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Quick reference guide

Self-harm

The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

Clinical Guideline 16

Developed by the National Collaborating Centre for Mental Health

Ordering information
Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG016quickrefguide or from the NHS response Line by telephoning 0870 1555 455 and quoting reference number N0625. Information for the public is also available from the NICE website of from the NHS Response Line (quote reference number N0626 for the English version, and N0627 for the version in English and Welsh).

This guidance is written in the following context
This guidance represents the view of the Institute, which was arrived at after careful consideration of the available evidence. Health professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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Contents

Grading of the recommendations

The recommendations are evidence-based. The grading system used is shown below. Further information on the grading of the recommendations and the evidence used to develop the guideline is presented in the full guideline (see back cover).

- **A** Based on level I evidence (at least one randomised controlled trial [RCT] or meta-analysis of RCTs)
- **B** Based on level II or level III evidence (non-randomised controlled trials or non-experimental descriptive studies) or extrapolated from level I evidence
- **C** Based on level IV evidence (expert committee reports or opinions and/or clinical experience of respected authorities)
- **GPP** Recommended good practice based on the clinical experience of the Guideline Development Group

See the NICE guideline (www.nice.org.uk/CG016NICEguideline) for further information.

Key priorities for implementation

Respect, understanding and choice

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated charcoal

- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.

- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.

- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

Assessment of needs

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

- Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

Advice for healthcare professionals in any setting

General principles

- Always treat people with care and respect. GPP
- Ensure privacy for the service user. GPP
- Take full account of the likely distress associated with self-harm. GPP
- Offer the choice of male or female staff for assessment and treatment. If it is not possible to give people a choice, explain why and write it in their notes. GPP
- Always ask the service user to explain in their own words why they have self-harmed. Remember, when people self-harm often, the reason for each act may be different on each occasion; don't assume it's done for the same reasons. GPP
- Involve the service user in clinical decision-making and provide information about treatment options. GPP

Relatives, carers and friends

- Include family or friends if the service user wants their support during assessment and treatment, although psychosocial assessment usually needs some time with the service user alone to ensure confidentiality. GPP
- Provide emotional support to relatives/carers if they need it. GPP

Consent

- Always assess mental capacity and interview relatives/friends to help assessment. GPP
- Assume mental capacity, unless there is evidence to the contrary. GPP
- Obtain fully informed consent before each treatment or procedure is started (this includes taking the service user to hospital). GPP

- Always attempt to gain consent for each and every new treatment, because capacity changes over time. GPP
- If the service user is mentally incapable, always act in their best interests even if against their wishes (this includes taking the service user to hospital if they have refused). GPP
- Have easy access to legal advice about issues relating to capacity and consent at all times. GPP

Specific issues regarding treatment and care

Physical treatments

- Always offer necessary physical treatments even if the person doesn't want psychosocial or psychiatric assessment. GPP
- Always use proper anaesthesia and/or analgesia if treatment for self-injury is painful. GPP
- Offer sedation if treatment may evoke distressing memories of previous sexual abuse, such as when repairing harm to the genital area. GPP

Activated charcoal

- Ambulance and emergency department staff involved in the treatment of self-harm by poisoning should ensure that activated charcoal is immediately available for use at all times. B
- Staff should know:
  - how to administer it
  - for which poisons activated charcoal should and should not be used
  - the potential dangers and contraindications of giving activated charcoal
  - that it's important to encourage and support service users when offering activated charcoal. B

The management of self-harm in primary care

- Urgently establish physical risk and mental state in a respectful and understanding way. GPP
- Assess risk of further self-harm (consider depression, hopelessness and suicidal intent). C
- Inform other relevant staff and organisations of the outcome of this assessment. C

Self-injury

- If there is significant risk to the service user, refer to an emergency department urgently. GPP
- If in doubt about whether to refer, discuss with an emergency consultant. GPP
- If the service user lives in a remote area and can't get to an emergency department quickly, discuss with an emergency consultant. Consider initiating treatment. GPP
- Arrange for an appropriate chaperone when the service user is going in the ambulance to an emergency department if:
  – there is risk of further self-harm
  – the person is reluctant to attend, and/or
  – the service user is very distressed. GPP

Self-poisoning

- Refer to an emergency department urgently unless you are sure this isn't necessary. GPP
- If in doubt about whether to refer, discuss with an emergency consultant. GPP
- If the service user lives in a remote area and can't get to an emergency department quickly, discuss with an emergency consultant. Consider initiating treatment and collect samples to test for paracetamol and other drugs, as indicated in TOXBASE. GPP

- Arrange for an appropriate chaperone when the service user is going in the ambulance to an emergency department if:
  – there is risk of further self-harm
  – the person is reluctant to attend, and/or
  – the service user is very distressed. GPP
- Remember – many people aren't sure what drugs they've taken. GPP

When urgent referral to an emergency department is not necessary

- Consider whether the person needs urgent referral to secondary mental health services. GPP
- Base your decision on risk and needs assessment, including:
  – social and psychological aspects of the episode of self-harm
  – mental health and social needs
  – hopelessness
  – suicidal intent. C
- Send full details of assessments and treatment to the appropriate secondary mental health team as soon as possible. GPP

Prescribing to service users at risk of self-poisoning

- When prescribing drugs to people who have previously self-poisoned, people who are at risk of self-poisoning, or people who live with someone at risk of self-poisoning:
  – always prescribe those drugs that are the least dangerous in overdose
  – prescribe fewer tablets at any one time
  – consider alternatives to co-proxamol. GPP

The assessment and initial management of self-harm by ambulance personnel

- Urgently establish physical risk and mental state in a respectful and understanding way. GPP
- Consider, wherever possible, the service user's preference if there is more than one emergency department nearby. GPP
- Ignore service user's preference if this increases risk. GPP

Self-injury

- Unless the service user's clinical condition requires urgent attention, record all relevant information at the scene, including home environment, social/family support network and history leading to self-harm. GPP
- If the service user does not require treatment at an emergency department, consider taking the person to an alternative appropriate service. Agree this with the alternative service and the service user. GPP

Self-poisoning

- Obtain all substances and/or medications found at the scene. GPP
- Give these to emergency department staff on arrival. GPP

If the substance ingested indicates use of activated charcoal

- Offer activated charcoal as early as possible, and within 1 hour after ingestion if the service user is at risk of significant harm, fully conscious, and able to protect his or her own airway. B
- Activated charcoal may also be considered between 1 and 2 hours after ingestion, because it may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. C

If unsure if pre-hospital treatment is needed, consult TOXBASE. If the service user has ingested an unusual substance, consult the National Poisons Information Service (NPIS). GPP

When the service user is likely to refuse treatment

- Assess mental capacity. GPP
- Provide information about the potential consequences of not receiving treatment. GPP
- Continue to try to gain valid consent and follow guidance on consent. GPP
- If consent is withheld, follow guidance on consent (page 6). GPP

The treatment and management of self-harm in emergency departments

Triage

- Consider using a combined physical and mental health triage scale such as the Australian Mental Health Triage Scale. C
- Urgently establish physical risk and mental state in a respectful and understanding way. GPP
- Take account of emotional distress as well as physical distress. GPP
- Remember – some people who self-harm may not show distress even when the injury is severe.
- Offer psychosocial assessment at triage to determine:
  – mental capacity
  – willingness to remain for further psychosocial assessment
  – distress levels
  – presence of mental illness. C

People waiting for physical treatments

- Don't delay psychosocial assessment until after medical treatment, except when:
  – the service user needs life-saving treatment
  – the service user is unconscious
  – the service user is incapable of assessment (e.g. intoxicated). GPP
- Provide verbal and written information about the care process in a language the service user understands. C
- Provide a safe and supportive environment where people can wait, and provide supervision to ensure safety, if appropriate, with a named member of staff. GPP

People who wish to leave before assessment and/or treatment

- If a person wishes to leave before a psychosocial assessment, assess for mental capacity/mental illness and record assessment in the notes. C

- Pass assessment to the service user's GP and to the relevant mental health services as soon as possible, to enable rapid follow up. C
- If mental capacity is diminished and/or the person has a significant mental illness, refer for urgent mental health assessment and prevent the person leaving. C

Medical and surgical management of self-harm: self-poisoning

General treatment for ingestion

- Consider gastrointestinal decontamination only if the patient presents early, is fully conscious, has a protected airway, and is at risk of significant harm from the ingested substance. B
- Offer activated charcoal, unless contraindicated, as early as possible, and within 1 hour. B
- Activated charcoal may also be considered between 1 and 2 hours, because it may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. C

Unless specifically recommended by TOXBASE or following consultation with the National Poisons Information Service (NPIS):

- don't offer multiple doses of activated charcoal B
- don't use emetics, including ipecac B
- don't use cathartics C
- don't use gastric lavage B
- don't use whole bowel irrigation. C

Collecting samples and interpreting results

- Collect samples of blood, ingested substances, and other samples if the NPIS requires them. GPP
- Consult TOXBASE to select and interpret assays (if in doubt, check with local laboratory; if still in doubt, consult with the NPIS). GPP

Information and laboratory services available to clinicians treating self-poisoning

- For poisons considered in this guideline:
  – consult TOXBASE in conjunction with this guideline
  – if in doubt, consult the NPIS. GPP
- For all other poisons:
  – consult TOXBASE
  – if the poison is an unusual one, pass the data to the NPIS. GPP

Paracetamol screening

- Plasma paracetamol concentrations should be measured in:
  – all conscious patients with a history of paracetamol overdose, or suspected paracetamol overdose
  – patients with a presentation consistent with opioid poisoning
  – unconscious patients with a history of collapse where drug overdose is a possible diagnosis. C
- Measure plasma paracetamol concentrations and take samples no earlier than 4 hours and no later than 15 hours after ingestion. C

Management of paracetamol overdose

Offer activated charcoal as indicated on page 13, and then use TOXBASE to guide further management. C

- Use intravenous acetylcysteine depending on plasma concentration levels, except:
  - for people who abuse intravenous drugs where intravenous access may be difficult
  - for people with needle phobia.

  In these cases, consult TOXBASE. C
- If the patient has an anaphylactoid reaction to acetylcysteine, consult TOXBASE, then the NPIS. GPP
- In cases of staggered ingestion of paracetamol, investigate for ingestion of other poisons, and consult TOXBASE, then the NPIS. GPP

Treatment and management of suspected or confirmed benzodiazepine overdose

- If benzodiazepine overdose is confirmed, investigate the possibility of mixed overdose as soon as possible, and especially if the patient's clinical progress suggests that he or she may later require admission to intensive care. GPP
- **Consider flumazenil*:**
  - if the patient is unconscious or shows marked impairment of consciousness, with evidence of respiratory depression likely to lead to admission to intensive care with endotracheal intubation.
  - only after a comprehensive assessment has been undertaken that includes a full clinical and biochemical assessment of the patient's respiratory status, and his or her ability to protect his or her own airway. B

*Although widely used, flumazenil is not currently licensed for the treatment of benzodiazepine overdose in the UK.

- **Do not use flumazenil** if:
  - the patient has co-ingested proconvulsants, including tricyclic antidepressants
  - the patient has a history of epilepsy
  - the patient is benzodiazepine-dependent. B
- **Administering flumazenil:**
  - ensure resuscitation equipment is immediately available GPP
  - use small doses GPP
  - give slowly GPP
  - use the minimum effective dose only for as long as it is clinically necessary B
  - warn the patient of the risk of re-sedation, particularly if the patient expresses the desire to leave the treatment setting. C

Only clinicians who have been explicitly trained in the use of flumazenil in the treatment of benzodiazpeine poisoning, as described in the NICE guideline, should administer flumazenil in this context. GPP

Treatment and management of poisoning with salicylates

- Use activated charcoal as indicated on page 13, and then use TOXBASE to guide further management. C

Treatment of opioid overdose

- If opioid poisoning is suspected and the patient has impaired consciousness and/or respiratory depression, use naloxone for diagnosis and treatment following Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. B
  - Use minimum effective dose. C
  - If patient is dependent on opioids, give slowly and prepare for agitation. GPP
  - If there are long-acting opioids present (e.g. methadone), consider intravenous infusion. C
  - Monitor vital signs and oxygen saturation until the patient is conscious and is breathing adequately without naloxone. GPP

Medical and surgical management of self-harm: self-injury

General treatment for self-injury

- Don't delay treatment because it is self-inflicted. GPP
- Take account of the distress involved in self-harm and in seeking treatment. GPP
- Explain the treatment options to the service user and discuss fully his or her treatment preferences. GPP
- Always use anaesthesia and/or analgesia if treatment may be painful. GPP
- For superficial uncomplicated injuries of 5 cm or less in length:
  - offer tissue adhesive as the first-line treatment, or A
  - offer skin closure strips if the service user prefers this. B
- For superficial uncomplicated injuries greater than 5 cm in length, or deeper injuries of any length, assess and explore the wound and follow good surgical practice. GPP

Support and advice for people who repeatedly self-harm

Advice for people who repeatedly self-poison

- Don't offer harm minimisation advice regarding self-poisoning – there are no safe limits. GPP
- Consider discussing the risks of self-poisoning with service users (and carers, where appropriate) who are likely to use this method of self-harm again. GPP

Advice for people who repeatedly self-injure

- Consider giving advice and instructions on:
  - self-management of superficial injuries, including providing tissue adhesive
  - harm minimisation issues and techniques
  - appropriate alternative coping strategies
  - dealing with scar tissue. GPP
- Discuss with a mental health worker which service users should be offered the advice above (voluntary organisations may have suitable materials). GPP

Psychosocial assessment: specialist mental health professionals

- Assess needs and risk as part of the therapeutic process to understand and engage the service user. GPP
- Consider integrating needs and risk assessment. GPP
- Record assessment in the service user's notes. C
- Share written assessment with the service user. GPP
- If there is a disagreement, consider offering the service user the opportunity to write this in the notes. GPP
- Pass assessment on to the service user's GP and to any relevant mental health services to enable follow up. GPP

Assessment of needs

- Offer needs assessment to all people who self-harm. C
- Include in the assessment:
  - social, psychological and motivational factors specific to the act of self-harm
  - current intent
  - hopelessness
  - mental health and social needs assessment. C

Assessment of risk

- Assess all people who self-harm for risk. C
- Include in the assessment:
  - identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide
  - identification of the key psychological characteristics associated with risk (depression, hopelessness and continuing suicidal intent). C
- Only use a standardised risk assessment scale to aid identification of those at high risk of repetition of self-harm or suicide. C
- Don't use standardised risk assessment scales to identify service users of supposedly low risk who are not then offered services. C

Referral, admission and discharge following psychosocial assessment

General considerations

- Base decisions about referral, discharge and admission on comprehensive assessment, including needs and risk. C
- Decide jointly with the service user whether to refer for further assessment, and/or treatment, or to discharge, where possible. GPP
- If it is not possible to decide options jointly with the service user because of reduced mental capacity or significant mental illness:
  - explain this to the service user
  - write the explanation in the notes
  - consider admission overnight and reassess the following day. GPP
- If the service user is very distressed, has an unsafe home environment, and/or it is too difficult to undertake psychosocial assessment, then consider admission overnight and reassess the following day. GPP

Referral

- Discuss treatment options and the service user's preference. GPP
- Provide the service user with relevant written information about treatments and services. GPP
- Do not refer only on the basis that the patient has self-harmed. C

Admission

- Consider offering an intensive therapeutic intervention combined with outreach to people who have self-harmed and are deemed to be at risk of repetition.
  - Intensive intervention should allow greater access to a therapist, home treatment when necessary and telephone contact, and outreach should include following up the service user when an appointment has been missed.
  - Continue therapeutic intervention plus outreach for at least 3 months. C
- Consider dialectical behaviour therapy for people with borderline personality disorder.
  - Don't, however, ignore other psychological treatments for people with this diagnosis that are outside the scope of this guideline. C

Discharge

- Decide to discharge a person without follow-up based on a combined assessment of needs and risk. C
- Do not discharge without follow-up solely on the basis of low risk and no mental illness. GPP

Special issues for children and young people

Triage, assessment and treatment

- Triage, assessment and treatment should be undertaken by paediatric nurses and doctors trained to work with children and young people who self-harm in a separate area of the emergency department for children and young people. GPP
- If you are involved with children or young people in the emergency treatment of self-harm, you should be adequately trained to assess mental capacity in children of different ages and must understand how issues of capacity and consent apply to this group and have access at all times to specialist advice about these issues. Special attention should be given to:
  - confidentiality
  - young person's consent (including Gillick competence)
  - parental consent
  - child protection issues
  - use of the Mental Health Act and the Children Act. GPP

Admission

- All children and young people should normally be admitted into a paediatric ward under the overall care of a paediatrician and assessed fully the following day. C
- Alternative placements may be needed, depending on:
  - age
  - circumstances of the child and their family
  - time of presentation
  - child protection issues
  - physical and mental health of the child or young person. C
- If the young person is 14 years or older, consider an adolescent paediatric ward. C
- Occasionally, an adolescent psychiatric ward may be needed. C
- After admission, the paediatric team should obtain consent for mental health assessment from the child or young person's parent, guardian or legally responsible adult. C

- During admission, the Child and Adolescent Mental Health services team should:
  - provide consultation for the young person, their family, the paediatric team, social services, and education staff C
  - undertake assessment addressing needs and risk for the child (similar to adults, see pages 18–19), the family, the social situation of the family and young person, and child protection issues. GPP
- Assessors should be specifically trained and supervised to work with self-harm in this age group. C

Other considerations

- For young people who have self-harmed several times, consider offering developmental group psychotherapy with other young people. This should include at least six sessions but can be extended by mutual agreement. B
- For all children and young people, advise carers to remove all means of self-harm, including medication, before the child or young person goes home. GPP

Special issues for older people

- Mental health professionals must be experienced in assessing older adults who have self-harmed to undertake assessment of this age group. GPP
- Be aware that all acts of self-harm in people over the age of 65 years should be taken as evidence of suicidal intent until proven otherwise. GPP
- Always consider admission for mental health assessment, risk and needs assessment, monitoring changes in mental state and levels of risk. GPP
- Follow the same principles as for the assessment of adults, but also include a full assessment with special attention to the possible presence of depression, cognitive impairment, physical ill health, and the person's social and home situation. GPP

Training issues

Managers of services need to ensure that training and support for staff who have contact with people who self-harm is available in the following areas.

- Clinical and non-clinical staff should be trained in the treatment and management of self-harm to equip them to understand and care for service users. C
- Staff should receive regular clinical supervision and support. GPP
- Staff should be trained in the assessment of mental capacity and issues of consent. GPP
- Service users should be involved in the training of staff. GPP
- Ambulance staff should receive basic training in mental health assessment as it pertains to self-harm. GPP
- Emergency departments and mental health services should aim to integrate mental health professionals into emergency departments and provide 24-hour services for people who self-harm. GPP
- Emergency department staff responsible for triage should have training in mental health triage systems. C
- Clinical staff involved in the emergency treatment of self-poisoning should be given training to make best use of TOXBASE and the NPIS. GPP

Please refer to the full guideline or the NICE guideline for more information (see back cover for details).

Implementation

The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

Local health communities should review their existing practice for self-harm against this guideline as they develop their Local Delivery Plans. The review should consider the resources required to implement the recommendations set out in Section 1 of the NICE guideline, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of service users that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.doh.gov.uk/nsf/mentalhealth.htm

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Further information

Distribution

This quick reference guide to the Institute's guideline on self-harm contains the key priorities for implementation, summaries of the guidance, and notes on implementation. The distribution list for this quick reference guide is available on the NICE website at www.nice.org.uk/CG016distributionlist

NICE guideline

The NICE guideline, *Self-harm: the physical and psychological management and secondary prevention of self-harm in primary and secondary care*, is available on the NICE website (www.nice.org.uk/CG016NICEguideline).

The NICE guideline contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Research recommendations; 5 Full guideline; 6 Review date. It also gives details of the scheme used for grading the recommendations, membership of the Guideline Development Group and the Guideline Review Panel, and technical details on criteria for audit.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline published by the National Collaborating Centre for Mental Health; it will be available from its website (www.rcpsych.ac.uk/cru/nccmh.htm), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

Information for the public

A version of this guideline for people who self-harm, their advocates and carers, and for the public (including information for children and young people) is available, in English and Welsh, from the NICE website (www.nice.org.uk/CG016publicinfo). Printed versions are also available – see below for ordering information.

Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Ordering information

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG016quickrefguide or from the NHS Response Line by telephoning 0870 1555 455 and quoting reference number N0625. Information for the public is also available from the NICE website or from the NHS Response Line (quote reference number N0626 for the English version, and N0627 for the version in English and Welsh).

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