National Institute for Health and Care Excellence

Final

Self-harm: assessment, management and preventing recurrence

[C] Evidence review for consent, confidentiality and safeguarding

NICE guideline NG225

Evidence reviews underpinning recommendations 1.2.1 to 1.2.2 and 1.3.1 to 1.3.2 in the NICE guideline

September 2022

Final

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

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

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

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

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. All NICE guidance is subject to regular review and may be updated or withdrawn.

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Consent, confidentiality and safeguarding

Review question

What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

Introduction

Self-harm may be associated with mental health concerns and can occur in people who are vulnerable. It is therefore important that people who attempt to help someone who struggles with self-harm are aware of how to gain consent, protect confidentiality and safeguard the wellbeing of that person. The aim of this review is to identify the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed.

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Inclusion: • All people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability Exclusion: • People displaying repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability
Intervention	Any approach to obtain consent, ensure confidentiality and/or promote safeguarding, either singly or in combination, when people have self-harmed
Comparison	Any other approach for the same aspect
Outcome	**Critical** • Self-harm repetition (for example, self-poisoning or self-cutting) • Suicide • Service user satisfaction **Important** • Quality of life • Safeguarding incidents (patient or dependent) • Serious incidents • Breaches of confidentiality

For further details see the review protocol in appendix A.

Methods and process

A modified version of the GRADE approach to rate the certainty of evidence in systematic reviews was used as part of a pilot project undertaken by NICE. Instead of using predefined clinical decision/minimal important difference (MID) thresholds to assess imprecision in GRADE tables, imprecision was assessed qualitatively during committee discussions. Other than this modification, GRADE was used to assess the quality of evidence for the selected outcomes and this evidence review developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are

described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Effectiveness evidence

Included studies

A systematic review of the literature was conducted but no studies were identified which were applicable to this review question.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix J.

Summary of included studies

No studies were identified which were applicable to this review question (and so there are no evidence tables in Appendix D).

Summary of the evidence

No studies were identified which were applicable to this review question (and so there are no GRADE tables in Appendix F).

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

Economic studies not included in the guideline economic literature review are listed, and reasons for their exclusion are provided in appendix J.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Economic

No economic studies were identified which were applicable to this review question.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

Self-harm repetition, suicide and service user satisfaction were prioritised as critical outcomes by the committee. Self-harm repetition and suicide were prioritised as critical outcomes because they are direct measures of any differential effectiveness associated with the method of initial contact and captures both fatal and non-fatal self-harm. Service user satisfaction was chosen as a critical outcome due to the importance of delivering services which are centred around the patients' experiences and because patient satisfaction is likely to influence whether the patient engages with the intervention..

The committee agreed that quality of life, safeguarding incidents (such as failure to ensure safeguarding), serious incidents and breaches of confidentiality should be important outcomes. Quality of life was chosen as an important outcome as it is a compound measure of well-being, which may capture health-related outcomes associated with the effectiveness of the interventions not captured by the other outcome measures. Safeguarding incidents, serious incidents and breaches of confidentiality were included as important outcomes as they are all direct measures of potential serious harms associated with the interventions and therefore important to take into account when assessing the effectiveness associated with the interventions.

The quality of the evidence

No studies were identified that met the inclusion criteria. There was no evidence on the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed, so the committee made recommendations by informal consensus based on their knowledge of current best practice as well as existing guidance and protocols.

Benefits and harms

Consent and confidentiality

The committee agreed, based on their knowledge and experience, healthcare professionals and social care practitioners should be aware of the Mental Capacity Act (2005) and Mental Health Act (1983; amended 1995 and 2007) to ensure staff understand and work within established legal and medical principles regarding consent when working with people who have self-harmed. The committee agreed the existing guidance was comprehensive, and although more widely applicable for staff working with people presenting for mental health reasons, the advice was also relevant for staff specifically working with people who had self-harmed. The committee also discussed what skills pertaining to consent were important for professionals to have when working with people who had self-harmed. They agreed it was necessary to highlight the importance of having the ability to assess mental capacity, so professionals could recognise circumstances when it may be necessary to give care without consent, as well as when it was inappropriate to do so. The committee agreed based on their experience that having this knowledge would allow healthcare professionals and social care practitioners to be as collaborative as possible when making decisions about care, while still ensuring the patient receives necessary treatment in the least restrictive way. The committee discussed the potential risks of healthcare professionals making decisions regarding consent without confidence and agreed this had the potential for patients to be given inappropriate care without consent, potentially leading to distress and future self-harm or suicide. Based on their discussion of the potential risks, the committee agreed that healthcare professionals and social care practitioners should feel empowered to seek guidance about consent when they were unsure of how to proceed with care for a person who had self-harmed. The committee also agreed, based on their knowledge and experience, that it was important for

healthcare professionals and social care practitioners to direct people to Independent Mental Capacity Advocates (IMCAs); for example, when a patient is lacking capacity. The committee discussed the benefits of access to IMCAs and agreed this would allow people who have self-harmed to feel confident that their opinions are being respected to allow for the best decisions to be made regarding their care. The committee also agreed it would be beneficial to signpost to the NICE guidelines on Decision-making and mental capacity (NG108), Service user experience in adult mental health (CG136) and Babies, children and young people's experience of healthcare (NG204), and the government's consensus statement on information sharing and suicide prevention so healthcare professionals and social care practitioners could make informed decisions about consent based on existing guidance.

The committee discussed how principles of consent applied specifically to children and young people, and again agreed that existing guidance about this topic for children and young people was comprehensive and relevant to those who had self-harmed. The committee therefore agreed any healthcare professionals and social care practitioners should be aware of this guidance, in particular the Children Act 1989, the Children and Families Act 2014, and the Mental Health Act 2007, in order to make appropriate decisions regarding the care of children and young people. Due to the variability of specific issues regarding consent depending on the age of the child, the committee also agreed it is important that health and social care staff know how to apply these principles for children and young people of different ages in order to prevent dissatisfaction with care if, for example, their capacity to consent is assessed inappropriately for their age. The committee also agreed it is important that healthcare professionals understand Gillick competence in order to assess competence adequately in children and young people of different ages. They agreed that having these skills would enable young people to make decisions with their care when appropriate, which could have the benefit of empowering the person and improving satisfaction with their care.

The committee discussed potential legal issues surrounding circumstances when decisions are made about a person's care without their consent or when confidentiality is broken, including incidents where staff working with people who have self-harmed have faced legal repercussions even when they thought as though they are acting in the best interests of the person. The committee discussed the benefits of having access to advice from specialists such as liaison psychiatrists and agreed it would provide reassurance to clinicians and allow them to have confidence in any decisions made regarding the person's capacity and consent. Access to this advice should always be available to health and social care staff as standard, to enable skill-sharing and good communication between staff members. The committee agreed that any staff seeking advice regarding the best course of action for a person who has self-harmed should also have access to formal legal advice as needed, to minimise the risk of staff withholding necessary care or providing inappropriate care due to lack of knowledge of specific law or fear of legal repercussions.

The recommendation regarding the limits of confidentiality was made after a committee discussion of the benefits and risks of information sharing. The committee agreed based on their experience that the risks of information sharing, such as breaching the person's consent and confidentiality, were widely acknowledged while the benefits were not as commonly discussed, and that this led to staff often feeling unable to share information about a patient even when it would benefit them. The committee discussed the principle that information sharing improves outcomes and agreed that withholding information can be a detriment to the person, as it carries the risk of other staff members delivering inappropriate care. The committee agreed to make a recommendation on the benefits of information sharing in order to prevent situations where confidentiality may become a barrier to collaborative working with other staff.

The committee similarly discussed the benefits of information sharing with family members and carers, for example where family members and carers may need information to continue with appropriate ongoing care. The committee acknowledged the potential safeguarding risks of information sharing and concluded that consent should still be sought when sharing information with family members and carers to ensure that the confidentiality requests of the person who has self-harmed are respected.

The committee agreed that whenever confidentiality is broken, staff should still endeavour to include patients in their own care at all times, including informing them about the breach if this is practical. The committee discussed the fact that it might not always be possible to inform the person of a confidentiality breach in advance if there are immediate concerns about the person's safety and the staff member expects that the person may not engage with services if informed of the breach. However, when possible, they agreed that doing so would prevent the person feeling disempowered and reduce the risk of service user dissatisfaction. Additionally, continuing to make decisions collaboratively with the person even after a break of confidentiality would protect the person's autonomy, allow them to stay engaged with their care, and reassure the person that the staff are working with their best interests in mind.

Safeguarding

The committee discussed whether additional consideration was necessary for children regarding safeguarding, but agreed that adults could be equally vulnerable when the person has self-harmed. They therefore agreed that safeguarding principles were similarly applicable to both children and vulnerable adults. For this reason, the committee made the safeguarding recommendations to encompass all people who have self-harmed. The committee referred to existing best practice when discussing issues regarding safeguarding and agreed that the guidance in the Care Act (2014), the Children Act 1989, and Children and Families Act 2014 was appropriate to signpost to, in order to ensure professionals and practitioners adhere to current safeguarding principles. The committee agreed it was important to highlight the potential for safeguarding concerns especially when working with people who have self-harmed, as presentation for self-harm can provide an opportunity for healthcare staff to intervene in situations where safeguarding is a concern. The committee discussed the risk of asking about abuse in front of a person who could potentially be their abuser and agreed that asking someone about safeguarding concerns when they are alone would remove this risk. However, they agreed that someone might have brought a person for support in order to disclose abuse and might need them there to have the courage to do so. Additionally, the committee discussed their experience that a family member, friend, or carer might be the one to bring up safeguarding issues instead of the person who has self-harmed. Due to the fact that friends, family members and carers may either support or inhibit disclosure, the committee agreed that consideration should be given to enquiring about safeguarding concerns in the most appropriate circumstances The committee therefore agreed staff should always consider whether such concerns exist for children and adults who have self-harmed and be prepared to enact safeguarding procedures when necessary, to reduce the risk of further harm to the person. The committee also agreed it would be beneficial to signpost to NICE guidelines on Domestic violence and abuse: multi-agency working (PH50), Looked-after children and young people (NG205), Child abuse and neglect (NG76), and Child maltreatment: when to suspect maltreatment in under 18s (CG89) so healthcare professionals could make informed decisions about safeguarding people who have self-harmed based on existing guidance.

The recommendation about a multi-agency approach to safeguarding was made after the committee agreed based on their knowledge and experience that a multi-agency approach would allow for collaborative working between different sectors, allowing for information-sharing which would ensure a holistic vision of a person's life informs their care and therefore improve the service provided to the person.

Cost effectiveness and resource use

The committee noted that no relevant published economic evaluations had been identified in the literature review. In addition, a bespoke economic model in this area of the guideline was not prioritised, as potential changes in current practice caused by the drafted recommendations were not expected to result in significant resource impact. When drafting the recommendations, the committee noted that, overall, these recommendations are in line with existing recommended practice, and should result in easier access to legal advice, better awareness of the benefits of information sharing as well as better communication and transitions across services through multi-agency approaches. The committee expressed the view that in some services there may be some increase in staff time to obtain consent from people who have self-harmed and their carers; they noted that there might also be extra costs incurred if specific extra training is required. However, such additional costs are likely to be minimal and may be offset by better health outcomes by improving the care and quality of life of people who have self-harmed.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.2.1-1.2.2 and 1.3.1-2.

References – included studies

Effectiveness

No studies were identified that met the inclusion criteria.

Economic

No studies were identified that met the inclusion criteria.

Appendices

Appendix A Review protocols

Review protocol for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

Table 2: Review protocol

Field	Content
PROSPERO registration number	CRD42021230660
Review title	Consent, confidentiality and safeguarding
Review question	What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?
Objective	To identify the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed.
Searches	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Database of Abstracts of Reviews of Effects (DARE) • Embase • Emcare • International Health Technology Assessment (IHTA) database • MEDLINE & MEDLINE In-Process • PsycINFO Searches will be restricted by: • English language studies • Human studies • Date: 2000 onwards as the current service context is different from pre-2000 Other searches: • Inclusion lists of systematic reviews

Field	Content
	The full search strategies will be published in the final review.
Condition or domain being studied	All people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability. 'Self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act. This does not include repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability.
Population	Inclusion: All people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability. Exclusion: People displaying repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability
Intervention	Any approach to obtain consent, ensure confidentiality and/or promote safeguarding, either singly or in combination, when people have self-harmed
Comparator/Reference standard/Confounding factors	Any other approach
Types of study to be included	Systematic review of randomised controlled trials (RCTs) or non-randomised comparative prospective and retrospective cohort studies RCTs Non-randomised comparative prospective cohort studies with N≥50 per treatment arm Non-randomised comparative retrospective cohort studies with N≥50 per treatment arm Conference abstracts will not be included. Non-randomised studies should adjust for the following covariates in their analysis when there are differences between groups at baseline: age, gender, previous self-harm, comorbidities (e.g. alcohol and drug misuse, psychiatric illness, physical illness), and current psychiatric treatment. Studies will be downgraded for risk of bias if important covariates are not adequately adjusted for, but will not be excluded for this reason.
Other exclusion criteria	Studies will not be included for the following reasons: Language: Non-English Publication status: Abstract only Studies published in languages other than English will not be considered due to time and resource constraints with translation.
Context	Settings:

Field	Content
	Inclusion: Primary, secondary and tertiary healthcare settings (including pre-hospital care, accident and emergency departments, community pharmacies, inpatient care, and transitions between departments and services) Home, residential and community settings, such as supported accommodation Supported care settings Education and childcare settings Criminal justice system Immigration removal centres.
Primary outcomes (critical outcomes)	Critical: Self-harm repetition (for example, self-poisoning or self-cutting) Suicide Service user satisfaction
Secondary outcomes (important outcomes)	Important: Quality of life Safeguarding incidents (patient or dependent) Serious incidents Breaches of confidentiality
Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into EPPI and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. Dual sifting will be performed on 10% of records; 90% agreement is required. Disagreements will be resolved via discussion between the two reviewers, and consultation with senior staff if necessary. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. The following data will be extracted: study details (reference, country where study was carried out, type and dates), participant characteristics, inclusion and exclusion criteria, details of the interventions, setting and follow-up, relevant outcome data, risk of bias and source of funding. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer.
Risk of bias (quality) assessment	Quality assessment of individual studies will be performed using the following checklists: ROBIS tool for systematic reviews Cochrane RoB tool v.2 for RCTs and quasi-RCTs Cochrane ROBINS-I tool for non-randomised (clinical) controlled trials and cohort studies The quality assessment will be performed by one reviewer and this will be quality assessed by a senior reviewer.

Field	Content
Strategy for data synthesis	Quantitative findings will be formally summarised in the review. Where multiple studies report on the same outcome for the same comparison, meta-analyses will be conducted using Cochrane Review Manager software. A fixed effect meta-analysis will be conducted and data will be presented as risk ratios if possible or odds ratios when required (for example if only available in this form in included studies) for dichotomous outcomes, and mean differences or standardised mean differences for continuous outcomes. Heterogeneity in the effect estimates of the individual studies will be assessed using the I2 statistic. I2 values of greater than 50% and 80% will be considered as significant and very significant heterogeneity, respectively. Heterogeneity will be explored as appropriate using sensitivity analyses and subgroup analyses based on identified covariates if they have not been adjusted for. If heterogeneity cannot be explained through subgroup analysis then a random effects model will be used for meta-analysis, or the data will not be pooled if the random effects model does not adequately address heterogeneity. The confidence in the findings across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group: http://www.gradeworkinggroup.org/
Analysis of sub-groups	Evidence (if data allows) will be stratified by: Age group: ≥65 years, 18-64 years, 16-17 years, <16
Type and method of review	Intervention
Language	English
Country	England
Anticipated or actual start date	01/02/2021
Anticipated completion date	26/01/2022
Stage of review at time of this submission	Review stage / Started / Completed Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐

Field	Content
	Risk of bias (quality) assessment ☐ ☐ Data analysis ☐ ☐
Named contact	5a. Named contact: National Guideline Alliance 5b Named contact e-mail: selfharm@nice.org.uk 5e Organisational affiliation of the review: National Institute for Health and Care Excellence (NICE) and National Guideline Alliance
Review team members	National Guideline Alliance
Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10148.
Other registration details	None
URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=230660
Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: notifying registered stakeholders of publication publicising the guideline through NICE's newsletter and alerts issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.
Keywords	Self-harm, assessment, management, health care

Field	Content
Details of existing review of same topic by same authors	None
Current review status	Ongoing
Additional information	Not applicable
Details of final publication	www.nice.org.uk

CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of Abstracts of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; MID: minimally important difference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk of bias; SD: standard deviation

Appendix B Literature search strategies

Literature search strategies for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

Clinical

Database(s): Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily – OVID interface

Date of last search: 1st February 2021

#	searches
1	self mutilation/ or self-injurious behavior/ or suicidal ideation/ or suicide, attempted/ or suicide, completed/ or suicide/
2	(auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*).ti,ab.
3	1 or 2
4	exp advance directives/lj or advance directives/ or bioethics/ or confidentiality/ or exp disclosure/ or ethics, professional/ or exp informed consent/ or mental competency/ or mental competency/lj or presumed consent/ or therapeutic misconception/
5	*coercion/ or restraint, physical/ or treatment refusal/es, lj
6	(((agree* or refus*) adj2 (procedur* or therap* or treatment*)) or (assess* adj2 capacity adj2 (decision* or mental)) or consent* or (informed adj2 (choice* or decision*))).ti,ab.
7	(confidential* or (privileged adj2 (information or communication*)) or (protect* adj2 (personal or sensitive) adj2 (data or information))).ti,ab.
8	(disclosure* or (duty adj2 (protect* or statutory or warn*))).ti,ab.
9	(((knowledge or legal or mental) adj2 capacity) or (((disclos* or share) adj information) or information sharing)).ti,ab.
10	(common assessment framework or ((ensur* or promot* or protect*) adj3 (welfare or wellbeing or well being)) or ((multiagen* or multi agen*) adj2 (approach* or involve* or plan*)) or (protect* adj2 vulnerable) or (protection adj (plan* or strateg*)) or safeguard* or safe guard*).ti,ab.
11	((ethic* or legal) adj2 (concern* or consideration* or decision* or issue*)).ti. or ((legal or legislative) adj3 protect*).ti,ab.
12	((advance adj (decision* or directive* or statement*)) or (antecedent adj (decision* or refus* or wish*)) or dnr or do*1 not*1 resuscitate or health?care power of attorney or

#	searches
	living will* or (mental adj (capacity or competenc* or health directive*)) or pre?emptive suicide or psychiatric will* or resuscitation order* or ulysses contract*).ti,ab.
13	(comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) adj2 (medication or procedur* or therap* or treatment*)) or safe ward* or safeward* or secluded or seclusion*).ti,ab,hw.
14	(adher* or against wish* or agree* or autonomy or capacity or care order* or clearance or competence or confidential* or consent* or ethic* or fidelit* or human rights or involuntary or jurisdiction or law or legal or legislation or legislative or mental health act).ti,ab,hw.
15	((fewer or improv* or less* or lower* or minim* or mitigate* or prevent* or protect* or reduc* or safe*) adj5 (challeng* or self* or suicid* or comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) adj2 (medication or procedur* or therap* or treatment*)) or safeward* or safe ward* or secluded or seclusion*)).ti,ab.
16	(es or lj).fs.
17	13 and (or/14-16)
18	((coercive or compulsory or force* or involuntary or manual* or mechanical or physical) adj2 (constrain* or contain* or restrain* or treatment*)).ti,ab.
19	physical intervention*.ti,ab.
20	((constrain* or restrain*) and (auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*)).ti.
21	((coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or restrain* or (physical adj (intervention* or restriction*)) or restrain* or restrictive) adj5 (intervention* or procedure* or program* or strateg* or treatment*)).ti,ab.
22	(coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive).ti,ab. and (pc.fs. use mesz or prevent*.sh.)
23	or/4-12,17-22
24	3 and 23
25	limit 24 to (english language and yr="2000 -current")

#	searches
26	letter/ or editorial/ or news/ or exp historical article/ or anecdotes as topic/ or comment/ or case report/ or (letter or comment*).ti. or (animals not humans).sh. or exp animals, laboratory/ or exp animal experimentation/ or exp models, animal/ or exp rodentia/ or (rat or rats or mouse or mice).ti.
27	25 not 26

Database(s): Embase and Emcare – OVID interface
Date of last search: 1st February 2021

#	searches
1	automutilation/ or exp suicidal behavior/
2	(auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*).ti,ab.
3	1 or 2
4	*ethics/ or exp confidentiality/ or informed consent/ or living will/ or *medical ethics/ or *mental capacity/ or professional ethics/ or therapeutic misconception/
5	*Coercion/ or (treatment refusal.sh. and (legal or right*).hw.) or physical restraint/
6	(((agree* or refus*) adj2 (procedur* or therap* or treatment*)) or (assess* adj2 capacity adj2 (decision* or mental)) or consent* or (informed adj2 (choice* or decision*))).ti,ab.
7	(confidential* or (privileged adj2 (information or communication*)) or (protect* adj2 (personal or sensitive) adj2 (data or information))).ti,ab.
8	(disclosure* or (duty adj2 (protect* or statutory or warn*))).ti,ab.
9	(((knowledge or legal or mental) adj2 capacity) or (((disclos* or share) adj information) or information sharing)).ti,ab.
10	(common assessment framework or ((ensur* or promot* or protect*) adj3 (welfare or wellbeing or well being)) or ((multiagen* or multi agen*) adj2 (approach* or involve* or plan*)) or (protect* adj2 vulnerable) or (protection adj (plan* or strateg*)) or safeguard* or safe guard*).ti,ab.
11	((ethic* or legal) adj2 (concern* or consideration* or decision* or issue*)).ti. or ((legal or legislative) adj3 protect*).ti,ab.
12	((advance adj (decision* or directive* or statement*)) or (antecedent adj (decision* or refus* or wish*)) or dnr or do*1 not*1 resuscitate or health?care power of attorney or living will* or (mental adj (capacity or competenc* or health directive*)) or pre?emptive suicide or psychiatric will* or resuscitation order* or ulysses contract*).ti,ab.

#	searches
13	(comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) adj2 (medication or procedur* or therap* or treatment*)) or safe ward* or safeward* or secluded or seclusion*).ti,ab,hw.
14	(adher* or against wish* or agree* or autonomy or capacity or care order* or clearance or competence or confidential* or consent* or ethic* or fidelit* or human rights or involuntary or jurisdiction or law or legal or legislation or legislative or mental health act).ti,ab,hw.
15	((fewer or improv* or less* or lower* or minim* or mitigate* or prevent* or protect* or reduc* or safe*) adj5 (challeng* or self* or suicid* or comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) adj2 (medication or procedur* or therap* or treatment*)) or safeward* or safe ward* or secluded or seclusion*)).ti,ab.
16	*ethics/ or *jurisprudence/ or *medical ethics/ or professional ethics/
17	13 and (or/14-16)
18	((coercive or compulsory or force* or involuntary or manual* or mechanical or physical) adj2 (constrain* or contain* or restrain* or treatment*)).ti,ab.
19	physical intervention*.ti,ab.
20	((constrain* or restrain*) and (auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*)).ti.
21	((coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or restrain* or (physical adj (intervention* or restriction*)) or restrain* or restrictive) adj5 (intervention* or procedure* or program* or strateg* or treatment*)).ti,ab.
22	(coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive).ti,ab. and prevent*.sh.
23	or/4-12,17-22
24	3 and 23
25	limit 24 to (english language and yr="2000 -current")
26	(animal/ not human/) or exp Animal Experiment/ or animal model/ or exp Experimental Animal/ or nonhuman/ or exp Rodent/ or (rat or rats or mouse or mice).ti.

#	searches
27	25 not 26

Database(s): PsyINFO – OVID interface
Date of last search: 1st February 2021

#	searches
1	self-injurious behavior/ or self-destructive behavior/ or self-inflicted wounds/ or self-mutilation/ or self-poisoning/ or exp suicide/ or suicidal ideation/
2	(auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*).ti,ab.
3	1 or 2
4	* advance directives/j or bioethics/ or privileged communication/ or professional ethics/ or informed consent/ or (competence and mental health).sh.
5	*coercion/ or physical restraing/ or (treatment refusal/ and legal*.hw.)
6	(((agree* or refus*) adj2 (procedur* or therap* or treatment*)) or (assess* adj2 capacity adj2 (decision* or mental)) or consent* or (informed adj2 (choice* or decision*))).ti,ab.
7	(confidential* or (privileged adj2 (information or communication*)) or (protect* adj2 (personal or sensitive) adj2 (data or information))).ti,ab.
8	(disclosure* or (duty adj2 (protect* or statutory or warn*))).ti,ab.
9	(((knowledge or legal or mental) adj2 capacity) or (((disclos* or share) adj information) or information sharing)).ti,ab.
10	(common assessment framework or ((ensur* or promot* or protect*) adj3 (welfare or wellbeing or well being)) or ((multiagen* or multi agen*) adj2 (approach* or involve* or plan*)) or (protect* adj2 vulnerable) or (protection adj (plan* or strateg*)) or safeguard* or safe guard*).ti,ab.
11	((ethic* or legal) adj2 (concern* or consideration* or decision* or issue*)).ti. or ((legal or legislative) adj3 protect*).ti,ab.
12	((advance adj (decision* or directive* or statement*)) or (antecedent adj (decision* or refus* or wish*)) or dnr or do*1 not*1 resuscitate or health?care power of attorney or living will* or (mental adj (capacity or competenc* or health directive*)) or pre?emptive suicide or psychiatric will* or resuscitation order* or ulysses contract*).ti,ab.
13	(comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or

#	searches
	refus*) adj2 (medication or procedur* or therap* or treatment*)) or safe ward* or safeward* or secluded or seclusion*).ti,ab,hw.
14	(adher* or against wish* or agree* or autonomy or capacity or care order* or clearance or competence or confidential* or consent* or ethic* or fidelit* or human rights or involuntary or jurisdiction or law or legal or legislation or legislative or mental health act).ti,ab,hw.
15	((fewer or improv* or less* or lower* or minim* or mitigate* or prevent* or protect* or reduc* or safe*) adj5 (challeng* or self* or suicid* or comfort room* or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) adj2 (medication or procedur* or therap* or treatment*)) or safeward* or safe ward* or secluded or seclusion*)).ti,ab.
16	*Ethics/ or *"law (government)"/ or *Professional Ethics/
17	13 and (or/14-16)
18	((coercive or compulsory or force* or involuntary or manual* or mechanical or physical) adj2 (constrain* or contain* or restrain* or treatment*)).ti,ab.
19	physical intervention*.ti,ab.
20	((constrain* or restrain*) and (auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*)).ti.
21	((coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or restrain* or (physical adj (intervention* or restriction*)) or restrain* or restrictive) adj5 (intervention* or procedure* or program* or strateg* or treatment*)).ti,ab.
22	(coercive or compulsory or constrain* or containment or ((hold* or tie or tying) adj2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical adj (intervention* or restriction*)) or restrain* or restrictive).ti,ab. and prevention*.hw.
23	or/4-12,17-22
24	3 and 23
25	limit 24 to (english language and yr="2000 -current")

Database(s): Cochrane Library - Wiley interface
Cochrane Database of Systematic Reviews, Issue 2 of 12, February 2021; Cochrane Central Register of Controlled Trials, Issue 2 of 12, February 2021
Date of last search: 1st February 2021

#	searches
1	MeSH descriptor: [poisoning] this term only
2	MeSH descriptor: [self-injurious behavior] explode all trees
3	MeSH descriptor: [self mutilation] this term only
4	MeSH descriptor: [suicide] this term only
5	MeSH descriptor: [suicidal ideation] this term only
6	MeSH descriptor: [suicide, attempted] this term only
7	MeSH descriptor: [suicide, completed] this term only
8	(automutilat* or "auto mutilat*" or cutt* or (self near/2 cut*) or selfdestruct* or "self destruct*" or selfharm* or "self harm*" or selfimmolat* or "self immolat*" or selfinflict* or "self inflict*" or selfinjur* or "self injur*" or selfmutilat* or "self mutilat*" or selfpoison* or "self poison*" or selfwound* or "self wound*" or suicid*):ti,ab.
9	{or #1-#8}
10	MeSH descriptor: [advance directives] explode all trees and with qualifier(s): [legislation & jurisprudence - LJ]
11	MeSH descriptor: [advance directives] this term only
12	MeSH descriptor: [bioethics] this term only
13	MeSH descriptor: [confidentiality] this term only
14	MeSH descriptor: [disclosure] explode all trees
15	MeSH descriptor: [ethics, professional] this term only
16	MeSH descriptor: [informed consent] explode all trees
17	MeSH descriptor: [mental competency] this term only
18	MeSH descriptor: [mental competency lj] this term only and with qualifier(s): [legislation & jurisprudence - LJ]
19	MeSH descriptor: [presumed consent] this term only
20	MeSH descriptor: [therapeutic misconception] this term only
21	MeSH descriptor: [coercion] this term only
22	MeSH descriptor: [restraint, physical] this term only
23	MeSH descriptor: [treatment refusal] this term only and with qualifier(s) : [ethics - ES, legislation & jurisprudence - LJ]
24	(((agree* or refus*) near/2 (procedur* or therap* or treatment*)) or (assess* near/2 capacity near/2 (decision* or mental)) or consent* or (informed near/2 (choice* or decision*))):ti,ab.

#	searches
25	(confidential* or (privileged near/2 (information or communication*)) or (protect* near/2 (personal or sensitive) near/2 (data or information))):ti,ab.
26	(disclosure* or (duty near/2 (protect* or statutory or warn*))):ti,ab.
27	(((knowledge or legal or mental) near/2 capacity) or (((disclos* or share) next information) or “information sharing”)):ti,ab.
28	(“common assessment framework” or ((ensur* or promot* or protect*) near/3 (welfare or wellbeing or “well being”)) or ((multiagen* or multi agen*) near/2 (approach* or involve* or plan*)) or (protect* near/2 vulnerable) or (protection next (plan* or strateg*)) or safeguard* or “safe guard*”):ti,ab.
29	((ethic* or legal) near/2 (concern* or consideration* or decision* or issue*)):ti. or ((legal or legislative) near/3 protect*):ti,ab.
30	((advance next (decision* or directive* or statement*)) or (antecedent next (decision* or refus* or wish*)) or dnr or “do* not*” resuscitate or health?care or “power of attorney” or “living will*” or (mental next (capacity or competenc* or “health directive*”)) or “pre?emptive suicide” or “psychiatric will*” or “resuscitation order*” or “ulysses contract*”):ti,ab.
31	(“comfort room*” or compulsory or constrain* or containment or ((hold* or tie or tying) near/2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical next (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) near/2 (medication or procedur* or therap* or treatment*)) or “safe ward*” or safeward* or secluded or seclusion*).ti,ab,hw.
32	(adher* or “against wish*” or agree* or autonomy or capacity or “care order*” or clearance or competence or confidential* or consent* or ethic* or fidelit* or human rights or involuntary or jurisdiction or law or legal or legislation or legislative or “mental health act”).ti,ab,hw.
33	((fewer or improv* or less* or lower* or minim* or mitigate* or prevent* or protect* or reduc* or safe*) near/5 (challeng* or self* or suicid* or “comfort room*” or compulsory or constrain* or containment or ((hold* or tie or tying) near/2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical next (intervention* or restriction*)) or restrain* or restrictive or ((agree* or refus*) near/2 (medication or procedur* or therap* or treatment*)) or safeward* or “safe ward*” or secluded or seclusion*)):ti,ab.
34	(legislation or jurisprudence or legal):kw.
35	{OR #31-33}
36	#34 and #35
37	((coercive or compulsory or force* or involuntary or manual* or mechanical or physical) near/2 (constrain* or contain* or restrain* or treatment*)):ti,ab.
38	“physical intervention*”:ti,ab.

#	searches
39	((constrain* or restrain*) and (“auto mutilat*” or automutilat* or “self cut*” or selfcut* or “self destruct*” or selfdestruct* or “self harm*” or selfharm* or “self immolat*” or selfimmolat* or “self inflict*” or selfinflict* or “self injur*” or selfinjur* or “self mutilat*” or selfmutilat* or “self poison*” or selfpoison* or suicid*)):ti.
40	((coercive or compulsory or constrain* or containment or ((hold* or tie or tying) near/2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or restrain* or (physical next (intervention* or restriction*)) or restrain* or restrictive) near/5 (intervention* or procedure* or program* or strateg* or treatment*)):ti,ab.
41	(coercive or compulsory or constrain* or containment or ((hold* or tie or tying) near/2 (arm* or down or wrist*)) or force or forced or locked* or mechanical or (physical next (intervention* or restriction*)) or restrain* or restrictive):ti,ab. and (prevent*:kw.)
42	{#10-30,#36-#41}
43	(#9 and #42) with Cochrane Library publication date Between Jan 2000 and Feb 2021

Economic

A global, population based search was undertaken to find for economic evidence covering all parts of the guideline.

Database(s): MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily – OVID interface
Date of last search: 12th August 2021

#	Searches
1	poisoning/ or exp self-injurious behavior/ or self mutilation/ or suicide/ or suicidal ideation/ or suicide, attempted/ or suicide, completed/
2	(automutilat* or auto mutilat* or cutt* or (self adj2 cut*) or selfdestruct* or self destruct* or selfharm* or self harm* or selfimmolat* or self immolat* or selfinflict* or self inflict* or selfinjur* or self injur* or selfmutilat* or self mutilat* or selfpoison* or self poison* or selfwound* or self wound* or suicid*).ti,ab.
3	or/1-2
4	Economics/
5	Value of life/
6	exp "Costs and Cost Analysis"/
7	exp Economics, Hospital/
8	exp Economics, Medical/
9	Economics, Nursing/
10	Economics, Pharmaceutical/
11	exp "Fees and Charges"/
12	exp Budgets/
13	budget*.ti,ab.
14	cost*.ti.
15	(economic* or pharmaco?economic*).ti.

#	Searches
16	(price* or pricing*).ti,ab.
17	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
18	(financ* or fee or fees).ti,ab.
19	(value adj2 (money or monetary)).ti,ab.
20	Quality-Adjusted Life Years/
21	Or/4-20
22	3 and 21
23	limit 22 to yr="2000 -current"

Database(s): Embase and Emcare – OVID interface
Date of last search: 12th August 2021

#	searches
1	automutilation/ or exp suicidal behavior/
2	(auto mutilat* or automutilat* or self cut* or selfcut* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or self mutilat* or selfmutilat* or self poison* or selfpoison* or suicid*).ti,ab.
3	or/1-2
4	health economics/
5	exp economic evaluation/
6	exp health care cost/
7	exp fee/
8	budget/
9	funding/
10	budget*.ti,ab.
11	cost*.ti.
12	(economic* or pharmaco?economic*).ti.
13	(price* or pricing*).ti,ab.
14	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
15	(financ* or fee or fees).ti,ab.
16	(value adj2 (money or monetary)).ti,ab.
17	Quality-Adjusted Life Year/

#	searches
18	Or/4-17
19	3 and 18
20	limit 19 to yr="2000 -current"

Database(s): Cochrane Library - Wiley interface
Cochrane Central Register of Controlled Trials, Issue 8 of 12, August 2021
Date of last search: 12th August 2021

#	Searches
1	MeSH descriptor: [poisoning] this term only
2	MeSH descriptor: [self-injurious behavior] explode all trees
3	MeSH descriptor: [self mutilation] this term only
4	MeSH descriptor: [suicide] this term only
5	MeSH descriptor: [suicidal ideation] this term only
6	MeSH descriptor: [suicide, attempted] this term only
7	MeSH descriptor: [suicide, completed] this term only
8	(automutilat* or “auto mutilat*” or cutt* or (self near/2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*):ti,ab.
9	{or #1-#8}
10	MeSH descriptor: [Economics] this term only
11	MeSH descriptor: [Value of life] this term only
12	MeSH descriptor: [Costs and Cost Analysis] explode all trees
13	MeSH descriptor: [Economics, Hospital] explode all trees
14	MeSH descriptor: [Economics, Medical] explode all trees
15	MeSH descriptor: [Economics, Nursing] this term only
16	MeSH descriptor: [Economics, Pharmaceutical] this term only
17	MeSH descriptor: [Fees and Charges"]
18	MeSH descriptor: [Budgets] this term only
19	budget*:ti,ab.
20	cost*.ti.
21	(economic* or pharmaco?economic*):ti.
22	(price* or pricing*):ti,ab.
23	(cost* near/2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)):ab.
24	(financ* or fee or fees):ti,ab.
25	(value near/2 (money or monetary)):ti,ab.
26	MeSH descriptor: [Quality-Adjusted Life Years] this term only
27	{OR #10-#26}
28	(#9 and #27) with Cochrane Library publication date Between Jan 2000 and Aug 2021

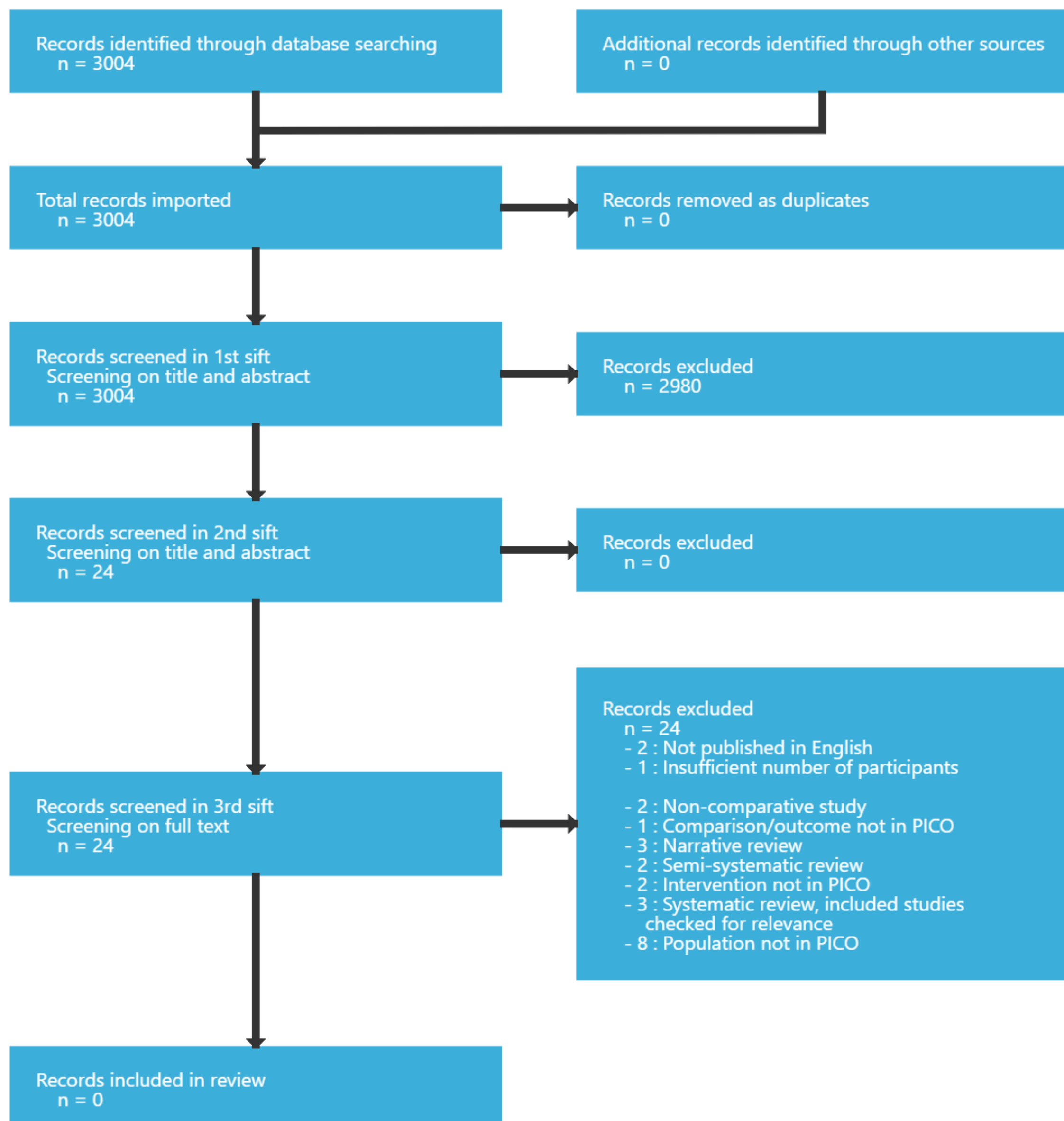
Database(s): NHS EED and HTA – CRD interface
Date of last search: 12th August 2021

#	Searches
1	MeSH descriptor: poisoning IN NHSEED, HTA
2	MeSH descriptor: self-injurious behavior EXPLODE ALL TREES IN NHSEED, HTA
3	MeSH descriptor: self mutilation IN NHSEED, HTA
4	MeSH descriptor: suicide IN NHSEED, HTA
5	MeSH descriptor: suicidal ideation IN NHSEED, HTA
6	MeSH descriptor: suicide, attempted IN NHSEED, HTA
7	MeSH descriptor: suicide, completed IN NHSEED, HTA
8	(automutilat* or “auto mutilat*” or cutt* or (self near2 cut*) or selfdestruct* or “self destruct*” or selfharm* or “self harm*” or selfimmolat* or “self immolat*” or selfinflict* or “self inflict*” or selfinjur* or “self injur*” or selfmutilat* or “self mutilat*” or selfpoison* or “self poison*” or selfwound* or “self wound*” or suicid*) IN NHSEED, HTA
9	(#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8) from 2000 to 2021

Appendix C Effectiveness evidence study selection

Study selection for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

Figure 1: Study selection flow chart



Appendix D Evidence tables

Evidence tables for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

No evidence was identified which was applicable to this review question.

Appendix E Forest plots

Forest plots for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F Modified GRADE tables

Modified GRADE tables for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

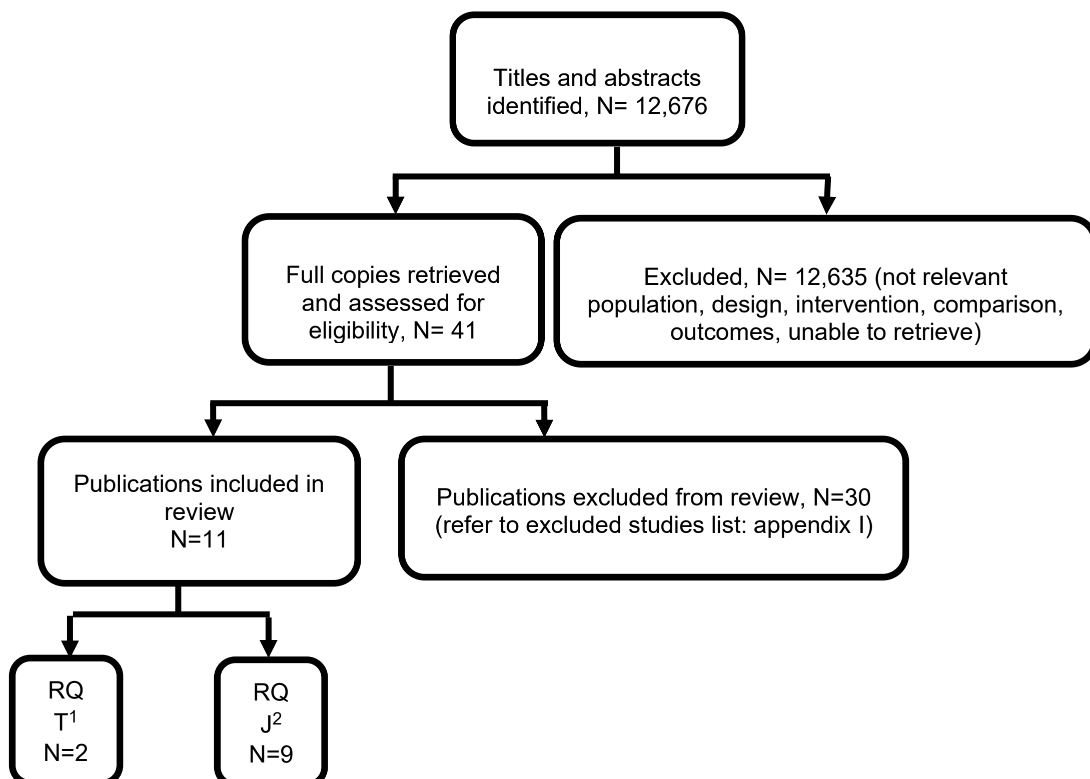
No evidence was identified which was applicable to this review question.

Appendix G Economic evidence study selection

Study selection for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

A global health economics search was undertaken for all areas covered in the guideline. Figure 2 shows the flow diagram of the selection process for economic evaluations of interventions and strategies associated with the care of people who have self-harmed.

Figure 2: Flow diagram of economic article selection for global health economic search



Abbreviations: RQ: Research question
Notes:
1 What are the most effective models of care for people who have self-harmed?
2 What psychological and psychosocial interventions (including safety plans and electronic health-based interventions) are effective for people who have self-harmed?

Appendix H Economic evidence tables

Economic evidence tables for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

No evidence was identified which was applicable to this review question.

Appendix I Economic model

Economic model for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

Excluded effectiveness studies

Table 3: Excluded studies and reasons for their exclusion

Study	Code [Reason]
Bowers, L., Alexander, J., Bilgin, H. et al. (2014) Safewards: The empirical basis of the model and a critical appraisal. Journal of Psychiatric and Mental Health Nursing 21: 354-364	- Narrative review
De Hert, M., Dirix, N., Demunter, H. et al. (2011) Prevalence and correlates of seclusion and restraint use in children and adolescents: A systematic review. European Child and Adolescent Psychiatry 20: 221-230	- Systematic review, included studies checked for relevance
Hochstrasser, L., Frohlich, D., Schneeberger, A. R. et al. (2018) Long-term reduction of seclusion and forced medication on a hospital-wide level: Implementation of an open-door policy over 6 years. European psychiatry : the journal of the Association of European Psychiatrists 48: 51-57	- Population not in PICO Mixed population, unclear how many of the population had self-harmed
Kapur, Nav, Ibrahim, Saied, While, David et al. (2016) Mental health service changes, organisational factors, and patient suicide in England in 1997-2012: a before-and-after study. The lancet. Psychiatry 3: 526-34	- Intervention not in PICO Service level changes to mental health services, for example, implementation of the NICE self-harm guidelines vs not
Kelly, B. D. (2017) Confidentiality and privacy in the setting of involuntary mental health care: What standards should apply?. Ethics, Medicine and Public Health	- Narrative review
Lefevre-Utile, J., Guinchat, V., Wachtel, L. E. et al. (2018) Personal protective equipment and restraints alternatives in the management of challenging behaviors in inpatients with autism and intellectual disability (Part 1: Patients' perspectives). Neuropsychiatrie de l'Enfance et de l'Adolescence 66: 443-459	- Not published in English
Lefevre-Utile, J., Guinchat, V., Wachtel, L. E. et al. (2018) Personal protective equipment and restraints alternatives in the management of challenging behaviors in inpatients with autism and intellectual disability (Part 2: Caregivers' perspectives). Neuropsychiatrie de l'Enfance et de l'Adolescence 66: 460-467	- Not published in English
Lowe, Susan (2009) Safeguarding patients. Emergency nurse : the journal of the RCN Accident and Emergency Nursing Association 16: 8-9	- Narrative review
Maguire, Tessa, Ryan, Jo, Fullam, Rachael et al. (2018) Evaluating the introduction of the Safewards model to a medium- to long-term	- Insufficient number of participants Not RCT and only 28 patients during study period; forensic mental health population with

Study	Code [Reason]
forensic mental health ward. Journal of Forensic Nursing 14: 214-222	schizophrenia or schizoaffective disorder, and it seems only a total of 6 self-harm events
McCue, Robert E., Urcuyo, Leonel, Lilu, Yehezkel et al. (2004) Reducing Restraint Use in a Public Psychiatric Inpatient Service. The Journal of Behavioral Health Services & Research 31: 217-224	- Population not in PICO Unclear whether any of the population had self-harmed; outside study dates (April 1996-March 1999 n = 6517; April 1999-March 2001: n=4236)
Pollard, Richard, Yanasak, Elisia V., Rogers, Steven A. et al. (2007) Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. The Psychiatric quarterly 78: 73-81	- Population not in PICO Unclear population, including whether any of the population had self-harmed
Powers, K. V.; Roane, H. S.; Kelley, M. E. (2007) Treatment of self-restraint associated with the application of protective equipment. Journal of Applied Behavior Analysis 40: 577-581	- Non-comparative study Case-study examining one participant
Rooker, Griffin W. and Roscoe, Eileen M. (2005) Functional analysis of self-injurious behavior and its relation to self-restraint. Journal of Applied Behavior Analysis 38: 537-542	- Non-comparative study Case-study examining one participant
Samples, T. C., Woods, A., Davis, T. A. et al. (2014) Race of Interviewer Effect on Disclosures of Suicidal Low-Income African American Women. Journal of Black Psychology 40: 27-46	- Comparison/outcome not in PICO Study compared disclosure of suicide risk factors by African-American women who were either interviewed by African-American or European-American interviewer
Silvana, S., Laura, F., Di Fabio, U. et al. (2012) Ergonomics in the psychiatric ward towards workers or patients?. Work (Reading, Mass.) 41suppl1: 1832-1835	- Population not in PICO Study population is nurses.
Simone, A. C. and Hamza, C. A. (2020) Examining the disclosure of nonsuicidal self-injury to informal and formal sources: A review of the literature. Clinical Psychology Review 82: 101907	- Semi-systematic review Study focus was disclosure of non-suicidal self-harm, not approaches to consent, confidentiality and safe-guarding
Sivak, Kim (2012) Implementation of comfort rooms to reduce seclusion, restraint use, and acting-out behaviors. Journal of Psychosocial Nursing and Mental Health Services 50: 24-34	- Population not in PICO Mixed population, unclear how many of the population had self-harmed
Strand, M. and Von Hausswolff-Juhlin, Y. (2015) Patient-controlled hospital admission in psychiatry: A systematic review. Nordic Journal of Psychiatry 69: 574-586	- Systematic review, included studies checked for relevance
Sullivan, Ann M., Bezmen, Janet, Barron, Charles T. et al. (2005) Reducing Restraints: Alternatives to Restraints on an Inpatient Psychiatric Service--Utilizing Safe and Effective Methods to Evaluate and Treat the Violent Patient. Psychiatric Quarterly 76: 51-65	- Population not in PICO Mixed population, unclear how many of the population had self-harmed
Thomsen, C. T., Benros, M. E., Maltesen, T. et al. (2018) Patient-controlled hospital admission for patients with severe mental disorders: a nationwide prospective multicentre study. Acta psychiatrica Scandinavica 137: 355-363	- Population not in PICO Mixed population; <13% in each treatment group were patients who had self-harmed

Study	Code [Reason]
Timlin, Ulla, Hakko, Helina, Riala, Kaisa et al. (2015) Adherence of 13-17 Year Old Adolescents to Medicinal and Non-pharmacological Treatment in Psychiatric Inpatient Care: Special Focus on Relative Clinical and Family Factors. Child psychiatry and human development 46: 725-35	- Population not in PICO Mixed population: 25 of 72 patients had self-harmed and 38 of 72 patients had attempted suicide; comparison not in PICO/non-comparative study suicide (multivariate analyses about predictors of adherence to treatment)
Tolland, H., McKee, T., Cosgrove, S. et al. (2019) A systematic review of effective therapeutic interventions and management strategies for challenging behaviour in women in forensic mental health settings. Journal of Forensic Psychiatry and Psychology 30: 570-593	- Systematic review, included studies checked for relevance
Weeden, Marc; Mahoney, Amanda; Poling, Alan (2010) Self-injurious behavior and functional analysis: where are the descriptions of participant protections?. Research in developmental disabilities 31: 299-303	- Semi-systematic review Intervention not in PICO (functional analysis)
While, David, Bickley, Harriet, Roscoe, Alison et al. (2012) Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. Lancet (London, England) 379: 1005-12	- Intervention not in PICO Service level changes to mental health services, for example, a 24-hour crisis team vs not; intervention not related to consent, confidentiality or safeguarding

Excluded economic studies

Table 4: Excluded studies from the guideline economic review

Study	Reason for Exclusion
Adrian, M., Lyon, A. R., Nicodimos, S., Pullmann, M. D., McCauley, E., Enhanced "Train and Hope" for Scalable, Cost-Effective Professional Development in Youth Suicide Prevention, Crisis, 39, 235-246, 2018	Not relevant to any of the review questions in the guideline - this study examined the impact of an educational training ongoing intervention, and the effect of the post-training reminder system, on mental health practitioners' knowledge, attitudes, and behaviour surrounding suicide assessment and intervention. As well, this study was not a full health economic evaluation
Borschmann R, Barrett B, Hellier JM, et al. Joint crisis plans for people with borderline personality disorder: feasibility and outcomes in a randomised controlled trial. Br J Psychiatry. 2013;202(5):357-364.	Not relevant to any of the review questions in the guideline - this study examined the feasibility of recruiting and retaining adults with borderline personality disorder to a pilot randomised controlled trial investigating the potential efficacy and cost-effectiveness of using a joint crisis plan
Bustamante Madsen, L., Eddleston, M., Schultz Hansen, K., Konradsen, F., Quality Assessment of Economic Evaluations of Suicide and Self-Harm Interventions, Crisis, 39, 82-95, 2018	Study design - this review of health economics studies has been excluded for this guideline, but its references have been hand-searched for any relevant health economic study
Byford, S., Barrett, B., Aglan, A., Harrington, V., Burroughs, H., Kerfoot, M., Harrington, R. C., Lifetime and current costs of supporting young adults who deliberately poisoned themselves in childhood and adolescence, Journal of Mental Health, 18, 297-306, 2009	Study design – no comparative cost analysis
Byford, S., Leese, M., Knapp, M., Seivewright, H., Cameron, S., Jones, V., Davidson, K., Tyrer,	Study design – no comparative cost analysis

Study	Reason for Exclusion
P., Comparison of alternative methods of collection of service use data for the economic evaluation health care interventions, Health Economics, 16, 531-536, 2007	
Byford, Sarah, Barber, Julie A., Harrington, Richard, Barber, Baruch Beautrais Blough Brent Brodie Byford Carlson Chernoff Collett Fergusson Garland Goldberg Harman Harrington Hawton Huber Kazdin Kerfoot Knapp Lindsey McCullagh Miller Netten Reynolds Sadowski Shaffer Simms Wu, Factors that influence the cost of deliberate self-poisoning in children and adolescents, Journal of Mental Health Policy and Economics, 4, 113-121, 2001	Study design – no comparative cost analysis
Denchev, P., Pearson, J. L., Allen, M. H., Claassen, C. A., Currier, G. W., Zatzick, D. F., Schoenbaum, M., Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients, Psychiatric Services, 69, 23-31, 2018	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of outpatient interventions (Postcards, Telephone outreach, Cognitive Behaviour Therapy) to reduce suicide risk among patients presenting to general hospital emergency departments
Dunlap, L. J., Orme, S., Zarkin, G. A., Arias, S. A., Miller, I. W., Camargo, C. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., Manton, A. P., Clark, R., Boudreaux, E. D., Screening and Intervention for Suicide Prevention: A Cost-Effectiveness Analysis of the ED-SAFE Interventions, Psychiatric services (Washington, D.C.), appips201800445, 2019	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of suicide screening followed by an intervention to identify suicidal individuals and prevent recurring self-harm
Fernando, S. M., Reardon, P. M., Ball, I. M., van Katwyk, S., Thavorn, K., Tanuseputro, P., Rosenberg, E., Kyeremanteng, K., Outcomes and Costs of Patients Admitted to the Intensive Care Unit Due to Accidental or Intentional Poisoning, Journal of Intensive Care Medicine, 35, 386-393, 2020	Study design – no comparative cost analysis
Flood, C., Bowers, L., Parkin, D., Estimating the costs of conflict and containment on adult acute inpatient psychiatric wards, Nursing economic$, 26, 325-330, 324, 2008	Study design – no comparative cost analysis
Fortune, Z., Barrett, B., Armstrong, D., Coid, J., Crawford, M., Mudd, D., Rose, D., Slade, M., Spence, R., Tyrer, P., Moran, P., Clinical and economic outcomes from the UK pilot psychiatric services for personality-disordered offenders, International Review of Psychiatry, 23, 61-9, 2011	Not relevant to any of the review questions in the guideline
George, S., Javed, M., Hemington-Gorse, S., Wilson-Jones, N., Epidemiology and financial implications of self-inflicted burns, Burns, 42, 196-201, 2016	Study design – no comparative cost analysis
Gunnell, D., Shepherd, M., Evans, M., Are recent increases in deliberate self-harm associated with changes in socio-economic conditions? An ecological analysis of patterns of deliberate self-harm in Bristol 1972-3 and 1995-6, Psychological medicine, 30, 1197-1203, 2000	Study design - cost-of-illness study

Study	Reason for Exclusion
Kapur, N., House, A., Dodgson, K., Chris, M., Marshall, S., Tomenson, B., Creed, F., Management and costs of deliberate self-poisoning in the general hospital: A multi-centre study, Journal of Mental Health, 11, 223-230, 2002	Study design – no comparative cost analysis
Kapur, N., House, A., May, C., Creed, F., Service provision and outcome for deliberate self-poisoning in adults - Results from a six centre descriptive study, Social Psychiatry and Psychiatric Epidemiology, 38, 390-395, 2003	Study design – no comparative cost analysis
Kinchin, I., Russell, A. M. T., Byrnes, J., McCalman, J., Doran, C. M., Hunter, E., The cost of hospitalisation for youth self-harm: differences across age groups, sex, Indigenous and non-Indigenous populations, Social Psychiatry and Psychiatric Epidemiology, 55, 425-434, 2020	Study design – no comparative cost analysis
O'Leary, F. M., Lo, M. C. I., Schreuder, F. B., "Cuts are costly": A review of deliberate self-harm admissions to a district general hospital plastic surgery department over a 12-month period, Journal of Plastic, Reconstructive and Aesthetic Surgery, 67, e109-e110, 2014	Study design – no comparative cost analysis
Olfson, M., Gameroff, M. J., Marcus, S. C., Greenberg, T., Shaffer, D., National trends in hospitalization of youth with intentional self-inflicted injuries, American Journal of Psychiatry, 162, 1328-1335, 2005	Study design – no comparative cost analysis
Ostertag, L., Golay, P., Dorogi, Y., Brovelli, S., Cromec, I., Edan, A., Barbe, R., Saillant, S., Michaud, L., Self-harm in French-speaking Switzerland: A socio-economic analysis (7316), Swiss Archives of Neurology, Psychiatry and Psychotherapy, 70 (Supplement 8), 48S, 2019	Conference abstract
Ougrin, D., Corrigall, R., Poole, J., Zundel, T., Sarhane, M., Slater, V., Stahl, D., Reavey, P., Byford, S., Heslin, M., Ivens, J., Crommelin, M., Abdulla, Z., Hayes, D., Middleton, K., Nnadi, B., Taylor, E., Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: a randomised controlled trial, The Lancet Psychiatry, 5, 477-485, 2018	Not self-harm. In addition, the interventions evaluated in this economic analysis (a supported discharge service provided by an intensive community treatment team compared to usual care) were not relevant to any review questions
Palmer, S., Davidson, K., Tyrer, P., Gumley, A., Tata, P., Norrie, J., Murray, H., Seivewright, H., The cost-effectiveness of cognitive behavior therapy for borderline personality disorder: results from the BOSCOT trial, Journal of Personality Disorders, 20, 466-481, 2006	Not self-harm
Quinlivan L, Steeg S, Elvidge J, et al. Risk assessment scales to predict risk of hospital treated repeat self-harm: A cost-effectiveness modelling analysis. J Affect Disord. 2019;249:208-215.	Not relevant to any of the review questions in the guideline - this study estimated the cost-effectiveness of risk assessment scales versus clinical assessment for adults attending an emergency department following self-harm

Study	Reason for Exclusion
Richardson JS, Mark TL, McKeon R. The return on investment of postdischarge follow-up calls for suicidal ideation or deliberate self-harm. Psychiatr Serv. 2014;65(8):1012-1019.	Not enough data reporting on cost-effectiveness findings
Smits, M. L., Feenstra, D. J., Eeren, H. V., Bales, D. L., Laurenssen, E. M. P., Blankers, M., Soons, M. B. J., Dekker, J. J. M., Lucas, Z., Verheul, R., Luyten, P., Day hospital versus intensive out-patient mentalisation-based treatment for borderline personality disorder: Multicentre randomised clinical trial, British Journal of Psychiatry, 216, 79-84, 2020	Not self-harm
Tsiachristas, A., Geulayov, G., Casey, D., Ness, J., Waters, K., Clements, C., Kapur, N., McDaid, D., Brand, F., Hawton, K., Incidence and general hospital costs of self-harm across England: estimates based on the multicentre study of self-harm, Epidemiology & Psychiatric Science, 29, e108, 2020	Study design – no comparative cost analysis
Tsiachristas, A., McDaid, D., Casey, D., Brand, F., Leal, J., Park, A. L., Geulayov, G., Hawton, K., General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis, The Lancet Psychiatry, 4, 759-767, 2017	Study design – no comparative cost analysis
Tubeuf, S., Saloniki, E. C., Cottrell, D., Parental Health Spillover in Cost-Effectiveness Analysis: Evidence from Self-Harming Adolescents in England, PharmacoEconomics, 37, 513-530, 2019	This study is not a separate study from one already included in the guideline for topic 5.2 (Cottrel 2018). This secondary analysis presents alternative parental health spillover quantification methods in the context of a randomised controlled trial comparing family therapy with treatment as usual as an intervention for self-harming adolescents of (Cottrel 2018), and discusses the practical limitations of those methods
Tyrer, P., Thompson, S., Schmidt, U., Jones, V., Knapp, M., Davidson, K., Catalan, J., Airlie, J., Baxter, S., Byford, S., Byrne, G., Cameron, S., Caplan, R., Cooper, S., Ferguson, B., Freeman, C., Frost, S., Godley, J., Greenshields, J., Henderson, J., Holden, N., Keech, P., Kim, L., Logan, K., Manley, C., MacLeod, A., Murphy, R., Patience, L., Ramsay, L., De Munroz, S., Scott, J., Seivewright, H., Sivakumar, K., Tata, P., Thornton, S., Ukoumunne, O. C., Wessely, S., Randomized controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: The POPMACT study, Psychological medicine, 33, 969-976, 2003	Study design - no economic evaluation
Van Roijen, L. H., Sinnaeve, R., Bouwmans, C., Van Den Bosch, L., Cost-effectiveness and Cost-utility of Shortterm Inpatient Dialectical Behavior Therapy for Chronically Parasuicidal BPD (Young) Adults, Journal of Mental Health Policy and Economics, 18, S19-S20, 2015	Conference abstract
van Spijker, B. A., Majo, M. C., Smit, F., van Straten, A., Kerkhof, A. J., Reducing suicidal	Not self-harm

Study	Reason for Exclusion
ideation: cost-effectiveness analysis of a randomized controlled trial of unguided web-based self-help, Journal of medical Internet research, 14, e141, 2012	

Appendix K Research recommendations – full details

Research recommendations for review question: What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?

No research recommendations were made for this review question.