NICE National Institute for Health and Care Excellence®

NICE guideline

Self-harm: assessment, management and preventing recurrence

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces CG16 and CG133.

This guideline is the basis of QS34 and QS189.

Overview

This guideline covers assessment, management and preventing recurrence for children, young people and adults who have self-harmed. It includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed.

In this guideline, self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose. The guideline does not cover repetitive, stereotypical self-injurious behaviour (such as head banging).

Who is it for?

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

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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.

Health and care professionals should follow our general guidelines for people delivering care:

- babies, children and young people's experience of healthcare
- decision making and mental capacity
- medicines adherence
- medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults
- medicines optimisation
- multimorbidity
- service user experience in adult mental health
- shared decision making
- supporting adult carers
- transition from children's to adults' services.

The recommendations apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group. Because of the wide variety of criminal justice system settings that exist and the

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need to take other relevant national guidance into account, the recommendations in the guideline may need to be tailored for certain criminal justice system settings during implementation.

Putting recommendations into practice can take time depending on how much change in practice or services is needed. Most of the recommendations in this guideline reinforce best practice and will not need additional resources to implement if previous guidance has been followed. If changes to current local practice are needed to implement the recommendations, they may take time and significant additional resources.

The recommendations apply to all people who have self-harmed, unless a recommendation specifically states that it is for adults or children and young people only.

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
- self-care (also see recommendation 1.11.12 in the section on harm minimisation), including when to seek help
- how to deal with injuries
- how to manage scars
- care plans and safety plans, and what they involve
- the impact of encountering stigma around self-harm
- what to do if they have any concerns
- what do to in an emergency.

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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 self-harm
- steps to reduce the likelihood of self-harm in the future
- the impact of encountering stigma around self-harm.

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, taking into account, for example:

- whether this is a first presentation or repeat self-harm
- the severity and type of self-harm
- if the person has any coexisting health conditions, neurodevelopmental conditions or a learning disability.

1.1.4 Recognise that support and information may need to be adapted for people who may be subject to discrimination, for example, people who are physically disabled, people with neurodevelopmental conditions or a learning disability, people from underserved groups, people from Black, Asian and minority ethnic backgrounds and people who are LGBTQ+.

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For a short explanation of why the committee made these recommendations and how they might affect practice, 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 of people who have self-harmed
- evidence review B: information and support needs of families and carers of people who have self-harmed.

1.2 Consent and confidentiality

Also see the Department of Health and Social Care's consensus statement on information sharing and suicide prevention.

1.2.1 If staff working with people who self-harm need to discuss issues relating to capacity and consent, they should have access to:

- specialist advice (for example, liaison psychiatry) at all times **and**
- legal advice as needed.

1.2.2 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.

For a short explanation of why the committee made these recommendations and how they might affect practice, 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.

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1.3 Safeguarding

1.3.1 All staff 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, looked-after children and young people, 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 and how they might affect practice, 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 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.

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1.4.2 If the person who has self-harmed finds it difficult to vocalise their distress when they are in need of care, support the person and their family members or carers (as appropriate) in trying alternative methods of communication (such as non-verbal language, letters, emotional wellbeing passports, and using agreed safe words, phrases or emojis).

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 in the management of people who have self-harmed.

1.5 Psychosocial assessment and care by mental health professionals

1.5.1 At the earliest opportunity after an episode of self-harm, a 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 drugs or alcohol, 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.

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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 needs and preferences of the person who has self-harmed as much as possible when carrying out the psychosocial assessment, for example, by:

- making appropriate adaptations for any learning disability or physical, mental health or neurodevelopmental condition the person may have **and**
- providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment when the person has requested this.

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

- the person's values, wishes and what matters to them
- the need for psychological interventions, social care and support, or occupational or vocational rehabilitation
- any learning disability, neurodevelopmental conditions or mental health problems
- 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.

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

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

1.5.11 For children and young people who have self-harmed, ensure that a mental health professional experienced in assessing children and young people who self-harm carries out the psychosocial assessment. They should ask about:

- their social, peer group, education and home situations
- any caring responsibilities
- the use of social media and the internet to connect with others and the effects of these on mental health and wellbeing
- any child protection or safeguarding issues (also see the section on safeguarding).

1.5.12 For older people who have self-harmed, ensure that a mental health professional experienced in assessing older people who self-harm carries out the psychosocial assessment. They should:

- pay particular attention to the potential presence of depression, cognitive impairment, physical ill health and frailty
- 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 there are higher rates of suicide after an episode of self-harm for older people.

1.5.13 For people with a learning disability who have self-harmed, ensure that a mental

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health professional experienced in assessing people with a learning disability who self-harm carries out the psychosocial assessment.

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

1.5.15 Together with the person who self-harms and their family and carers (if appropriate), develop or review a care plan using the key areas of needs and safety considerations 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 the plan as soon as possible with relevant healthcare professionals and social care practitioners 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 and support, and others who may need to be involved, to agree a joint plan and approach. This should involve:

- identifying an appropriately trained professional or practitioner 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.

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on psychosocial assessment and care by mental health professionals.

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

- evidence review F: assessment in specialist settings
- evidence review G: risk assessment and formulation.

1.6 Risk assessment tools and scales

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

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

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

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

1.6.5 Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

1.6.6 Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on risk assessment tools and scales.

Full details of the evidence and the committee's discussion are in evidence review G: risk assessment and formulation.

1.7 Assessment and care by healthcare professionals and social care practitioners

Principles for assessment and care by healthcare professionals and social care practitioners

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

- establish the means of self-harm and, if accessible to the person, discuss removing this with therapeutic collaboration or negotiation, to keep the person safe
- 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; be aware and accept that the person may have a different view and this needs to be taken into account
- 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 and their families or carers (as appropriate), their current support network, any safety plan or coping strategies.

1.7.2 When a person presents to a healthcare professional or social care practitioner following an episode of self-harm, the professional should establish the following as soon as possible:

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- the severity of the injury and how urgently medical treatment is needed
- the person's emotional and mental state, and level of distress
- whether there is immediate concern about the person's safety
- whether there are any safeguarding concerns
- whether the person has a care plan
- if there is a need to refer the person to a specialist mental health service for assessment.

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

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

1.7.5 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

1.7.6 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 consent from the person and their family members or carers (as appropriate).

1.7.7 Make referral to mental health professionals a priority when:

- the person's levels of concern or distress are rising, high or sustained
- the frequency or degree of self-harm or suicidal intent is increasing
- the person providing assessment in primary care is concerned

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- the person asks for further support from mental health services
- levels of distress in family members or carers of children, young people and adults are rising, high or sustained, despite attempts to help.

1.7.8 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 appointments with their GP for review of self-harm
- a medicines review
- information about available 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

1.7.9 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 the best way that the ambulance service can help them
- follow the person's care plan and safety plan if available
- seek advice from mental health professionals, where necessary
- record relevant information about the following, and pass this information to 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

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— any medicines found at their home.

1.7.10 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 by or receive treatment from an appropriate alternative service, such as a specialist mental health service or their GP.

1.7.11 When deciding whether the person can receive treatment from an appropriate alternative service, ambulance staff and paramedics should assess immediate safety concerns, as well as the availability and accessibility of alternative services at that time.

Assessment and care by non-mental health emergency department professionals

1.7.12 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 physical treatment is needed
- the person's emotional and mental state, and level of distress
- whether there is immediate concern about the person's safety
- 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.

1.7.13 When a person attends the emergency department or minor injury unit following an episode of self-harm, offer referral to age-appropriate liaison psychiatry services, or for children and young people, crisis response service (or an equivalent specialist mental health service or a suitably skilled mental health professional) as soon as possible after arrival, for a psychosocial assessment

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(see the section on psychosocial assessment and care by mental health professionals and the section on risk assessment tools and scales), and support and assistance alongside physical healthcare.

1.7.14 An age-appropriate 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.

1.7.15 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.

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

1.7.17 Ensure that appropriate joint governance arrangements are in place so that physical 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 physical and mental healthcare
- 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.

1.7.18 Do not use mechanical restraint in emergency departments to prevent self-harm or to prevent a person from leaving the emergency department.

Also see the NICE guideline on violence and aggression for recommendations about mechanical restraint.

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

1.7.20 Ensure that policies and 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 in the section on psychosocial assessment and care by mental health professionals).

Assessment and care in general hospital settings

1.7.21 When a person is admitted to hospital following an episode of self-harm, offer referral to age-appropriate 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 assessment and care by mental health professionals and the section on risk assessment tools and scales), and support and assistance alongside physical healthcare.

1.7.22 An age-appropriate 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.

1.7.23 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.

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

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- access to a specialist child and adolescent mental health service (CAMHS or children and young people's mental health services [CYPMHS]) or age-appropriate liaison psychiatry 24 hours a day
- a joint daily review by both the paediatric team and children and young people's mental health team
- daily access to their family members or carers
- regular multidisciplinary meetings between the general paediatric team and mental health services.

Assessment and care in social care

1.7.25 When working with people who have self-harmed, social care practitioners 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.

1.7.26 If self-harm has been identified during a social care assessment or through ongoing work, seek advice from, or refer the person to, the local urgent and emergency mental health service.

1.7.27 Continue to offer social care support and involvement to a person who has self-harmed, particularly if the person may be looked after or have ongoing social care needs.

Also see the NICE guidelines on domestic violence and abuse, looked-after children and young people, child abuse and neglect and child maltreatment.

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on assessment and care by healthcare professionals and social care practitioners.

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

- evidence review E: assessment in non-specialist settings
- evidence review T: models of care for people who have self-harmed.

1.8 Assessment and care by professionals from other sectors

The recommendations in this section apply to all staff in non-healthcare and social care settings. Because of the wide variety of criminal justice system settings that exist and the need to take other relevant national guidance into account, staff working in the criminal justice system may need to tailor the recommendations for certain criminal justice system settings during implementation.

Principles for assessment and care by professionals from other sectors

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

- treat the person with respect, dignity and compassion, with an awareness of cultural sensitivity
- work collaboratively with the person to ensure that their views are taken into account when making decisions
- 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

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- seek advice from a healthcare professional or social care practitioners, 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, Combat Stress helpline, NHS111 and Childline, and that people know how to seek help promptly
- address any safeguarding issues, or refer the person to the correct team for safeguarding.

1.8.2 When a person presents to a non-health professional, for example, a teacher or a member of staff in the criminal justice system, the non-health professional 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 there is immediate concern about the person's safety
- whether there are any safeguarding concerns
- whether the person has a care plan
- if there is a need to refer the person to a specialist mental health service for assessment.

Assessment in schools and educational settings

1.8.3 Educational settings should have policies and procedures for staff to support students who self-harm. These 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.

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1.8.4 Educational settings should have a designated lead responsible for:

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

1.8.5 All educational staff should:

- be aware of the policies and procedures for identifying and assessing the needs of students who self-harm
- know how to implement the policies and procedures within their roles and responsibilities
- know who to go to for support and supervision.

1.8.6 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.

1.8.7 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

1.8.8 Staff in criminal justice settings and other secure settings such as immigration removal centres should be aware that those in their care have higher rates of self-harm and suicide.

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1.8.9 Staff in criminal justice settings and other secure settings such as immigration removal centres should be aware of support services available to them to support their own wellbeing.

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

- transferring people to a healthcare setting when necessary
- in-reach or onsite support
- their responsibilities for information sharing
- how to access health services.

1.8.11 Staff in criminal justice settings and other secure settings such as immigration removal centres should follow local guidance on assessing people who have self-harmed, and healthcare professionals and social care practitioners in these settings should also follow the NICE guideline on mental health of adults in contact with the criminal justice system.

1.8.12 Staff in criminal justice settings and other secure settings such as immigration removal 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 and how they might affect practice, see the rationale and impact section on assessment and care by professionals from other sectors.

Full details of the evidence and the committee's discussion are in evidence review E: assessment in non-specialist settings.

1.9 Admission to and discharge from hospital

The recommendations in this section apply to all healthcare professionals and social care practitioners.

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

- there are concerns about the safety of the person (for example, the person is at risk of violence, abuse or exploitation) and psychiatric admission is not indicated
- safeguarding planning needs to be completed and psychiatric admission is not indicated
- the person is unable to engage in a psychosocial assessment (for example, because they are too distressed or intoxicated).

1.9.2 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.

1.9.3 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.

1.9.4 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.

1.9.5 If a person self-harms during a hospital admission, follow the local hospital policy for investigating untoward incidents and undertake a full investigation. Local areas should be aware of the NHS Patient Safety Incident Response Framework.

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

- a psychosocial assessment has taken place
- a plan for further management has been drawn up with all appropriate agencies and people
- a discharge planning meeting with all appropriate agencies and people has taken place **and**
- arrangements for aftercare have been specified, including clear written communication with the primary care team.

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For a short explanation of why the committee made these recommendations and how they might affect practice, 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.

1.10 Initial aftercare after an episode of self-harm

The recommendations in this section apply to all healthcare professionals and social care practitioners.

1.10.1 After an episode of self-harm, discuss and agree with the person, and their family members and carers (as appropriate), the purpose, 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.

1.10.2 If there are ongoing safety concerns for the person after an episode of self-harm, the mental health team, GP, team who carried out the psychosocial assessment or the team responsible for their care should provide initial aftercare within 48 hours of the psychosocial assessment.

For a short explanation of why the committee made these recommendations and how they might affect practice, 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 for people who have self-harmed.

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1.11 Interventions for self-harm

The recommendations in this section apply to all healthcare professionals unless otherwise stated.

1.11.1 When planning treatment following self-harm, take into account any associated coexisting conditions and the psychosocial assessment.

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

- Alcohol-use disorders
- Autism spectrum disorder in adults
- Autism spectrum disorder in under 19s
- Bipolar disorder
- Borderline personality disorder
- Care and support of people growing older with learning disabilities
- Challenging behaviour and learning disabilities
- 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
- Learning disabilities and behaviour that challenges
- Mental health problems in people with learning disabilities
- Obsessive-compulsive disorder and body dysmorphic disorder

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- Psychosis and schizophrenia in adults
- Post-traumatic stress disorder.

1.11.3 Offer a structured, person-centred, cognitive behavioural therapy (CBT)-informed psychological intervention (for example, CBT or problem-solving therapy) that is specifically tailored for adults who self-harm. Ensure that the intervention:

- starts as soon as possible
- is typically between 4 and 10 sessions; more sessions may be needed depending on individual needs
- is tailored to the person's needs and preferences.

1.11.4 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). Take into account the age of the child or young person and any planned transition between services.

1.11.5 Healthcare staff should be appropriately trained and supervised in the therapy they are offering to people who self-harm.

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

1.11.7 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 individualised coping strategies, including problem solving any factors that may act as a barrier
- 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

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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.

1.11.8 The safety plan should be:

- developed in collaboration with family and carers, as appropriate
- use a problem-solving approach
- held by the person
- shared with the family, carers and relevant professionals and practitioners as decided by the person
- accessible to the person and the professionals and practitioners involved in their care at times of crisis.

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

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

Harm minimisation

Although ways to self-harm safely are often considered a harm minimisation strategy, this guideline does not make any recommendations about the use of safer self-harm.

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

- in the spirit of hope and optimism, and to reduce the severity and/or recurrence of injury
- as part of an overall approach to the person's ongoing recovery-focused care

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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.

1.11.12 Mental health professionals should discuss with the person harm minimisation strategies that could help to avoid, delay or reduce further episodes of self-harm and reduce complications, for example:

- distraction techniques or coping strategies
- approaches to self-care
- wound hygiene and aftercare
- providing factual information on the potential complications of self-harm
- the impact of alcohol and recreational drugs on the urge to self-harm.

1.11.13 Be aware that harm minimisation strategies may not be appropriate for all people who self-harm.

Therapeutic risk taking

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

- include other relevant professionals involved in the care of the person who has self-harmed
- draw on the person's strengths and coping strategies and what matters to them
- focus on positive outcomes
- be part of an ongoing assessment to revisit the decision
- be concurrent with psychiatric care if necessary.

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For a short explanation of why the committee made these recommendations and how they might affect practice, 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: psychological and psychosocial interventions
- evidence review K: pharmacological interventions
- evidence review L: harm minimisation strategies
- evidence review M: therapeutic risk taking strategies
- evidence review P: skills required by staff in specialist settings
- evidence review R: skills required by staff in non-specialist settings
- evidence review T: models of care for people who have self-harmed.

1.12 Supporting people to be safe after self-harm

1.12.1 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.

1.12.2 Do not use staff who are untrained in clinical observation (for example, security staff or trainee health and social care staff) to undertake such observations in a person who has self-harmed.

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

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

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1.12.5 Assess the safety of the environment, balancing respect for the person's autonomy against the need for restrictions. Use the least restrictive measures.

1.12.6 Consider removing items that may be used to self-harm and involve the person who has self-harmed in this decision.

1.12.7 At the earliest opportunity, healthcare staff should 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.

1.12.8 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 and how they might affect practice, 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 after self-harm.

1.13 Safer prescribing and dispensing

The recommendations in this section apply to all healthcare professionals.

1.13.1 When prescribing medicines to someone who has previously self-harmed or who may self-harm in the future, 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, the risk of misuse, and possible interaction with prescribed medicines
- the person's wider access to medicines prescribed for themselves or others
- the need for effective communication where multiple prescribers are involved.

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Also see the section on reducing access to methods of suicide in the NICE guideline on preventing suicide in community and custodial settings.

1.13.2 Use shared decision making to discuss limiting the quantity of medicines supplied to people with a history of self-harm (for example, weekly prescriptions), and ask them to return unwanted medicines for safe disposal.

1.13.3 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. For people with learning disabilities or autism or both, the NHS England STOMP-STAMP principles may be useful.

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

1.13.5 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 and how they might affect practice, 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.

1.14 Training

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

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- involve people who self-harm and, where appropriate, their families or carers, 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 (including non-healthcare staff), values, beliefs and biases
- be appropriate to the level of responsibility of the staff member
- be provided on a regular and ongoing basis.

1.14.2 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:

- the range of different behaviours that can be considered self-harm
- 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, triggers or motives 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

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interact with self-harm

- balancing patient autonomy and safety when providing care for people who have self-harmed
- assessing the needs and safety of the person who has 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.

1.14.3 In addition to the training in recommendation 1.14.2, mental health professionals who work with people of any age who self-harm should have training on conducting psychosocial assessments and risk formulation.

1.14.4 All staff observing 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 and how they might affect practice, see the rationale and impact section on training.

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

- evidence review P: skills required by staff in specialist settings
- evidence review R: skills required by staff in non-specialist settings
- evidence review N: supporting people to be safe after self-harm.

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1.15 Supervision

1.15.1 All staff who work with people of any age who self-harm should have the opportunity for 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 best to support them
- promote the delivery of compassionate care
- focus on ongoing skill development
- include reflective practice
- promote confidence and competence in staff working with people who have self-harmed.

1.15.2 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 and how they might affect practice, see the rationale and impact section on supervision.

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

- evidence review Q: supervision required for staff in specialist mental health settings
- evidence review S: supervision required for staff in non-specialist settings.

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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 the needs and safety considerations of the service user, the interventions that will support their recovery, as well as the key professionals and practitioners involved in their care.

Cognitive behavioural therapy-informed psychological intervention

Cognitive behavioural therapy (CBT)-informed 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.

Clinical observation

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

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 developing

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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.

Dialectic behavioural therapy for adolescents

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-consultation group for therapists. DBT-A aims to equip young people and their parents and carers with the skills to reduce or stop self-harm and suicidal behaviours, effectively manage their emotions and improve their relationships.

Harm minimisation

Harm minimisation is an approach to self-harm that accepts the person's continued urge to self-harm while aiming to keep long-term damage and frequency of injury to a minimum. It can include suggestions to avoid, delay or reduce self-harm.

Mechanical restraint

A method of physical intervention involving the use of authorised equipment, for example, handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals.

Psychosocial assessment

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

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

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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.

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.

Self-harm

Intentional self-poisoning or injury irrespective of the apparent purpose of the act. The treatment and care of repetitive, stereotypical, self-injurious behaviour (such as head banging) is not covered by this guideline.

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. Inappropriately withholding or withdrawing care (such as treatment or assessment) without adequate assessment or collaboration cannot be considered therapeutic risk taking.

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Recommendations for research

The guideline committee has made the following 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 recommendation for research, see the rationale section on assessment and care by healthcare professionals and social care practitioners.

Full details of the evidence and the committee's discussion are in evidence review T: models of care for people who have self-harmed.

2 Assessment in non-specialist settings

What are the most effective approaches to assessment in non-specialist settings?

Healthcare professionals and social care practitioners

For a short explanation of why the committee made this recommendation for research, see the rationale section on assessment and care by healthcare professionals and social care practitioners.

Full details of the evidence and the committee's discussion are in evidence review E: assessment in non-specialist settings.

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Professionals from other sectors

For a short explanation of why the committee made this recommendation for research, see the rationale section on assessment and care by professionals from other sectors.

Full details of the evidence and the committee's discussion are in evidence review E: assessment in non-specialist settings.

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 recommendation for research, 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 recommendation for research, see the rationale section on interventions for self-harm.

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

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5 Harm minimisation

What is the experience, feasibility, acceptability and effectiveness of harm minimisation strategies for people who self-harm?

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

Full details of the evidence and the committee's discussion are in evidence review L: harm minimisation strategies.

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Rationale and impact

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

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.

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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 and 1.2.2

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 discussed the risk of legal repercussions for staff either when making

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decisions about a person's care without their consent or when breaching confidentiality. They recommended that staff have access to experienced colleagues for advice at all times, and to legal advice as needed to allow them to provide care with confidence.

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.

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

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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 and 1.4.2

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 harms and benefits, so the committee based the recommendations on the evidence and their own knowledge and experience.

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

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have self-harmed. 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 are expected to be small and will result in a higher quality of care for people who self-harm.

Return to recommendations

Psychosocial assessment and care by 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.

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 meaningfully engage in the assessment (for example, if the person is unconscious or has very high levels of intoxication), 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.

The committee agreed that care plans should be followed where possible to ensure a

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higher standard of care and inform the assessment, including whether certain questions should be prioritised.

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

The committee agreed the self-harm functions and factors to explore. The committee agreed these would allow coexisting conditions to be taken into account and enable staff to provide a higher quality of care. The committee also agreed that using the psychosocial 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 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.

The committee 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 and social care practitioners 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.

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.

How the recommendations might affect practice

The recommendations should change how psychosocial assessments are conducted, to 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 better quality care.

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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

Risk assessment tools and scales

Recommendations 1.6.1 to 1.6.6

Why the committee made the recommendations

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.

The committee agreed that assessment of a person's needs, vulnerabilities, and safety should be a part of every assessment and that 'risk' should not be used to determine care management in isolation of other factors. They agreed that all staff should use their clinical judgement when assessing someone who has self-harmed and they should refer to the non-specialist assessment recommendations for what to do in the event they are concerned about the person and their safety. Additionally, mental health staff should conduct a risk formulation to place the person's safety considerations in context with their strengths and difficulties.

How the recommendations might affect practice

The recommendations should change how assessments are conducted to take into account the person's needs and safety as standard and reduce reliance on assessment of a person's 'risk' in isolation of other factors. This should result in a reduction in the occurrence of arbitrary thresholds being used to determine access to care.

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Risk assessment tools and scales are still used in some settings to determine access to treatment and care. The recommendations might have an initial effect on costs, depending on how services currently assess people who have self-harmed; however, service provision should already be determined by a person's needs rather than risk thresholds. Additionally, the change in practice should result in lower costs over time because people will receive the care they need rather than have it determined by unreliable risk tools and scales, potentially reducing repeat self-harm.

Return to recommendations

Assessment and care by healthcare professionals and social care practitioners

Recommendations 1.7.1 to 1.7.27

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 recommendation for research 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 recommendation for research on models of care for children and young people who self-harm.

Principles for assessment and care by healthcare professionals and social care practitioners

Recommendations 1.7.1 to 1.7.5

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

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the person carrying out the assessment should gather information from other sources, such as professionals, practitioners 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 healthcare professionals and social care practitioners should establish a number of specific presenting factors to inform their assessment and care. Healthcare professionals and social care practitioners should also be involved in the care of people who have self-harmed as much as possible but know when to refer them to mental health services (as set out in the sections on assessment and care in different health and social care settings), to ensure that the care is appropriate.

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 healthcare professionals and social care practitioners 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 repeat self-harm or suicide.

Assessment and care in primary care

Recommendations 1.7.6 to 1.7.8

The committee agreed that referring people to mental health services would be reassuring and ensure that people are in the most appropriate setting, and that referral should be prioritised in certain situations to prevent further distress.

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 1.7.9 to 1.7.11

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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 when the situation is appropriate could facilitate the person's engagement with services. The committee also discussed factors that should be considered when deciding whether alternative services should be used, to ensure that the person receives the best possible care without delay.

Assessment and care by non-mental health emergency department professionals

Recommendations 1.7.12 to 1.7.20

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 and accommodate the person's needs and safety considerations.

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.

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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 policy or 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 have ongoing safety concerns are identified so appropriate follow-up contact can be made. The committee also agreed it is important that mechanical restraint is not used on people to prevent them from leaving the emergency department or from self-harming, because in their experience, this results in increased distress and a loss of autonomy and dignity for the person, potentially resulting in a loss of trust in services and an unwillingness to seek help in the future.

The committee agreed that policies and 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 1.7.21 to 1.7.24

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.

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Assessment and care in social care

Recommendations 1.7.25 to 1.7.27

The committee agreed that a shared approach between healthcare professionals and social care practitioners 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.

The committee agreed that in many circumstances, self-harm is identified by social care practitioners through a safeguarding concern. They agreed that when this occurs, social care practitioners should refer the person to local mental health services to ensure they start on a care pathway and receive appropriate care. The committee agreed that social care services should be provided in conjunction with mental health care, to ensure that the person continues to receive social care support as needed.

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 age-appropriate 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

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Assessment and care by professionals from other sectors

Recommendations 1.8.1 to 1.8.12

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

Principles for assessment and care by professionals from other sectors

Recommendations 1.8.1 and 1.8.2

The committee agreed that people who have self-harmed can often initially present to non-health 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 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 healthcare professionals or social care practitioners on discovery of self-harm.

The committee agreed there were factors of a person's presentation that professionals should establish to inform how they care for the person who has self-harmed. Non-health professionals should also be involved in the care of people who have self-harmed as much as possible but know when to refer them to mental health services, to ensure that the care is appropriate.

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Assessment and care in schools and educational settings

Recommendations 1.8.3 to 1.8.7

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 need policies and procedures for how to identify and respond to students who have self-harmed. 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 policies and procedures 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 1.8.8 to 1.8.12

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 rates of self-harm would allow them to be better prepared to assess and care for people who self-harm. They also agreed staff should be aware of support services that are available to them to ensure that their own support needs are met.

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.

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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 1.9.1 to 1.9.6

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.

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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 or if there are safeguarding concerns.

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 a ward that is not equipped to meet the needs of young people.

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 plan for further management drawn up could be detrimental because people who have self-harmed are likely to need further care and support. A lack of a plan could result in repeat self-harm or suicide, and would create a barrier to care for the person.

The committee made a recommendation for research 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

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Initial aftercare after an episode of self-harm

Recommendations 1.10.1 and 1.10.2

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 reduced rates 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 most likely to repeat 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. However, there were concerns about resourcing and capacity to provide initial aftercare to all patients within this timeframe. The committee agreed that, although follow-up within 48 hours would be ideal for everyone, not all people who have self-harmed will need immediate aftercare. To ensure priority is given to those who need it most, aftercare within 48 hours should be provided to people with ongoing safety concerns to reduce rates 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

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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. Providing initial aftercare within 48 hours for people if there are ongoing safety concerns should reduce repeat self-harm and suicide, and improve satisfaction and engagement with services. Any resource impact associated with this would be a worthwhile use of resources.

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 1.11.1 to 1.11.14

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. They agreed this would ensure that treatment for any coexisting conditions that could be linked to self-harm are prioritised, enabling healthcare professionals to provide the most appropriate intervention for the

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individual, and resulting in more person-centred, higher-quality care. The committee referred to a number of other NICE guidelines for conditions that can be linked to self-harm, and agreed it is important that healthcare professionals plan treatment for people who have self-harmed in line with the guidance for any underlying or coexisting conditions before other interventions are considered.

The evidence showed that psychotherapies informed by cognitive behavioural therapy (CBT) have 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. Additionally, the evidence was limited by the wide interpretation of 'CBT-based psychotherapies' as being inclusive of other types of therapies in addition to CBT, and the indistinct categorisation of all interventions throughout the evidence review. The committee agreed other therapies might be effective for adults who have self-harmed as long as they are informed by CBT, as indicated by the evidence.

The evidence 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 had all self-harmed more than once, were all older than 12 years and most were 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 it is in over-12s and girls; however, the committee agreed they could not be sure that DBT-A would be similarly effective for children and young people who did not frequently self-harm.

The evidence for other therapies was uncertain, and the evidence for 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 committee agreed that any therapy offered should be delivered by staff with training in the relevant therapy and who are receiving appropriate supervision. This is to ensure the competence of the professional delivering the training allows for the needs of the person to be met and for the treatment to be tailored for people who self-harm. The committee

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agreed that further limitations on which staff could deliver therapies were unnecessary and could result in implementation difficulties and delays in treatment provision.

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 individualised coping strategies 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 ensuring a copy is available 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.

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

Harm minimisation

Recommendations 1.11.11 to 1.11.13

There was no evidence, so the recommendations are based on the committee's knowledge and experience. They agreed there are benefits to providing advice on coping strategies. However, the lack of evidence meant they were unable to make any recommendations about the use of safer self-harm strategies, or to be more specific in the recommendations.

The committee agreed that harm minimisation strategies can be helpful when a 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 some harm minimisation strategies are not appropriate for all people who self-harm, depending on the person's care and support needs.

The committee made a recommendation for research on the experience, feasibility, acceptability and effectiveness of harm minimisation strategies for people who self-harm to better inform future guideline development.

Therapeutic risk taking

Recommendation 1.11.14

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 reduced rates of self-harm. However, the committee discussed the fact that a misunderstanding of

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therapeutic risk taking resulting in assessment or care being withheld could potentially lead to significant increased rates of 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. The committee also agreed that other relevant professionals and practitioners would need to be involved to help with implementing the therapeutic risk-taking approach and to ensure that the approach has been communicated to the relevant teams.

How the recommendations might affect practice

The recommendations should increase the number of people receiving psychological interventions after an episode of self-harm, and reduce the number of people denied appropriate interventions because of limited or no availability. In turn, this should reduce repeat self-harm and suicide, and improve satisfaction and engagement with services. The recommendations should also 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 rates 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-informed psychological interventions 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 where appropriate 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 1.12.1 to 1.12.8

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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 rates 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 when rates of self-harm are higher. 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. However, the committee agreed that safety considerations should not be prioritised over the person's autonomy and dignity, and therefore the least restrictive measures should always be used, dependant on the safety of the person.

The committee agreed that staff should consider removing certain items from the environment, according to the individual's specific needs and vulnerabilities. This could include sharp objects, potential ligatures and possible ligature points and things that might cause harm when ingested. However, the committee agreed that the need for this should be reviewed and only done when necessary to avoid excessive restrictions.

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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 reduce distress and the rate 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 who have self-harmed. 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 1.13.1 to 1.13.5

Why the committee made the recommendations

There was no evidence, so the committee based the recommendations on their knowledge and experience. 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 drug or alcohol misuse and interactions with prescribed treatment, and the person's wider access to medicines prescribed for themselves or others, to limit the risk of overdose. They also agreed the need for effective communication when there are multiple prescribers.

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.

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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 and STOMP-STAMP principles for people with learning disabilities or autism or both.

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 potential for 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.

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Training

Recommendations 1.14.1 to 1.14.4

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Why the committee made the recommendations

The recommendations are based on the evidence from specialist and non-specialist staff, people who have self-harmed who have had care provided by specialist and non-specialist staff, and their parents and carers, which showed that there is a significant overlap between the kind of training considered important for both mental health and non-specialist professionals when working with people who have self-harmed.

Both reviews found that formal training on how to work with people who have self-harmed was considered important by all participants, 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 for 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 and risk formulation.

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 therapeutic 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.

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Supervision

Recommendations 1.15.1 and 1.15.2

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 supervision and accessible 'on-the-job' support. The committee agreed that all staff should have the opportunity to access supervision that is distinct from general clinical supervision and case load management, but that staff who work with people who self-harm have a particular need for high-quality formal supervision and support. 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 rates 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 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

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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.

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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.

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Finding more information and committee details

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

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

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Update information

September 2022: This guideline updates and replaces NICE guideline CG16 (published July 2004) and NICE guideline CG133 (published November 2011).

Minor changes since publication

August 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the NICE guideline on service user experience in adult mental health).

This is a presentational change only, and no changes to practice are intended.

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