NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QUALITY STANDARDS PROGRAMME

Quality standard topic: Self-harm

Output: Briefing paper

Introduction

This briefing paper presents a structured evidence review to help determine the suitability of recommendations from the key development sources listed below, to be developed into a NICE quality standard. The draft quality statements and measures presented in this paper are based on published recommendations from these key development sources:

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

Structure of the briefing paper

The body of the paper presents supporting evidence for the draft quality standard reviewed against the three dimensions of quality: effectiveness, experience and safety. Information is also provided on available cost-effectiveness evidence and current clinical practice for the proposed standard. Where possible, evidence from the clinical guideline is presented. When this is not available, other evidence sources have been used.

1 General principles – respect and dignity

1.1 NICE CG16 1.1.1.1 [KPI] and NICE CG133 1.1.1 [KPI]

1.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.1.1.1 People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm. CG133 1.1.1 Health and social care professionals working with people who self-harm should: • aim to develop a trusting, supportive and engaging relationship with them • be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach • ensure that people are fully involved in decision-making about their treatment and care • aim to foster people's autonomy and independence wherever possible • maintain continuity of therapeutic relationships wherever possible • ensure that information about episodes of self-harm is communicated sensitively to other team members. CG133 1.1.9 Health and social care professionals who work with people who self-harm (including children and young people) should be: • trained in the assessment, treatment and management of self-harm • educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes.
Proposed quality statement	People who self-harm are treated with the same respect, dignity and privacy as any patient.
Draft quality measure	**Structure:** The proportion of staff working with people who self-harm who are trained in the assessment, treatment and management of self-harm. Numerator – The number of staff in the denominator trained in the assessment, treatment and management of self-harm. Denominator – The number of staff who work with people who self-harm. **Outcome:** Evidence from feedback that people who self-harm feel treated with respect, dignity and privacy.

1.1.2 Clinical and cost-effectiveness evidence

Clinical guideline 16 recommendation 1.1.1.1 is recommended good practice based on the clinical experience of the development group. In examining the literature on service user experience and the data from focus groups, the group felt it clear that people who self-harm consider the main cause of poor experiences to be staff attitude. The development group discussed findings that staff can have punitive attitudes, lack of understanding, and be rude or blaming. This can increase service user distress leading to further self-harm or avoidance of medical attention. Conversely, reports showed experience was greatly improved when healthcare professionals showed respect and were calm, reassuring and considerate.

Developers of clinical guideline 133 undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Where people felt positive and satisfied with services, this was usually due to the compassionate support offered. Likewise, overall, service users were more satisfied with their treatment when they felt that the professional was genuinely concerned about them, respected them and did not try to belittle them.

In reviewing existing literature, the group also found that some of the negative attitudes addressed by the literature (for example, that self-harm is a means of seeking attention) were quoted as common misconceptions in the perspectives of service users. A number of studies exposed that many healthcare professionals felt that people who self-harm were labelled as ‘attention seeking’. Also, in the systematic review a number of studies indicated an over-representation of attention-seeking as a motive for self-harm. This was found to be less common in psychiatric staff compared with general hospital staff.

1.1.3 Experience

The Royal College of Psychiatrists[1] report on a number of studies of service users’ views and experiences of contact with health services after self-harm. They emphasise that above all, people need an empathic non-judgemental approach to their self-harming behaviour, based on understanding the issues involved and the functions self-harm may fulfil for the individual. In examining a systematic review of the international literature on service users’ experiences at A&E departments, they conclude that poor communication between patients and staff and a perceived lack of staff knowledge with regard to self-harm are common.

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[1] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

A Royal College of Psychiatrists survey of 509 patients[2] reported the main themes connected with positive staff attitudes:

- Sensitivity
- Concern
- Friendliness
- Non-judgemental

Main themes reported by patients on negative staff attitudes include:

- Disapproval
- Dismissal of physical health needs
- Patronising comments
- Rudeness

Furthermore, 42% of people felt they were not offered pain relief they felt they needed whilst waiting for treatment. Of people receiving painful treatment (such as stitches), 24% were not given pain relief.

1.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

1.1.5 Current practice

NICE uptake database 'ERNIE' contains information on local audit of in-patient psychiatric care of self-harm in 2008. Results found that 14/14 nurses stated that they were respectful to service users. Nine of the nurses had in-house training but none had formal training.

A local study in 2006[3] of102 staff involved in acute paediatric care found that 64.4% were not confident in treating and caring for those with self-harm. Only 4.8% reported good formal training and 33.6% had some training in adolescent self-harm management.

1.1.6 Current indicators

No current NHS indicators identified.

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[2] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

[3] Semmens A, Powell C (2009) Study of Self-Harm in Children and Young People: do we think we follow the NICE Guidelines?

2 General principles – shared decision making

2.1 NICE CG16 1.1.1.6, 1.8.1.1 and CG133 1.1.1 [KPI]

2.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.1.1.6 Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide people who self-harm with full information about the different treatment options available. CG16 1.8.1.1 The decision to refer for further assessment and/or treatment or to discharge the service user should be taken jointly by the service user and the healthcare professional whenever this is possible. When this is not possible, either as a result of diminished mental capacity or the presence of significant mental illness, this should be explained to the service user and written in their notes. CG133 1.1.1 Health and social care professionals working with people who self-harm should: • ensure that people are fully involved in decision-making about their treatment and care.
Proposed quality statement	People who self-harm are involved in making decisions about their care.
Draft quality measure	**Structure:** Evidence of local arrangements to provide information and access to resources on the different options available to people who self-harm. **Process:** a) The proportion of people presenting with a new episode of self-harm who are involved in making decisions about their care. Numerator – The number of people in the denominator involved in making decisions about their care. Denominator – The number of people presenting with a new episode of self-harm and with mental capacity to make decisions about their care. b) The proportion of people receiving longer-term care for self-harm who are involved in making decisions about their care. Numerator – The number of people in the denominator involved in making decisions about their care. Denominator – The number of people receiving longer-term care for self-harm. **Outcome:** Evidence from feedback that people who self-harm feel they were involved in making decisions about their care.

2.1.2 Clinical and cost-effectiveness evidence

Clinical guideline 16 recommendations 1.1.1.6 and 1.8.1.1 are recommended good practice based on the clinical experience of the development group. Focus group respondents reported that they want to be involved in discussions regarding treatment – for example, the method of suturing used – and reported more positive experiences of wound care when staff had involved them in decision-making. Those who were able to care for their own wounds appreciated being prescribed skin closure strips by their GP. Some reported that a lack of control surrounding their treatment and care resulted in them feeling anxious, panicked and more likely to injure themselves again. This included being involved in decisions to refer to follow-up services.

Guidance developers of clinical guideline 133 undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Six studies reported problematic issues with regard to communication with professionals, specifically, inadequate sharing of information by healthcare professionals. Individuals were not given the opportunity to be involved in decision-making about their treatment because little information was shared.

2.1.3 Experience

The Royal College of Psychiatrists[4] report on a number of studies of service users' views and experiences of contact with health services after self-harm: "Timely provision of information about their treatment and good communication are helpful. However, having their views taken seriously, participating in decisions about their care and treatment, and having clear explanations for decisions are highly rated".

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[5] that "almost half (45%) of service users in a UK study said they received enough information from staff about the nature of their injury or condition. Service users appreciated when "they tried to tell me what they could". Inclusion in treatment decisions was not universal. In one study, some patients said they were left with no information about blood-test results and felt staff carried out procedures without discussing options or providing explanations. Some UK service users said staff did not address their needs and concerns: insufficient information about treatment options was reported by 49% of participants in one study".

The National Inquiry into self-harm among young people (2006), heard evidence from some young people who self-harm and had spoken with an

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[4] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

[5] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

adult that "once they had done this, all decision-making and control were taken from them. They were not being consulted about the services that might be contacted, or about the exact sort of help and information that would support and help them deal with their self-harm. Many were unsure – and felt unable to ask about – who else would be told or involved after they had disclosed private and sensitive information".

In a Royal College of Psychiatrists survey of 509 patients[6], 59% reported that ambulance personnel explained what they were doing and why. 45% reported that ambulance personnel checked they agreed to whatever they were doing.

10% of those attending A&E needed an interpreter or other support but it was not offered or provided. 1% reported they did receive it. Respondents requiring physical treatment reported a lack of information:

Do you feel you were given enough information about:	Yes	No	Don't know	N/A
The nature of your injury / condition?	39%	42%	10%	9%
The different treatment options available to you?	21%	56%	10%	13%
The likely effect of the treatment (benefits, any side effects etc.)?	27%	51%	9%	13%
Updates on what was happening, waiting times etc?	22%	60%	12%	6%

Of those receiving physical treatment in emergency departments, 25% explicitly recall being given a choice about whether or not to have treatment 36% of service users reported not feeling sufficiently involved in decisions about the care they might receive upon discharge.

2.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

2.1.5 Current practice

NICE uptake database 'ERNIE' contains information on local audit of in-patient psychiatric care of self-harm in 2008. 40% of the service users were not happy with the quality of information about treatment options.

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[6] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

2.1.6 Current indicators

No current NHS indicators identified.

3 General principles – safeguarding

3.1 NICE CG133 1.1.2.1

3.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG133 1.1.21 When working with people who self-harm, consider the risk of domestic or other violence or exploitation and consider local safeguarding procedures for vulnerable adults and children in their care. Advice on this can be obtained from the local named lead on safeguarding adults.
Proposed quality statement	People who self-harm are protected under local safeguarding procedures.
Draft quality measure	**Structure:** a) The proportion of staff who work with people who self-harm, who are trained in safeguarding vulnerable adults and children. Numerator – The number of staff in the denominator trained in safeguarding vulnerable adults and children. Denominator – The number of staff who work with people who self-harm. b) Evidence of arrangements establishing a local named safeguarding lead.

3.1.2 Clinical and cost-effectiveness evidence

This recommendation is based on the legal framework and is recommended good practice based on the clinical experience of the development group. The guideline development groups highlight a number of factors associated with self-harm with relevance to safeguarding arrangements: presence of mental disorders, alcohol and drug use, child abuse and domestic violence.

3.1.3 Experience

No information is presented on experience.

3.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

3.1.5 Current practice

SCIE[7] examined the governance arrangements of Adult Safeguarding Boards reporting that engagement with training and workforce development is widespread, and is one of the most longstanding functions of [adult safeguarding] boards. There has been little attention, however, to the outcomes of training provided, thus making it difficult to assess the effectiveness in terms of practice and impact for people who use services.

A survey of local safeguarding children board chairs[8] reported vacancy rates for safeguarding nurses in 2011 of 11%, for safeguarding doctors of 14% and for designated looked after children professionals of 22%.

Since 2009 vacancy rates have risen in all three types of role:

- from 5% to 11% in 2011 for safeguarding nurses;
- from 4% to 14% for safeguarding doctors; and
- from 19% to 22% for designated looked after children professionals.

17% of respondents reported one or more vacancies in one of the three roles in 2009, 24% in 2010 and 27% in 2011. 3 LSCBs had no designated safeguarding or LAC leads in 2011, compared with none in 2010 and 2009.

3.1.6 Current indicators

No current NHS indicators identified.

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[7] Social Care Institute for Excellence (2011) Report 45: The governance of adult safeguarding: findings from research into Safeguarding Adults Boards

[8] Association of Directors of Children's Services (2011) survey of Local Safeguarding Children Board Chairs

4 General principles – communication with family, carers or significant others.

4.1 NICE CG133 1.1.22

4.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG133 1.1.22 Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate.
Proposed quality statement	People who self-harm are asked if they want their family, carers or significant others to be involved.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that staff understand the rights of people who self-harm to confidentiality. **Process:** a) The proportion of people presenting with a new episode of self-harm who are asked if they want their family, carers or significant others to be involved. Numerator – The number of people in the denominator asked if they want their family, carers or significant others to be involved Denominator – The number of people presenting with a new episode of self-harm. b) The proportion of people receiving longer-term care for self-harm who are asked if they want their family, carers or significant others to be involved. Numerator – The number of people in the denominator asked if they want their family, carers or significant others to be involved Denominator – The number of people receiving longer-term care for self-harm. **Outcome:** Evidence from feedback that people who self-harm were asked if they wanted their family, carers or significant others to be involved.
Definition	CG133 defines ‘significant others’ as partners, friends and any person the service user considers important to them.

4.1.2 Clinical and cost-effectiveness evidence

Guidance developers for clinical guideline 133 undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Social support in the form of community support groups, support from family and friends and website support groups appeared to be important for people who self-harm as feelings of isolation, low self-esteem and alienation are very common. Most young people did acknowledge that having a therapist to mediate allowed them to talk to their parents about issues that they felt they could not raise on their own.

In systematically reviewing the literature on carers’ experiences the group reported that many parents felt excluded from their children’s care planning and treatment. Carers highlighted the need for more information about suicidal behaviour in young people, skills for parenting and advice on managing further incidences.

4.1.3 Experience

The National Inquiry into self-harm among young people (2006), heard evidence that “approximately half of the young people from the Inquiry’s consultation sites said that they had confided in friends at school and that their friends had in turn disclosed to teachers. The majority described their sense of lack of control about who else was then told about their self-harm (their parents, other teachers, other staff, and/or other professionals)”.

4.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

4.1.5 Current practice

No information is presented on current practice.

4.1.6 Current indicators

No current NHS indicators identified.

5 All settings - Initial assessment

5.1 NICE CG16 1.2.1.2, 1.3.1.1 and 1.4.1.1

5.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.2.1.2 All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user. CG16 1.3.1.1 When ambulance staff attend a person who has self-harmed, they should urgently establish the likely risk, and the person's emotional and mental state, in an atmosphere of respect and understanding. CG16 1.4.1.1 When an individual presents in the emergency department following an episode of self-harm, emergency department staff responsible for triage should urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.
Proposed quality statement	People who self-harm have an initial assessment of their emotional and mental state, and likely risk of repetition or suicide.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that staff initially assessing people presenting with self-harm, are trained to undertake assessments of emotional and mental state, and likely risk of repetition or suicide. **Process:** The proportion of people presenting with a new episode of self-harm who have an initial assessment of their emotional and mental state, and likely risk of repetition or suicide. Numerator – The number of people in the denominator initially assessed for their emotional and mental state, and likely risk of repetition or suicide. Denominator – The number of people presenting with a new episode of self-harm.

5.1.2 Clinical and cost-effectiveness evidence

The three recommendations are based on long-standing policy, expert opinion/reports and are recommended good practice based on the clinical experience of the development group.

Based on the evidence review of risk assessment conducted for clinical guideline 133, the following risk factors in particular should be considered when assessing risk of repeated self-harm or suicide: previous self-harm and depressive symptoms. These two factors were supported by pooled quantitative analysis.

5.1.3 Experience

No information is presented on experience.

5.1.4 Safety

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (see Appendix A). A comprehensive analysis of recent reported incidents (please see full accompanying report from the patient safety function at the NHS Commissioning Board Special Health Authority) identifies the following issue relating to patient safety:

- Lack of initial risk assessments taking place.

5.1.5 Current practice

In a Royal College of Psychiatrists survey of 509 patients[9], 92% of respondents attended the emergency department for treatment. At their initial assessment on arriving at the department, 48% were asked about their mental distress as well as their physical condition. 37% were not asked, 14% could not remember.

The National Inquiry into self-harm among young people[10], heard evidence from the Royal College of General Practitioners' Adolescent Task Group that "many GPs are not sure how to approach the issue directly with the young person, or where or how to direct them on to the most appropriate services - guidelines on this issue from the National Institute for Clinical Excellence (NICE) are not particularly relevant to GPs as they focus on Accident and Emergency Department procedures".

A local audit of A&E practice in 2004[11], revealed 5.8% of 103 attendances had an initial assessment of risk, rising to 97% after the introduction of a standardised assessment tool.

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[9] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

[10] Mental Health Foundation (2006) Truth Hurts - Report of the National Inquiry into Self-harm among Young People

[11] Hughes L; Kosky N (2007) Meeting NICE self-harm standards in an accident and emergency department

5.1.6 Current indicators

No current NHS indicators identified relating to assessments.

The Health and Social Care Information Centre’s Indicator Portal (www.indicators.ic.nhs.uk) includes suicide mortality indicators.

6 Preliminary psychosocial assessment

6.1 NICE CG16 1.4.1.2 and 1.4.1.5 [KPI]

6.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.4.1.5 All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.
Proposed quality statement	People who self-harm are offered a preliminary psychosocial assessment at the initial assessment.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that staff initially assessing people presenting with self-harm, are trained to undertake a preliminary psychosocial assessment. **Process:** The proportion of people presenting with a new episode of self-harm who have a preliminary psychosocial assessment as part of their initial assessment. Numerator – The number of people in the denominator who have a preliminary psychosocial assessment as part of their initial assessment. Denominator – The number of people receiving an initial assessment for a new episode of self-harm.
Definition	CG16 states a ‘preliminary psychosocial assessment’ should determine • mental capacity • willingness to remain for further psychosocial assessment • level of distress • possible presence of mental illness.

6.1.2 Clinical and cost-effectiveness evidence

This recommendation is based on expert committee reports or opinions and/or clinical experiences of respected authorities. The evidence behind clinical guideline 133 recommendations on psychosocial assessments is presented in section 10 below.

6.1.3 Experience

For service user experiences of psychosocial assessment in general, see 10.1.3 below.

6.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

6.1.5 Current practice

The Royal College of Psychiatrists[12] report on a number of studies of service users' views and experiences of contact with health services after self-harm "Fewer than 50% of respondents to the College Members' survey considered that they (or their team) had the training to undertake psychosocial assessments of risk and need with people who had harmed themselves. The highest percentage of those who have been trained were in liaison settings (62.7%). Over two-thirds of the 85 psychiatric trainees and doctors working in A&E departments rated their training in conducting psychosocial assessments as 'insufficient'".

A local audit of A&E practice in 2004[13], showed:

- 0% record of capacity to consent, rising to 91% post introduction of a standardised proforma
- 4.8% record of willingness to stay for treatment, rising to 87%
- 2% record of the presence of mental illness, rising to 74%.

6.1.6 Current indicators

No current NHS indicators identified.

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[12] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

[13] Hughes L; Kosky N (2007) Meeting NICE self-harm standards in an accident and emergency department

7 Referral to emergency departments or specialist mental health services.

7.1 *NICE CG16 1.2.1.8 and 1.8.1.2*

7.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.2.1.8 If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services. CG16 1.8.1.2 Referral for further assessment and treatment should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto the service user's GP and to any relevant mental health services as soon as possible to enable follow-up.
Proposed quality statement	People who self-harm are referred to an emergency department or specialist mental health service if indicated by an assessment of needs and risks.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that the needs and risks of people who self-harm are assessed to guide referral to an emergency department or specialist mental health service. **Process:** The proportion of people presenting with a new episode of self-harm who are considered for referral to an emergency department or specialist mental health service based on an assessment of needs and risks. Numerator – The number of people in the denominator considered for referral to an emergency department or specialist mental health service based on an assessment of needs and risks Denominator – The number of people presenting with a new episode of self-harm.

7.1.2 Clinical and cost-effectiveness evidence

The recommendations are good practice based on the clinical experience of the development group.

7.1.3 Experience

No information is presented on experience.

7.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

7.1.5 Current practice

In its description of the current service provision, the guideline development group state “There are no accurate figures for the number of presentations to emergency departments, but extrapolated from registers held at centres in the UK there are around 200,000 attendances in England annually. One hallmark of service provision for self-harm has been its variability, which has been consistent over time”.

7.1.6 Current indicators

No current NHS indicators identified.

8 Acute care – environment

8.1 NICE CG16 1.4.2.3 [KPI]

8.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.4.2.3 If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.
Proposed quality statement	People who self-harm and are waiting for medical or surgical treatment in an emergency department are offered a safe and supportive environment in which to wait.
Draft quality measure	**Structure:** Evidence of local arrangements to provide a safe and supportive environment for people waiting to have medical or surgical treatment for self-harm. **Process:** The proportion of people attending an emergency department for medical or surgical treatment of self-harm who waited for treatment in a safe and supportive environment. Numerator – The number of people in the denominator who waited for treatment in a safe and supportive environment. Denominator – The number of people attending an emergency department who require medical or surgical treatment for self-harm. **Outcome:** Evidence from feedback that people requiring medical or surgical treatment in an emergency department for self-harm, could wait in a safe and supportive environment.

8.1.2 Clinical and cost-effectiveness evidence

The recommendation is good practice based on the clinical experience of the development group. In examining the data from focus groups, the guidance development group noted that “a safe environment and being listened to is especially important since service users may reveal information about their injuries that makes them feel vulnerable, fearing negative repercussions”.

Guidance developers of clinical guideline 16 undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. One study reported that “some service users said treatment rooms did not provide privacy, either due to the location of treatment, for example in a waiting room, or lack of respect given by healthcare professionals, for example ‘showing off’ service users to other members of staff”.

8.1.3 Experience

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[14] that “although many service users advocated having a separate waiting area, some patients who were placed in a quiet, private area expressed unhappiness. These patients found that separate wait areas made them feel even more alone and isolated, increasing their distress. Some patients felt that they were ‘shoved out of sight’ and left alone. The feeling of being left alone seemed to be a major factor in patients’ dislike of private wait rooms”.

In a Royal College of Psychiatrists survey of 509 patients[15], the time waited for physical treatment varied significantly. 16 people commented specifically on prompt treatment, while 23 people had negative comments about waiting times. 54% of people reported that staff did not make contact at intervals to check how they were. 42 respondents highlighted the reception and triage areas lacked privacy. 25 comments reflected concern about lack of privacy and safety when waiting for treatment. Throughout the survey there were additional comments about the distress that can be caused by staff referring to the self-harm in front of other patients, particularly when staff publicly criticise the person for self-harm.

8.1.4 Safety

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (see Appendix A). A comprehensive analysis of recent reported incidents (please see full accompanying report from the patient safety function at the NHS Commissioning Board Special Health Authority) identifies the following priority areas relating to patient safety:

- Emergency departments can be high-risk environments for patients who self-harm.

8.1.5 Current practice

No information is presented on current practice.

8.1.6 Current indicators

No current NHS indicators identified.

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[14] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

[15] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

9 Acute care – liaison services

9.1 NICE CG16 1.1.2.9

9.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.1.2.9 Emergency departments and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day.
Proposed quality statement	People who self-harm and attend an emergency department are seen by a liaison psychiatry service.
Draft quality measure	**Structure:** Evidence of local arrangements to provide an integrated psychiatric liaison service. **Process:** Proportion of people who self-harm and attend an emergency department who are seen by a psychiatric liaison service. Numerator – The number of people in the denominator seen by a psychiatric liaison service t. Denominator – The number of people who self-harm and attend an emergency department.

9.1.2 Clinical and cost-effectiveness evidence

The recommendation is good practice based on the clinical experience of the development group.

9.1.3 Experience

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[16] differences in satisfaction with staff attitudes and approaches. Some patients report more positive experiences with staff delivering psychosocial assessments than other emergency department staff.

9.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

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[16] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

9.1.5 Current practice

The Royal College of Psychiatrists[17] report on views and experiences of health professionals in contact with people who self-harm. Respondents to the College Members' survey and other evidence received from the College Faculties emphasised the need for better access to liaison psychiatrists and higher levels of funding. The lack of paediatric liaison services and those specialising in the care of older people was also raised. The decline and closure of comprehensive liaison psychiatry services and poor commissioning of liaison psychiatry services was cited as a pressing problem.

In a Royal College of Psychiatrists survey of 509 patients[18], 59% of service users attending an emergency department reported being seen by a mental health professional.

NICE uptake database 'ERNIE' contains information on local audit of 5370 treated episodes of self-harm in Manchester (2005 to 2007). There were 2807 episodes assessed by mental health specialists (52%), of which 70% were completed by nurses and 28% by senior house officers.

9.1.6 Current indicators

No current NHS indicators identified.

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[17] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

[18] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

10 Comprehensive psychosocial assessment

10.1 NICE CG16 1.7.2.1 and 1.7.3.1 [KPIs]

NICE CG133 1.3.1, 1.3.2 and 1.3.6

10.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.7.2.1 All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment. CG16 1.7.3.1 All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent. CG133 1.3.1 Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5) and risks (see recommendations 1.3.6–1.3.8) to understand and engage people who self-harm and to initiate a therapeutic relationship. CG133 1.3.2 and 1.3.6 give specific examples of the contents of needs and risk assessments.
Proposed quality statement	People who self-harm are offered a comprehensive psychosocial assessment.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that staff are trained to undertake comprehensive psychosocial assessments. **Process:** The proportion of people presenting with a new episode of self-harm 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.
Definition	CG133 states a 'psychosocial assessment' is the assessment of needs and risks to understand and engage people who self-harm and initiate a therapeutic relationship.

10.1.2 Clinical and cost-effectiveness evidence

Clinical guideline 16 recommendations on psychosocial assessment are based on expert committee reports or opinions and/or clinical experiences of respected authorities. Based on an evidence review of 49 prospective cohort studies, the following risk factors in particular should be considered when assessing risk of repeated self-harm or suicide: previous self-harm and depressive symptoms. These two factors were supported by pooled quantitative analysis. However, due to the studies being very different from each other and therefore not meta-analysable, there was insufficient evidence to draw any conclusions regarding the association between psychosocial assessment and improvement in outcomes.

The guideline development group also examined evidence on risk assessment tools and scales to assess risk of repetition and suicide. However on consideration the group decided not to recommend such tools (sample sizes and high rates of false positives).

For clinical guideline 133 recommendations 1.3.1 and 1.3.2, guidance developers undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Four studies investigated the views of service users about psychosocial assessment. From these four studies it was clear that not all service users received a psychosocial assessment while in hospital, and, for those service users that did, their experience varied across studies. Participants had a more positive experience of assessment when they were given information about it beforehand. Moreover, the relational aspect of assessment was a key determining factor in service users' appraisal of assessment, highlighting the importance of the therapeutic relationship in the provision of care. Participants experienced assessment positively when it involved a beneficial, hopeful engagement with healthcare professionals and when it involved the restoration of hope or the possibility of change in their circumstances. Another important aspect of assessment was the opportunity to talk to someone, with the majority of participants finding this a valuable experience. However, not all participants felt they were given adequate opportunity and it was not always evaluated as a positive experience.

Conversely, assessment was experienced negatively when participants felt devalued by the assessor, were treated in a judgemental manner or felt they were not understood. Similarly, service users who reported being disappointed with their psychosocial management found fault primarily with their lack of involvement in decisions or when the assessor did not give them sufficient time to talk during the assessment.

10.1.3 Experience

In a Royal College of Psychiatrists survey of 509 patients[19], the main themes reported by patients on the positive experiences of receiving a psychosocial assessment were:

- Respectful, kind, considerate and supportive staff
- Opportunity to talk
- Clear information

Main themes reported by patients on the negative experiences of receiving a psychosocial assessment:

- Poor communication / lack of involvement
- Lack of mental health staff / delays
- Lack of privacy

Of those who did receive an psychosocial assessment by a mental health professional, 84% felt that they were given the opportunity to talk about their self-harm and what led to it. Comments consistently stressed the importance of being listened to and taken seriously. Half of the service users felt their views were taken into account when their risk was being assessed. 39% were not given sufficient information about who else would be told about their visit to the emergency department. The majority (79%) were not given a copy of any plan for post-discharge care.

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[20] that “patients who receive a psychosocial assessment may encounter a wide range of experiences with regard to the professionals they come across, the assessment itself and its administration, and the environment. Service users’ experiences of psychosocial management after a DSH episode varied across studies. Many patients welcomed the chance to discuss their problems and the issues that led up to their DSH episode. However, service users’ expectations of the assessment and the way in which they interpreted staff management of their psychosocial assessment had a large impact on their satisfaction”.

10.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes, including evidence of people dying by suicide on the same day as discharge from hospital).

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[19] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

[20] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

10.1.5 Current practice

The Royal College of Psychiatrists[21] report on views and experiences of health professionals in contact with people who self-harm. Fewer than 50% of respondents to the College Members' survey considered that they (or their team) had the training to undertake psychosocial assessments of risk and need with people who had harmed themselves. The highest percentage of those who have been trained were in liaison settings (62.7%). Over two-thirds of the 85 psychiatric trainees and doctors working in A&E departments rated their training in conducting psychosocial assessments as 'insufficient'.

Respondents to the College Members' survey voiced that "positive risk taking and overall patient well-being were both jeopardised by defensive practice arising from the preoccupation with risk assessment. Use of separate risk assessment tools is dangerous as overreliance on them too easily leads to complacency and can misdirect people into thinking that there is a short-cut to assessment that ignores detailed history and mental state assessment and the need to synthesise a detailed clinical formulation based upon these".

Between 40 and 50% of all participants in the College Members' survey reported personally undertaking psychosocial assessments with all patients who had self-harmed; 64–71% reported that the teams in which they worked undertook these assessments with all patients. Those reporting liaison as a specialty were more likely to undertake assessments of all types with all patients reporting self-harm (between 78 and 82%).

When asked if they had received a psychosocial assessment, 62% of service users replying to the College survey said yes, although a third were dissatisfied with the quality of assessment they had received. In some cases, service users felt that the assessment was something that was 'done to me, rather than with me'.

NICE uptake database 'ERNIE' contains information on a local audit of 5370 treated episodes of self-harm in Manchester (2005 to 2007). Of those that were admitted to a medical bed, 54% received a psychosocial assessment by a mental health specialist.

A local audit in Ireland of 834 attendances to A&E for self-harm (12-month period, 2006)[22] revealed 59% of cases included a psychosocial assessment by a member of the mental health team. Of those that did not receive a psychosocial assessment: 39% were males under 45, 59% had a history of

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[21] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

[22] Mullins D, Machale S, Cotter D (2010) Compliance with NICE guidelines in the management of self-harm.

psychiatric illness, 44% had a history of self-harm. Of those who did not receive a psychosocial assessment, 141 (41%) re-attended during the 12-month study period.

10.1.6 Current indicators

No current NHS indicators identified.

11 Consent and competency of children and young people

11.1 NICE CG16 1.9.1.8 and NICE CG133 1.1.18

11.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.9.1.8 In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act. CG133 1.1.18 Health and social care professionals who have contact with children and young people who self-harm should be trained to: • understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm • understand how issues of capacity and consent apply to different age groups • assess mental capacity in children and young people of different ages. They should also have access at all times to specialist advice about capacity and consent.
Proposed quality statement	Children and young people who self-harm are assessed and treated with attention to competency and consent.
Draft quality measure	**Structure:** a) Evidence of local arrangements to ensure that staff working with children and young people who self-harm can access specialist advice about capacity and consent. b) The proportion of staff working with children and young people who self-harm who are trained to understand capacity and consent issues in children and young people. Numerator – The number of staff in the denominator trained to understand capacity and consent issues in children and young people. Denominator – The number of staff working with children and young people who self-harm.

11.1.2 Clinical and cost-effectiveness evidence

Clinical guideline 16 recommendation 1.9.1.8 is good practice based on the clinical experience of the development group and the legal framework.

Clinical guideline 133 recommendation 1.1.18 is based on long-standing policy, the legal framework, expert opinion/reports and are recommended good practice based on the clinical experience of the development group. Healthcare professionals who have contact with young people should be aware of the Mental Health Act (1983; amended 1995 and 2007; HMSO, 2007), the Mental Health Act code of practice (HMSO, 2008) and the Children Acts (HMSO, 1989; amended 2004) and how these relate to capacity and consent in young people.

Issues of confidentiality are particularly challenging with children and young people who self-harm and have capacity yet refuse the involvement of their parents or carers in their treatment or refuse consent to disclose issues relating to their safety to their parents or carers. In these circumstances healthcare professionals need to carefully weigh the rights of the young person to confidentiality and the risk to the therapeutic relationship of a breach of confidentiality against providing the family and carers with sufficient information to enable them to appropriately protect and care for the young person.

11.1.3 Experience

No information is presented on experience.

11.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

11.1.5 Current practice

The National Inquiry into self-harm among young people (2006), heard evidence from the Royal College of General Practitioners' Adolescent Task Group that "GPs are also often concerned about confidentiality and/or child protection; and what they should do for the young person whilst waiting for them to be seen by the local child and adolescent mental health services (CAMHS)".

11.1.6 Current indicators

No current NHS indicators identified.

12 Issues for older people

12.1 NICE CG16 1.10.1.1

12.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG16 1.10.1.1 All people older than 65 years of age who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to the potential presence of depression, cognitive impairment and physical ill health, and should include a full assessment of their social and home situation. CG133 1.3.3 All people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for working-age adults (see recommendations 1.3.1 and 1.3.2). In addition: • pay particular attention to the potential presence of depression, cognitive impairment and physical ill health • include a full assessment of the person's social and home situation, including any role they have as a carer, and • take into account the higher risks of suicide following self-harm in older people.
Proposed quality statement	Older people who self-harm are assessed and treated with attention to possible depression, cognitive impairment, physical ill health, and their social and home situation.
Draft quality measure	**Structure:** a) Evidence of local arrangements to ensure that staff working with older people who self-harm can access specialist advice about possible depression, cognitive impairment, physical ill health, and their social and home situation. b) The proportion of staff working with older people who self-harm who are trained to understand and manage self-harm in older people. Numerator – The number of staff in the denominator trained to understand and manage self-harm in older people. Denominator – The number of staff working with older people who self-harm.

12.1.2 Clinical and cost-effectiveness evidence

Clinical guidelines 16 and 133 explain that while older people appear to be less likely to self-harm, the consequences are often more serious; it has been estimated that one out of every five older people who self-harm will later die by suicide. Consistent with this, older people who have self-harmed score highly on scales that measure suicidal intent, and their profile resembles that of older people who die by suicide. In particular, older people who self-harm have high rates of physical ill health, social isolation and depression. One study of 730 people who were 60 years or older and had presented to hospital following self-harm found very high suicidal intent and, at follow-up over 20 years, very high suicide rates (4.5%). A further study of older people with depression found that two thirds had significant suicidal intent. Older people with depression who self-harmed were more likely to have a poorly integrated social network; loneliness and lack of support from services were identified as important factors in determining suicidal behaviour in older adults.

12.1.3 Experience

No information is presented on experience.

12.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

12.1.5 Current practice

No information is presented on current practice.

12.1.6 Current indicators

No current NHS indicators identified.

13 Longer term management – care plans

13.1 NICE CG133 1.4.2, 1.4.3 and 1.4.4 [KPIs]

13.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG133 1.4.2 Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to: • prevent escalation of self-harm • reduce harm arising from self-harm or reduce or stop self-harm • reduce or stop other risk-related behaviour • improve social or occupational functioning • improve quality of life • improve any associated mental health conditions. Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. CG133 1.4.3 Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans 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 (see below) • be shared with the person's GP. CG133 1.4.4 A risk management plan should be a clearly identifiable part of the care plan and should: • address each of the long-term and more immediate risks identified in the risk assessment • address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide • include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail • ensure that the risk management plan is consistent with the long-term treatment strategy. Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.

Proposed quality statement	People who self-harm accepting longer-term care and treatment are involved in developing a comprehensive care plan that is reviewed at least once every 12 months.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that care plans for people who self-harm accepting longer-term care and treatment are comprehensive and reviewed in the last 12 months. **Process:** The proportion of people receiving longer term care and treatment for self-harm who have a comprehensive care plan reviewed in the last 12 months. Numerator – The number of people in the denominator who have a comprehensive care plan reviewed in the last 12 months. Denominator – The number of people who self-harm receiving longer term care and treatment. **Outcome:** Evidence from feedback that people receiving longer term care and treatment are involved in the development of their care plan and that it is reviewed at least once a year.
Definition	CG133 states a 'comprehensive 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.

13.1.2 Clinical and cost-effectiveness evidence

The recommendations are based on long-standing policy, expert opinion/reports and are recommended good practice based on the clinical experience of the development group.

Guidance developers undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Service users reported feeling frustrated when organising their own aftercare because often they could not reach services through the telephone numbers provided.

13.1.3 Experience

In a Royal College of Psychiatrists survey of 509 patients[23], half of service users felt their views were taken into account when their risk was being assessed. 39% were not given sufficient information about who else would be

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[23] Royal College of Psychiatrists (2007) Service users experiences of emergency services following self-harm: A National Survey of 509 patients.

told about their visit to the emergency department. The majority (79%) were not given a copy of any plan for post-discharge care.

The National Inquiry into self-harm among young people (2006), heard evidence that “instead of being given different options (which was what they wanted) a lot of young people were given medication (mostly SSRIs) straightaway, with no other follow-up or support”.

13.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

13.1.5 Current practice

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[24] that “post-hospitalisation management was an area in which interviewees had a variety of experiences. Many patients never receive follow-up care following self-harm. In one study information was collected on emergency admissions for self-harm in 30 locations. Thirty-four per cent of patients were discharged and referred to community mental health teams or their general practitioner and eleven per cent of patients were discharged with no follow-up”.

13.1.6 Current indicators

No current NHS indicators identified.

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[24] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

14 Longer term management – Psychological interventions

14.1 NICE CG133 1.4.8 [KPI]

14.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	CG133 1.4.8 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.
Proposed quality statement	People who self-harm accepting longer-term care are offered 3 to 12 sessions of a psychological intervention 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:** The proportion of people receiving longer term care for self-harm who receive at least 3 sessions of a psychological intervention structured for people who self-harm. Numerator – The number of people in the denominator who receive at least 3 sessions of a psychological intervention structured for people who self-harm. Denominator – The number of people receiving longer term care for self-harm.

14.1.2 Clinical and cost-effectiveness evidence

CG133 1.4.8 Based on the clinical review, there is some evidence showing clinical benefit of psychological interventions in reducing repetition of self-harm episodes, compared with routine care. However, there is considerable uncertainty and heterogeneity with respect to the population, treatment length and treatment modality and settings, which lowers the quality of the evidence. Interventions in the analysis included cognitive behavioural, psychodynamic, or problem-solving elements. The number of sessions in studies varied, with an average of six sessions, and the GDG opted to recommend a range of three to twelve sessions.

From the health economic evidence, there is some evidence to suggest that a psychological intervention is potentially cost effective in reducing repetition of self-harm episodes. In the long term, the health and economic benefit is also significant. However, given the extent of uncertainty around the treatment effect estimate, there is a need to be cautious in the implementation of a psychological intervention. Further research is necessary to determine the extent of the benefit of intensive psychological intervention, the usefulness of the QALY as an outcome in self-harm interventions, and the effect of the settings in which the intervention is delivered.

Guidance developers undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Seven studies examined the experience of psychological treatment, reporting diverse experience and preferences. Positive experiences included access to community based interventions, time to talk about experiences and meet other people who self-harm. Conversely some reported negative experiences associated with the stigma of visiting a psychiatrist or psychologist and retelling or sharing their story.

A number of other psychosocial interventions were also reviewed, namely intensive intervention, provision of emergency cards, establishing contact by telephone support and sending postcards to individuals. However, compared with usual care, there was insufficient evidence to determine clinical effects between interventions and routine care in the reduction of the proportion of participants who repeated self-harm. Thus, no conclusions could be made regarding psychosocial interventions for reducing repetitions of self-harm.

14.1.3 Experience

The National Inquiry into self-harm among young people (2006) examined the sort of help young people would want on offer. 142 respondents to a multiple choice questionnaire indicated that face to face support would be most useful:

Type of help young people thought would be useful	N	%
1:1 support / counselling	121	85.2
Group support / drop in	101	71.1
Self-help group (facilitated)	86	60.6
Creative initiatives	85	59.9
Multimedia / internet access	81	57
Information point	72	50.7
Outreach Team	64	45.1

Family support	53	37.3
Self-help (no facilitator)	29	20.4

14.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

14.1.5 Current practice

The Royal College of Psychiatrists[25] report on views and experiences of health professionals in contact with people who self-harm. In liaison, general adult, addictions, and learning disabilities about 50–55% of respondents agreed that such therapies were widely available in their organisation for people who self-harmed. This contrasts with 73–78% of those respondents practicing in child and adolescent, psychotherapy and forensic settings.

14.1.6 Current indicators

No current NHS indicators identified.

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[25] Royal College of Psychiatrists (2010) Self-harm, Suicide and Risk: Helping People who Self-harm.

15 Longer term management – transitions

15.1 NICE CG133 1.1.2.5

15.1.1 Relevant NICE clinical guideline recommendations and proposed quality statement

Guideline recommendations	NICE CG133 1.1.2.5 Anticipate that the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm, and: • Plan in advance these changes with the person who self-harms and provide additional support, if needed, with clear contingency plans should crises occur. • Record plans for transition to another service and share them with other health and social care professionals involved. • Give copies to the service user and their family, carers or significant others if this is agreed with the service user.
Proposed quality statement	People who self-harm accepting longer-term care are involved in planning any move between services and understand who to contact in a crisis.
Draft quality measure	**Structure:** Evidence that local services plan, configure and deliver integrated services for people who self-harm. **Process:** The proportion of people moving between services for the longer term care of self-harm who are involved in planning the move. Numerator – The number of people in the denominator involved in planning the transition. Denominator – The number of people with moving between services for the longer term care of self-harm. **Outcome:** Evidence from feedback that the people moving between services for the longer term care of self-harm knew who to contact in a crisis and were involved in planning the move.

15.1.2 Clinical and cost-effectiveness evidence

CG133 1.1.2.5 Guidance developers undertook a systematic search for published reviews of relevant qualitative studies of people who self-harm. Common suggestions for the improvement of services included enhancing continuity of care and ensuring that service users are involved in making decision about their care.

15.1.3 Experience

The National Institute for Health Research Service Delivery and Organisation Programme reported in 2008[26] that "although many patients were provided with a referral for aftercare, some were unhappy about the type of referral they received. Often patients were given contact numbers for community organisations. However, some patients were uncomfortable dialling these organisations without any prior connection to them".

15.1.4 Safety

No patient safety evidence was identified (see full report from the patient safety function at the NHS Commissioning Board Special Health Authority for broader themes).

15.1.5 Current practice

SCIE[27] report concerns in the transition of all young people with mental health problems from adolescent to adult services:

"Difficulties in providing good support during mental health service transitions are linked to broader issues in providing effective, age-appropriate, accessible mental health support to young people. The mental health needs of this diverse group are distinct from those of both children and adults. The way in which CAMHS and AMHS are organised does not always fit easily with the ways in which mental health problems are experienced by young people.

A young person may find him- or herself without a service for various reasons. These include:

- Differences in referral criteria and entry thresholds in CAMHS and AMHS.
- Inconsistencies in age cut-off points, with some services ending when a young person is 16 while other services have a lower age limit of 18.
- For some groups (e.g. young people with learning disabilities, ADHD and ASDs), long-term experiences and outcomes into adulthood are not well documented. Young people with these difficulties who receive help from CAMHS are likely to need ongoing support as adults - however, there is a lack of adult services to cater for them.

Even when young people are successfully referred to adult services, the move may not go well. Practice is frequently inconsistent and often poor, resulting in negative experiences for young people and their families."

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[26] The National Institute for Health Research Service Delivery and Organisation Programme (2008) Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review of the literature

[27] Social Care Institute for Excellence (2011) Guide 44: Mental health service transitions for young people

15.1.6 Current indicators

No current NHS indicators identified.

15.1.6 Current indicators

Appendix A: Definition of patient safety

The National Patient Safety Agency (NPSA) defines patient safety in the following terms:

Every day more than a million people are treated safely and successfully in the NHS, but the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. When things go wrong, patients are at risk of harm, and the effects are widespread and often devastating for patients, their families and the staff involved. Safety incidents also incur costs through litigation and extra treatment, and in 2009/10 the NHSLA paid out approximately £827, 000,000 in litigation costs and damages. These incidents are often caused by poor system design rather than the error of individuals i.e. ‘they are an accident waiting to happen’.

In short patient safety could be summarised as ‘The identification and reduction of risk and harm associated with the care provided to patients ‘or ‘Preventing patients from being harmed by their treatment’. Examples of this might be ‘operating on or removing the wrong organ, ten times the dose of an opioid, giving a colonoscopy to the wrong patient with the same name as someone else in the waiting room etc.’ These risks are unlikely to be identified through clinical trials or traditional evidence bases and so other evidence sources, such as the National Reporting and Learning System, need to be analysed to highlight the risks and improve system development. This does not however give an accurate picture of prevalence in that way that methods such as casenote review may do.