Complete Summary

GUIDELINE TITLE

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

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. London (UK): National Institute for Clinical Excellence (NICE); 2004. 199 p. [267 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Self-harm (including self-poisoning and self-injury)

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Critical Care
Emergency Medicine
Family Practice
Internal Medicine
Nursing
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Health Care Providers
Hospitals
Nurses
Patients
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To make recommendations and good practice points for medical and surgical treatments and the use of psychological, psychosocial and service-level interventions in combination with medical and surgical treatments in the three phases of care. Specifically the guideline aims to:

- Evaluate the role of specific medical and surgical interventions in the first 48 hours of care following an episode of self-harm
- Evaluate the role of risk assessment for people who have self-harmed
- Evaluate the role of specific psychological and pharmacological interventions following an episode of self-harm
- Evaluate the role of specific service delivery systems and service-level interventions in the treatment and care of people who have self-harmed
- Integrate the above to provide best practice advice on the care of individuals who have self-harmed through the first 48 hours of care and referral to mental health services if appropriate

TARGET POPULATION

Individuals aged 8 years and over who have self-harmed, and their families/carers

INTERVENTIONS AND PRACTICES CONSIDERED

General Management

1. Appropriate communication and attitude of healthcare providers

2. Treating patients with respect and understanding, and offering patients choice in treatment
3. Involvement of relatives, friends, and advocates of patient in treatment
4. Appropriate planning of services and staff training for treatment of people who self harm
5. Appropriate obtainment of patient consent

Initial Patient Management

1. Primary care management of patients
2. Assessment and initial management of patients by ambulance services
3. Availability and use of activated charcoal
4. Treatment and management of patients in the emergency department
    - Appropriate triage
    - Assessment of patients waiting for physical treatments
    - Assessment of patients who wish to leave before treatment

Medical and Surgical Management of Patients

1. Availability of TOXBASE to all clinical staff and use of procedures outlined in TOXBASE
2. General treatment for ingestion, including activated charcoal
3. Management of paracetamol overdose, including intravenous acetylcysteine administration
4. Use of flumazenil in benzodiazepine overdose
5. Treatment of salicylate poisoning
6. Treatment of opiate overdose using naloxone
7. General treatment for self injury, including superficial wound closure
8. Referral, hospital admission, and discharge
9. Special issues for children and young people (under 16 years)
10. Special issues for older people (older than 65 years)

Intervention considered but not recommended include use of emetics (e.g. ipecac), cathartics, gastric lavage and whole bowel irrigation

Support and Advice for People who Repeatedly Self Harm

1. Advice for people who repeatedly self-poison, including discussion of risks
2. Advice for people who repeatedly self-injure, including self-management of superficial injuries, harm minimization strategies, alternative coping strategies, and information on dealing with scar tissue

Psychosocial Assessment

1. Assessment of needs and risk
2. Assessment of risk, including identification of main clinical, demographic, and psychological characteristics associated with risk of self-harm and/or suicide
3. Risk-assessment scales to identify users at high risk

Psychological, Pharmacological and Service Level Interventions

1. Comprehensive psychiatric, psychological, and social assessment
2. Intensive therapeutic interventions, combined with outreach
3. Dialectical behaviour therapy
4. Developmental group psychotherapy

Other therapies considered but not recommended include problem orientated therapies, cognitive behavioural therapy and psychodynamic interpersonal therapy, inpatient behavioural therapy, insight-oriented therapy, long- and short-term therapy, home-based family therapy, antipsychotic agents (flupenthixol, fluphenazine, antidepressant agents (paroxetine, mianserin), methionine, placebo use, intensive intervention, standard aftercare, emergency card use, same or different therapist use, general practitioner letter, nurse-led case management.

MAJOR OUTCOMES CONSIDERED

- Rate of self-harm behaviour
- Risk of self-harm
- Complication rate from self-harm
- Hospitalisation rate and duration of stay
- Rate of admission to intensive care unit (ICU)
- Plasma concentrations of ingested agents (paracetamol, phenobarbital, amlodipine, salicylates)
- Rate and duration of mechanical ventilation
- Outcomes for activated charcoal administered at different time intervals
- Complications of wound healing
- Optimal wound repair techniques
- Health of the Nation Outcome Scales for Children and Adolescents score.
- Hopelessness scale score
- Score on Suicidal Ideation Scale
- Repetition of self-harm behaviours (including fatal and non-fatal suicide attempts)
- Hospital readmission rate
- Discontinuation of treatment rate
- Suicide rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Development of Search Filters

The review team developed search filters to search electronic databases that combined subject headings with free-text phrases. A filter was developed for the general topic "self-harm." This was combined with specific filters for a particular clinical question and appropriate research design (for example, "systematic

review" or "RCT") as necessary. Occasionally, for example, for the review of the treatment of poisoning, the self-harm filter was modified. Search filters are listed in Appendix 7 of the original guideline document.

Searching for Existing Systematic Reviews

The National Collaborating Centre for Mental Health (NCCMH) review team undertook searches for existing systematic reviews published in English since 1995 (an arbitrary cut-off date to reduce the number of references found, and to restrict evidence to more recent material), which would answer the clinical questions posed by the Guideline Development Group (GDG). The initial searches were undertaken in June 2002. A search of PubMed (MEDLINE) was also undertaken weekly beginning in April 2003 until the end of the guideline development process. The following databases were searched: EMBASE, MEDLINE, PsycINFO, Cochrane Library, CINAHL, Web of Science.

Systematic reviews were assessed for quality and eligibility (Appendices 8 and 9 of the original guideline document) before being assessed by the GDG for relevance to a clinical question. Where a relevant systematic review was identified searches were undertaken for studies published too late to be included, beginning two years before the publication date of the review in question. Where authors stated the date searches had been undertaken, the NCCMH review team undertook new searches from the beginning of that year. Each study included in an existing review was subjected to the same quality checks as those located through NCCMH searches, and the data were re-extracted according to NCCMH protocols. Where existing reviews had been undertaken using Review Manager (any version) authors were approached for data sets, although any used were checked for accuracy. For clinical questions where no existing systematic review was identified, searches were undertaken for all relevant evidence.

Searching for Studies

To answer clinical questions concerned with interventions an initial search was undertaken for all randomized controlled trials (RCTs) in the area of self-harm. Where this did not reveal any studies to answer a particular clinical question, additional searches were undertaken outside of the area of self-harm—for example, for the management of wounds. Material to answer other clinical questions was searched for separately. For all questions the following electronic databases were searched: EMBASE, MEDLINE, PsycINFO, Cochrane Library, CINAHL, TOXLINE. For the review of service user experience the grey literature database, Sigle, was also searched. In addition, hand searches were made of the reference lists of all eligible studies, as well as of the list of evidence submitted by registered stakeholders (Appendix 3 of the original guideline document). Known experts in the field (see Appendix 5 of the original guideline document), based both on the references identified in earlier steps and on advice from GDG members, were approached for unpublished RCTs (Unpublished full trial reports were accepted where sufficient information was available to judge eligibility and quality.). Studies were considered provided a full trial report was available. Studies published in languages other than English were used provided a native speaker was available.

If no RCTs were found to answer a clinical question the GDG adopted a consensus process (see section 3.4.5 of the original guideline document and section under "Description of Methods Used to Analyze the Evidence" entitled "Method used to answer a clinical question in the absence of appropriately designed, high quality research"). Future guidelines will be able to update and extend the usable evidence base starting from the evidence collected, synthesized, and analysed for this guideline.

Study Selection

All references located in searches of electronic databases were downloaded into Reference Manager and searched liberally to exclude irrelevant papers. The titles of excluded papers were double-checked by a second reviewer. All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility. Appendix 8 of the original guideline document lists the standard inclusion and exclusion criteria. Additional eligibility criteria were developed to assess trials of pharmacotherapy, and these are listed in Chapter 7 of the original guideline document. All eligible papers were critically appraised for methodological quality (see Appendix 10 of the original guideline document). The eligibility of each study was confirmed by at least one member of the appropriate topic group.

For some clinical questions, it was necessary to prioritise the evidence with respect to the UK context. To make this process explicit, the topic group members took into account the following factors when assessing the evidence:

- Participant factors (e.g., gender, age, ethnicity)
- Provider factors (e.g., model fidelity, the conditions under which the intervention was performed, the availability of experienced staff to undertake the procedure)
- Cultural factors (e.g., differences in standard care, differences in the welfare system)

It was the responsibility of each topic group to decide which prioritisation factors were relevant to each clinical question in light of the UK context, and then decide how they should modify their recommendations.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I: Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Synthesising Evidence from Randomised Controlled Trials (RCTs)

Data Extraction

Where possible, outcome data from all eligible studies that met quality criteria were extracted onto a data extraction form (Appendix 11 of the original guideline document) and input into Review Manager 4.2. Where trial reports contained incomplete data and it was possible to contact the original authors, additional information was sought. Where mean endpoint or change scores were extracted and trial reports did not provide standard deviations, standard conversion formulas were used (see Appendix 12 of the original guideline document).

All dichotomous outcomes were calculated on an intention-to-treat basis (i.e., a "once randomised-always-analyse" basis). This assumes that those participants who ceased to engage in the study--from whatever group--had an unfavourable outcome (with the exception of the outcome of "death by suicide" and "complications arising from wound closure methods"). The effects of high attrition rates (defined as more than 50% of participants in a particular group leaving treatment early) were examined with sensitivity analyses, and studies were removed from efficacy outcomes if the possibility of bias was detected.

Consultation was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer directly into Review Manager and checked by a second reviewer. Where consensus could not be reached, a third reviewer was consulted. Masked assessment (i.e., blind to the journal from which the article comes, the authors, the institution, and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

Information describing each study was also extracted and input into Review Manager 4.2. This was used to generate evidence tables (see Appendix 17 of the original guideline document). Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were also presented in the evidence tables.

Meta-analysis

Where possible meta-analysis was used to synthesise data. If necessary, sub-analyses were used to answer clinical questions not addressed in the original studies or reviews.

The Guideline Development Group (GDG) was given a graphical presentation of the results using forest plots generated with Review Manager. Each forest plot displayed the effect size and 95% confidence interval (CI) for each study as well as the overall summary statistic with its 95% CI. The graphs were organised so that the display of data in the area to the left of the "line of no effect" indicated a "favourable" outcome for the treatment in question.

Dichotomous outcomes were presented as relative risks (RR) with the associated 95% CI (see Figure 1 of the original guideline document). A relative risk (or risk ratio) is the ratio of the treatment event rate to the control event rate. An RR of 1 indicates no difference between treatment and control.

The number needed to treat (NNT) or the number needed to harm (NNH) was reported for each statistically significant outcome where the baseline risk (i.e., control group event rate) was similar across studies. In addition, NNTs calculated at follow-up were reported only where the length of follow-up was similar across studies. When length of follow-up or baseline risk varies (especially with low risk), the NNT is a poor summary of the treatment effect.

Continuous outcomes were analysed as weighted mean differences (WMD) or standardised mean differences (SMD) when different measures (or different versions of the same measure) were used in different studies to estimate the same underlying effect (see Figure 2 of the original guideline document).

To check for heterogeneity between studies, both the I^2 test of heterogeneity and the chi-squared test of heterogeneity ($p<.10$), as well as visual inspection of the forest plots, were used. The I^2 statistic describes the proportion of total variation in study estimates that is due to heterogeneity. An I^2 of less than 30% was taken to indicate mild heterogeneity, and a fixed effects model was used to synthesise the results. This assumes that the underlying effect is the same. An I^2 of more than 50% was taken as notable heterogeneity. In this case, an attempt was made to explain the variation. If studies with heterogeneous results were found to be comparable, a random effects model was used to summarise the results. In the random effects analysis, heterogeneity is accounted for both in the width of CIs and in the estimate of the treatment effect. With decreasing heterogeneity the random effects approach moves asymptotically towards a fixed effects model. An I^2 of 30 to 50% was taken to indicate moderate heterogeneity. In this case, both the chi-squared test of heterogeneity and a visual inspection of the forest plot were used to decide between a fixed and random effects model.

To explore the possibility that the results entered into each meta-analysis suffered from publication bias, data from included studies were entered, where there were sufficient data, into a funnel plot. Asymmetry of the plot was taken to indicate possible publication bias and investigated further.

Synthesising Qualitative Material

Qualitative material was used to answer the clinical question about user experiences of services. Synthesising the material using a formal meta-synthesis methodology was initially considered. However, such techniques are not well developed and the studies found in literature searches were unsuitable for such analysis. Therefore, a simple content analysis was undertaken. In order to triangulate the findings--that is, compensate for possible weaknesses in one data collection or analysis method by using additional methods--material from a systematic literature review was combined with that from two focus groups and an interview conducted by the GDG.

Method Used to Answer a Clinical Question in the Absence of Appropriately Designed, High Quality Research

In the absence of level-I evidence (or a level that is appropriate to the question), or where the GDG were of the opinion (on the basis of previous searches or their knowledge of the literature) that there was unlikely to be such evidence, an informal consensus process was adopted. This process focused on those questions that the GDG considered a priority.

Informal Consensus

The starting point for this process of informal consensus was that a member of the topic group identified, with help from the systematic reviewer, a narrative review that most directly addressed the clinical question. Where this was not possible, a brief review of the recent literature was initiated. This existing narrative review or new review was used as a basis for beginning an iterative process to identify lower levels of evidence relevant to the clinical question and to lead to written statements for the guideline. The process involved a number of steps:

- A description of what is known about the issues concerning the clinical question was written by one of the topic group members
- Evidence from the existing review or new review was then presented in narrative form to the GDG and further comments were sought about the evidence and its perceived relevance to the clinical question
- Based on the feedback from the GDG, additional information was sought and added to the information collected. This may include studies that did not directly address the clinical question but were thought to contain relevant data
- If, during the course of preparing the report, a significant body of primary-level studies (of appropriate design to answer the question) were identified, a full systematic review was done
- At this time, subject possibly to further reviews of the evidence, a series of statements that directly addressed the clinical question were developed

- Following this, on occasions and as deemed appropriate by the development group, the report was then sent to appointed experts outside the GDG for peer review and comment. The information from this process was then fed back to the GDG for further discussion of the statements
- Recommendations were then developed and could also be sent for further external peer review
- After this final stage of comment, the statements and recommendations were again reviewed and agreed upon by the GDG.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Guideline Development Group (GDG) Meetings

Twenty-one GDG meetings were held between June 2002 and December 2003. During each day-long meeting clinical evidence was reviewed and assessed to develop statements and recommendations. At each meeting all GDG members declared any potential conflict of interests. Service user and carer concerns were routinely discussed as part of a standing agenda.

Developing Statements and Graded Recommendations

The summary statistics (effect sizes; ES) and evidence tables formed the basis for developing clinical statements and recommendations.

In order to facilitate consistency in generating and drafting the clinical statements the Guideline Development Group (GDG) utilised a statement decision tree (see Flowchart 1: Guideline Statement Decision Tree of the full version of the original guideline document). The flowchart was designed to assist with, but not replace, clinical judgement.

Developing Graded Recommendations

Once all evidence statements relating to a particular clinical question were finalised and agreed by the GDG, the associated recommendations were produced and graded.

Recommendations were graded A to C based on the level of associated evidence, or as a good practice point (GPP) (see "Rating Scheme for the Strength of the Recommendations").

Grading allowed the GDG to distinguish between the level of evidence and the strength of the associated recommendation. It is possible that a statement of evidence would cover only one part of an area in which a recommendation was to be made or would cover it in a way that would conflict with other evidence. In order to produce more comprehensive recommendations suitable for people in England and Wales, the GDG had to extrapolate from the available evidence. This

led to a weaker level of recommendation (i.e., B, as data were based upon level-I evidence). In addition, it is possible to have methodologically sound (level-I) evidence about an area of practice that is of little direct clinical relevance or has such a small effect that it is of little practical importance. In this case, the evidence would attract a lower strength of recommendation (i.e., there would be necessity for extrapolation).

The process also allowed the GDG to moderate recommendations based on factors other than the strength of evidence. Such considerations include the applicability of the evidence to the people in question, economic considerations, values of the development group and society, or the group's awareness of practical issues.

It is important to understand that the grading of a recommendation relates to the source of evidence upon which the recommendation is based; it is not a reflection of the importance or value the GDG place upon the recommendation. Many GPPs are much more important than some A-level recommendations, especially those GPPs that aim to improve the experience of care for service users.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Recommendations

Grade A - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation

Grade B - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence

Grade C - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

Good Practice Point (GPP) - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline has been validated through two consultation exercises. First consultation drafts of the guideline (this full version and a shorter version--the

National Institute of Clinical Excellence [NICE] guideline) were submitted to the NICE Guidelines Review Panel and posted on the NICE Web site (www.nice.org.uk). Stakeholders and other reviewers nominated by the Guideline Development Group (GDG) were then informed that the documents were available for review.

The GDG reviewed comments from stakeholders, the NICE Guidelines Review Panel, a number of health authority and trust representatives, and a wide range of national and international experts from the first round of consultation. The GDG then responded to all comments and prepared second consultation drafts of the guideline (the full guideline, the NICE guideline, the algorithm, and the *Information for the Public*). These were made available on the NICE Web site, and stakeholders were informed. Following additional comments, the drafts were amended and responses to comments were made.

The final versions were then submitted to NICE to be signed off after review by the Guidelines Review Panel. Stakeholder comments from the two consultation phases, together with the GDG responses, are posted on the NICE Web site.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grading of recommendations (A-C and GPP) are defined at the end of the Major Recommendations field.

Issues for All Services and Healthcare Professionals

Users' Experience of Services

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

Respect, Understanding, and Choice

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

GPP - Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.

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

GPP - When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words.

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

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

When Relatives or Carers are Present

GPP - People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend, or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality and to allow discussion about issues that may relate to the relationship between the service user and carers.

GPP - Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety.

Specific Issues Regarding Treatment and Care

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

GPP - Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.

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

Staff Training and Service Planning

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

Staff Training

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

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

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

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

Planning of Services

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

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

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

GPP - In jointly planning an integrated emergency department service for people who self-harm, service managers should consider integrating mental health professionals into the emergency department, both to improve the psychosocial assessment and initial treatment for people who self-harm, and to provide routine and regular training to non-mental-health professionals working in the emergency department.

GPP - Emergency department and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day.

Consent to Care

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

GPP - All healthcare professionals who have contact, in the emergency situation, with people who have self-harmed should be adequately trained to assess mental

capacity and to make decisions about when treatment and care can be given without consent.

GPP - Primary healthcare practitioners, ambulance staff, triage nurses, and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed. Within the bounds of patient confidentiality, and subject to the patient's consent, staff should attempt to obtain relevant information from relatives, friends, carers, and other key people to inform the assessment.

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

GPP - Staff should provide full information about the treatment options and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

GPP - If a person is assessed as being mentally incapable, staff have a responsibility, under common law, to act in that person's best interests. If necessary, this can include taking the person to hospital and detaining them to allow assessment and treatment against the person's stated wishes.

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

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

GPP - Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times.

Activated Charcoal

For the majority of drugs taken in overdose, taking activated charcoal as early as possible, preferably within 1 hour of ingestion, can prevent or reduce absorption of the drug. Activated charcoal should be immediately available for rapid and appropriate use.

B - Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

B - All healthcare professionals who are able to offer activated charcoal to people who have self-poisoned should ensure that they know how and when this should be administered. This should include:

- Knowing for which poisons activated charcoal should and should not be used
- The potential dangers and contraindications of giving activated charcoal
- The need to encourage and support service users when offering activated charcoal

The Management of Self-Harm in Primary Care

Primary care has an important role in the assessment and treatment of people who self-harm. Careful attention to prescribing drugs to people at risk of self-harm, and their relatives, could also help in prevention. In remote areas, access to TOXBASE (the national database of the National Poisons Information Service [NPIS]) may be necessary.

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

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

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

GPP - In most circumstances, people who have self-poisoned and present to primary care should be urgently referred to the nearest emergency department, because the nature and quantity of the ingested substances may not be clearly known to the person who has self-poisoned, making accurate risk assessment difficult.

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

GPP - Consideration should be given to the service user's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate person where there is a risk of further self-harm or reluctance to attend other care centres, or the service user is very distressed.

GPP - In remote areas at considerable distance from an emergency department or where access is likely to be delayed, consideration should be given to initiating assessment and treatment of self-harm in the primary care setting, following discussion with the nearest emergency department consultant. This should include taking samples to test for paracetamol and other drugs, as indicated in TOXBASE.

When Urgent Referral to an Emergency Department is Not Necessary

GPP - If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services.

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

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

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

Service Users at Risk of Self-Poisoning in Primary Care

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

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

GPP - As medication intended for relatives is often used in self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose when prescribing medication to relatives who live with a person who is considered at risk of self-poisoning. They should also consider prescribing fewer tablets at any one time. Care must be taken, however, to preserve confidentiality appropriately.

The Assessment and Initial Management of Self-Harm by Ambulance Services

Ambulance staff have an increasingly important role in the assessment and early treatment of self-harm, a role that needs to be well supported through effective collaboration with other professional groups.

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

GPP - Ambulance staff should be trained in the assessment and early management of self-harm. Training should particularly address the different

methods of self-harm and the appropriate treatments, the likely effects if untreated, and issues of consent and mental capacity, as these apply both to adults, and to children and young people.

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

GPP - Ambulance Trusts, the emergency department, and Mental Health Trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self-harmed, where this is appropriate and does not increase the risks to the service user.

GPP - In cases of self-poisoning, ambulance staff should obtain all substances and/or medications found at the scene of an emergency call, whether thought to be involved in the overdose or not, and pass these to staff upon arrival at the emergency department.

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

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

B - When a person who has self-poisoned presents to the ambulance service within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, ambulance staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

C - Activated charcoal may also be considered between 1 and 2 hours after ingestion as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

GPP - In the emergency treatment of opioid overdose when using intravenous naloxone, ambulance staff should adhere to the guidelines established by the Joint

Royal Colleges Ambulance Liaison Committee. Particular attention should be given to the possible need for repeated doses of naloxone and frequent monitoring of vital signs, because the effects of naloxone are short-lived in comparison with the effects of most opioids and service users frequently relapse once the effect of naloxone has worn off. All people who have overdosed with opioids should be conveyed to the hospital, even if the initial response to naloxone has been good.

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

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

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

GPP - Ambulance Trusts should regularly update ambulance staff about any change in local arrangements for services available for the emergency treatment of people who have self-harmed.

GPP - Ambulance Trusts should routinely audit incidents of overdose, both to ensure that interventions are being used consistently and effectively, and to monitor adverse incidents.

The Treatment and Management of Self-Harm in Emergency Departments

The emergency department provides the main services for people who self-harm. Emergency department staff should assess risk and emotional, mental, and physical state quickly, and try to encourage people to stay to organise psychosocial assessment.

Triage

GPP - When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk and the person's emotional and mental state in an atmosphere of respect and understanding.

GPP - Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment.

C - Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.

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

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

People Waiting for Physical Treatments

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

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

GPP - If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe and supportive and that minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

People Who Wish to Leave Before Assessment and/or Treatment

C - For a person who has self-harmed and presents to services, but wishes to leave before psychosocial assessment has been undertaken, assessment of mental capacity and the presence of mental illness should be undertaken before the person leaves the service. This assessment should be clearly recorded in his or her notes. The assessment should be passed on to the person's General Practitioner (GP) and to the relevant mental health services as soon as possible to enable rapid follow-up.

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

Medical and Surgical Management of Self-Harm

Self-poisoning can be treated by reducing absorption, increasing elimination, and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with tissue adhesive, whilst more complicated injuries will need surgical assessment and possibly exploration.

General Treatment for Ingestion

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

B - When a person who has self-poisoned presents to the emergency department within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, emergency department staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

C - When a person who has self-poisoned is fully conscious and able to protect his or her own airway, activated charcoal may also be considered between 1 and 2 hours after ingestion, as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

B - Multiple doses of activated charcoal should not be used in the management of self-poisoning to reduce absorption or to promote elimination of poisons unless specifically recommended by TOXBASE or following consultation with the National Poisons Information Service (NPIS).

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

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

B - Gastric lavage should not be used in the management of self-poisoning unless specifically recommended by TOXBASE or following consultation with the NPIS.

C - Whole bowel irrigation should not be used in the management of self poisoning, unless specifically recommended by TOXBASE or following consultation with the NPIS.

Collecting Samples and Interpreting Results

GPP - Staff involved in the emergency treatment of self-poisoning should collect appropriate samples for analysis; usually this will be a sample of blood, although samples of urine, vomit, or sometimes gastric contents may be indicated following

discussion with the NPIS. If possible, samples of the suspected poison should also be collected.

GPP - Hospital laboratory staff should provide emergency department staff with regular updates about which toxicology tests are available, both locally and at the nearest specialised toxicology laboratory. These should include information on the correct methods of collecting, handling, and storing samples, and how samples should be transferred to the laboratory.

GPP - Where emergency department staff are unsure about the value of undertaking a toxicology assay or about whether an assay is available locally, advice should be sought from TOXBASE, the local hospital laboratory, a specialised toxicology laboratory, or the NPIS.

GPP - When emergency department staff are unsure about the interpretation of assay results, advice should be sought from the local hospital laboratory, specialised toxicology laboratory, or the NPIS.

Information and Laboratory Services Available to Clinicians Treating Self-Poisoning

Emergency department staff should have easy access to TOXBASE, be fully trained in its use, and know how and when to contact the NPIS.

GPP - TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. TOXBASE should be the first point of call for poisons information.

GPP - The NPIS telephone number should be permanently and easily available to clinical staff involved in the emergency treatment of self-poisoning. The NPIS should normally be contacted only directly after clinicians have accessed TOXBASE or if there is concern about the severity of poisoning in a particular case.

GPP - Clinical staff involved in the emergency treatment of self-poisoning should be given training to better understand human toxicology, in order to make best use of TOXBASE and the NPIS telephone service. Emergency departments, in conjunction with local hospital laboratories or regional toxicology units, or NPIS units, should ensure all staff receive regular training.

GPP - In cases where the suspected poison is a substance for which little toxicology data exists, clinical and laboratory data about exposure and absorption should be passed to the NPIS to help in the development of TOXBASE and other poisons information databases.

GPP - For further information about the management of overdose with substances covered by this guideline and for the specific management and treatment of overdose with substances not covered in this guideline, clinicians should consult TOXBASE or discuss the individual case with the NPIS.

Paracetamol Screening

C - Plasma paracetamol concentrations should be measured in all conscious patients with a history of paracetamol overdose or suspected paracetamol overdose, as recommended by TOXBASE. They should also be taken in patients with a presentation consistent with opioid poisoning and in unconscious patients with a history of collapse where drug overdose is a possible diagnosis. Plasma paracetamol levels should be measured for risk assessment no earlier than 4 hours and no later than 15 hours after ingestion as results are not reliable outside this time period.

Management of Paracetamol Overdose

C - Following gut decontamination with activated charcoal as recommended in this guideline, TOXBASE should be used to guide the further management of paracetamol poisoning. TOXBASE should be easily available to all clinicians treating paracetamol poisoning.

C - Intravenous acetylcysteine should be considered as the treatment of choice for paracetamol overdose (although the optimum dose is unknown). If acetylcysteine is not available or cannot be used, for example in people who abuse intravenous drugs where intravenous access may be difficult, or for people with needle phobia, then TOXBASE should be consulted.

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

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

Flumazenil in Benzodiazepine Overdose

If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help reduce the need for admission to intensive care. Although widely used, flumazenil is not currently licensed for the treatment of benzodiazepine overdose in the UK.

GPP - When a positive diagnosis of self-poisoning with a benzodiazepine has been made, the possibility of mixed overdose should be considered and investigated, if necessary, at the earliest opportunity, especially if the patient's clinical progress suggests that he or she may later require admission to intensive care.

B - In patients who are unconscious or showing marked impairment of consciousness, with evidence of respiratory depression likely to lead to admission to intensive care with endotracheal intubation, and in whom self-poisoning with a benzodiazepine is suspected, flumazenil should be considered as a therapeutic option to avoid intubation and artificial ventilation. The decision to administer flumazenil should be based upon a comprehensive assessment including a full clinical and biochemical assessment of the patient's respiratory status and his or her ability to protect his or her own airway. Clinicians should, however, avoid the use of flumazenil in: patients who may have ingested proconvulsants, including tricyclic antidepressants; those who have a history of epilepsy; and patients who are dependent upon benzodiazepines.

GPP - When using flumazenil in the treatment of benzodiazepine poisoning, clinicians should use small doses, comparable to those used in other contexts, and administer slowly, to avoid the emergence of the more serious adverse reactions associated with the use of flumazenil.

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

C - When using flumazenil in the treatment of benzodiazepine poisoning, care should be taken to ensure that patients who become agitated should be closely monitored and warned of the risk of re-sedation, especially if the patient expresses the desire to leave the treatment setting.

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

GPP - Only clinicians who have been explicitly trained in the use of flumazenil for the treatment of benzodiazepine poisoning, as described in this guideline, should undertake to administer flumazenil in this context.

Treatment and Management of Poisoning with Salicylates

C - Following gut decontamination with activated charcoal, where this is indicated by this guideline, the further treatment of self-poisoning with salicylates should follow the current guidance outlined in TOXBASE.

Treatment of Opioid Overdose

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

C - The minimum effective dose of naloxone should be used to reverse respiratory depression caused by opioids without causing the patient to become agitated. This is especially important in people who are dependent upon opioids.

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

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

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

General Treatment for Self-Injury

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

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

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

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

Superficial Wound Closure

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

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

Support and Advice for People who Repeatedly Self-Harm

Advice for People who Repeatedly Self-Poison

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

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

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

Advice for People who Repeatedly Self-Injure

Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies, and how best to deal with scarring should be considered for people who repeatedly self-injure.

GPP - For people presenting for treatment who have a history of self-harm, clinicians may consider offering advice and instructions for the self management

of superficial injuries, including the provision of tissue adhesive. Discussion with a mental health worker may assist in the decision about which service users should be offered this treatment option.

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

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

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

Psychosocial Assessment

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

Engaging the Service User

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

Assessment of Needs (Specialist Mental Health Professionals)

C - All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological, and motivational factors specific to the act of self-harm, current suicidal intent, and hopelessness, as well as a full mental health and social needs assessment.

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

GPP - To encourage joint clinical decision making, service users and the assessor should both read through the written assessment of needs, wherever possible, to mutually agree the assessment. Agreement should be written into the service user's notes. Where there is significant disagreement, the service user should be offered the opportunity to write his or her disagreement in the notes. The assessment should be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

Assessment of Risk (Specialist Mental Health Professionals)

C - All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide and identification of

the key psychological characteristics associated with risk, in particular depression, hopelessness, and continuing suicidal intent.

GPP - The assessment of risk should be written clearly in the service user's notes. The assessment should also be passed on to their GP and to any relevant mental health services as soon as possible to enable follow-up.

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

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

GPP - Consideration should be given to combining the assessment of risk into a needs assessment framework to produce a single integrated psychosocial assessment process.

Training

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

Referral, Admission, and Discharge Following Self-Harm

Referral, treatment, and discharge following self-harm should be based on the overall assessment of needs and risk.

GPP - The decision to refer for further assessment and/or treatment or to discharge the service user should be taken jointly by the service user and the healthcare professional whenever this is possible. When this is not possible, either as a result of diminished mental capacity or the presence of significant mental illness, this should be explained to the service user and written in their notes.

C - Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto the service user's GP and to any relevant mental health services as soon as possible to enable follow-up.

C - The decision to discharge a person without follow-up following an act of self-harm should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto their GP and to any relevant mental health services.

GPP - In particular, the decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal

problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.

GPP - Temporary admission, which may need to be overnight, should be considered following an act of self-harm, especially for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity thereafter.

Special Issues for Children and Young People (Under 16 Years)

Children and young people who self-harm have a number of special needs, given their vulnerability. Physical treatments will follow similar principles as for adults.

GPP - Children and young people under 16 years of age who have self-harmed should be triaged, assessed, and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

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

C - All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues, and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary.

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

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

C - Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person.

GPP - Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues.

GPP - In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people, and the Children Act.

GPP - During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team, and social services and education staff as appropriate.

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

C - Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self harmed should:

- Be trained specifically to work with children and young people, and their families, after self-harm
- Be skilled in the assessment of risk
- Have regular supervision
- Have access to consultation with senior colleagues.

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

B - For young people who have self-harmed several times, consideration may be given to offering developmental group psychotherapy with other young people who have repeatedly self-harmed. This should include at least six sessions. Extension of the group therapy may also be offered; the precise length of this should be decided jointly by the clinician and the service user.

Special Issues for Older People (Older Than 65 Years)

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

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

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

GPP - Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and levels of risk.

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

Psychological, Psychosocial and Pharmacological Interventions

Referral for further assessment and/or treatment should be based upon a comprehensive psychosocial assessment, and should be aimed at treating a person's underlying problems or particular diagnosis rather than simply treating self-harming behaviour, although intensive therapeutic help with outreach may reduce the risk of repetition. Whatever the treatment plan, primary care and mental health services should be informed.

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

GPP - Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, including the likely benefits and disadvantages, in a spirit of collaboration, before treatments are offered. The provision of relevant written material with time to talk over preferences should also be provided for all service users.

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

C - For people who have self-harmed and are deemed to be at risk of repetition, consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow frequent access to a therapist, when needed, home treatment when necessary, and telephone contact; and outreach should include following up the service user actively when an appointment has been missed to ensure that the service user is not lost from the service. The therapeutic intervention plus outreach should continue for at least 3 months.

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

Definitions:

Evidence Categories

I: Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Recommendation Grades

Grade A - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation

Grade B - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level-I evidence

Grade C - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

Good Practice Point (GPP) - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)

CLINICAL ALGORITHM(S)

Clinical algorithms are provided for:

- Advice for healthcare professionals in any setting
- Decision making in the event of a person refusing treatment for the physical effects of self harm
- Management of self harm in primary care
- Assessment and initial management of self harm by ambulance personnel
- Treatment and management of self harm in emergency departments
- Medical and surgical management of self harm
- Psychosocial assessment
- Referral, discharge and admission following psychosocial assessment
- Special issues for older people
- Special issues for children and young people

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Implementation of the recommendations may ensure that people who self-injure receive consistent management and care to improve outcomes and minimize the recurrence of self injury.

POTENTIAL HARMS

- If a person is mentally capable of making the decision regarding treatment then his or her decision about whether to receive treatment or care must be respected; even if a refusal may risk permanent injury to that person's health or even lead to premature death.
- Intravenous acetylcysteine may produce an anaphylactic reaction in some patients.
- Flumazenil may provoke serious adverse reactions when benzodiazepines have been ingested with tricyclic antidepressants or other proconvulsants, in people with epilepsy, and in people who are dependent upon benzodiazepines.
- Multiple doses of activated charcoal may cause mild, transient constipation and occasionally bowel obstruction has been reported.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Activated charcoal is contraindicated if the patient has an unprotected airway (absence of gag reflex), or when the level of consciousness is depressed and the patient has no airway protection.
- Ipecac is contraindicated following ingestion of a substance likely to cause depressed levels of consciousness or convulsions, and following ingestion of hydrocarbons with high aspiration potential, or ingestion of corrosive substances.
- Gastric lavage is contraindicated when the patient has an unprotected airway or after ingestion of a hydrocarbon with high aspiration potential, or in patients at risk of haemorrhage or gastrointestinal perforation.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guidance represents the view of the Institute, which was arrived at after careful consideration of the available evidence. Health professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Guidelines are not a substitute for professional knowledge and clinical judgement. Guidelines can be limited in their usefulness and applicability by a number of different factors: the availability of high quality research evidence, the quality of the methodology used in the development of the guideline, the generalisability of research findings, and the uniqueness of individual patients.
- Although the quality of research in self-harm is variable, the methodology used here reflects current international understanding on the appropriate practice for guideline development (AGREE: Appraisal of Guidelines for Research and Evaluation Instrument; www.agreecollaboration.org), ensuring the collection and selection of the best research evidence available, and the systematic generation of treatment recommendations applicable to the majority of patients and situations. However, there will always be some patients for whom clinical guideline recommendations are not appropriate and situations in which the recommendations will not be readily applicable. This guideline does not, therefore, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or carer (or significant other).
- In addition to the clinical evidence, cost-effectiveness information, where available, is taken into account in the generation of statements and recommendations of the clinical guidelines. While national guidelines are concerned with clinical and cost effectiveness, issues of affordability and implementation costs are to be determined by the NHS.
- In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. In addition, of particular relevance in mental health, evidence-based treatments are often delivered within the context of an overall treatment programme including a range of activities, the purpose of which may be to help engage the patient, and provide an appropriate context for the delivery of specific interventions. It is important to maintain and enhance the service context in which these interventions are delivered; otherwise the specific benefits of effective interventions will be lost. Indeed, the importance of organising care, so as to support and encourage a good therapeutic relationship, is at times more important than the specific treatments offered.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

General

The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

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

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

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

Audit

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

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in

primary and secondary care. London (UK): National Institute for Clinical Excellence (NICE); 2004. 199 p. [267 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group (GDG)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group Members: Professor Paul Lelliott (Chair) Director, Royal College of Psychiatrists' Research Unit, Consultant Psychiatrist, Oxleas Mental Health NHS Trust; Dr Tim Kendall, Co-Director, National Collaborating Centre for Mental Health, Deputy Director, Royal College of Psychiatrists' Research Unit, Medical Director and Consultant Psychiatrist, Sheffield Care Trust, Facilitator, Guideline Development Group; Mr Simon Armson, Chief Executive, Samaritans (until July 2004), Psychotherapist and Mental Health Act Commissioner; Mr Simon Baston, Charge Nurse, Emergency Nurse Practitioner, A&E Department, Sheffield Teaching Hospitals; Ms Pamela Blackwood, Social Worker and Mental Health Locality Manager, Greenwich Social Services (until May 2003), Caller Services Manager, Samaritans, Lead, Topic Group on User Experience; Ms Rachel Burbeck, Lead Systematic Reviewer, National Collaborating Centre for Mental Health; Ms Michelle Clark, Project Manager (until November 2002), National Collaborating Centre for Mental Health; Professor Allan House, Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds, Lead, Topic Group on Psychosocial Issues and Interventions; Mr Keith Jackson, Paramedic & Staff Officer, London Ambulance Service NHS Trust; Mr Richard Jenkins, Systematic Reviewer, National Collaborating Centre for Mental Health; Dr Marcia Kelson, Director, Patient Involvement Unit for NICE; Ms Rebecca King, Project Manager (from November 2002), National Collaborating Centre for Mental Health; Dr Huw Lloyd, General Practitioner and Chair of Mental Health Group, Royal College of General Practitioners; Mr Richard Pacitti, Carer and Chief Executive, Mind in Croydon; Mr Carlos Perez-Avila, Consultant in Emergency Medicine, Royal Sussex County Hospital, Brighton; Ms Preethi Premkumar, Research Assistant, National Collaborating Centre for Mental Health; Dr Clare Taylor, Editor, National

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

At each Guideline Development Group (GDG) meeting, all GDG members declared any potential conflict of interests.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format [PDF] format from the National Institute for Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline. 2004 Jul. 48 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Quick reference guide. 2004 Jul. 24 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Summary of management and treatment. Clinical practice algorithms. 2004 Jul. 12 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Additionally, Audit Criteria can be found in Appendix D of the NICE version of the guideline.

PATIENT RESOURCES

The following is available:

- Self-harm: short-term treatment and management. Understanding NICE guidance - information for people who self-harm, their advocates and carers, and the public (including information for young people under 16 years). 2004 Jul. 56 p. Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on February 15, 2005. The information was verified by the guideline developer on March 9, 2005.

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