NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Draft quality standard for self-harm

1 Introduction

The term self-harm is used in this quality standard to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

Self-harm often exists together with other mental health conditions such as borderline personality disorder, depression, bipolar disorder, schizophrenia and drug and alcohol-use disorders. People who self-harm have a 50- to 100-fold higher likelihood of dying by suicide in a 12-month period than people who do not self-harm.

This quality standard covers the initial management of self-harm and longer-term support. For more information see the scope for this quality standard.

The standard is made up of a set of measurable statements, which together with the guidance on which it is based, should contribute to the improvements outlined in the following outcome frameworks:

- The NHS Outcomes Framework 2013/14
- A public health outcomes framework for England, 2013–2016

The table below shows the indicators from the frameworks that the quality standard could contribute to:

NHS outcomes framework 2013/14	Domain 1: Preventing people from dying prematurely	1.5 Excess under-75 mortality rate in people with serious mental illness
	Domain 4: Ensuring that people have a positive experience of care	4a Patient experience of primary care 4b Patient experience of hospital care 4.2 Responsiveness to inpatients' personal needs 4.3 Patient experience of A&E services 4.7 Patient experience of community mental health services
	Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	5a Patient safety incidents reported 5b Severity of harm of patient safety incidents reported
A public health outcomes framework for England, 2013–2014	Domain 2: Health improvement	2.10 Hospital admissions as a result of self-harm
	Domain 4: Healthcare public health and preventing premature mortality	4.9 Excess under-75 mortality in adults with serious mental illness 4.10 Suicide

2 Draft quality standard for self-harm

Overview

The draft quality standard for self-harm requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to people who self-harm.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners should cross-refer across the library of NICE quality standards when designing high-quality services.

The quality standard should be read in the context of national and local guidelines on training and competencies. All professionals involved in assessing, caring for and treating people who self-harm (including those who assess remotely using algorithms written by medical professionals) should be sufficiently and appropriately trained in recognising the condition, and competent to deliver the actions and interventions described in the quality standard.

No.	Draft quality statements
1	People who have self-harmed are cared for with compassion and the same respect and dignity as any patient.
2	People who have self-harmed have an initial assessment of their physical health, mental state, social circumstances and risk of suicide.
3	People who have self-harmed have an assessment that specifically considers safeguarding issues, including risks to themselves and others.
4	People who have self-harmed are cared for on a documented care pathway.
5	People who have self-harmed are offered a comprehensive psychosocial assessment with a specialist mental health professional.
6	People in acute care who have self-harmed receive the supervision they need in a setting that has been assessed for environmental risks.

7	People who accept longer-term support for self-harm are involved in developing a care plan that includes risk management.
8	People who accept longer-term support for self-harm discuss with their lead professional the potential benefit of psychological interventions specifically structured for people who self-harm.
9	People who accept longer-term support for self-harm are involved in producing a written plan about their continuing care when moving between services.

In addition, quality standards that should also be considered when commissioning and providing high-quality services for people who self-harm are listed in section 7.

General questions for consultation:

Question 1 Can you suggest any appropriate healthcare outcomes for each individual quality statement?

Question 2 What important areas of care, if any, are not covered by the quality standard?

Question 3 What, in your opinion, are the most important quality statements and why?

Question 4 Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives?

Please refer to Quality standards in development for additional general points for consideration.

Draft quality statement 1: Respect and dignity

Draft quality statement	People who have self-harmed are cared for with compassion and the same respect and dignity as any patient.
Draft quality measure	**Structure:** a) Evidence of local arrangements to provide health and social care professionals who work with people who have self-harmed with training on assessment, treatment and management. b) Evidence of local arrangements to involve people who have self-harmed in the design and delivery of training on assessment, treatment and management of self-harm. c) Proportion of health and social care professionals working with people who have self-harmed who are trained in the assessment, treatment and management of self-harm. Numerator – the number of health and social care professionals in the denominator trained in the assessment, treatment and management of self-harm. Denominator – the number of health and social care professionals working with people who have self-harmed. **Outcome:** a) Evidence from feedback that people who have self-harmed feel treated with compassion and the same respect and dignity as any patient. b) Evidence from feedback that people who have self-harmed feel involved in making decisions about their care.
Description of what the quality statement means for each audience	**Service providers** ensure training is provided on the assessment, treatment and management of self-harm and is designed and delivered with involvement from people who have self-harmed. **Health and social care professionals** working with people who have self-harmed to ensure they have appropriate training in the assessment, treatment and management of self-harm, and treat people who have self-harmed with compassion and the same respect and dignity as any patient. **Commissioners** ensure they commission services where health and social care professionals working with people who have self-harmed are trained in the assessment, treatment and management of self-harm. **People who have self-harmed** can expect to be cared for with compassion and the same respect and dignity as any patient.

Source clinical guideline references	NICE clinical guideline 16 recommendations 1.1.1.1, 1.1.2.1 and 1.1.2.2 NICE clinical guideline 133 recommendations 1.1.1, 1.1.9 and 1.1.10
Data sources	**Structure:** Local data collection. Activity data on the training of staff can be collected using the baseline assessment tool for NICE clinical guideline 133. **Outcome:** Local data collection. NHS surveys ask questions about dignity when using services; however data on diagnosis are not collected.

Draft quality statement 2: Initial assessment

Draft quality statement	People who have self-harmed have an initial assessment of their physical health, mental state, social circumstances and risk of suicide.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that initial assessments of people who have self-harmed include physical health, mental state, social circumstances and risk of suicide. **Process:** Proportion of people who have self-harmed who have an initial assessment of their physical health, mental state, social circumstances and risk of suicide. Numerator – the number of people in the denominator with an initial assessment of their physical health, mental state, social circumstances and risk of suicide. Denominator – the number of people presenting with a new episode of self-harm.
Description of what the quality statement means for each audience	**Service providers** ensure initial assessments of people who have self-harmed involve the assessment of physical health, mental state, social circumstances and risk of suicide. **Healthcare professionals** ensure that the initial assessment of people who have self-harmed covers physical health, mental state, social circumstances and risk of suicide. **Commissioners** ensure they commission services that undertake an initial assessment of physical health, mental state, social circumstances and risk of suicide for people who have self-harmed. **People who have self-harmed** have their physical health, mental state, social circumstances and risk of suicide assessed.
Source clinical guideline references	NICE clinical guideline 16 recommendations 1.2.1.2, 1.3.1.1 and 1.4.1.1
Data source	**Structure:** Local data collection. **Process:** Local data collection.

Definitions	**Mental state** Factors that should be recorded in an initial assessment of mental state include: • mental capacity • level of distress • presence of mental health problems • willingness to remain for further psychosocial assessment. **Social circumstances** Factors that should be recorded in an initial assessment of social circumstances include: • family members, significant others or carers who can provide support • dependents • housing • personal or financial problems
Equality and diversity considerations	NICE clinical guideline 16 recommendation 1.9.1.1 states that children and young people under 16 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.

Draft quality statement 3: Safeguarding

Draft quality statement	People who have self-harmed have an assessment that specifically considers safeguarding issues, including risks to themselves and others.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who have self-harmed have an assessment that specifically considers safeguarding issues, including risks to themselves and others. **Process:** Proportion of people who have self-harmed who have had an assessment that specifically considers safeguarding issues, including risks to themselves and others. Numerator – the number of people in the denominator who have had an assessment that specifically considers safeguarding issues, including risks to themselves and others. Denominator – the number of people presenting with a new episode of self-harm.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for the specific consideration of safeguarding issues, including risks to themselves and others, for people who have self-harmed. **Healthcare professionals** ensure they specifically consider safeguarding issues of people who have self-harmed, including risks to themselves and others. **Commissioners** ensure they commission services that specifically consider safeguarding issues for people who have self-harmed, including risks to themselves and others. **People who have self-harmed** have an assessment that specifically considers safeguarding issues, including risks to themselves and others.
Source clinical guideline references	NICE clinical guideline 133 recommendation 1.1.21
Data source	**Structure:** Local data collection. **Process:** Local data collection.
Definitions	**Safeguarding** Safeguarding is the protection of vulnerable people from harm. It can apply to people of all ages, including adults, older people, children and young adults. It includes consideration of risks to the person who has self-harmed and to any children or adults in the person's care.

Draft quality statement 4: Care pathway

Draft quality statement	People who have self-harmed are cared for on a documented care pathway.
Draft quality measure	**Structure:** Evidence of a documented care pathway for people who have self-harmed. **Process:** Proportion of people who have self-harmed who are cared for on a documented care pathway. Numerator – the number of people in the denominator cared for on a documented care pathway. Denominator – the number of people presenting with a new episode of self-harm.
Description of what the quality statement means for each audience	**Service providers** ensure a documented care pathway is in place for people who have self-harmed. **Health and social care professionals** ensure people who have self-harmed are cared for on a documented care pathway. **Commissioners** ensure they commission integrated services to cover the whole care pathway for people who self-harm. **People who have self-harmed** are cared for on a documented care pathway.
Source clinical guideline references	NICE clinical guideline 16 recommendation 1.1.2.5.
Data source	**Structure:** Local data collection. **Process:** Local data collection.
Definitions	**Care pathway** A care pathway describes the delivery of effective interventions by the appropriate staff at the correct time. It should describe the possible next steps in a patient's journey, for example following initial assessment, safeguarding assessment or psychosocial assessment. A care pathway helps professionals decide which actions to take.

Draft quality statement 5: Comprehensive psychosocial assessment

Draft quality statement	People who have self-harmed are offered a comprehensive psychosocial assessment with a specialist mental health professional.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure specialist mental health professionals can undertake comprehensive psychosocial assessments for people who have self-harmed. **Process:** a) Proportion of people who have self-harmed who are offered a comprehensive psychosocial assessment. Numerator – the number of people in the denominator offered a comprehensive psychosocial assessment. Denominator – the number of people presenting with a new episode of self-harm. b) Proportion of people who have self-harmed who receive a comprehensive psychosocial assessment by a specialist mental health professional. Numerator – the number of people in the denominator receiving a comprehensive psychosocial assessment by a specialist mental health professional. Denominator – the number of people presenting with a new episode of self-harm.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for specialist mental health professionals to undertake comprehensive psychosocial assessments for people who have self-harmed. **Healthcare professionals** ensure people who have self-harmed are offered a comprehensive psychosocial assessment with a specialist mental health professional. **Commissioners** ensure they commission services that provide comprehensive psychosocial assessments by specialist mental health professionals for people who have self-harmed. **People who have self-harmed** are offered a comprehensive psychosocial assessment with a specialist mental health professional.
Source clinical guideline references	NICE clinical guideline 16 recommendations 1.7.2.1 and 1.7.3.1 NICE clinical guideline 133 recommendations 1.3.1 to 1.3.6

Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE audit support for longer-term management of self-harm (NICE clinical guideline 133): • Assessment of needs • Assessment of risk
Definitions	**Comprehensive psychosocial assessment** NICE clinical guidelines 16 and 133 state that a psychosocial assessment is the assessment of needs and risks by specialist mental health professionals to understand and engage people who self-harm and initiate a therapeutic relationship. Recommendations 1.3.1 to 1.3.6 in NICE clinical guideline 133 give further details on undertaking comprehensive psychosocial assessments. A comprehensive psychosocial assessment should account for the following factors found to be associated with self-harm: • socioeconomic status • sexual orientation • drug or alcohol disorders • age • associated mental health problems.
Equality and diversity considerations	NICE clinical guideline 16 recommendation 1.9.1.10 and clinical guideline 133 recommendation 1.3.4 state that children and young people should be assessed by professionals experienced in the assessment of children and young people who self-harm. NICE clinical guideline 16 recommendation 1.9.1.10 states that assessment of children and young people should follow the same principles as for adults, but should also include a full assessment of the family, their social situation and child protection issues. NICE clinical guideline 16 recommendation 1.10.1.1 and clinical guideline 133 recommendation 1.3.3 state that older people (over 65) should be assessed by professionals experienced in the assessment of older people who self-harm. NICE clinical guideline 16 recommendation 1.10.1.1 states that assessment of older people should follow the same principles as for adults, but should also pay attention to the potential presence of depression, cognitive impairment or physical ill health and include a full assessment of their home and social situation.

Draft quality statement 6: Acute care environment

Draft quality statement	People in acute care who have self-harmed receive the supervision they need in a setting that has been assessed for environmental risks.
Draft quality measure	**Structure:** a) Evidence of local arrangements to ensure that people in acute care who have self-harmed are supervised according to their need. b) Evidence of local arrangements to undertake environmental assessments of acute care settings, including assessing risks to vulnerable patients. **Outcome:** a) Evidence from feedback that people presenting to acute care with self-harm feel the environments were safe and supportive. b) Incidents of self-harm occurring in acute care.
Description of what the quality statement means for each audience	**Service providers** ensure they undertake environmental assessments of acute care settings to ensure they are safe for people have self-harmed. **Healthcare professionals** ensure people in acute care who have self-harmed are supervised according to their need in a setting that has been assessed for environment risks. **Commissioners** ensure they commission services that provide supervision for people who have self-harmed and assess settings for environmental risks. **People in acute care who have self-harmed** receive the supervision they need in a setting that has been assessed for risks to their safety.
Source clinical guideline references	NICE clinical guideline 16 recommendation 1.4.2.3
Data source	**Structure:** Local data collection. The NHS Litigation Authority risk management standards assess the process for managing the risks associated with: • the physical security of premises and assets • the observation and engagement of patients. **Outcome:** Local data collection. NHS surveys ask questions about the environment of services; however data on diagnosis are not collected. The National Reporting and Learning System contains national and local figures on patient safety incidents including self-harm.

Definitions	**Supervision** A safe and supportive environment will include appropriate observation and accompaniment of people who have self-harmed, either by acute care staff or by the families and carers of people who have self-harmed with the support of acute care staff. **Environmental risks** Consideration should be given to the individual needs and safety requirements of each patient. Examples of environmental risks to people who self-harm include, but are not limited to: • ligature points • open windows • access to sharps • access to medication.
Equality and diversity considerations	NICE clinical guideline16 recommendation 1.9.1.1 states that children and young people under 16 who have self-harmed should be assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

Draft quality statement 7: Care plan

Draft quality statement	People who accept longer-term support for self-harm are involved in developing a care plan that includes risk management.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure people who accept longer-term support for self-harm are involved in developing a care plan that includes risk management. **Process:** Proportion of people accepting longer- term support for self-harm who are involved in developing a care plan that includes risk management. Numerator – the number of people in the denominator involved in developing a care plan that includes risk management. Denominator – the number of people accepting longer- term support for self-harm. **Outcome:** Evidence from feedback that people who accept longer-term support for self-harm feel involved in the development of a care plan that includes risk management.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place to involve people who accept longer-term support for self-harm in developing care plans that include risk management. **Health professionals** ensure people who accept longer-term support for self-harm are involved in developing a care plan that includes risk management. **Commissioners** ensure they commission services that involve people who accept longer-term support for self-harm in developing their care plan and risk management plan. **People who accept longer-term support for self-harm** are involved in developing a care plan that includes a plan to manage and reduce risks connected to self-harm.
Source clinical guideline references	NICE clinical guideline 133 recommendations 1.4.2 to 1.4.4
Data source	**Structure:** Local data collection. **Process:** Local data collection. Contained within NICE audit support for longer-term management of self-harm (NICE clinical guideline 133): Care plans. **Outcome:** Local data collection.

Definitions	**Care plan** NICE clinical guideline 133 recommendation 1.4.3 states that a care plan should: • identify realistic and optimistic long-term goals, including education, employment and occupation • identify short-term treatment goals (linked to the long-term goals) and steps to achieve them • identify the roles and responsibilities of any team members and the person who self-harms • include a jointly prepared risk-management plan • be shared with the person's GP.
Equality and diversity considerations	NICE clinical guideline 133 recommendation 1.3.3 highlights the higher risks of suicide following self-harm in people aged over 65. These risks should be reflected in developing care and risk management plans these people.

Draft quality statement 8: Psychological interventions

Draft quality statement	People who accept longer-term support for self-harm discuss with their lead professional the potential benefit of psychological interventions specifically structured for people who self-harm.
Draft quality measure	**Structure:** Evidence of local arrangements to provide psychological interventions specifically structured for people who self-harm. **Process:** Proportion of people accepting longer-term support for self-harm who receive at least 3 sessions of a psychological intervention specifically structured for people who self-harm. Numerator – the number of people in the denominator receiving at least 3 sessions of a psychological intervention specifically structured for people who self-harm. Denominator – the number of people accepting longer-term support for self-harm. **Outcome:** Evidence from feedback that people who accept longer-term support for self-harm have discussed with their lead professional, the potential benefit of psychological interventions specifically structured for people who self-harm.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for people who accept longer-term support for self-harm to have 3 to 12 sessions of a psychological intervention specifically structured for people who self-harm. **Healthcare professionals** ensure they discuss with people who accept longer-term support for self-harm the potential benefit of psychological interventions specifically structured for people who self-harm. **Commissioners** ensure they commission services that can provide people who accept longer-term support for self-harm with 3 to 12 sessions of a psychological intervention specifically structured for people who self-harm. **People who accept longer term support for self-harm** discuss with their lead professional the potential benefit of psychological interventions specifically structured for people who self-harm.
Source clinical guideline references	NICE clinical guideline 133 recommendation 1.4.8
Data source	**Structure:** Local data collection. **Process:** Local data collection. **Outcome:** Local data collection.

Definition	**Lead professional** This refers to the professional with overall responsibility for the care and support of a person who has self-harmed. This could include professionals from, but is not limited to: • General Practitioners • Secondary mental health services • Community mental health services **Psychological interventions** NICE clinical guideline 133 recommendation 1.4.8 states: Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition: • the intervention should be tailored to individual need, and could include cognitive–behavioural, psychodynamic or problem-solving elements. • therapists should be trained and supervised in the therapy they are offering to people who self-harm. • therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Draft quality statement 9: Moving between services

Draft quality statement	People who accept longer-term support for self-harm are involved in producing a written plan about their continuing care when moving between services.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that people who accept longer-term support for self-harm are involved in producing a written plan about their continuing care when moving between services. **Process:** Proportion of people accepting longer-term support for self-harm who are involved in producing a written plan about their continuing care when moving between services. Numerator – the number of people in the denominator involved in producing a written plan about their continuing care. Denominator – the number of people accepting longer-term support for self-harm who are moving between services. **Outcome:** Evidence from feedback that people who accept longer-term support for self-harm are involved in producing a written plan about their continuing care when moving between services.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place to involve people who accept longer-term support for self-harm in producing a written plan about their continuing care when moving between services. **Health and social care professionals** ensure people who accept longer- term support for self-harm are involved producing a written plan about their continuing care when moving between services. **Commissioners** ensure they commission services that involve people who accept longer-term support for self-harm in producing a written plan about their continuing care when moving between services. **People who accept longer-term support for self-harm** are involved in producing a written plan about their continuing care when moving between services.
Source clinical guideline references	NICE clinical guideline 133 recommendation 1.1.25
Data source	**Structure:** Local data collection. **Process:** Local data collection. Activity data on plans for transitions can be collected using the baseline assessment tool for NICE clinical guideline 133. **Outcome:** Local data collection.

3 Status of this quality standard

This is the draft quality standard released for consultation from 7 January 2013 until 4 February 2013. This document is not NICE's final quality standard on self-harm. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 4 February 2013. All eligible comments received during consultation will be reviewed by the Topic Expert Group and the quality statements and measures will be refined in line with the Topic Expert Group considerations. The final quality standard will be available on the NICE website in June 2013.

4 Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the evidence sources section.

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. As quality standards are intended to drive up the quality of care, achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, we recognise that this may not always be appropriate in practice when taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their Indicators for Quality Improvement Programme. For statements for which national quality indicators

do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard?

5 Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments will be published on the NICE website with the final version of the quality standard.

Good communication between professionals and people who self-harm is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People who self-harm should have access to an interpreter or advocate if needed.

6 How this quality standard was developed

The evidence sources used to develop this quality standard are listed in appendix 1, along with relevant policy context, definitions and data sources. Further explanation of the methodology used can be found in the Quality Standards Programme interim process guide.

7 Related NICE quality standards

Service user experience in adult mental health. NICE quality standard (2012).

Patient experience in adult NHS services. NICE quality standard (2012).

Depression. NICE quality standard (2011).

Appendix 1: Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Self-harm: longer-term management. NICE clinical guideline 133 (2011).
Self-harm. NICE clinical guideline 16 (2004).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.
Department of Health (2011) Consultation on preventing suicide in England: a cross-government outcomes strategy to save lives.
Department of Health (2002) National suicide prevention strategy for England.

Definitions and data sources for the quality measures

References included in in the definitions and data sources sections:

Picker Institute NHS surveys

NHS Commissioning Board National Reporting and Learning System

NHS Litigation Authority Risk management standards