

Self-harm: longer-term management

Issued: November 2011

NICE clinical guideline 133

guidance.nice.org.uk/cg133

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Introduction

This guideline follows on from [Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care](#) (NICE clinical guideline 16), which covered the treatment of self-harm within the first 48 hours of an incident. This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments (these can be found in [NICE clinical guideline 16](#)).

The term self-harm is used in this guideline 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. There are several important exclusions that this term is not intended to cover. These include harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

Self-harm is common, especially among younger people. A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year. For all age groups, annual prevalence is approximately 0.5%. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period. A wide range of psychiatric problems, such as borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders, are associated with self-harm.

Self-harm is often managed in secondary care – this includes hospital medical care and mental health services. About half of the people who present to an emergency department after an incident of self-harm are assessed by a mental health professional.

People who self-harm also have contact with primary care. About half of the people who attend an emergency department after an incident of self-harm will have visited their GP in the previous month. A similar proportion will visit their GP within 2 months of attending an emergency department after an incident of self-harm.

The guideline is relevant to all people aged 8 years and older who self-harm, and it addresses all health and social care professionals who come into contact with them. Where it refers to children and young people, this applies to all people who are between 8 and 17 years inclusive.

Person-centred care

This guideline offers best practice advice on the care of adults, children and young people who self-harm.

Treatment and care should take into account service users' needs and preferences. People who self-harm should have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals. If service users do not have the capacity to make decisions, health and social care professionals should follow the guidance in the [code of practice that accompanies the Mental Capacity Act](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

If the service user is under 16, health and social care professionals should follow the guidelines in [Seeking consent: working with children](#).

Good communication between health and social care professionals and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are 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.

If the service user agrees, families, carers and significant others^[1] should have the opportunity to be involved in decisions about treatment and care. Families, carers and significant others should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in [Transition: getting it right for young people](#).

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people who self-harm. Management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

^[1] 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Working with people who self-harm

- 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.

Psychosocial assessment

- 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.
- Assessment of needs should include:
 - skills, strengths and assets
 - coping strategies
 - mental health problems or disorders
 - physical health problems or disorders
 - social circumstances and problems

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- psychosocial and occupational functioning, and vulnerabilities
 - recent and current life difficulties, including personal and financial problems
 - the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
 - the needs of any dependent children.

Risk assessment

- When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:
 - methods and frequency of current and past self-harm
 - current and past suicidal intent
 - depressive symptoms and their relationship to self-harm
 - any psychiatric illness and its relationship to self-harm
 - the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
 - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
 - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
 - significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
 - immediate and longer-term risks.

Risk assessment tools and scales

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

Care plans

- 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.

- 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^[2]. 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 [recommendations 1.4.4 and 1.4.5](#))
 - be shared with the person's GP.

Risk management plans

- A risk management plan should be a clearly identifiable part of the care plan and should:

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- 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.

Interventions for self-harm

- 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.
- Do not offer drug treatment as a specific intervention to reduce self-harm.

Treating associated mental health conditions

- Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:
 - [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE clinical guideline 115).

- Depression (NICE clinical guideline 90).
- Schizophrenia (NICE clinical guideline 82).
- Borderline personality disorder (NICE clinical guideline 78).
- Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
- Bipolar disorder (NICE clinical guideline 38).

^[2]'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

1 Guidance

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

1.1 *General principles of care*

Working with people who self-harm

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.

1.1.2 Health and social care professionals who work with people who self-harm should be:

- familiar with local and national resources, as well as organisations and websites that offer information and/or support for people who self-harm, and
- able to discuss and provide advice about access to these resources.

Access to services

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- 1.1.3 Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS).
- 1.1.4 Ensure that children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate.
- 1.1.5 When language is a barrier to accessing or engaging with services for people who self-harm, provide them with:
- information in their preferred language and in an accessible format
 - psychological or other interventions, where needed, in their preferred language
 - independent interpreters.

Self-harm and learning disabilities

- 1.1.6 People with a mild learning disability who self-harm should have access to the same age-appropriate services as other people covered by this guideline.
- 1.1.7 When self-harm in people with a mild learning disability is managed jointly by mental health and learning disability services, use the Care Programme Approach (CPA).
- 1.1.8 People with a moderate or severe learning disability and a history of self-harm should be referred as a priority for assessment and treatment conducted by a specialist in learning disabilities services.

Training and supervision for health and social care professionals

- 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, and

- educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes.

1.1.10 Health and social care professionals who provide training about self-harm should:

- involve people who self-harm in the planning and delivery of training
- ensure that training specifically aims to improve the quality and experience of care for people who self-harm
- assess the effectiveness of training using service-user feedback as an outcome measure.

1.1.11 Routine access to senior colleagues for supervision, consultation and support should be provided for health and social care professionals who work with people who self-harm. Consideration should be given of the emotional impact of self-harm on the professional and their capacity to practice competently and empathically.

Consent and confidentiality

1.1.12 Health and social care professionals who work with people who self-harm should be trained to:

- understand and apply the principles of the Mental Capacity Act (2005) and Mental Health Act (1983; amended 1995 and 2007)
- assess mental capacity, and
- make decisions about when treatment and care can be given without consent.

1.1.13 Be familiar with the principles of confidentiality with regard to information about a person's treatment and care, and be aware of the circumstances in which disclosure of confidential information may be appropriate and necessary.

1.1.14 Offer full written and verbal information about the treatment options for self-harm, and make all efforts necessary to ensure that the person is able, and has the opportunity, to give meaningful and informed consent.

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- 1.1.15 Take into account that a person's capacity to make informed decisions may change over time, and that sometimes this can happen rapidly in the context of self-harm and suicidal behaviour.
- 1.1.16 Understand when and how the Mental Health Act (1983; amended 1995 and 2007) can be used to treat the physical consequences of self-harm.
- 1.1.17 Health and social care professionals who work with people who self-harm should have easy access to legal advice about issues relating to capacity and consent.
- 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.

Safeguarding

- 1.1.19 CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local [safeguarding procedures](#).
- 1.1.20 If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:
- use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
 - consider using the [Common Assessment Framework](#)^[3]; advice on this can be sought from the local named lead for safeguarding children.

If serious concerns are identified, develop a child protection plan.

- 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.

Families, carers and significant others^[4]

- 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.

- 1.1.23 When families, carers or significant others are involved in supporting a person who self-harms:

- offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
- offer contact numbers and information about what to do and whom to contact in a crisis
- offer information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers or significant others to access these
- inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.

- 1.1.24 CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with perceived risks and the responsibilities and views of parents or carers.

Managing endings and supporting transitions

1.1.25 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.

1.1.26 CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services.

- Time the transfer to suit the young person, even if it takes place after they reach the age of 18 years.
- Continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.

1.1.27 Mental health trusts should work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services, as described in this guideline.

1.2 Primary care

1.2.1 If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:

- levels of distress are rising, high or sustained
- the risk of self-harm is increasing or unresponsive to attempts to help
- the person requests further help from specialist services

- levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

1.2.2 If a person who self-harms is receiving treatment or care in primary care as well as secondary care, primary and secondary health and social care professionals should ensure they work cooperatively, routinely sharing up-to-date care and risk management plans. In these circumstances, primary health and social care professionals should attend CPA meetings.

1.2.3 Primary care professionals should monitor the physical health of people who self-harm. Pay attention to the physical consequences of self-harm as well as other physical healthcare needs.

1.3 Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks

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.

Assessment of needs

1.3.2 Assessment of needs should include:

- skills, strengths and assets
- coping strategies
- mental health problems or disorders
- physical health problems or disorders
- social circumstances and problems

- psychosocial and occupational functioning, and vulnerabilities
- recent and current life difficulties, including personal and financial problems
- the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
- the needs of any dependent children.

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.

1.3.4 Follow the same principles as for adults when assessing children and young people who self-harm (see recommendations 1.3.1 and 1.3.2), but also include a full assessment of the person's family, social situation, and child protection issues.

1.3.5 During assessment, explore the meaning of self-harm for the person and take into account that:

- each person who self-harms does so for individual reasons, and
- each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.

Risk assessment

A risk assessment is a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the

judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm.

- 1.3.6 When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:
- methods and frequency of current and past self-harm
 - current and past suicidal intent
 - depressive symptoms and their relationship to self-harm
 - any psychiatric illness and its relationship to self-harm
 - the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
 - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
 - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
 - significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
 - immediate and longer-term risks.
- 1.3.7 Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking.
- 1.3.8 When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others'^[4] medications.

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- 1.3.9 In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person.
- 1.3.10 Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

Risk assessment tools and scales

Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

- 1.3.11 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.
- 1.3.12 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.
- 1.3.13 Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6.

Developing an integrated care and risk management plan

- 1.3.14 Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8) and use these to develop a care plan (see [recommendations 1.4.2 and 1.4.3](#)) and a risk management plan (see [recommendations 1.4.4 and 1.4.5](#)) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP.
- 1.3.15 If there is disagreement between health and social care professionals and the person who self-harms about their needs or risks, consider offering the person the opportunity to write this in their notes.

1.4 Longer-term treatment and management of self-harm

Provision of care

1.4.1 Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see [section 1.3](#)) and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS^[5].

Care plans

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.

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^[4]. 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.

Risk management plans

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.

1.4.5 Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.

Provision of information about the treatment and management of self-harm

1.4.6 Offer the person who self-harms relevant written and verbal information about, and give time to discuss with them, the following:

- the dangers and long-term outcomes associated with self-harm

- the available interventions and possible strategies available to help reduce self-harm and/or its consequences (see [recommendations 1.1.1](#) and 1.4.10)
- treatment of any associated mental health conditions (see [section 1.5](#)).

1.4.7 Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to [information for the public](#) that NICE has produced for [this guideline](#) and for the [short-term management of self-harm](#) (NICE clinical guideline 16).

Interventions for self-harm

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.

1.4.9 Do not offer drug treatment as a specific intervention to reduce self-harm.

Harm reduction

1.4.10 If stopping self-harm is unrealistic in the short term:

- consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
- consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
- advise the service user that there is no safe way to self-poison.

1.5 Treating associated mental health conditions

1.5.1 Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:

- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE clinical guideline 115).
- [Depression](#) (NICE clinical guideline 90).
- [Schizophrenia](#) (NICE clinical guideline 82).
- [Borderline personality disorder](#) (NICE clinical guideline 78).
- Drug misuse ([psychosocial interventions](#) or [opioid detoxification](#)) (NICE clinical guidelines 51 and 52).
- [Bipolar disorder](#) (NICE clinical guideline 38).

1.5.2 When prescribing drugs for associated mental health conditions to people who self-harm, take into account the toxicity of the prescribed drugs in overdose. For example, when considering antidepressants, selective serotonin reuptake inhibitors (SSRIs) may be preferred because they are less toxic than other classes of antidepressants. In particular, do not use tricyclic antidepressants, such as dosulepin, because they are more toxic.

^[3] It should be noted that the Common Assessment Framework is not applicable in Wales.

^[4] 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

^[5] Tier 2 CAMHS: primary care; Tier 3 CAMHS: community child and adolescent mental health teams.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about [how NICE clinical guidelines are developed](#) on the NICE website and in [How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS](#).

3 Implementation

NICE has developed [tools](#) to help organisations implement this guidance.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see [section 5](#)).

4.1 Effectiveness of training

For healthcare professionals who work with people who self-harm, does the provision of training in assessment and management improve outcomes compared with no additional specialist training?

A well-powered randomised controlled trial should examine the effectiveness of training. Researchers should consider the format and length of training. The outcomes chosen should include both healthcare professionals' and service users' evaluation of the training, and the effect on subsequent knowledge, attitude and behavioural changes. It should include longer-term follow-up of 12 months or more.

Why this is important

Current studies of training have been limited in their assessment of changes in healthcare professionals' knowledge, attitudes and behaviour. Crucially no studies have examined whether training has any impact on service users' experience and outcomes. Healthcare professionals frequently report that treating service users who self-harm is challenging and they are likely to find training helpful as it provides an opportunity to think about and understand this aspect of their work. Studies to date, however, have not looked beyond these initial outcomes of training, which are more indicative of satisfaction with training rather than addressing whether training has had an impact on practice, service user experience and outcomes. Future research should consider a wider range of outcomes – for example, attitudes, changes in assessment practice, changes in interventions and improvement in service user experience and outcomes. The longer-term impact of training should also be assessed.

4.2 Effectiveness of psychosocial assessment with a valid risk scale

For people who self-harm (including young people), does the provision of psychosocial assessment with a validated risk scale, compared with psychosocial assessment alone, improve outcomes?

This question should be answered using a well-conducted randomised controlled trial. The assessment should be conducted by mental health professionals in community mental health teams. The main outcomes should include both hospital-reported and self-reported repetitions of self-harm. Outcomes such as service users' experience of assessment and the impact on therapeutic engagement should also be included. The duration of the study should be at least 6 months.

Why this is important

There are many different scales aimed at predicting the risk of self-harm and these are widely used in clinical practice. The sensitivity and specificity of these scales are, at best, modest. While individual scales may provide useful prompts for making a psychosocial assessment, it is possible that they may disrupt engagement and encourage clinicians to treat risk as dichotomous rather than continuous. It is therefore important to establish how they are used, how their use is experienced and whether scales do or do not improve tangible service-user outcomes.

4.3 Clinical and cost effectiveness of psychological therapy with problem-solving elements for people who self-harm

For people who have self-harmed, does the provision of a psychological therapy with problem-solving elements, compared with treatment as usual, improve outcomes? What is the differential effect for people with a past history of self-harm, compared with people who self-harm for the first time?

This question should be answered using a well-conducted randomised controlled trial. Consider six sessions of psychological therapy with problem-solving elements, delivered immediately after discharge for the index episode of self-harm. The therapist should be trained and experienced in working with people who self-harm. Participants' history of previous self-harm, methods used and

psychiatric history should be noted. Primary outcomes should include both hospital-reported and self-reported repetitions of self-harm. Other important outcomes, such as quality of life, depressive symptoms, service users' experience and adverse events (for example, distress or exacerbation of symptoms associated with therapy) should be included. The study design should take into account the complex motives that underpin self-harm. Studies need to be large enough to determine the intervention's costs and cost effectiveness.

Why this is important

Although review of the research evidence suggests that psychological therapy with problem-solving elements offers promise, it is not clear which components are the active ingredients of any such intervention, or whether such an intervention is effective for people with a past history of self-harm compared with those who have self-harmed for the first time. Further, only a few studies have looked at a broad range of outcomes for different populations who self-harm.

4.4 Clinical effectiveness of low-intensity/brief psychosocial interventions for people who self-harm

For people who self-harm, does the provision of potentially cheap low-intensity/brief psychosocial interventions, compared with treatment as usual, improve outcomes?

This question should be answered using a well-conducted randomised controlled trial. Consider using a variety of approaches, including postcards, emergency cards, phone calls, or the use of electronic media in community mental health settings. The outcomes should include service users' engagement and experience, and hospital-reported and self-reported repetitions of self-harm. Other important outcomes, such as quality of life, depressive symptoms and adverse events (for example, distress or exacerbation of symptoms associated with contact with services) should be included.

Why this is important

Many people do not engage with available treatments following self-harm. If acceptable, alternative approaches, such as the low-intensity contact interventions indicated above, can be relatively easily and widely implemented, with the potential to improve outcomes, at relatively low cost, in individuals who may be otherwise difficult to engage.

4.5 Observational study exploring different harm-reduction approaches

What are the different approaches to harm reduction following self-harm in NHS settings?

A study should be carried out to investigate the different approaches to harm reduction following self-harm currently in use in NHS settings. This could use survey methodology with all, or a selected sample of, mental health service providers. Audit data should be used to provide a preliminary evaluation of potential utility. Promising interventions might be tested in small-scale pilot randomised controlled trials, which use frequency and severity of self-harm, and standard measures of distress and psychological symptoms, as outcome measures. Other outcomes such as quality of life, service users' experience and adverse events should be included.

Why this is important

Although cessation of the behaviour remains the treatment goal for many professionals providing care to people who self-harm, this may not be realistic or possible in the short term for some individuals. An alternative strategy for services is to reduce the severity and frequency of self-harm. Anecdotally, a variety of approaches to harm reduction are used in health service settings – for example, minimising the physical harm associated with episodes or suggesting alternatives to self-harming behaviours. However, the extent to which such management strategies are used across services is uncertain, as is their effectiveness.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, [Self-harm: longer-term management in adults, children and young people](#), contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health, and is available from www.nccmh.org.uk and from [our website](#).

5.2 NICE pathway

The recommendations from this guideline have been incorporated into a [NICE pathway](#).

5.3 Information for the public

NICE has produced [information for the public](#) explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials about self-harm.

6 Related NICE guidance

- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#). NICE clinical guideline 115 (2011).
- [Depression: the treatment and management of depression in adults](#). NICE clinical guideline 90 (2009).
- [Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care](#). NICE clinical guideline 82 (2009).
- [Borderline personality disorder: treatment and management](#). NICE clinical guideline 78 (2009).
- [Drug misuse: opioid detoxification](#). NICE clinical guideline 52 (2007).
- [Drug misuse: psychosocial interventions](#). NICE clinical guideline 51 (2007).
- [Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care](#). NICE clinical guideline 38 (2006).
- [Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care](#). NICE clinical guideline 16 (2004).

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

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Mr Robin Beal Consultant in Accident and Emergency Medicine, Isle of Wight

Dr Mark Hill Head of Medical Affairs, Novartis Pharmaceuticals UK Ltd

Ms Victoria Thomas (PPIP stood in as lay member) Associate Director, Patient and Public Involvement Programme, NICE

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

The recommendations from this guideline have been incorporated into a [NICE Pathway](#). We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

Changes after publication

June 2012: minor maintenance

March 2013: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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