National Institute for Health and Care Excellence

Clinical Guideline: Self harm assessment, management and preventing recurrence Stakeholder Workshop

Thursday 10th October 2019

Presentations

The group were welcomed to the meeting and informed about the purpose of the day. The Stakeholder Workshop is an opportunity for stakeholders to review the draft scope and give their input into whether it is appropriate.

The group received presentations about NICE's work, the guideline development process and the role of the committee. The Chair of the guideline development group also presented the key elements of the draft scope.

After the introductory presentations, the following comments and questions were raised:

- Risk assessment section should be renamed risk formulation.
- Question on the age limit of above 8's. What about children aged 7.5 years? Suggestion that the age limit is removed.
- Which terminology should be avoided e.g. 'non-suicidal self harm' versus 'suicidal self harm' this can be misleading. This guideline has a very wide scope.
- Discrepancy between existing short term and long-term guidelines – 'continued suicidal intent' in short-term assumes self harm with intent to commit suicide, long term assesses whether there is suicidal intent behind self harm at all.

Following questions, the stakeholder representatives were divided into 4 groups each including a facilitator and a scribe. Each group had a structured discussion around the key issues.

Scope

General comments

There was a resounding feeling from all stakeholders that the guideline was a huge topic with a very wide scope.

It was noted that due to the nature of the guideline, there is a large negative perception, the terminology is key.

It was mentioned that phrases like 'dealing with' are not people centred. Better to use 'working with' avoid the connotation that the person is a 'problem'.

Consideration should be given to changing the title of the guideline. 'Self harm in over 8s' excludes those under the age of 8. 'Assessment' also needs to appear in the title.

Additionally, the following questions were raised:

- How do we define self harm, e.g. risk taking behaviour (excessive alcohol, drugs, sexual activity) in youth can also be self harm. Should it be defined as an action or motivation?
- Does the guideline apply to those who have 'stopped/ceased' self harming?
- Does this cover those who have only self harmed once?
- Can the guideline also mention that the act of self harm does not have to be a long-term affliction or action?
- How best do we refer to those who receive medical care/help in this guideline? The term 'service user' does not allow for a personal 'human' touch.

Population

The groups highlighted the following issues related to the population of the guideline:

- It was noted that ethnic minorities and people with autism need to be included in the scope.
- Careful consideration needs to be given if including very young children, as they are very different in terms of risk factors and assessment. However, it is important to include them, as teachers in primary schools with children below 8 years old who have self harmed are unsure of where to refer the children.
- It was suggested that there is a need for guidance on those who self harm with drugs and alcohol and this should not be excluded. There is a need for distinction between those who get intoxicated on purpose and those who use alcohol to self harm.
- It was suggested a section needs to be included in the guideline for those working in Emergency departments and Crisis departments.

Suggestions for the inclusion of some specific groups were made:

Ethnic minorities, people with autism and children of uncertain immigration status should be included in the scope.

Equalities

The topic of how inequalities affecting people who self-harm was discussed in the groups and suggestions were made.

- It was suggested that it can be harmful to admit children to hospital and this can lead to repeat self harm, and repeat admission.
- It was noted Trans people who self-harm may not contact mental health services out of fear that it will harm their transition
- It was mentioned a proportion of the LGBTQ+ population do not have a family based support group. Language could be more focused on 'communities' and 'support networks' rather than specifically relating to families and carers.
- It was noted that inequalities surrounding women in the perinatal period were not mentioned.
- It was noted that children and adults will long-term conditions (diabetes) were not being considered.

- It was noted that there are gaps in the service with the transition from children/Young people to adults.

Setting

Discussions in the groups on the settings to be included:

It was mentioned that 'settings' should relate not just to an individual's physical environment, but to the psychological environment – trauma informed services/ approaches should be discussed.

Consideration should be given to highlight custodial settings e.g. the criminal justice, court settings. It should be made explicit within the guideline that the custodial settings have a very different context, but that there are similarities to healthcare settings.

It was noted that vulnerable groups (including those within criminal justice) need to be thought about regarding the settings in which risk assessment happens and how this changes risk factors e.g. healthcare in prisons is less managed by healthcare professionals and managed more by the prison staff.

It was suggested crisis resolution and home care teams need to be included.

It was noted that all childcare organisations and settings need to be included (childminders, youth centres, holiday clubs, after school clubs).

Management

Key areas that will be covered

In groups, the Stakeholders discussed all the issues covered in the 'key areas that will be covered' section of the scope. The main points included:

- It was suggested risk and psychosocial assessment should be together as they are interlinked.
- It was noted that addressing people who lack capacity; 'restraint'; treating people without consent/ against their wishes in both health and non-health focused settings should be considered in this guideline.
- It was mentioned Risks to other children (especially within a household) should be addressed.
- It was suggested something around 'accountability' needs to be included.

Section 1.5 Areas that will not be covered

In groups, the Stakeholders discussed the areas that are not covered.

- Agreed it was appropriate to exclude the physical management.

- It was noted that potentially screening for other overdoses (self-poisoning), blood screening before discovering an overdose of, for example, paracetamol. People may have over-dosed on other things, should be included.
- It was mentioned that there was no reference to 'mental capacity'. This may create some legal implications and should be included.
- It was suggested that Front line support and Helplines should be included.

Section 1.6 Main outcomes

Overall, the stakeholders were satisfied with the outcomes suggested. In addition to those stated; care giver burden, educational outcomes (attendance), costs were suggested.

Section 1.7 Key issues and draft questions

Stakeholders agreed that the questions addressed the key areas, but made some general additional comments and suggestions:

- Review questions 2.1 and 2.2 should be the other way around in order.
- Risk and needs assessments' – 'Needs' should stay in the wording.
- The word engagement needs to come into the search Phrase the question as "Engagement at the first point of presentation or contact".
- Social care representation is needed on the committee.
- The offer for 'safer' self-harm – although there is ethical grey areas, taking away the option would leave to more severe outcomes and incidents.
- There should be consideration for how cross-agency supervision can affect risk assessment.
- The difference between risk assessment and risk management – risk assessment may fall onto health professionals, however key factors for risk management can fall outside of healthcare settings e.g. in schools.
- Many adults fall through the system, are we just thinking about suicide and care, not support, which makes the whole difference
- Delivery of care: Transition between child and adult services; can be very difficult to be 17-19 years, especially difficult for looked after children as lots of other services/support stop around that time.
- Is safe prescribing already covered by the suicide prevention guideline? Could potentially exclude this question
- A question about rapid tranquilisation for people who are a danger to themselves and self-harm in the clinical setting, but concern about that practice being linked to self-harm management
- Clusters of self-harm, notion of it being contagious or an epidemic, would be useful to say something about that
- Need to balance safeguarding with having an appropriate response to self-harm
- User defined outcomes will be important to measure the effectiveness of treatments. The Opal project collects useful data.
- Would be helpful for third sector to be able to refer into services.
- RCT evidence is not a helpful study design for looking at research in this area.

Section 1.8 Economic aspects
The Stakeholders did not highlight any particular economic aspects.
Guideline Committee composition
The Stakeholders made the following suggestions for the proposed members of the committee: • Volunteer from the tertiary healthcare setting • Child Psychologist and a Child Psychiatrist • Co-opted Youth worker • Paediatric nurse • Paediatrician • There is not enough Lay members. It was suggested 3 to 4 lay members on the committee. • There needs to be a representative from the third sector. • Police officer as a full member of the guideline rather than a co-opted member. • Mental health commissioner as a full member of the guideline rather than a co-opted member. • There was a suggestion of having a focus group in combination with the guideline development.