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Appendix 1: Scope for the development of a clinical guideline on the management of self-harm

1 Guideline title

Self-harm: the short-term physical and psychological management and secondary prevention of intentional self-harm in primary and secondary care.[1]

1.1 Short title

Self-harm

2 Background

a) The National Institute for Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Mental Health to develop a clinical guideline on intentional self-harm for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health and National Assembly for Wales (see Appendix). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.
b) The Institute's clinical guidelines will support the implementation of National Service Frameworks (NSFs) in those aspects of care where a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued will have the effect of updating the Framework.

3 Clinical need for the guideline

a) Intentional self-harm (often referred to as deliberate self-harm or DSH) results in about 150,000 attendances at accident and emergency departments each year. It is one of the top five causes of acute medical admission.
b) Rates of self-harm in the UK have increased over the past decade and are among the highest in Europe.

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[1]The title was changed to 'Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care' by the GDG during the development process. See Chapter 2 for a note on terminology.

c) Rates of self-harm are much higher among groups with high levels of poverty and in adolescents and younger adults.
d) Those who have self-harmed are 100 times more likely than the general population to die by suicide in the subsequent year. One-half of the 4000 people who die by suicide each year will have self-harmed at some time in the past.
e) Self-poisoning with prescription and non-prescription drugs is by far the commonest means of intentional self-harm. The ingestion of large doses of these drugs can cause severe physical damage and is sometimes fatal.
f) Most people who have intentionally self-harmed, who come to the attention of medical services, are treated initially in a hospital accident and emergency department. More than one-half are discharged without being assessed by a specialist mental health care worker.
g) Three-quarters of people who have harmed themselves arrive at hospital in the evening.
h) One-half of people who self-harm have also consumed alcohol; about 10% are alcohol-dependent.
i) Health services staff frequently have a negative attitude towards those who carry out acts of self-harm, particularly those who harm themselves repeatedly.

4 The guideline

a) The guideline development process is described in detail in three booklets that are available from the NICE website (see 'Further information'). *The Guideline Development Process – Information for Stakeholders* describes how organisations can become involved in the development of a guideline.
b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health and National Assembly for Wales (see Appendix).
c) The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Definition of self-harm

The definition of self-harm adopted by the guideline is 'intentional self-poisoning or injury, irrespective of the apparent purpose of the act'. Self-harm includes poisoning, asphyxiation, cutting, burning and other self-inflicted injuries.

4.1.2 Groups that will be covered

a) The guideline will be relevant to all people aged 8 years and over who have carried out an act of intentional self-harm, regardless of whether the behaviour is accompanied by a mental illness.
b) The guideline will be sensitive to the varying approaches of different races and cultures and be aware of the issues of both internal and external social exclusion.

4.1.3 Groups that will not be covered

a) The guideline will cover the acute care of self-harm in people with learning disabilities, but not repetitive self-injurious behaviour, such as head banging.

4.2 Healthcare setting

a) The guideline will offer guidance about care provided by primary, community and secondary health and social care services.

b) The guideline will be relevant to all professionals who have direct contact with, and make decisions concerning the care of people who intentionally self-harm. This includes: primary care doctors, nurses and counsellors; ambulance and paramedical staff; doctors and nurses working in accident and emergency departments; hospital physicians; and psychiatrists, mental health nurses, psychologists, social workers, paediatricians and all healthcare staff who assess or treat people who have self-harmed.

4.3 Clinical management

a) The guideline will address medical and psychiatric assessment, early medical management and prevention of repeated self-harm (secondary prevention).

b) The guideline will not address separately the management of the mental illnesses that may accompany self-harming behaviour.

c) The guideline will recognise the role of the family and potential carers in the care of people who have self-harmed.

d) The guideline will include, where relevant, considerations for people of different age groups (for example, children, older people and the transition between services provided for different age groups, where relevant).

4.3.1 Medical assessment and care

The guideline will provide guidance in the following areas.

a) The immediate first aid assessment and care of people who have intentionally self-harmed, including criteria for referral to A&E or specialist services, for primary care staff.

b) The short-term (up to 48 hours) medical assessment, investigation and treatment of the effects of self-harm. This will include the investigation of those where it is not known which substance has been ingested. There will be an emphasis on the early medical management of the effects of self-poisoning with:

- Paracetamol
- Salicylates
- Antidepressants
- Minor tranquillisers and sedatives
- Major tranquillisers.

c) The factors that predict physical health outcome following self-poisoning.

4.3.2 Psychosocial assessment and care

4.3.2.1 The guideline will offer guidance on the following areas.

a) The immediate psychiatric assessment of people who have self-harmed including assessment of suicide risk, the indications for close observation, admission to a psychiatric ward or intensive home treatment.

b) Demographic, social, psychiatric and any medical factors that predict the likelihood of future acts of self-harm or of suicide.

c) The potential for therapeutic interventions, both short- and long-term, to prevent further acts of self-harm or of suicide.

d) Strategies for ensuring that people are treated with dignity, privacy and respect as well as guidance for staff on responding to challenging behaviour.

e) Information for the patient who is discharged on local supports (for example,

primary care services, social services or self-help groups).

4.3.2.2 The guideline will not cover the long-term psychiatric care of people who repeatedly self-harm.

4.4 Additional considerations

The guideline will include review criteria for audit, which will enable objective measurements to be made of the extent and nature of local implementation of this guidance, particularly its impact upon practice and outcomes for patients.

4.5 Status

4.5.1 Scope

This is the final version of the scope. It has been drafted by the National Collaborating Centre for Mental Health and approved by the Institute following consultation with stakeholders.

4.5.2 Guideline

The development of the guideline recommendations will begin in May 2002.

5 Further information

Information on the guideline development process is provided in:

- *The Guideline Development Process – Information for the Public and the NHS*
- *The Guideline Development Process – Information for Stakeholders*
- *The Guideline Development Process – Information for National Collaborating Centres and Guideline Development Groups*

These booklets are available as PDF files from the NICE website (www.nice.org.uk). Information of the progress of the guideline will also be available from the website.

Remit from the Department of Health and National Assembly for Wales

'To prepare clinical guidelines for the NHS in England and Wales on the management of intentional self-harm (intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act):

a) Guideline for ambulance staff to include:

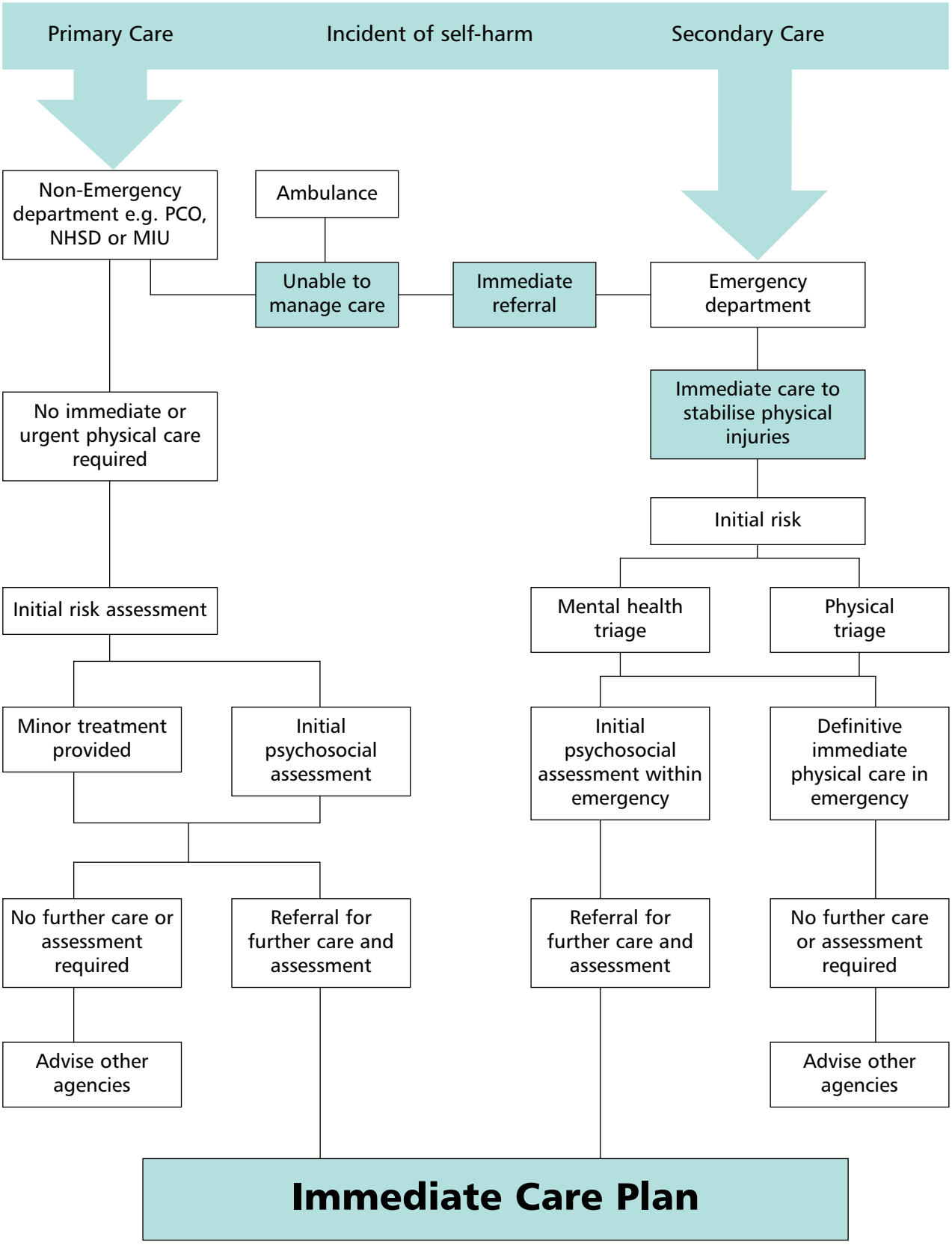
- General support
- Drugs and treatments that should be used.

b) Guideline for A&E staff to include:

- Immediate management in A&E
- Criteria for admission or discharge
- Referral for a psychiatric assessment
- Psychosocial management.

c) Guideline for staff in medical wards to include general medical management on the ward.'

Appendix 2: Flowchart showing service user 'journey' through services



Appendix 3: Stakeholders who responded to early requests for evidence

Independent Healthcare Association

Inner Cities Mental Health Group

Merck Pharmaceuticals

Northern Deanery Regional MRCPsych Course

Appendix 4: Stakeholders and experts who responded to the first consultation draft of the guideline

Stakeholders

Association of the British Pharmaceuticals Industry (ABPI)

Association of Therapeutic Communities

British Association of Art Therapists

British Association for Behavioural & Cognitive Psychotherapies (BABCP)

British Association for Counselling and Psychotherapy

British False Memory Society

British Geriatrics Society

CIS'ters

College of Occupational Therapists

Conwy & Denbighshire NHS Trust

Critical Psychiatry Network

Department of Health

Derbyshire Mental Health Trust

Lundbeck Limited

Mind

National Mental Health Partnership

National Nurse Consultants in CAMHS forum

National Poisons Information Service (NPIS)

Newcastle North Tyneside and Newcastle Mental Health Trust

North Cumbria Acute Hospitals NHS Trust

Paracetamol Information Centre

Royal College of Nursing (RCN)

Royal College of Paediatrics and Child Health

Royal College of Psychiatrists

Royal College of Surgeons, Faculty of A&E Medicine

St Mungos

Self Harm Alliance

SIARI (Self-Injury and Related Issues)

The Survivors Trust

Welsh Assembly Government (formerly National Assembly for Wales)

West London Mental Health Trust

Experts

Sue Bailey

Jonathan Bisson

Helen Blackwell

Catherine Itzin Borowy

Paul Dargan

Michael Dennis

Paul Gill

David Gunnell

The late Richard Harrington

Nav Kapur

Medical Protection Society

Anthony Perini

Mary Piper

Simon Thomas

Appendix 5: Researchers and organisations contacted who submitted information or unpublished research

Bristol Crisis Service for Women

Mind

National Self-Harm Network

PAPYRUS (Prevention of Suicides)

Samaritans

SANE

Professor Peter Tyrer

YoungMinds

Appendix 6: Clinical questions

A.	**Medical Topic Group**
1.	In patients who self-harm, has the current surveillance system improved outcomes compared with that in place 10 years ago?
2.	In unconscious trauma patients where there is evidence of self-harm, does a routine paracetamol screen lead to improved outcomes compared with not screening?
3.	In trauma patients who have arrived at an emergency department unconscious and for whom there is no clear explanation of their trauma, does a psychosocial assessment improve detection and outcome of self-harm?
4.	In patients who self-harm by poisoning, does routine paracetamol levels estimation improve outcome compared with no routine estimation?
5.	In a patient who self-harms does restricting the pack size reduce the incidence and/or severity of the non-accidental overdose?
6.	In patients who self-harm does labelling, product information or verbal information influence the selection of pharmaceuticals taken as a means of self-harm?
7.	In patients who self-poison does any form of gastric emptying/decontamination as opposed to no intervention influence outcome a) after 1 hour of ingestion b) between >60 minutes and < 4 hr c) greater than 4 hr.
8.	What is the impact of different triage systems on outcomes?
9.	In persons who self-harm by cutting, is there any evidence that a specific type of wound closure significantly influences rates of infections, scarring, etc.?
B.	**Psychosocial Topic Group**
1.	Are there factors related to the individual (either characteristics of the individual or of the act of self-harm) that predict outcome (including suicide, non-fatal repetition, other psychosocial outcomes)? How strong are these predictors either singly or in combination and what are their positive and negative predictive power?
2.	For people who have harmed themselves, or expressed intent, does formal risk assessment, compared with a non-standardised assessment, alter decision-making, change engagement or affect outcomes?
3.	What proportion of people who have self-harmed and attend an emergency department leave after being triaged but before having a psychosocial assessment and what are the consequences? Are certain groups more likely to leave than others?
4.	For those people who self-harm and attend an emergency department does a psychosocial assessment lead to a different outcome compared with no psychosocial assessment?
5.	For any factors associated with self-harm that have an effect on outcome (see Q1)

5.1. What is the effect of applying an intervention for these factors?
5.2. Which of these factors can and should be assessed in the emergency department?
6. For people who have had a psychosocial assessment after an episode of self-harm, which specific psychosocial interventions improve outcomes compared with no treatment or treatment as usual (e.g. DBT, problem-solving, interpersonal therapy, CBT, counselling, etc.)?
7. For people who have had a psychosocial assessment after an episode of self-harm, which pharmacological interventions improve outcomes compared with no treatment or treatment as usual (e.g. antidepressants, neuroleptics, ECT, lithium, carbamazepine, etc.)?
8. For people who have had a psychosocial assessment after an episode of self-harm, which social interventions improve outcomes compared with no treatment or treatment as usual (e.g. rehousing, crisis intervention, respite, debt counselling, networking, befriending, etc.)?
9. For people who have had a psychosocial assessment after an episode of self-harm, which 'non-statutory' or 'user-defined' interventions improve outcomes compared with no treatment or treatment as usual (e.g. self-help, voluntary counselling, peer advocacy, harm minimisation, etc.)?
10 Does training of staff in the recognition, assessment and management of people who self-harm, or aimed at improving attitudes to self-harm, have an impact on outcomes, including rates of detection?
11. In services which have specialist teams to make psychosocial assessments of people who self-harm, are there better rates of detection of people who self-harm, better engagement with services and improved outcomes?
12. Are there models of GP care that improve patient outcomes and reduce the need for specialist care?
C. Service User Experience Topic Group
1. What is the experience of services of people who self-harm, and does this affect outcomes?

Appendix 7: Search strategies for the identification of clinical studies

Standard search strings

Self harm

1. suicide/ or suicide, attempted/ or overdose/ or exp self-injurious behavior/
2. exp suicidal behavior/ or automutilation/ or drug overdose/
3. suicide/ or attempted suicide/ or self destructive behavior/ or self inflicted wounds/ or self mutilation/ or drug overdoses/
4. suicide/ or suicidal ideation/ or suicide, attempted/ or self-injurious behavior/ or injuries, self inflicted/ or overdose/
5. suicide/ or suicide attempted/ or exp self injurious behavior/
6. (self-harm$ or self?harm$ or self-injur$ or self?injur$ or self-mutilat$ or self?mutilat$ or suicid$ or self-destruct$ or self?destruct$ or self-poison$ or self?poison$ or (self adj2 cut$) or cutt$ or overdose$ or self-immolat$ or self?immolat$ or self-inflict$ or self?inflict$ or auto-mutilat$ or auto-mutilat$).tw.
7. or/1-6

Systematic reviews

[1.–7. self harm string above]

8. meta analysis.fc.
9. literature review-research review.fc. and ((medline or medlars or embase or scisearch or psychinfo or psycinfo or psychlit or psyclit or cinahl or cochrane).ti,ab,sh. or ((hand adj2 search$) or (manual adj2 search$) or (electronic adj2 database$) or (bibliographic adj2 database$) or (POOL$ adj2 ANALYSIS) or PETO or DER?SIMON$ or (FIXED adj1 EFFECT$) or (RANDOM adj1 EFFECT$) or (MANTEL adj1 HAENZEL)).tw.)
10. (meta?analys$ or (systematic$ adj4 review$) or (systematic$ adj4 overview) or (QUANTITATIVE$ adj2 REVIEW) or (QUANTITATIVE$ adj2 OVERVIEW) or (METHODOLOGIC$ adj2 REVIEW) or (METHODOLOGIC$ adj2 OVERVIEW) or (INTEGRATIVE adj2 RESEARCH adj2 REVIEW$) or (RESEARCH adj2 INTEGRATION) or (QUANTITATIVE$ adj2 SYNTHESIS) or (DATA adj2 SYNTHESIS)).tw.
11. (or/8-10) not (comment or letter).fc.
12. ((review or review, academic or review, tutorial, review literature).pt. or (professional practice, evidence based/ or review/)) and ((medline or medlars or embase or scisearch or psychinfo or psycinfo or psychlit or psyclit or cinahl or cochrane).ti,ab,sh. or ((hand adj2 search$) or (manual adj2 search$) or (electronic adj2 database$) or (bibliographic adj2 database$) or (POOL$ adj2 ANALYSIS) or PETO or DER?SIMON$ or (FIXED adj1 EFFECT$) or (RANDOM adj1 EFFECT$) or (MANTEL adj1 HAENZEL)).tw.)
13. meta-analysis/ or meta-analysis.pt. or systematic review/
14. (10 or 12 or 13) not (letter/ or comment/)
15. 11 or 14
16. Animal$/ not (animal$/ and human$/)

17. 15 not 16
18. 7 and 17
19. remove duplicates from 18
20. limit 19 to yr=1996-2002

RCTs

1. exp clinical trials/ or cross-over studies/ or random allocation/ or double-blind method/ or single-blind method/
2. random$.pt.
3. exp clinical trial/ or crossover procedure/ or double blind procedure/ or single blind procedure/ or randomization/
4. exp clinical trials/ or crossover design/ or random assignment/
5. exp clinical trials/ or double blind method/ or random allocation/
6. random$.mp.
7. (cross-over or cross?over or (clinical adj2 trial$) or single-blind$ or single?blind$ or double-blind or double?blind$ or triple-blind or triple?blind).tw.
8. or/1-7
9. animals/ not (animals/ and human$.mp.)
10. animal$/ not (animal$/ and human$/)
11. meta-analysis/
12. meta-analysis.pt.
13. systematic review/
14. or/9-13
15. 8 not 14

Search strings supporting specific reviews

User experience of services

Date	10.12.2002	No. of hits	1688
Search databases	**CINAHL** 1982 to December Week 1 2002 **EMBASE** 1980 to 2002 Week 48 **MEDLINE** 1996 to December Week 1 2003 **PsycINFO** 1872 to December Week 1 2003		

[1.–7. self harm string above]

8. nursing methodology research/
9. qualitative studies/ or ethnological research/ or ethnonursing research/ or focus groups/ or grounded theory/ or phenomenological research/ or exp qualitative validity/ or phenomenology/ or ethnography/ or exp observational methods/ or life experiences/
10. (ethnon: or emic or etic or ethnograph: or participant observ: or constant compar: or focus group: or grounded theory or narrative analysis or thematic analysis or lived experience or life experience: or user experience: or patient experience: or inside$ perspective$ or discourse analysis or content analysis or social constructi$ or semi-structured or group interview$).tw.
11. (qualitative research or qualitative stud$ or qualitative approach or qualitative method$ or qualitative analysis).tw.

12. phenomenolog$.tw.
13. or/8-12
14. 7 and 13
15. remove duplicates from 14
16. exp *health surveys/ or *health care surveys/
17. exp *surveys/
18. *health survey/ or *short survey/
19. (survey$ or question$).ti.
20. (survey$ or question$).ab.
21. (experien$ or attitud$).ti.
22. (experien$ or attitud$).ab.
23. (assisted adj suicide).mp. [mp=ab, hw, ti, sh, it, tn, ot, dm, mf, rw, ty, id]
24. suicide/
25. euthanasia.mp. [mp=ab, hw, ti, sh, it, tn, ot, dm, mf, rw, ty, id]
26. *patient attitude/
27. or/16-20
28. 21 or 22 or 26
29. or/23-25
30. 7 and 27 and 28
31. 30 not (29 or 15)
32. remove duplicates from 31

Search string used for Sigle:

1. suicide
2. overdose
3. self mutilat*
4. self poison*
5. self inflict*
6. self harm*
7. self injur*
8. self cut*
9. self destruct*
10. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9

Overdose

[1.–15. RCT string above]

16. cathartics/ or emetics/ or gastric emptying/ or exp irrigation/ or charcoal/ or vomiting/ or ipecac/
17. exp laxative/ or exp emetic agent/ or exp gastrointestinal motility/ or stomach emptying/ or exp lavage/ or prokinetic agent/ or copper sulfate/ or vomiting/ or activated carbon/ or ipecac/
18. exp gastrointestinal motility/ or exp irrigation/ or exp cathartics/ or vomiting/ or charcoal/
19. exp emetic drugs/
20. (bowel adj (irrigation or lavage or wash$ or decontamination or empty$ or evacuation)).tw.
21. (gastr$ adj (irrigation or lavage or wash$ or decontamination or empty$ or evacuation)).tw.
22. (intestin$ adj (irrigation or lavage or wash$ or decontamination or empty$ or evacuation)).tw.

23. (stomach adj (irrigation or lavage or wash$ or decontamination or empty$ or evacuation)).tw.
24. (gut adj (irrigation or lavage or wash$ or decontamination or empty$ or evacuation)).tw.
25. (cathartic$ or laxative$ or copper sulfate$ or ipecac$ or vomit$ or gastro?lavage$).tw.
26. (activated adj (charcoal or carbon)).tw.
27. or/16-27
28. exp overdose/
29. drug overdose/ or self poisoning/ or drug intoxication/
30. drug overdoses/
31. (poison$ or overdos$ or intoxicat$).tw.
32. or/28-31
33. vomiting/ and exp neoplasms/
34. (27 and 32) not 33
35. 15 and 34

Paracetamol screening

Date	16.01.2003	No. of hits	1688
Search databases	**CINAHL** 1982 to December Week 4 2002 **All EBM Reviews – Cochrane DSR, ACP Journal Club, DARE, and CCT** **EMBASE** 1980 to 2003 Week 2 **MEDLINE** 1996 to January Week 1 2003 **PsycINFO** 1872 to January Week 2 2003		

1. *paracetamol/
2. *acetomenophen/
3. *acetominophen/
4. (anacin or panadol or tylenol or paracetamol or acet?menophen or acet?minophen).tw.
5. (Acetamidophenol or Hydroxyacetanilide or Acamol or Acetaco or Algotropyl or Datril).tw.
6. or/1-5
7. overdose/
8. drug overdose/
9. drug overdoses/
10. (poison$ or toxic$ or overdos$).mp.
11. or/7-10
12. 6 and 11
13. drug usage screening/
14. drug screening/
15. substance abuse detection/
16. (screen$ or level$ or concentration$ or estimat$ or test$ or detect$).tw.
17. or/13-16
18. 12 and 17

Triage

Date	30.01.2003	No. of hits	2158
Search databases	**CINAHL** 1982 to December Week 4 2002 **All EBM Reviews – Cochrane DSR, ACP Journal Club, DARE, and CCTR** **EMBASE** 1980 to 2003 Week 4 **MEDLINE** 1966 to January Week 2 2003 **PsycINFO** 1872 to January Week 4 2003		

1. emergency service, hospital.sh.
2. emergency service.sh.
3. emergency services.sh.
4. emergency ward.sh.
5. ((accident adj1 emergency) or "A&E" or casualty or emergency room or emergency department).tw.
6. *triage/ or triage$.ti,ab.
7. or/1-6

Wound closure

Date	20.02.2003	No. of hits	1094
Search databases	**CINAHL** 1982 to February Week 2 2003 **All EBM Reviews – Cochrane DSR, ACP Journal Club, DARE, and CCTR** **EMBASE** 1980 to 2003 Week 6 **MEDLINE** 1966 to January Week 2 2003 **PsycINFO** 1872 to February Week 1 2003		

[1.–15. RCT string above]

16. wound healing/
17. wound closure/
18. (sutur$ or ster?strip$ or (glue$ not sniff$) or stapl$ or dressing$ or closure$ or adhesive$).tw.
19. or/16-18
20. ((cut$ or wound).tw. or laceration$.mp.) and (skin$ or surface or superficial or tissue).tw.
21. 4 and 5
22. (burn$ or ulcer$ or sore$).tw.
23. 6 not 7
24. remove duplicates from 24
25. animal$/ not (animal$/ and human$/)
26. animals/ not (animals/ and human$.mp.)
27. exp neoplasms/
28. exp neoplasm/
29. (cancer$ or neoplasm$).tw.
30. exp reproduction/
31. exp pregnancy/

32. or/26-32
33. 25 not 33
34. 15 and 33

Naloxone – first search

Date	10.10.2002	No. of hits	123
Search databases	**CINAHL** 1982 to August Week 5 2002 **All EBM Reviews – Cochrane DSR, ACP Journal Club, DARE, and CCTR** **EMBASE** 1980 to 2002 Week 40 **MEDLINE** 1966 to October Week 1 2002 **MEDLINE** Daily Update October 04, 2002 **PREMEDLINE and MEDLINE** 1966 to Present **PREMEDLINE** October 04, 2002		

exp overdose/
drug overdose/ or self poisoning/ or drug intoxication/
drug overdoses/
(poison$ or overdos$ or intoxicat$).tw.
or/13-16
cinahl
naloxone/
embase
naloxone/ or naloxone benzoylhydrazone/ or naloxone 6 spirohydantoin/
Medline
Naloxone/
Psycinfo
Naloxone/
*naloxone/
*naloxone benzoylhydrazone/ or *naloxone 6 spirohydantoin/
(naloxone or narcan).tw.
or/1-3
exp overdose/
drug overdose/ or self poisoning/ or drug intoxication/
drug overdoses/
(poison$ or overdos$ or intoxicat$).tw.
or/5-8
4 and 9
animal$/ not (animal$/ and human$/)
animals/ not (animals/ and human$.mp.)
exp neoplasms/
exp neoplasm/
(cancer$ or neoplasm$).tw.
or/11-15
10 not 16
remove duplicates from 17

Naloxone – second search

Date	02.10.2003	No. of hits	136
Search databases	**CINAHL** 1982 to September Week 4 2003 **EMBASE** 1980 to 2003 Week 39 **MEDLINE** 1966 to September Week 3 2003 **PsycINFO** 1872 to September Week 5 2003		

(1-15 RCT string above) 16. naloxone.sh.
17. opioid-related disorders/
18. narcotics.sh.
19. opiates.sh.
20. opiate.sh.
21. or/17-20
22. 16 and 21
23. 15 and 22
24. remove duplicates from 23
25. limit 24 to "300 adulthood "
26. limit 25 to adulthood <18+ years>
27. limit 26 to (adult <18 to 64 years> or aged <65+ years>)

Health economics

Date	04.09.2002	No. of hits
Search databases	Medline, PreMedline, Embase, Cinahl, PsycINFO	2770
	CDSR, CCTR, DARE	165
	HTA and NHS EED	39

SH – General +

1. (burden adj2 illness).mp.
2. (burden adj2 disease).mp.
3. (cost$ adj2 evaluat$).mp.
4. (cost$ adj2 benefit$).mp.
5. (cost$ adj2 utilit$).mp.
6. (cost$ adj2 minimi$).mp.
7. (cost$ adj2 illness).mp.
8. (cost$ adj2 disease).mp.
9. (cost$ adj2 analys$).mp.
10. (cost$ adj2 assess$).mp.
11. (cost$ adj2 study).mp.
12. (cost$ adj2 studies).mp.
13. (cost$ adj2 allocation).mp.
14. (cost$ adj2 outcome$).mp.
15. (cost$ adj2 consequence$).mp.
16. (cost$ adj2 effect$).mp.
17. (cost$ adj2 treatment$).mp.
18. (economic adj2 evaluat$).mp.

19. (economic adj2 analysis$).mp.
20. (economic adj2 study).mp.
21. (economic adj2 studies).mp.
22. (economic adj2 assess$).mp.
23. (economic adj2 consequence$).mp.
24. (economic adj2 outcome$).mp.
25. (resource$ adj2 allocation$).mp.
26. (resource$ adj2 utili$).mp.
27. expenditure$.mp.
28. exp economics/
29. exp "costs and cost analysis"/
30. exp "health economics"/
31. or/1-30

Strategy used for **HTA** and **NHS EED:**

suicide/ OR suicide, attempted/ OR overdose OR self-injurious behavior OR self mutilation (Subject Headings)

Details of additional searches undertaken to support the development of Chapter 2 and for clinical questions for which no evidence was found are available on request.

Appendix 8: Systematic review and RCT eligibility checklist

Eligibility checklist	Report reference ID:	Eligibility
Checklist completed by:	Date completed:	Y N (circle one)
Topic Areas: 1 2 3 (circle all applicable)		
Overall assessment		
Comment		
Exclusion criteria		**Code options**
Only concerned with:		
• Patients under 8 years of age		
• Care options not routinely made available by the NHS in primary, community and secondary health and social care services		
• Long-term psychiatric care of people who repeatedly self-harm		
• Guidance about care specific to prison healthcare		
• Patients with repetitive self-injurious behaviour, such as head banging, in people with learning disabilities		
Inclusion criteria		
Population		
• Reported results from patients who have intentionally self-harmed (irrespective of the apparent purpose of the act), including poisoning, asphyxiation, cutting, burning and other self-inflicted injuries, regardless of whether behaviour is accompanied by a mental illness		
Topic Area		
1. Medical assessment and care		
1.1. Immediate first-aid assessment and care, and short-term (48 hours) medical assessment, investigation and treatment of:		
1.1.1. Self-poisoning		
1.1.1.1. Where substance ingested not known		
1.1.1.2 Paracetamol		
Continued over…		

1.1.1.3. Antidepressants	
1.1.1.4. Minor tranquillisers and sedatives	
1.1.1.5. Major tranquillisers	
1.1.2. Cutting	
1.2. Factors predicting physical health outcome following self-poisoning	
2. Psychosocial assessment and care	
2.1. Assessment of suicide risk, including indications for close observations, admission to psychiatric ward or intensive home treatment	
3. Prevention of repeated self-harm	
3.1. Factors predicting future self-harm or suicide	
3.1.1. Demographic factors	
3.1.2. Social factors	
3.1.3. Psychiatric factors	
3.1.4. Medical factors	
3.2. Therapeutic interventions to prevent further acts of self-harm or suicide	
3.2.1. Psychological interventions	
3.2.2. Pharmacological interventions	
3.2.3. Psychosocial interventions	
4. Other issues	
4.1. Criteria for referral	
4.2. Strategies for ensuring that people are treated with dignity, privacy and respect	
4.3. Dealing with challenging behaviour	
4.4. Primary care services, self-help groups and voluntary agencies	
4.5. Review criteria for audit	
Primary Outcomes	Code options
• Adverse effects of treatment	
• Carer/family outcomes	
• Cognitive functioning	
• Compliance with:	
a) Drug treatment	
b) Other non-drug treatments	
• Death (any cause and sudden unexpected death or suicide)	
• Economic outcomes	
• Engagement	

Continued over…

• Hospital admission	
• Mental state:	
a) Criterion-based improvement (as defined in individual studies) with reference to the positive and negative symptoms of schizophrenia	
b) Continuous measures of mental state	
• Occupational status	
• Other intervention-specific outcomes	
• Patient satisfaction	
• Psychological well being:	
a) Criterion-based improvement (as defined in individual studies) with respect to general psychological well-being, such as self-esteem or distress	
b) Continuous measures of psychological well-being	
• Quality of life	
• Relapse (as defined in the individual studies)	
• Social functioning	
• Any other unexpected or unwanted effect	

Appendix 9: Systematic review quality checklist

Quality checklist for a systematic review (notes for reviewer are in italics)	
Checklist completed by:	**Report reference ID:**

SECTION 1: VALIDITY	
Evaluation criteria	**Comments**
1.1 Does the review address an appropriate and clearly focused question?	
Unless a clear and well-defined question is specified, it will be difficult to assess how well the study has met its objectives or how relevant it is to the question you are trying to answer on the basis of its conclusions.	
1.2 Does the review include a description of the methodology used?	
A systematic review should include a detailed description of the methods used to identify and evaluate individual studies. If this description is not present, it is not possible to make a thorough evaluation of the quality of the review, and it should be rejected as a source of Level 1 evidence. (Though it may be useable as Level 4 evidence, if no better evidence can be found.) Unless a clear and well-defined question is specified, it will be difficult to assess how well the study has met its objectives or how relevant it is to the question you are trying to answer on the basis of its conclusions.	
1.3 Was the literature search sufficiently rigorous to identify all relevant studies?	
Consider whether the review used an electronic search of at least one bibliographic database (searching for studies dating at least 10 years before publication of the review). Any indication that hand searching of key journals, or follow up of reference lists of included studies were carried out in addition to electronic database searches can normally be taken as evidence of a well conducted review.	
1.4 Was study quality assessed and taken into account?	
A well conducted systematic review should have used clear criteria to assess whether individual studies had been well conducted before deciding whether to include or exclude them. At a minimum, the authors should have checked that there was adequate concealment of allocation, that the rate of drop out was minimised, and that the results were analysed on an "intention to treat" basis. If there is no indication of such an assessment, the review should be rejected as a source of Level 1 evidence. If details of the assessment are poor, or the methods considered to be inadequate, the quality of the review should be downgraded.	

SECTION 2: OVERALL ASSESSMENT	**Comments**	**Code**
2.1 Low risk of bias	*All or most criteria met*	**A**
Moderate risk of bias	*Most criteria partly met*	**B**
High risk of bias	*Few or no criteria met*	**C**

Appendix 10:
RCT quality checklist

Quality checklist for a RCT		
Report reference ID:		
Checklist completed by:	**Date completed:**	
SECTION 1: INTERNAL VALIDITY		
Evaluation criteria	**How well is this criterion addressed?**	
1.1 Was the assignment of subjects to treatment groups randomised?		
If there is no indication of randomisation, the study should be rejected. If the description of randomisation is poor, or the process used is not truly random (e.g., allocation by date, alternating between one group and another) or can otherwise be seen as flawed, the study should be given a lower quality rating.		
1.2 Was an adequate concealment method used?		
Centralised allocation, computerised allocation systems, or the use of coded identical containers would all be regarded as adequate methods of concealment, and may be taken as indicators of a well conducted study. If the method of concealment used is regarded as poor, or relatively easy to subvert, the study must be given a lower quality rating, and can be rejected if the concealment method is seen as inadequate.		
SECTION 2: OVERALL ASSESSMENT	**Comments**	**Code**
2.1 Low risk of bias	*Both criteria met*	**A**
Moderate risk of bias	*One or more criteria partly met*	**B**
High risk of bias	*One or more criteria not met*	**C**

Appendix 11: Clinical study data extraction form

Completed by:												Report reference ID:											
1 TREATMENT GROUP:																							
Single dichotomous outcomes	Death			Leaving study early			Relapse: treatment end			Relapse: follow-up													
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												
Continuous outcomes post-treatment																							
	n	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*											
Continuous outcomes follow-up																							
	n	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*											
Dichotomous outcomes post-treatment																							
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												
Dichotomous outcomes follow-up																							
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												
2 TREATMENT GROUP:																							
Single Dichotomous outcomes	Death			Leaving study early			Relapse: treatment end			Relapse: follow-up													
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												
Continuous outcomes post-treatment																							
	n	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*											
Continuous outcomes follow-up																							
	n	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*	*n*	*Mean*	*SD*											
Dichotomous outcomes post-treatment																							
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												
Dichotomous outcomes follow-up																							
	n	*N*		*n*	*N*		*n*	*N*		*n*	*N*												

Appendix 12: Methods for calculating standard deviations

The following formulae were used to calculate standard deviations (SD) where these were not available in study reports:

(n = sample size of group)

$$SD = \text{Standard Error} \times \sqrt{n}$$

$$SD = \frac{(\text{upper 95\% Confidence Interval} - \text{mean})}{1.96} \times \sqrt{n}$$

$$SD = \frac{(\text{mean}_1 - \text{mean}_2)}{\sqrt{F}\,(\sqrt{1/n_1} + \sqrt{1/n_2})}$$

(If F ratio is not given, then $F = t_2$)

Appendix 13: Focus group information sheet and consent form

Obtaining user views to inform a guideline on the treatment and care of people who self-harm: A discussion group

INFORMATION SHEET

The National Collaborating Centre for Mental Health, based at the research unit of the Royal College of Psychiatrists and the British Psychological Society, would like to invite you to a discussion group to talk about NHS services provided to people who have self-harmed. We have written this sheet to help you decide if you would like to take part in the discussion group. The sheet describes the purpose of the project and what taking part will involve.

Purpose of the discussion group

The National Institute for Clinical Excellence (NICE) has asked the National Collaborating Centre for Mental Health to develop a clinical guideline on self-harm. The guideline will make recommendations to the NHS, based on the best research evidence available, on the treatment and care of people who self-harm *in the first 48 hours*. The recommendations should cover the full range of care that should be routinely made available from the NHS (ambulance service, GPs and hospitals) as well as assessment and referral to and reception by other services. The guideline will not cover longer-term psychiatric services and treatments.

In the past, many clinical guidelines have not had any input from the people whose care they will influence. For the self-harm guideline however, we want to take into account the views of people who have experienced services. To do this, we plan to invite a group of people who have self-harmed and used NHS services to a discussion group. We will be asking participants to discuss their experiences of NHS services, and to highlight issues the guideline should address. We will not be asking participants about why they self-harm.

The information obtained in these discussions will be used to ensure that user views inform the development of a new clinical guideline which will help shape the way in which NHS services are provided in the future.

What does taking part involve?

If you agree to take part we would like to invite you to a discussion group to be held in _____2003. The exact date will depend on the availability of people who volunteer to participate. Although the discussion group will be held in_____we would like to include people who have used services outside the London area. We will pay all travel expenses.

At the discussion group we will be asking you to describe your experiences of the services provided by the NHS to people who have self-harmed. We are interested in both what worked well and what worked badly when you needed to use NHS services.

We will then ask the group to draw on those experiences to identify some key issues that should be addressed in the guideline. This might include suggestions for improving services or examples of good practice that could be built on in the future.

The group will be run to provide everyone with the opportunity to speak on the different issues raised. However, if you don't feel like speaking at any point you can just sit and listen. Most people find the experience of taking part in a discussion group interesting and stimulating. However, you are free to take a break at any time, or to withdraw from the discussion altogether, should you wish to do so.

Information from the discussions will be fed back to the group that is developing the guideline to help inform what is written in the guideline. This group is made up of health professionals (psychiatrists, GPs, emergency department staff and ambulance staff) and lay people.

Who will run the discussion group?

The discussion group will be run by Marcia Kelson and Pamela Blackwood/ Beccy King.

Marcia is a researcher with experience of running discussion groups and interviews. She works for the College of Health, a national charity that promotes patients' interests in the NHS. She also works with NICE to develop better methods and opportunities for service users and patients to inform its work. Pamela is a Samaritan volunteer with considerable professional experience working in mental health with people who self-harm. Beccy King is the Project Manager for the development of the Self-harm guideline and works for The National Collaborating Centre for Mental Health.

If everyone who volunteers to take part agrees, we would like to tape the discussions. The recording will only be used by the guideline group and their research staff (for example to check the detail of specific issues discussed) and will not be heard by or made available to any third party.

What should you do now?

– If you are happy with the description of the project and want to take part, please complete the reply/consent form and return it to Beccy King at the Mental Health Collaborating Centre.

– If you need more details about the project before you decide, please telephone Marcia who can answer any queries you have (tel: 020 8392 1175).

– If you do not, after all, wish to take part, please tick the appropriate section of the reply form to let us know.

REPLY/CONSENT FORM

Please read the following statement before filling in, signing and returning the form.

I have read the information sheet describing the purpose of the discussion group and what taking part will involve. I understand that, having agreed to take part, I can if I wish, change my mind and withdraw from the exercise at any point. I also understand that if I attend the discussion group, I can take a break at any time, or withdraw from the discussion altogether, should I wish to do so.

Please print

1. Your name: . . . . . .

2. Address: . . . . . .

. . . . . .

3. Telephone no: . . . . . .

4. Email (if you would like to be contacted by email)

. . . . . .

5. Signature . . . . . .

6. Please tick one of the following:

a. I **would** like to take part in the discussion group

b. I **do not** wish to take part in the discussion group

7. If you are willing to attend please indicate which time(s) you could attend and which you cannot (please tick)

Times	Able to attend	Unable to attend
Weekday morning		
Weekday afternoon		
Weekday evening		
Weekend		

Please return this form to:
Beccy King
National Collaborating Centre for Mental Health
College Research Unit
6th Floor, 83 Victoria Street
London SW1H 0HW

Appendix 14: Focus group interview schedule

1. Structure of discussion group and any questions
2. First contact with services during an episode of care (e.g. ambulance, GP or emergency department)
3. Experiences of treatment in emergency departments
    - GDG prompt 1: preferences for glue vs stitching
    - GDG prompt 2: views on advice for self-management of wounds
4. Experiences of referral to psychiatric services
    - GDG prompt: referral to or experiences of non-statutory services
5. Experiences of GP services
6. Other issues
7. Service user recommendations for Self-harm Guideline Development Group

Appendix 15: Focus group and individual interview reports

User views of services for people who self-harm (first 48 hours of care) London

Introduction

The Self-harm Guideline Development Group (GDG) consulted with service users to seek their views on their experiences of services to inform the development of this guideline. This paper reports the findings of a discussion group carried out to explore service users' experiences of, and recommendations for, NHS services in the first 48 hours of care after an episode of self-harm. To preserve confidentiality names have been changed.

Methods

The Central London branch of the Samaritans approached people in contact with their services who have a history of self-harm, and who they thought might be interested in taking part in a group discussion. People expressing an interest were given an information sheet [reproduced in Appendix 13] explaining the study and what taking part in the group discussion would involve. A contact for obtaining further details was supplied together with a consent form to compete if they wanted to take part.

The focus group was held in May 2003 in a lecture room at the Central London Samaritans premises. The discussion was facilitated by Marcia Kelson and Pam Blackwood.

Three women living in the London area and recruited through the Samaritans volunteered to take part. A fourth woman, a friend of one of the original volunteers, who lives in the West Country, also volunteered to take part. The participants described themselves as follows:

'Laura' (51 years) is in regular contact with her local mental health services, attending a psychiatric hospital five days a week

'Hannah' (42 years) has used services for about 15 years, including being a caller of the Samaritans; she has been involved in co-ordinating a self-harm self-help group

'Susan' is 21, works in a special needs school and has been using mental health services since she was eleven

'Julie' works for a mental health user group; she has been using services since the age of 15.

One other volunteer did not feel her experiences were appropriate to discuss in a group setting and she agreed to be interviewed individually. A report on this interview is available separately [see below].

Context and format of the focus group

It was explained to participants, both in the information sheets and at the start of the group discussion, that the purpose of the discussion group was to ask people who had used services to reflect on their experiences to inform the development of a clinical guideline that would make recommendations about the treatment and care of people who self-harm *in the first 48 hours*. It was also explained that participants would not be asked about the reasons why they self-harm.

The group discussion was divided into two sessions. In the first session, participants were asked to describe their own experiences (both positive and negative) of treatment and care. With the group's permission, the discussion was taped, on the understanding that the tape would be used only to aid in the writing of this report, and would not be available to other parties. After a tea break the group reconvened and was asked if they would like to make specific recommendations that they would like the guideline developers to take into account when producing the guideline. These were recorded on a flip chart.

This paper presents key issues discussed by group participants in the first session.

FINDINGS

Attitudes, use of language, taking account of distress

Views of GPs were generally positive. Laura described how her GP willingly comes out to see her urgently even when she does not have an appointment.

Similarly, when discussing their role, ambulance staff were generally, but not exclusively, viewed favourably. On occasions when Hannah has called for an ambulance she has usually found the staff to be very good, non-judgemental, calm and able to ***'take the heat out of the situation'***.

Hannah described an episode when the police had been called and described how the particular policeman who arrived at her door had been very helpful: ***'He just talked things through with me and allowed me not to call an ambulance.'***

Emergency operators came in for some praise. Hannah appreciated the fact that a 999 operator accepted that she was not a risk to others and did not call the police: ***'The 999 operator was extremely helpful, very calm … reassuring, calm, advised me to put something warm round me because of the shock.'***

Participants felt that some staff responded inappropriately to service users, for example in their use of language, in the questions they ask, the assumptions (often unfounded) they make, and in how they communicate with and respond to people who self-harm.

Communications between staff and people who self-harm

The group noted several occasions where staff made assumptions or held preconceptions about why people self-harmed. They had been asked inappropriate questions about their wounds, or had been asked by several different members of staff about the reasons for their self-harm.

Participants reported staff making remarks made about people having done it ***'to punish themselves'*** or ***'on purpose'***, or being ***'attention seeking'***. When accompanied by a friend, one participant reported that she was told she was ***'involving them in my self-harm'***.

Staff also made judgemental comments, sometimes extreme, for example, ***'She said, "you are trying to disgust me".'*** In addition staff sometimes respond with anger, especially for repeated presentation for self-harm.

'They sit you in the chair and what is happening to the person is never taken into account.'

'Whatever has happened to that individual, they would have the best knowledge of what is actually happening to them… If they never listen to us they will never understand.'

Inappropriate actions

Julie described how the police had reacted inappropriately by going in to her children's school and phoning a neighbour to look after the children. This was done without consulting her or her husband. She felt this was a huge over-reaction and displayed lack of understanding and inadequate training. ***'They know how to stop cars that are speeding but give them a person in distress…'***

Susan agreed that people made unfounded assumptions. At school when she was 13 or 14, staff would consider her a risk and call the police, who took her away and put her in a cell.

Susan related how she once had to phone an ambulance after an incident using razor blades. The ambulance staff asked if she had blades in the house (she said 'yes') and was she holding one at the moment (she said 'no'). Considering her a danger, the police were called and she was strip-searched by a police officer before the ambulance crew would attend to her. She was on her own and has never been a danger to anyone else.

On one occasion, Hannah was desperate not to call services because she was applying for jobs and didn't want things on her medical record at that time. She rang up to ask for the policeman who had come before but he wasn't on duty and three other policemen turned up. ***'I was bleeding quite badly. I was on the floor. I just remember these huge boots. Three sets of boots. Three male police officers. They were not sympathetic – very dismissive sort of attitude – just called an ambulance.'***

Julie described how humiliated she felt when a nurse invited her friends (other staff in the unit not involved in her care) to come and look at her injuries.

Susan described being left in a full waiting room with a sick bowl after an overdose, and having her blood taken there.

Susan reported how, because she was a young girl, staff assumed she had been abused, resulting in her father being investigated by the police.

Giving advice

The group agreed that staff offer advice inappropriately. Julie included the Samaritans in this category reporting that she had been given advice about taking her medication. On one occasion one of the ambulance staff started to give Hannah advice about telling her psychiatrist. ***'I don't really welcome advice from someone who is not in a position to know.'***

Participants also described how staff suggested alternative methods of self-harm: ***'He said to me once – why burn yourself with an iron, why not use something else?'***

'She was really angry with me [because this participant had rubbed her skin against a sharp Artex wall in the hospital toilet]. She said "but you could tear up a CD and do it with that, you could twist a coke tin and do it with that, you could do it with a ball point pen". So I tried all these things afterwards, but they weren't as good as the wall!'

Access to services, treatment and follow-up

Waiting times and surroundings

Hannah described an episode of care that did work well. The ambulance staff took her straight through to the clinical area where she was attended to immediately. A nurse asked her every 15 minutes or so if she was OK. She was offered pain relief – for the first time ever.

Long waiting times were an issue for many in the group. Susan said that she had once waited 16 hours, and was told off for falling asleep! Hannah told how she was left on a chair for two hours after an overdose. She lost consciousness, and fell onto the floor.

The total lack of care available to Laura has been so extreme that she once arrived in an emergency department with iron burns and was left to wait eight hours before being seen by a duty psychiatrist, who then arranged for her burn to be attended to. Laura gave the impression that this has happened on a number of (ongoing) occasions.

'As soon as they find out that I have mental health problems, I have to sit there, for hours sometimes, waiting for someone to look at me. It is horrible.'

'They just say, "have you harmed yourself?" As soon as you mention psychiatrists that's it, they don't want to know. I wait there hours and hours, and then when she comes, she tells them to dress it.'

Some poor clinical care was attributed to long waiting times which sometimes led to poorer outcomes. On one occasion, Susan had been left so long that a wound could not be sutured and, on another occasion, had been left for four hours before being treated for an overdose.

All members of the group discussed that it wasn't just waiting that was a problem, but being left on your own, sometimes in areas or rooms where there were items that could be used for further self-harm. ***'Being left on your own is a dreadful thing.'***

'You're left in there [alone] ***with drawers that say "scalpels" on the outside!'***

Both Laura and Susan described how they prefer to pace up and down while they wait to help relieve their anxiety, but have been told to sit down or told off for disturbing other patients.

Referrals

The participants noted that GPs were often as frustrated by the system as the service users.

Hannah's GP tried to arrange admission for her, but was told that this could be done only after a domiciliary visit by the crisis team.

Hannah had used a local minor injuries unit for dressings, and found staff there particularly helpful.

Wound care

Susan had been offered the choice between a local and a general anaesthetic, which she appreciated. Hannah described how a doctor gave her a skin graft with great patience and care: ***'I was really quite touched that he cared enough to do that. Just so I would have less scarring even though my legs were very scarred already.'***

Susan described staff reaction when she said that being sutured without an anaesthetic was painful: ***'I said it hurts. They said, "well it didn't hurt when you cut it".'***

Withholding treatment

Some staff threaten to withhold treatment if someone were to ***'do it again'***.

Because she harms herself repeatedly, Susan is now refused admission to her local psychiatric services, leaving emergency department staff with nowhere to send her. ***'They phoned up my psycho ward who said, "We're not having her back".'*** Staff sometimes do not respond at all: ***'I felt ignored, totally and utterly ignored'.***

Susan had once asked for her arms to be plastered so she couldn't tamper with the stitches but was refused.

Rights, consent and capacity

The lack of privacy and lack of attention to people's dignity or needs were problems for people attending emergency departments.

They also talked about taking another person with them, such as a friend, although this was not always viewed positively by staff. ***'When I've taken someone … been told I was "involving them in my self-harm".'***

Hannah remembers being asked if someone could take a photograph which she now realises had nothing to do with her own clinical care. In retrospect she feels she was asked to do this when not in a fit state to give consent and had not understood what the photograph would be used for.

User views of services for people who self-harm (first 48 hours of care)

Nottingham

Introduction

The Self-harm Guideline Development Group (GDG) consulted with service users to seek their views on their experiences of services to inform the development of this guideline. This paper reports on the findings of a discussion group carried out to explore service users' experiences of, and recommendations for, NHS services in the first 48 hours of care. To preserve confidentiality names have been changed.

Methods

A self-harm self-help group based in Nottingham was contacted to see if members would be interested in taking part in a group discussion. They were given an information sheet [reproduced in Appendix 13] about the purpose of the study and what taking part in the group discussion would involve.

The discussion group was held in June 2003 in the offices of the National Self-Harm Network in Nottingham. Marcia Kelson and Beccy King facilitated the discussion.

Seven women, six living in the Nottingham area and one from Lincoln, volunteered to take part. The participants described themselves as follows:

'Abigail' (44 years) Set the group up 6 years ago

'Sarah' (24 years) Has been coming to the group for 2 years and lives in Lincoln

'Christine' (24 years) This discussion group was her second meeting with the self-help group

'Lucy' (43 years) Has been coming to the group for a little over a year now

'Jackie' (22 years) Has been with the group for about 2 and a half years

'Emily' (35 years) Started the group last week, is married with 9 year-old twins

'Sophie' (21 years) Lives in Nottingham and has been coming to the group for a year now although does not come that much any more.

Context and format of the focus group

It was explained to participants, both in the information sheets and at the start of the group discussion, that the purpose of the discussion group was to ask people who had used services to reflect on their experiences to inform the development of a clinical guideline that would make recommendations about the treatment and care of people who self-harm *in the first 48 hours*. It was also explained that participants would not be asked about the reasons why they self-harm.

The group discussion was divided into two sessions. In the first session, participants were asked to describe their own experiences (both positive and negative) of treatment and care. With the group's permission, the discussion was taped, on the understanding that the tape would be used only to aid in the writing of this report but would not be available to other parties. After a tea break the group reconvened and was asked if they would like to make specific recommendations that they would like the guideline developers to take onto account when producing the guideline. These were recorded on a flip chart.

This paper presents key issues discussed by group participants in the first session.

FINDINGS

Attitudes, use of language, taking account of distress

The experiences of the group varied considerably in terms of the attitudes they encountered from staff. For example, Abigail noted, ***'My doctor shows me respect ... the way he talks about me to this other professional … he is saying this person's ok … but I'm just so lucky to have a real good GP who can do that.'*** Other members had encountered less helpful attitudes from staff: ***'I got not an exactly positive response, but a response we were both able to work with.'*** There was consensus about what the group wanted from the staff: ***'I need people to work with me … you know a partnership … if my rights and everything's taken away then I'm panic*** **[sic]** ***and I'm more likely to injure myself.'***

Communications between staff and people who self-harm

Sarah noted that on occasions when she had been conscious, both following a self-harm episode and following an overdose, paramedics had been really considerate. For example, the first time she called them out, she was really scared, but the ambulance staff (both male and female) had been very helpful.

' …They helped me to write like a note and that to let my parents know what had happened…'

Although Sarah had had largely good experiences with emergency department nurses she noted that their attitudes seemed to reflect a lack of education about self-harm. They seemed to believe that if they treated you badly enough you would not come back to the emergency department. When the paramedics didn't know she had self-harmed they seemed almost automatically to think it was a suicide attempt that had failed.

Despite some good experiences of nursing staff many of the group found emergency department staff generally to be blunt and unsympathetic to their needs.

Jackie noted how her GP had said some very inappropriate things, and she felt that the information he was asking for was private, and as such she would release it when she wanted to, and not on demand.

' …He doesn't understand and like uses horrible words like "mutilation".'

Abigail felt very strongly that she does not call an ambulance now following several bad experiences, and prefers to take care of herself. She noted the inappropriate and negative attitude towards her.

' …being really sarcastic the two of them and making comment like I was stupid and I wasn't there … I would just never ever be in the position … **[where]** ***I'm not in control.'***

Inappropriate and unsympathetic questioning were common experiences. Abigail noted that often following an episode of self-harm you do not know the reasoning behind why you've done it.

'…all you know is that you're in absolute turmoil … you just know that that **[self-harm]** ***will help … you're dead vulnerable and you're dead um … I don't know it's like in shock almost…'***

Wanting to be in control and having that control and power taken away from them by staff was a common experience. This included judgemental comments and being talked about as though they were not there by ambulance staff.

' …Oh god, it's her again.'

This had a direct impact on the individuals in the group with some stating that the experience would prevent them from contacting the emergency services again.

' …even if my life was in danger … I'd rather sit at home and sit it out and see whether I'd survived than risk the humiliation.'

Sophie noted how a friend felt following an overdose when the paramedics were talking to Sophie despite the fact that her friend was conscious and could have answered their questions.

' …she did it, she took an overdose because she was feeling really powerless … it made her feel even worse the fact that because I was there they were only asking questions to me…'

The participants noted the frustrations that ambulance staff must face including lack of time and resources, but felt that much of how they wanted to be treated was simply about being treated with dignity and respect and would therefore not be costly to implement. In addition to this Lucy noted it should be the way all people should be treated regardless of the nature of their injury.

Abigail described emergency department staff as ***'devious'***. She noted how on one occasion when she had injured her hand staff asked her to wait while they called a hand specialist. However, it transpired that they were actually waiting for a psychiatrist to come to see her. Abigail found this deception deeply disturbing and 'legged it' despite being in agony from her injury, as the situation had caused her to panic and she no longer felt in control.

'Maybe if they'd asked me … um I might even have said yes to a psychiatrist. It's the way it was done.'

The group all reported occasions when they felt that staff were not listening to them, and that staff questions were driven by a need to cover themselves in case the service user went on to die by suicide.

Christine remembered the effect of unhelpful comments about how stupid she was being and the damage she was doing to herself.

' …it made me even more and more distressed and I've actually felt like leaving the hospital and going and self-harming again because that's the only way I can deal with the distress.'

'I thought if you don't give them the ammunition they can't throw it at you…'

Lucy noted the difficulties in talking to her GP about other medical issues and in getting treatment without the subject of mental health being raised.

'It's quite a fight on to get an appointment with a specialist about that. They seem to think that everything has to revolve around mental health…'

Inappropriate actions

Emily discussed how she had locked herself in her bathroom following an overdose and how the ambulance staff had been really aggressive, banging the door and yelling at her to come out or they would call the police.

'I mean they're supposed to be calming the situation and making threats like that, you know, it's just over the top and it's just going to make the situation much worse.'

Emily noted how her conversation with the receptionist was particularly frightening, as she had been asked highly inappropriate questions in full hearing of the other people waiting to be seen in the department.

A number of the group noted occasions when they were being assessed or receiving treatment and doors were left open and curtains remained undrawn. This increased their general distress, and made them feel powerless to change their situation.

'When you go into triage the door is always wide open and you've got a great queue of people and obviously they can hear what's being said and you do feel as though you can't say please shut the door.'

'He* [consultant in an emergency department] *quizzed me quite a lot … in a cubicle with the curtains open so everybody was like walking past and … I'd cut myself.'

Jackie recalled an experience where ***'*[after stitching a wound] *one called the other nurse over and said hey come and have a look at this … job I've done, oh, that's a really good job, but it was really like … a bit degrading.'***

Jackie explained how on one occasion following a cut to her upper leg the doctor requested that she showed him the cut but did not close the treatment room door. Jackie was therefore in full view of anyone passing.

When being stitched, Jackie remembered how the nurse stitching her wound called another nurse into the cubicle to look at the quality of her stitches, which she felt was inappropriate given the circumstances.

Sophie noted how after stating she wanted to go home and did not need to see a psychiatrist, a staff member asked her boyfriend about whether she needed to see one.

Access to services, treatment and follow up

Relationships between the participants and their GPs varied although a number had established a ***'good working relationship'***. Abigail commented how her GP would ***'cut corners'*** to ensure that she did not have to spend unnecessary time in the emergency department, which he knew she found particularly distressing.

Sophie discussed how she did not like the way in which the quality of services was extremely variable.

'you don't know what kind of service you're gonna get because you might actually go to A&E or go to the doctor's and find it really helpful but you don't you can't guarantee that it is going to be and that's what put me off going … if there was sort of like you knew there was going to be a certain consistency you knew it wasn't going to make you feel worse…'

Waiting times and surroundings

Sarah felt that generally the ambulance staff she had come into contact with were really good and arrived quickly.

A couple of members of the group noted how they had asked to be allowed to sit in a quieter area than the waiting room. Sarah had been offered the children's play area which, although quieter than the waiting room was not appropriate as she was bleeding quite heavily and there were obviously children about.

Christine had been refused permission to move from the trolley where she was lying and staff eventually got a security guard to stand by her to prevent her from leaving, despite her intention simply being to sit somewhere quiet and to feel less vulnerable.

'…and I found it really difficult to be around people and so to be in that environment where there's … lots of people milling about and there's nurses coming flying and the doctors just walk through.'

Referrals

Sarah spoke of the problems she has encountered in trying to get referred on to specialist help via her GP. She noted that her GP was very sympathetic but was not able to offer her any help. In the end Sarah paid for her own psychotherapy and found this particularly helpful. Two years later she has just received notification that she has been referred for therapy through the NHS.

'Like when I really needed it, two years ago, it wasn't there.'

In addition to voicing concerns about how emergency department staff make decisions about referring people on to a psychiatrist or psychiatric nurse (see previous section)

participants also queried the quality of the services provided if they did engage with them.

Sarah felt she was not offered help by people she had seen. She would have liked someone with time to talk to her, to sort out with her the reasons for the self-harm and to be non-judgemental. She described having been seen by a specialist self-harm nurse who she felt just assessed her suicide risk but did not initiate any follow-up, which she would have appreciated.

Jackie discussed how her experience of referral to mental health services was inadequate as the dedicated self-harm team would be able to offer her only a couple of sessions which she felt would not be long enough to be helpful and therefore a waste of time.

'I'm sure I'm "non-compliant and unwilling to engage in treatments" written on my notes…'

'Psychiatrists say, "we think this is best for you". They just want to cover themselves against suicide … **[they're]** ***not interested in you as a person.'***

Sophie noted that even on the occasions when she was asked whether she would like to see a psychiatrist, staff did not listen to her wishes not to see one, as she already saw a psychiatrist regularly and had sought help from her university counselling service.

Christine commented that if the procedure of being referred to the psychiatric services in the emergency department had been explained to her, it would have been a lot less frightening and she would have been willing to engage in the situation.

Wound care

Abigail noted that her GP regularly prescribed skin closure strips to enable her to manage her own wound care.

' …there's less drama, less you know people don't need to know … I think that's about power and control again.'

Abigail recognised the extra strain on her surgery, both financially (usually skin closure strips would be given by the emergency department) and on her GP's time, and was extremely grateful for this.

Withholding treatment

Jackie noted how her GP had refused to supply her with dressings for a burn as he thought that it would encourage her to do it again. Jackie responded by stating that she was going to be self-harming again anyway and that, in the long run, if she did not dress her wounds appropriately they would become infected. This would result in more expense for the GP's surgery.

Jackie commented on a particular experience whereby an emergency department staff member ignored her request for more pain relief when she noted that what she had previously been given was beginning to wear off.

' …and she didn't believe me when I said that it was starting to hurt like and she was stitching and like I need some more pain relief it's well like I'll just do a couple more…'

Similarly, Sarah described an occasion when a doctor who was stitching her wound told her that it couldn't be hurting.

Sarah noted how a doctor in an emergency department had threatened to stitch her wound without anaesthetic, and proceeded to tease her with a syringe prepared with anaesthetic.

'Obviously you enjoy the pain, you know so so **[sic]** ***maybe you need stitching up without it.'***

Rights, consent and capacity

Of particular concern to the group were the occasions whereby they had been threatened with being sectioned if they did not comply with a staff member's requests. Emily noted,

'the doctor said "You need to stay in overnight" and I didn't want to, I just wanted to go home and there was real arguments about it and in the end he said " If you don't stay in overnight then I'll section you for four weeks" so, they take the power from you, they don't listen to you…'

Equity

The group discussed experiences of having different types of stitches in wounds which were not explained, and that this made them feel that they were being treated differently from people who had injuries that were not the result of self-harm. They suggsted that staff should explain treatment fully.

Emily commented how she was now worried about going back to her closest emergency department as they knew her and her history.

The impact of the experiences at the emergency department led Lucy to withhold the real reason for her injury as she could not cope with the reaction she would get if staff knew she had self-harmed.

Training

The group felt that a lot of the negative experiences they have had resulted from a lack of understanding by staff about what self-harm is and consequently the lack of training they have had to enable them to react appropriately. The common presumption that the group faced from staff was that their self-harm was a suicide attempt.

User views of services for people who self-harm (first 48 hours of care)

Mary's story

Introduction

The Self-harm Guideline Development Group (GDG) is seeking user views on their experiences with services to inform the development of this guideline. Two discussion groups have been held, one in London involving participants recruited through the Samaritans and one in Nottingham, with participants recruited through a local self-help group.

One person approached by the Samaritans queried if she was eligible as she has chosen not to use NHS services. The Special Topic Group felt that her views could still be important so 'Mary' (her name has been changed to maintain anonymity) was asked and agreed to be interviewed on a one-to-one basis.

Method

The interview was conducted by Marcia Kelson at the Central London office of the Samaritans.

The interview was semi-structured with possible topics for discussion identified by the GDG Special Topic Group introduced into the discussion as the interview progressed. There was also opportunity for Mary to raise issues not suggested by the interviewer. The interviewer took notes and, with Mary's permission, taped the discussion. Key issues raised by Mary in the course of the interview are described below. Some of the issues raised relate to experiences of services beyond the first 48 hours but are included in the discussion below because they help to illustrate why Mary might not seek help within the first 48 hours of a future episode.

Background information

Mary is 44 years old, married with a 19-year-old daughter. She has worked for 27 years in social services, mostly with younger children and their families. Although she now loves her work she found the early years difficult as she worked in residential homes with young people with considerable needs. She feels now that she was not given the training or support to cope with such demands.

FINDINGS

Attitudes, use of language, taking account of distress

Communication between staff and people who self-harm

Mary's GP knows nothing about her current self-harm. She goes to him for treatment for her diabetes but not for anything stress-related. He makes references to her previous history but in a jovial way.

'I see him as the person who started it all. Started the ball rolling when I went in to hospital. I guess it's not his fault but … I don't speak to him about anything.'

Mary has been to an emergency department for a deep cut to her arm and for two subsequent injuries because they were too serious to deal with herself. She knew too that although it was a logical action to her it wouldn't be seen in that way at the emergency department so she wasn't open about what she had done.

The first time, because she had caused quite a straight cut with a knife across her arm, she said she had slipped with a scalpel while decorating.

'That was easily swallowed. I'd not presented at casualty before to be stitched.'

The second time, Mary, who is also diabetic, was dizzy at work so someone called an ambulance against her wishes. She discharged herself as soon as her husband got there but she got so panicky that after he went back to work she '***stuck a knife right up my leg***'. She told her husband she had passed out and fallen on the knife and, because she had presented at the emergency department already that morning, it was easily believed when she went back.

On this occasion she did think they were a little suspicious but that might have been because she thought she wouldn't get away with it again. Mary saw a triage nurse who said it definitely needed stitches but she got really anxious when a doctor commented that she had had stitches before. She felt this was made in a judgemental way not a concerned way.

'He said, um, "you've had stitches before, haven't you?" I said well actually I can see to this myself. He said "you can't discharge yourself. Well you can", he said, "but I strongly advise you not to, it needs stitching". I don't know, I just picked up from his attitude.'

She didn't wait to be treated but went home and did it up herself.

'I made a quite a good job of it actually.'

'I would like to go and know that I could be honest, but I wouldn't want that to lead anywhere. It would take a lot of the anxiety away for me to be able to say yes I've done this, please help me sort it out and I'm going away … I know it's a problem because it's gone on so long I don't need to be told that.'

Mary feels that although previously her wounds were dressed at hospital none of the staff ever spoke about them or discussed them with her. The reasoning behind the self-harm was not discussed either and the focus was on how to stop.

Access to services, treatment, follow–up

After discharge Mary went backwards and forwards to see the community psychiatric nurse (CPN), and she identified one tool that she felt was useful. This was a chart that she used to write down when she felt she was going to self-harm (not just harming in cuts but also abusing with alcohol).

'Just to write it down meant you could see how much you were relying on those behaviours and that was one of her **[the community psychiatric nurse's]** ***ways of focusing how often you were doing it and recognising it yourself.'***

Mary felt the chart helped.

'I reduced a lot of self-defeating behaviours, but not because the underlying problem had been dealt with, because I was terrified of ever being admitted again. So I also cheated with the charts!'

Mary has had three Samaritan befrienders at different times over the last three years and found them extremely supportive. She feels she can come to the Samaritans when she needs extra support and describes it as a ***'totally safe place – nothing ever goes any further'***. A key feature is that the service is non-judgemental and she is free to tell the truth.

She also got support from another organisation offering one-to-one support but came away because, unlike with the Samaritans, you have to give information including your name and address and GP's name. ***'That's tantamount to saying we'll contact him if we're worried about you.'***

Mary found hospital a ***'more anxious, provoking environment than anything else.'***

Referrals

With her GP's help Mary was offered support from a community psychiatric nurse (CPN). After a while the CPN suggested a voluntary admission to hospital to escape from the pressure of home commitments and responsibilities that the CPN felt she was 'hiding behind'. These included responsibilities of living next door to her parents, her mother's ill health and her job. The CPN felt she could then work more closely with a psychiatrist. Mary described her reaction to this suggestion as ***'it horrified me'*** but in consultation with her husband and the psychiatrist she agreed, having been reassured that she could leave when she wanted to.

Wound care

Mary was ambivalent about whether it might be helpful to teach people who do present to services how to manage their own cuts. Mary herself feels she does not self-harm for attention but for herself. However, she has met a lot of people in hospital who she felt harmed themselves in front of people to seek attention to be seen to and she felt that this might be defeating by encouraging people to go further to get attention.

The interviewer asked Mary about treatment for cuts in the emergency department, and if she had any preferences between stitches, glue or skin closure strips.

'I don't know. My preference is to get out of there as quickly as possible!'

Having used skin closure strips herself she is surprised how well they work on a really deep cut. She feels that the deep injury that she treated herself scarred less than the others and is by far the least noticeable.

Rights, consent, capacity

Mary decided that hospital was not the right place and would discharge herself at which point she was sectioned on the ground she was a danger to herself.

'Yes, I'm self-harming and I didn't then quite understand why, but I wasn't a danger to myself.'

Mary's adverse reactions to her admission included broken reassurances about the nature of her admission. She was similarly wary when she saw a private counsellor: ***'It was, like "this is all between us, this is confidential, unless I've got cause for concern." And that with me is like saying we're going to get something on you.'***

Mary was admitted to hospital taking no medication, but left nine weeks later taking so much medication that she felt unable to function.

Appendix 16: Recommendations generated during focus groups

Attitudes, use of language, taking account of distress

- Staff should have a non-judgemental approach and try to understand people who self-harm.
- Staff should listen to the service user, trust their views and avoid making assumptions.
- Staff should be aware that an individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.
- Service users should be involved in discussions about their care and should not be talked over.
- When assessing the service user staff should not rely solely on risk assessment tools; it's important to ask the individual and to let them explain in their own words.
- Staff should be prepared to acknowledge and handle any distress from the individual and manage their own personal feelings about the situation without compromising their professional role and responsibilities. It is important to note that the degree of injury is not an indicator of the level of distress the individual may be feeling.
- Staff should not 'write off' people who self-harm if they have not been able to meet their needs. It is important to understand that stopping self-harm behaviour is not a 'cure', exploring and coming to terms with the behaviour may be much more helpful to the individual.
- Staff should recognise that their role may be to calm the situation.
- Building an honest relationship with the service user will help both parties. Time and consideration are important in this process as is giving control back to the service user.

Access to services, treatment and follow–up

- It is extremely important to give the service user choices about where they would like to wait and whether they would like to be on their own. In any situation it is important not to leave service users alone for long periods of time.
- It is recommended that a quiet place should be available for service users to wait in should they so wish.
- Staff should keep service users informed about how long they may need to wait for treatment.
- Staff should address the immediate safety issues in a sensitive manner, including asking whether the service user would like to hand in anything that they may have on their person which may make them feel safer. Service users should not be searched without explanation. Wherever the individual waits treatment staff must ensure that the person is accommodated in an environment where they cannot harm themselves further.
- If possible, the company of a non-clinical person to provide support while people

wait in an emergency department should be offered. Alternatively an advocate or chaperone may be contacted at the service user's request to accompany them.

- A fast-tracking of service users through the system should be considered to minimise harm resulting from their injury and to minimise distress. In all cases staff should provide timely treatment and/or referral.
- If possible, service users should be offered the choice of being treated by a male or female staff member.
- In suspected cases of overdose, staff should ask the service user what they have taken, and not assume.
- Staff should avoid making assumptions about whether the injury is a result of a suicide attempt or self-harm, by asking the service user outright.
- Service users should participate in discussions about their treatment and should always be offered choices if available. Treatment may need to be explained to ensure the service user is fully informed about what will happen to them.
- Many wounds may be treated equally with Steristrips or sutures and therefore personal choice may be the overriding decider. Consideration and discussion about scarring and resistance of the method to tampering may help to inform both staff and service user about the best possible method for that individual.
- Emergency department doctors should check for nerve damage resulting from the injury.
- The service user should be provided with information and suitable dressings to take home and enable them to manage the care of their wound.
- If prescribed medication, service users should receive full information about the purpose of the medication and possible side effects. Antidotes should be offered where available for drugs with known side effects.
- Service users should never be discharged while they are still physically unwell.
- Staff should be able to offer signers and interpreters where appropriate.
- It is important for discussions to be held about self-management of wound care.
- Appropriate levels of anaesthesia should be used at all times and if a service user advises that the pain relief is wearing off or is insufficient more should be given.
- The role of GPs should be recognised and they should not be penalised financially for supplying dressings, etc. to service users who prefer to be treated in their GP's surgery or by self-management for wound care at home.
- Acute treatment should be available to service users without any longer-term repercussions.
- GPs and practice nurses can be helpful in liaising with psychiatric services and shortcutting routes into care.
- Out-of-hours GPs need to be aware of various routes into hospital.
- Liaison between emergency departments and psychiatric services: psychiatric liaison staff should be available 24 hours a day.
- Staff should ensure that service users are offered the choice of seeing a crisis team (some people may not wish to make use of this service).
- Any information obtained at an emergency department should be passed on to the appropriate services to ensure continuity of care and avoid duplication of questions, which may cause additional unnecessary distress to the service user.
- Staff should discuss with service users suitable methods of follow-up. This may include utilising the Samaritans' follow-up service.
- Arrangements should be agreed with the service user before setting processes in motion.

Rights, consent and capacity

- Staff should ask the person how s/he wants to be treated, following advance directives if available. Decisions made in advance directives should not be altered without an assessment of risk.
- Under 18s or under 16s: parents may have to be contacted but the young person should be informed of this situation and involved in any decision-making about seeing their parents. Staff should ask if it might be appropriate to invite someone other than a parent to provide support.
- Service users must be informed if the Mental Health Act is implemented and involved in decisions to detain them.
- Service users should always be given the opportunity to have someone of their choice with them.
- It is totally unacceptable to use scare tactics, for example refusal to use anaesthetic or threaten service users with sectioning.
- Ideally a named person should be identified to ensure that any service user who is not happy with the service they have received may contact this individual to raise any relevant issues.
- It is not acceptable to 'talk over' the service user to their friends/family/advocate if the person is conscious and has capacity.

Equity

- Service users have the right to be treated with dignity and respect and valued as human beings and are therefore entitled to receive the relevant information, be consulted about their care and to be given choices. Staff should offer privacy and maintain confidentiality.
- Information and consultation with service users should include:

  i. Discussing with the person the pros and cons of different treatment options

  ii. Asking the person how they want to be treated and what they would like to happen (both in terms of immediate treatment and follow-up arrangements)

  iii. Taking individual needs and preferences into account (relates to treatment options but also to choices about who should treat them, e.g. choice of gender)

  iv. Advising people about the purpose of any medication prescribed and warning people about what side effects might be experienced

  v. Asking the person about their risk.

Training and specialist skills

- Funding for and provision of staff training, with active involvement of service users, is vital.
- Training should be aimed at helping people understand the issues and maintaining a dialogue between staff and service users.
- Part of the training should acknowledge and address staff fears and prejudices.
- Training should identify what is expected of staff.
- Support and supervision should be provided for staff.
- Training should be available for all staff (not just emergency departments but also plastics department, reception staff and staff on non-psychiatric wards that users may be admitted to, e.g. surgical wards).
- Training for staff should include involvement from service users and local groups that work with them.

- Adequate funding needs to be sought to ensure training is delivered.
- Training should address the differences between self-harm and attempted suicide, that self-harm is not always simply attention-seeking behaviour, the consequences of labelling and the use of language to describe people who self-harm.
- Training for GPs: should be more willing to talk about issues surrounding a person who is self-harming and give choices to the individual regardless of the degree of their injury.
- Some staff have made a difference to individuals who have self-harmed.
- Staff should utilise the existing information available about self-harm, for example, the NSHN message board and be aware of the services offered by voluntary organisations and the value that service users have gained from these.

Appendix 17: Characteristics of reviewed studies (on CD)

Appendix 18: References to studies reviewed (on CD)

Appendix 19 Forest plots (on CD)