost or resource impact because this should already be standard practice.

Return to recommendations

Assessment and care by non-health and social care professionals

Recommendations 1.7.1 to 1.7.10

Why the committee made the recommendations

There was no evidence, so the committee based the recommendations on their knowledge and experience. They agreed it is important to give advice about assessment and care in different settings, but the lack of evidence meant they were unable to be more specific.

The committee made a research recommendation on the most effective approaches to psychosocial assessment in non-specialist settings to better inform future guideline development.

Principles for assessment and care by non-health and social care professionals

Recommendation 1.7.1

The committee agreed that people who have self-harmed can often present to non-health and social care professionals, and agreed principles on compassion and preserving the dignity of the person who has self-harmed, regardless of whether the professional has healthcare training. The committee also agreed that non-health and social care professionals should address immediate physical health needs if necessary to prevent further potential harm, but should also seek appropriate clinical support or refer to healthcare services to ensure that the care is appropriate. There was also qualitative evidence from the review on information and support needs of parents and carers, which showed that carers often urgently seek information from qualified health or social care professionals on discovery of self-harm.

Assessment and care in schools and educational settings

Recommendations 1.7.2 to 1.7.6

The recommendations are based on the committee's knowledge that both non-specialist staff and specialist mental health staff can work in educational settings with children and young people who have self-harmed, and therefore all staff in educational settings should have guidance for how to identify and respond to students who have self-harmed or are at risk of self-harm. The recommendations are also based on qualitative evidence from the review on skills for specialist staff, which showed that school mental health staff want policies for how to respond to people who have self-harmed because they often feel unsupported and unsure whether they are acting in the best interest of the student.

The committee agreed that formal guidance and a designated lead on self-harm would ensure educational staff would be equipped with appropriate means to respond to self-harm and be supported in their decision making, boosting staff confidence and competence, and improving the quality of care of children and young adults who have self-harmed.

The committee agreed that collaboration with other mental health staff would support the person's access to services and help prevent repeat self-harm, while taking into account the effect on the person's friends and peers would allow support to be provided.

Assessment and care in the criminal justice system and other secure settings

Recommendations 1.7.7 to 1.7.10

The committee based the recommendations on the NICE guideline on mental health of adults in contact with the criminal justice system and their knowledge and experience. They agreed that staff awareness of the high risk for self-harm would allow them to be better prepared to assess and care for people who self-harm.

The committee agreed that people who have self-harmed in secure settings need onsite support or, where that is not possible, transfer to healthcare settings. As a result, the committee agreed that staff in these settings should be aware of the arrangements in place, so they can facilitate appropriate care and support if a person self-harms.

The committee also agreed that the NICE guideline on the mental health of adults in contact with the criminal justice system contained a lot of detail about assessment, especially in prisons, and that staff knowledge of this guideline would ensure staff in these settings followed best practice.

The committee discussed the benefits of providing a safe place to people who had self-harmed and agreed that this could reduce the person's distress and their access to means to self-harm, as well as reducing the risk for people to be subject to punitive measures such as isolation after self-harm.

How the recommendations might affect practice

The recommendations should change the way in which assessments are conducted in a range of settings to reduce the potential for distress after self-harm and improve the person's satisfaction and engagement with services. The recommendations should also allow for better communication between services, including between non-health and healthcare settings.

Most of the recommendations are based on existing best practice with some additional considerations that should have a minimal effect on costs, depending on how services currently assess people who have self-harmed.

Return to recommendations

Admission to and discharge from hospital

Recommendations 1.8.1 to 1.8.6

Why the committee made the recommendations

The evidence showed that there were no significant short- or long-term differences in repeat self-harm by poisoning, regardless of whether people were admitted to hospital or discharged home. There was no evidence for other types of self-harm or other outcomes. The recommendations are based on the available evidence and the committee's experience and knowledge that admission to hospital carries a greater risk of distress to people of all ages than any potential benefit.

The committee agreed that despite the lack of evidence for the benefit of admitting people to hospital, in some cases it can be helpful to give the person time to recover.

If it is necessary to admit a young person who has self-harmed into hospital, the committee agreed that it can be distressing for them to be admitted to an adults' ward.

The committee agreed that treatment for physical injuries should never be used as a reason to delay or deny a psychosocial assessment because this would be considered malpractice, potentially resulting in heightened distress or neglect of the person's other healthcare needs.

The committee discussed current practice about what happens when a person self-harms while in hospital, and agreed that full investigations should continue to be recommended when an incident occurs to consistently improve services and ensure that further incidents are prevented.

The committee also agreed that discharging a person before they had been assessed and a follow-up plan agreed could be detrimental because the person may

be likely to repeat self-harm or might need further care. This could result in repeat self-harm or suicide, and would create a barrier to care for the person.

The committee made a research recommendation on routine or automatic hospital admission for young people or adults to better inform future guideline development.

How the recommendations might affect practice

The recommendations should reduce variation in practice, and reduce the potential for distress because of any unnecessary admissions.

The recommendations could increase the number of beds available in hospitals and reduce overall costs related to overnight admissions to hospital for people who have self-harmed.

Return to recommendations

Initial aftercare after an episode of self-harm

Recommendations 1.9.1 and 1.9.2

Why the committee made the recommendations

There was evidence that discharge protocols with enhanced initial aftercare provide important benefits such as increased engagement with services and treatment, and a reduced risk of repeat self-harm compared with usual discharge. The committee based the recommendations on the evidence and their knowledge and experience that prioritising person-centred care and empowering people who have self-harmed to make decisions about their own care could improve service user satisfaction and reduce distress or hopelessness. The committee agreed that any aftercare arrangements should be shared with the person, based on their knowledge that this is an important facet of collaborative care, and that providing contact details encourages engagement with care.

The committee discussed that people who have self-harmed are at the highest risk of repeating self-harm within 2 to 3 days of their previous episode of self-harm. They discussed current best practice in line with the existing NICE guideline on transition between inpatient mental health settings and community or care home settings, which includes follow up within 48 hours of presentation. Quantitative evidence was

consistent with this, because it showed that telephone contact within 48 hours after discharge had a positive effect on service engagement. The evidence also found a possible important reduction in the number of suicide attempts for those receiving initial contact 3 days after discharge compared with those receiving initial contact within 7 days of discharge, although the different settings in which follow up was conducted may also have affected the outcomes. Qualitative evidence from the review on information and support needs for people who have self-harmed also showed that people value proactive, prompt follow up and find long waiting times frustrating. The committee agreed that aftercare is therefore most crucial within 48 hours to reduce the risk of repeat self-harm.

There was limited evidence that continuity of personnel has a positive effect on service engagement and repeat self-harm. The committee agreed, based on their experience, that continuity of personnel from initial assessment to aftercare allows people to gain familiarity with particular professionals, improving satisfaction and service engagement, and reducing the risk of distress or hopelessness. Evidence from the review on models of care showed that a continuity chain protocol has a possible important benefit in terms of engagement with services compared with usual care. The committee agreed that this is most important for people who have received treatment from a mental health service, based on their knowledge that the person who had self-harmed would have spent more time with mental health staff and may have built up trust with particular staff members, as well as evidence from the review on models of care, which showed that specialist community mental health follow up has an important benefit in terms of self-harm repetition over 12 months.

How the recommendations might affect practice

The recommendations are mostly in line with current practice. They should lead to a reduction in people waiting for up to 72 hours for aftercare following presentation for self-harm. The recommendations should mean a reduced overall wait time for aftercare, which in turn should reduce repeat self-harm and suicide, and improve satisfaction and engagement with services.

The recommendations for continuity of personnel may have a resource impact depending on how often the same staff members who have carried out an

assessment or mental healthcare also carry out aftercare. Where this is not the case, there will be an increased workload for these healthcare professionals.

Return to recommendations

Interventions for self-harm

Recommendations 1.10.1 to 1.10.9

Why the committee made the recommendations

The committee agreed that the psychosocial assessment should be used to develop a meaningful narrative that would inform the care plan. The committee agreed this would allow comorbidities to be taken into account and enable healthcare professionals to provide a higher quality of care.

The evidence showed that cognitive behavioural therapy (CBT) has positive effects on repetition of self-harm at long-term follow up and on depression, hopelessness and suicidal ideation over time for adults. However, the evidence did not show an effect on repeat self-harm at other follow-up times. It also showed that dialectic behavioural therapy for adolescents (DBT-A) has a positive effect on repetition of self-harm at post-intervention for adolescents. However, the evidence was limited by the fact that participants in studies were all older than 12 years and overwhelmingly female, and there was no evidence of effect of DBT-A on repeat self-harm by 12-month follow up. The committee extrapolated the evidence based on their confidence that DBT-A is likely to be similarly effective in younger children and boys, as well as the low risk of harm in offering DBT-A to all children and young people compared with the high risk of repeat self-harm if no therapeutic intervention is offered to these populations. The evidence on other therapies was uncertain, and the evidence on the effects of pharmacological interventions was limited. The pharmacological evidence showed an uncertain effect of newer-generation antidepressants or antipsychotics on repetition of self-harm for adults, and no evidence of effect for mood stabilisers or natural products on repetition of self-harm for adults. The recommendations are based on the available evidence and the committee’s knowledge and experience of the current practice of offering psychological or psychosocial interventions.

The recommendation that treatment should be offered without delay was based on the committee's knowledge that delaying treatment could lead to further self-harm or suicide, and on evidence from the review on involving families and carers in the management of self-harm, which showed that long waiting times for treatment is often a barrier to seeking help.

The safety planning recommendations were based on the committee's knowledge and experience that safety plans equip people who have self-harmed with the ability to identify and use their strengths and sources of support to overcome crisis moments and prevent repeat self-harm. This was supplemented by qualitative evidence from both staff skills reviews, which showed that coping techniques are important to people who have self-harmed, and that specialist staff identified safety planning as an important technique to help manage self-harm. The committee considered the components of safety planning interventions from 3 studies included in the Cochrane review on psychosocial interventions, and used this evidence to recommend important aspects of safety plans that the committee agreed would prevent further self-harm.

The recommendations about how the safety plan should be implemented were based on the committee's knowledge and experience that collaborative decision making improves engagement with services, and that providing a copy to the person emphasises this collaborative aspect. The committee agreed that sharing the care plan with family and friends when appropriate could provide the benefit of social connectedness between the person and their sources of support, which is a protective factor against self-harm. The committee agreed that safety plans should always be accessible to ensure that people receive the most appropriate care, especially if they are too distressed to remember their plan.

The committee agreed that psychological or psychosocial interventions should always be available for those who may need them, based on their knowledge and experience that exclusion from these services even when they are appropriate for the individual increases the potential for repeat self-harm or suicide.

The committee agreed, based on the uncertain evidence on pharmacological interventions and their knowledge and experience, that drug treatment is usually

offered for other comorbidities such as depression, and should not be offered specifically for self-harm.

The committee made a research recommendation on specific psychological interventions (digital and/or face-to-face) to better inform future guideline development.

Harm minimisation

Recommendations 1.10.10 to 1.10.12

There was no evidence, so the recommendations are based on the committee's knowledge and experience. They agreed that there are benefits to providing advice on coping strategies. However, the lack of evidence meant they were unable to be more specific.

The committee agreed that harm minimisation strategies can be helpful in a small number of cases, where the person is working towards stopping self-harm but has not yet managed to do so. In these circumstances, it may be possible to discuss harm minimisation strategies with the person who has self-harmed; however, this should only be done as part of a therapeutic partnership where treatment is ongoing. The aim of these strategies should be to work towards stopping the self-harm, while minimising the harm before this is possible for the person. The committee also agreed that harm minimisation strategies are not appropriate for many forms of self-harm, such as self-poisoning because there is no safe way to self-poison.

Therapeutic risk taking

Recommendation 1.10.13

There was no evidence, so the committee based the recommendation on their knowledge and experience. They agreed that there are benefits to taking therapeutic risks when working with people who have self-harmed. However, the lack of evidence meant they were unable to be more specific about when therapeutic risk taking should be considered. The committee agreed that therapeutic risk taking could promote autonomy, problem-solving skills and positive thinking, leading to improved patient satisfaction and a reduced risk for self-harm. However, the committee discussed the fact that a misunderstanding of therapeutic risk taking

resulting in assessment or care being withheld could lead to a significant increased risk for repeat self-harm or suicide, and agreed it is important to recommend that risk-taking strategies should only follow a psychosocial assessment and be used concurrently with any other psychiatric care. They also agreed that risk-taking strategies should be a part of ongoing assessments to determine the efficacy of the approach for the person.

How the recommendations might affect practice

The recommendations should increase the number of people receiving CBT or DBT-A after an episode of self-harm, and reduce the number of people denied appropriate psychological or psychosocial interventions because of availability. In turn, this should reduce repeat self-harm and suicide, and improve satisfaction and engagement with services. The recommendations also advise higher levels of caution when using harm minimisation strategies, and should ensure that a therapeutic risk-taking approach will not lead to the withholding of assessment or treatment for people who have self-harmed, potentially improving the quality of care provided, service user satisfaction, and reducing the risk of repeat self-harm or suicide.

The recommendations for specific therapies are likely to increase overall costs related to the provision of psychological interventions to people who self-harm, if CBT and DBT-A are offered to more service users. The recommendation that psychological interventions should be available could also have a resource impact depending on how many centres do not currently offer these therapies. For those that do not, training and additional staffing may be needed for these interventions to be available to all service users. Using therapeutic risk-taking approaches is unlikely to increase overall costs; instead, approaches such as discharging patients from hospital earlier than when risk is considered to be minimal may have a positive resource impact on, for example, the availability of hospital beds.

Return to recommendations

Supporting people to be safe after self-harm

Recommendations 1.11.1 to 1.11.8

Why the committee made the recommendations

Where possible, the recommendations are based on evidence, but because of concerns over the quality and scarcity of evidence, the committee also used their knowledge and experience.

The committee discussed the evidence on the consistency and continuity of staffing, and agreed that this is a fundamental aspect of supporting people to be safe after self-harm because minimising the number of staff that people who have self-harmed see minimises distress and reduces the risk of repeat episodes of self-harm.

The committee discussed the limited evidence on observation for people who have self-harmed. They highlighted that observation could cause harm to people who have self-harmed if carried out by untrained clinical staff and if a therapeutic interaction is not established or maintained.

The committee discussed safety considerations when transferring between settings and agreed the importance of care plans being available to staff involved in their care in primary and secondary care and other settings to promote continuity of care.

There was limited evidence on the benefits of ensuring staff presence during periods in inpatient settings considered high risk for episodes of self-harm. Using this and their knowledge and experience, the committee agreed that it is particularly important for staff to remain visible and accessible during handovers and busy periods to maintain continuity of care and ensure patient safety. By being visible, it minimises barriers between staff and patients, making it more likely that both parties can help and ask for help if needed.

Although it is important to ensure a safe physical environment for all mental health inpatients, the committee noted that a particular focus on safety is needed for people who have self-harmed, so that ways of self-harming are not accessible to them. This could include sharp objects, potential ligatures and possible ligature points and things that might cause harm when ingested. The committee agreed that the need for this should be reviewed and only done when necessary, to maintain the person's dignity and autonomy.

Although there was no evidence on the benefits of familiarising the patient with the procedures and physical environment of inpatient settings, the committee agreed that this is an important component of person-centred care, which should be carried out at the earliest opportunity to help can reduce distress and the risk of repeat self-harm.

Although there was limited evidence, the committee highlighted the importance of all staff working in care settings knowing how to promptly raise concerns about people at risk of self-harm. The committee agreed that open communication channels are important to ensure prompt responses to any signs of repeat self-harm.

How the recommendations might affect practice

These recommendations are in line with existing recommended practice, but they emphasise the importance of consistency and continuity of care and the therapeutic role of clinical observation. The recommendations may lead to trust-specific staff training in caring for people who have self-harmed.

Return to recommendations

Safer prescribing and dispensing

Recommendations 1.12.1 to 1.12.5

Why the committee made the recommendations

There was no evidence, so the committee based the recommendations on their knowledge and experience. The committee also referred to the existing NICE's key therapeutic topic on suicide prevention. The committee agreed that when prescribing medicines to people after an episode of self-harm, it is important to take into account the toxicity of the prescribed medicines, the likelihood of alcohol misuse and the person's access to other medicines to limit the risk of overdose.

The committee acknowledged the importance of shared decision making with people who have self-harmed when prescribing medicines in order to balance the risk of the person stockpiling medicines with their autonomy to improve patient satisfaction and adherence to medicines, and referred to the existing NICE guideline on shared decision making.

The committee agreed that a review of all current and any new medicines should be considered after an episode of self-harm. The committee identified that healthcare professionals could consider contacting the National Poisons Information Service for further advice and referred to the existing NICE guideline on medicines optimisation.

The committee agreed that when pharmacy staff are aware of warning signs and when healthcare professionals are prepared to use consultations to discuss self-harm, the opportunities for people to self-poison or overdose are reduced. The committee also agreed that the recommendations provide the chance for staff to enact safe prescribing principles.

The committee agreed that consultations and medicines reviews provide an opportunity for healthcare staff to assess self-harm, and therefore whether any existing or new medicines might be taken in overdose. This would allow for staff to amend any prescriptions as appropriate to reduce the risk of future self-poisoning.

How the recommendations might affect practice

These recommendations should improve safety for people after an episode of self-harm and improve person-centred care by involving people in decisions about safer prescribing practices.

For prescribers, these recommendations may mean that they review current prescriptions more routinely after an episode of self-harm with respect to the person's risks of toxicity from overdose. For primary healthcare professionals, these recommendations may increase communication with healthcare professionals from other settings, such as specialist mental health centres and specialist pharmacies when prescribing and reviewing medications. Improved communication between healthcare professionals should limit variations in prescribing practices and improve continuity of care.

Return to recommendations

Training

Recommendations 1.13.1 to 1.13.4

Why the committee made the recommendations

The recommendations are based on the evidence from both specialist and non-specialist staff, which showed there is a significant overlap between the kind of training both specialist mental health and non-specialist professionals want when working with people who have self-harmed.

Both reviews found that specialist and non-specialist staff want formal training on how to work with people who have self-harmed, so the committee agreed that all staff who work with people who self-harm should receive regular, ongoing training to address the areas where people felt their skills needed developing. The committee discussed the overlap between the specialist and non-specialist skills reviews and agreed that, although the evidence showed that similar skills are required by all staff, there would be different levels of skill required for each group of people. The committee agreed that the list of topics should be considered by those running the training to ensure the training would be appropriate to each professional's level of responsibility, because it would be unreasonable and impractical to expect specialist and non-specialist staff to receive the same level of training.

The recommendation listing topics to cover in training was based on the evidence on the skills that both specialist and non-specialist staff need. The committee agreed that specialist staff should also receive additional training about how to conduct a psychosocial assessment.

The committee discussed using security staff for observation of people who have self-harmed, and agreed that this is not appropriate and usually results in people feeling intimidated and distressed. They agreed, based on their knowledge and experience, that training in observation methods that promote therapeutic engagement and rapport building would allow staff to undertake clinical observation in a way that is least distressing for patients.

How the recommendations might affect practice

These recommendations should increase the frequency of formal self-harm specific training for all staff. There may be cost implications associated with the provision of high-quality training depending on the current frequency of formal training deemed necessary within different settings.

Return to recommendations

Supervision

Recommendations 1.14.1 and 1.14.2

Why the committee made the recommendations

There was evidence that staff value different types of supervision for specific purposes, and the committee agreed recommendations on regular formal self-harm specific supervision and accessible 'on-the-job' self-harm specific support. The committee agreed that all staff working with people who self-harm should receive regular, high-quality formal supervision that is distinct from general clinical supervision and case load management. There was limited evidence to determine the regularity of formal self-harm supervision, and the committee agreed this would be decided on setting-specific factors, such as the risk of self-harm, the acuteness of self-harm and available resources.

The committee highlighted that supervision should focus on ongoing skills development, because there was evidence that staff feel that they are not suitably trained or confident in caring for people who had self-harmed, especially in crisis situations. There was evidence that staff view reflective practice as an invaluable means to learn and improve their clinical practice; however, often this was not prioritised because of time and resource constraints. The committee agreed that formal self-harm supervision should aim to promote confidence and competence in staff when caring for people who self-harm, and this is particularly important for non-specialist staff who may feel less capable of managing difficult situations.

In addition to formal supervision, there was evidence that staff value having accessible and immediate support from senior colleagues. The committee were concerned that anxiety around fear of litigation in difficult situations could impact quality of care, and agreed that supervision support for staff working with people who self-harm should reinforce lines of responsibility and provide advice to facilitate staff in making the most appropriate decisions.

There was evidence of the value placed on professional emotional support after an episode of self-harm or suicide, with staff describing how it helped them to process

their experience and normalise their feelings and reactions and return to practice. The committee agreed that in their experience and expertise, it is often more appropriate for the member of staff to speak to someone removed from the situation and not necessarily their clinical supervisor, and agreed that all staff should have access to emotional support or emotional support services, as preferred by the member of staff, when requested.

How the recommendations might affect practice

These recommendations should increase the frequency of formal self-harm specific supervision for all staff. There may be cost implications associated with the provision of high-quality supervision depending on the frequency of formal supervision deemed necessary within different settings.

The recommendations on everyday supervision and support are in line with recommended practice but should help to foster a culture of supervision within all settings for staff working with people who self-harm. The committee discussed the cost implications of providing accessible emotional support or emotional support services to all staff and concluded that in most clinical settings, 24-hour support was already available.

Return to recommendations

Context

Self-harm is defined as intentional self-poisoning or self-injury irrespective of the apparent purpose of the act. Prevalence statistics are unreliable because it is a problem that is sometimes hidden, but a recent national study reported that 7.3% of girls aged 11 to 16, and 3.6% of boys aged 11 to 16, had self-harmed or attempted suicide at some point. The figures for 17- to 19-year-olds were 21.5% for girls and 9.7% for boys. Self-harm can occur at any age, but there is evidence that there has been a recent increase in self-harm among young people in England.

Only a minority of people who have self-harmed present to hospital services, but it remains one of the commonest reasons for hospital attendance. Some estimates suggest upwards of 200,000 presentations in England every year, mostly for self-poisoning. For some people, self-harm is a one-off episode but repetition is also

common, with 20% of people repeating self-harm within a year. People who have self-harmed are at greatly increased risk of suicide, with a 30- to 50-fold increase in risk in the year after hospital presentation.

Self-harm can present in a variety of locations including community, home, educational, custodial, social care and healthcare settings. However, much of the evidence on management comes from hospitals. Despite the potential seriousness, only about half of the people who present to emergency departments after an episode of self-harm are assessed by a mental health professional. Treatments include psychosocial and pharmacological interventions, and harm minimisation strategies. People who have self-harmed have often had contact with primary care. About half of the people who attend an emergency department after an episode of self-harm will have visited their GP in the previous month.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on self-harm.

For details of the guideline committee, see the committee member list.

Update information

This guideline is an update of NICE guideline CG16 (published July 2004) and NICE guideline CG133 (published November 2011) and will replace them.