NICE guidance for the assessment and management of self-harm

National Conference - Preventing Suicide and Self Harm
Cardiff, March 2023

Professor Nav Kapur

Outline

- Context
- The guideline process
- The new NICE self-harm guidelines – selected highlights

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- **Context**
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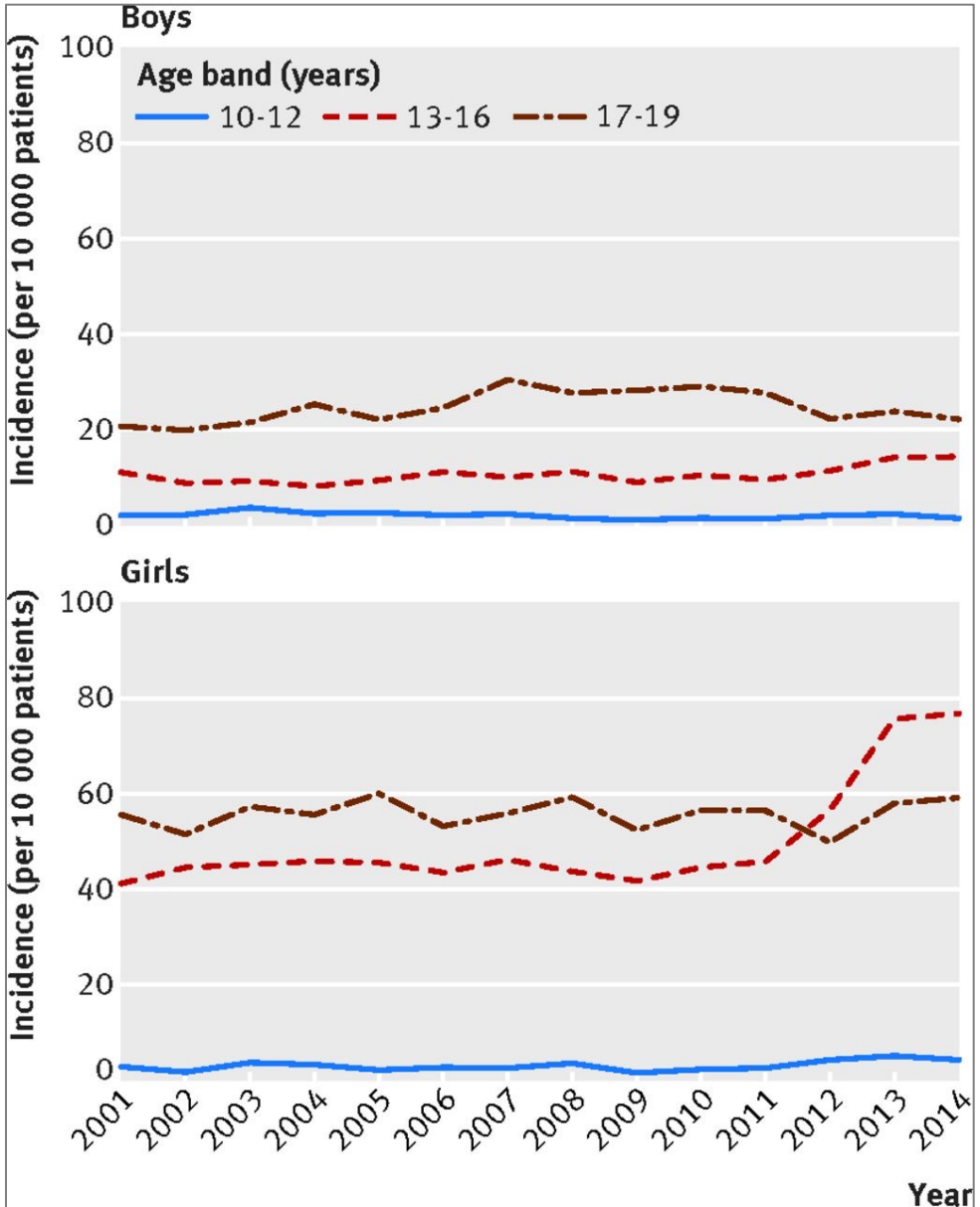
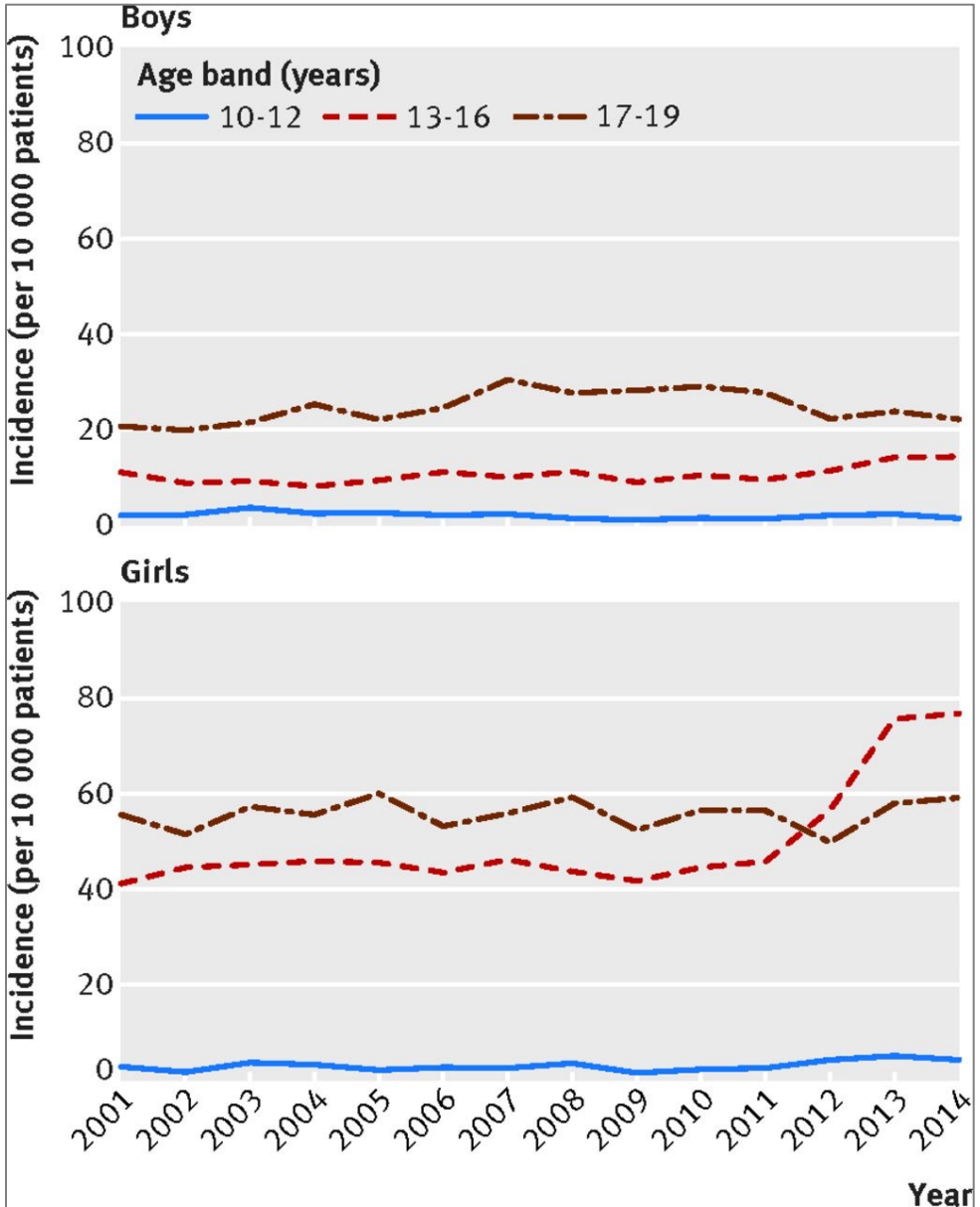
Trends in self-harm in young people



Source: Morgan et al. (2017) https://doi.org/10.1136/bmj.j4351

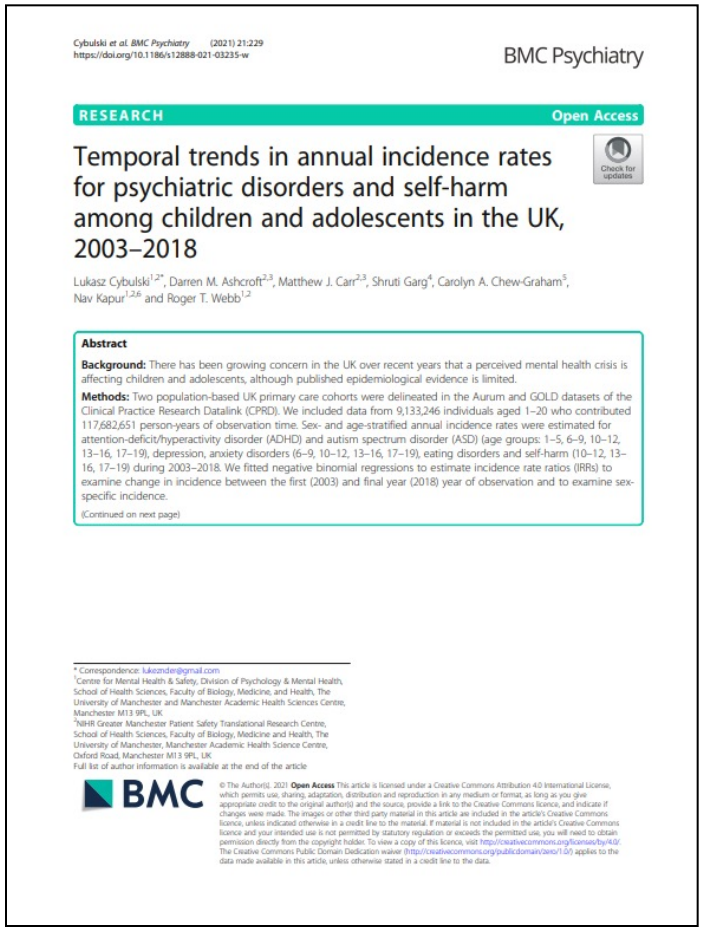
Trends in self-harm in young people



- Inverse care law

Source: Morgan et al. (2017) https://doi.org/10.1136/bmj.j4351

Young people



Cybulski et al. BMC Psychiatry (2021) 21:229
https://doi.org/10.1186/s12888-021-03235-w

BMC Psychiatry

RESEARCH Open Access

Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018

Lukasz Cybulski[1,2*], Darren M. Ashcroft[2,3], Matthew J. Carr[2,3], Shruti Garg[4], Carolyn A. Chew-Graham[5], Nav Kapur[1,2,6] and Roger T. Webb[1,2]

Abstract

Background: There has been growing concern in the UK over recent years that a perceived mental health crisis is affecting children and adolescents, although published epidemiological evidence is limited.

Methods: Two population-based UK primary care cohorts were delineated in the Aurum and GOLD datasets of the Clinical Practice Research Datalink (CPRD). We included data from 9,133,246 individuals aged 1–20 who contributed 117,682,651 person-years of observation time. Sex- and age-stratified annual incidence rates were estimated for attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) (age groups: 1–5, 6–9, 10–12, 13–16, 17–19), depression, anxiety disorders (6–9, 10–12, 13–16, 17–19), eating disorders and self-harm (10–12, 13–16, 17–19) during 2003–2018. We fitted negative binomial regressions to estimate incidence rate ratios (IRRs) to examine change in incidence between the first (2003) and final year (2018) year of observation and to examine sex-specific incidence.

(Continued on next page)

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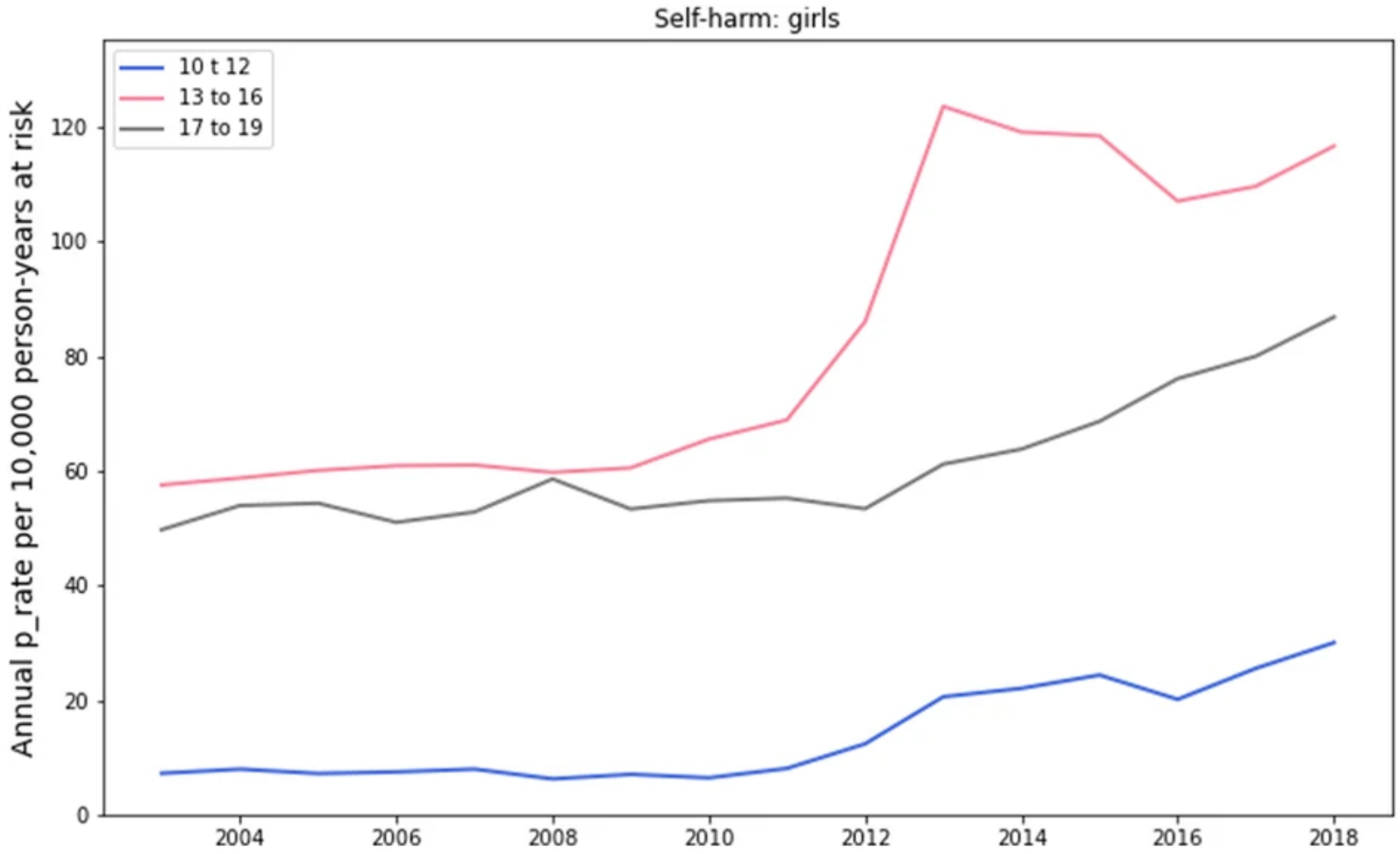


Cybulski L, Ashcroft DM, Carr MJ, Garg S, Chew-Graham CA, Kapur N, Webb RT. Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. BMC psychiatry. 2021 Dec;21(1):1-2.

Self-harm in older adults

Articles

Self-harm in a primary care cohort of older people: incidence, clinical management, and risk of suicide and other causes of death

Catharine Morgan, Roger T Webb, Matthew J Carr, Evangelos Kontopantelis, Carolyn A Chew-Graham, Navneet Kapur, Darren M Ashcroft

Summary

Background Self-harm is a major risk factor for suicide, with older adults (older than 65 years) having reportedly greater suicidal intent than any other age group. With the aging population rising and paucity of research focus in this age group, the extent of the problem of self-harm needs to be established. In a primary care cohort of older adults we aimed to investigate the incidence of self-harm, subsequent clinical management, prevalence of mental and physical diagnoses, and unnatural-cause mortality risk, including suicide.

Methods The UK Clinical Practice Research Datalink contains anonymised patient records from general practice that routinely capture clinical information pertaining to both primary and secondary care services. We identified 4124 adults aged 65 years and older with a self-harm episode ascertained from Read codes recorded during 2001–14. We calculated standardised incidence and in 2854 adults with at least 12 months follow-up examined the frequency of psychiatric referrals and prescription of psychotropic medication after self-harm. We estimated prevalence of mental and physical illness diagnoses before and after self-harm and, using Cox regression in a matched cohort, we examined cause-specific mortality risks.

Findings Overall incidence of self-harm in older adults aged 65 years and older was 4·1 per 10 000 person-years with stable gender-specific rates observed over the 13-year period. After self-harm, 335 (11·7%) of 2854 adults were referred to mental health services, 1692 (59·3%) were prescribed an antidepressant, and 336 (11·8%) were prescribed a tricyclic antidepressant (TCA). Having a diagnosed previous mental illness was twice as prevalent in the self-harm cohort as in the comparison cohort (prevalence ratio 2·10 [95% CI 2·03–2·17]) and with a previous physical health condition prevalence was 20% higher in the self-harm cohort compared to the comparison cohort (1·20 [1·17–1·23]). Adults from the self-harm cohort (n=2454) died from unnatural causes an estimated 20 times more frequently than the comparison cohort (n=48 921) during the first year. A markedly elevated risk of suicide (hazard ratio 145·4 [95% CI 53·9–392·3]) was observed in the self-harm cohort.

Interpretation Within primary care, we have identified a group of older adults at high risk from unnatural death, particularly within the first year of self-harm. We have highlighted a high frequency of prescription of TCAs, known to be potentially fatally toxic in overdose. We emphasise the need for early intervention, careful alternative prescribing, and increased support when older adults consult after an episode of self-harm and with other health conditions.

Lancet Psychiatry 2018; 5: 905–12

Published Online October 15, 2018 http://dx.doi.org/10.1016/S2215-0366(18)30348-1

See Comment page 859

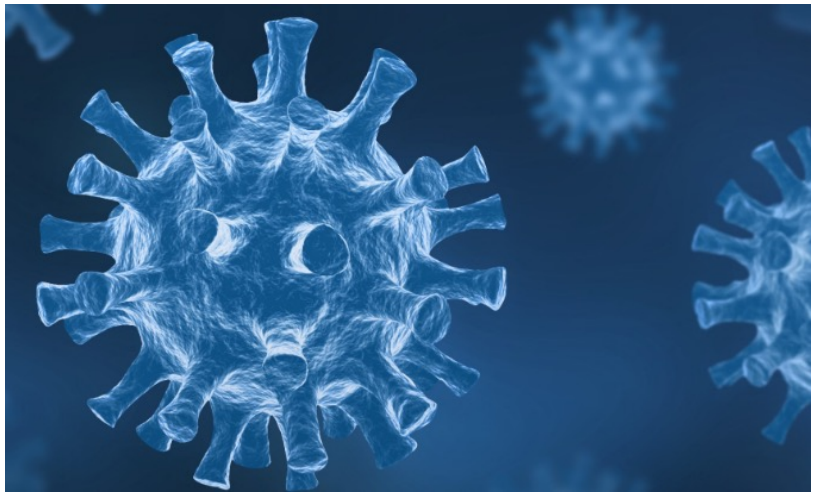
Centre for Mental Health and Safety (Prof R T Webb PhD, Prof N Kapur FRCPsych, M J Carr PhD), National Institute for Health Research (NIHR) School for Primary Care Research, Division of Informatics, Imaging and Data Sciences (Prof E Kontopantelis PhD), Centre for Suicide Prevention (Prof N Kapur), Centre for Pharmacoepidemiology and Drug Safety (Prof D M Ashcroft PhD, C Morgan PhD), Faculty of Biology, Medicine and Health, NIHR Greater Manchester Patient Safety Translational Research Centre, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK; Research Institute, Primary Care and Health Sciences, West Midlands, Collaboration for Leadership in Applied Health Research and Care, Keele

Older adults who self-harmed

- **145 times** more likely to die by suicide
- Only **12%** referred to mental health services
- Over 1 in 10 prescribed TCAs
- Psychiatric disorder, physical illness, social isolation could be targets for intervention

Source: Morgan et al., (2018) https://doi.org/10.1016/S2215-0366(18)30348-1

Challenges to implementation - Permacrisis?



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Ukraine conflict: What we know about the invasion

24 February

Russia-Ukraine war

Cost of living crisis

Analysis

Cost of living crisis: what governments around the world are doing to help

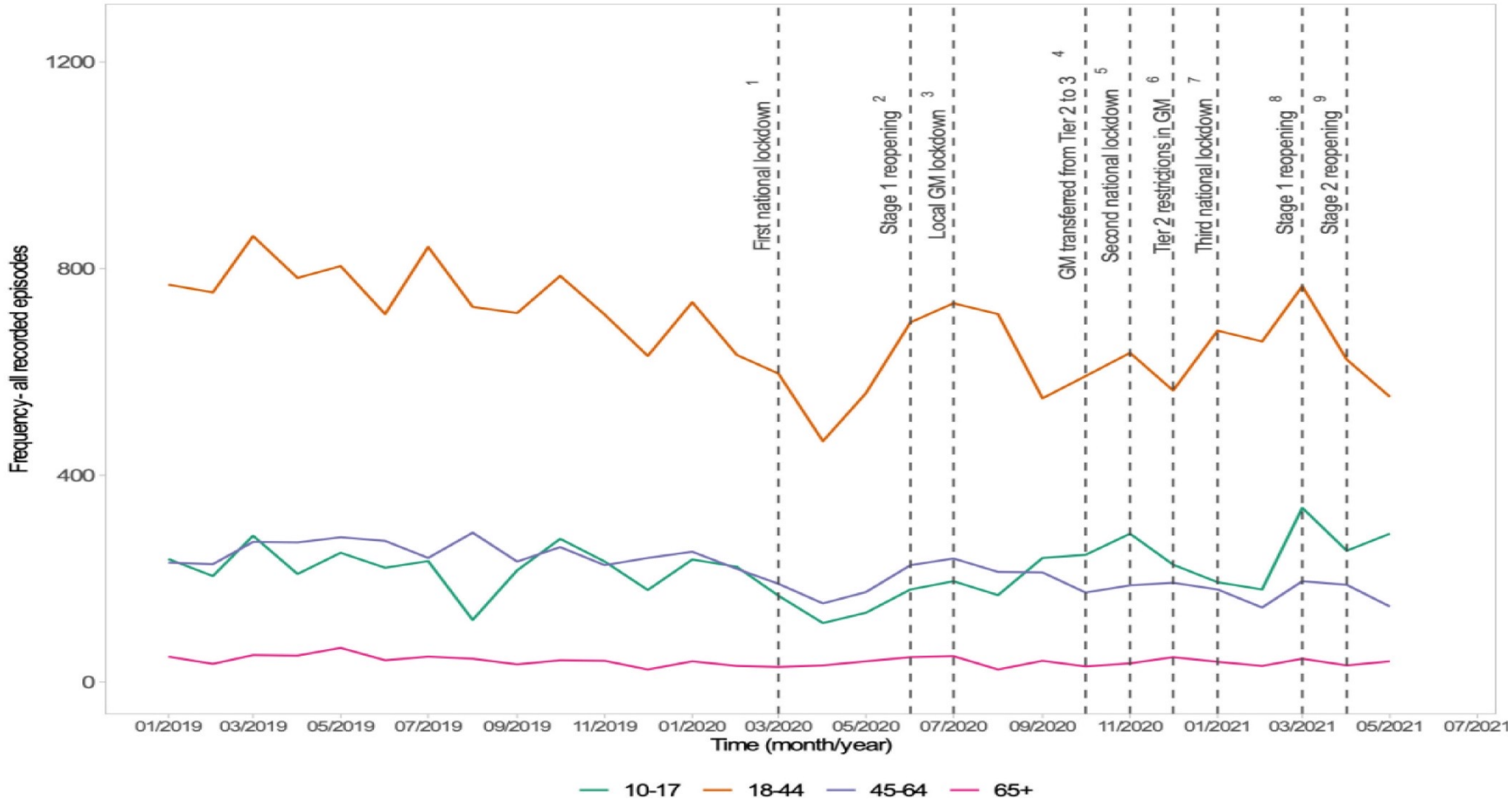
Sam Jones and agency

From cancelling student loan debt to raising minimum wage, different strategies aim to reduce effects of soaring prices

Wed 7 Sep 2022 13.10 BST

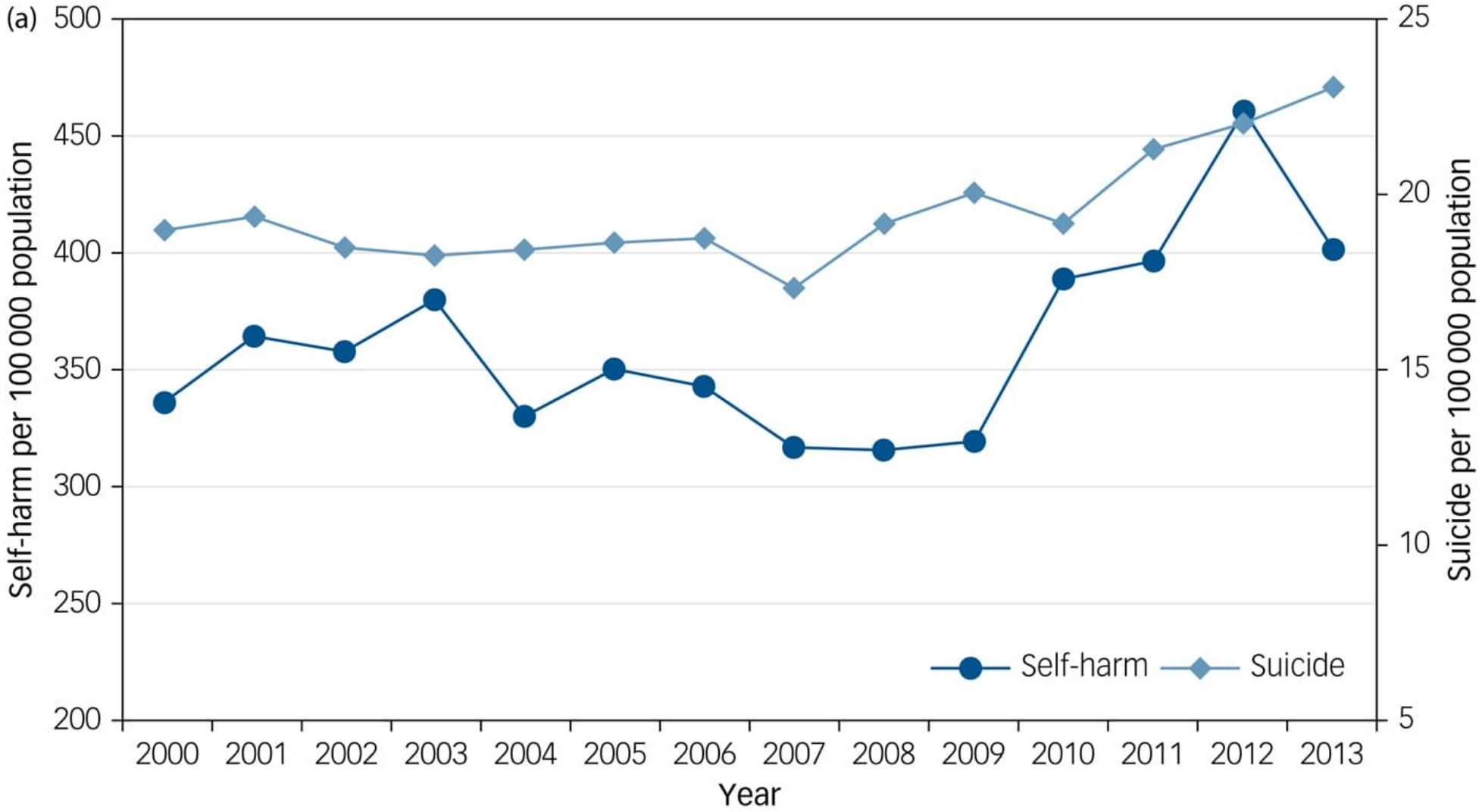
India imposed restrictions on exports of food items including wheat and sugar. Photograph: Anadolu Agency/Getty Images

Primary care data on self–harm



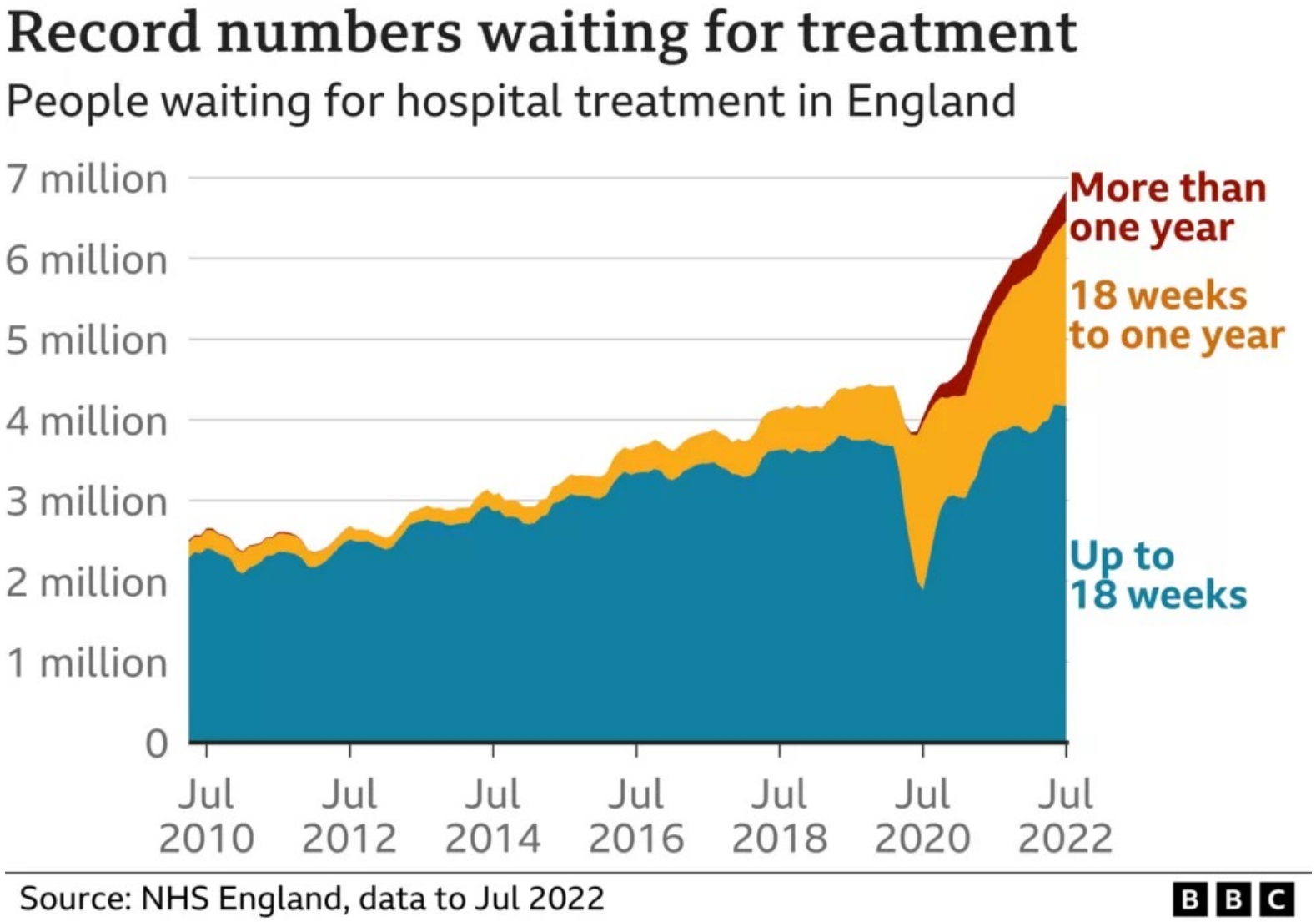
https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00455-7/fulltext

Self-harm in midlife



Clements et al 2019 DOI: https://doi.org/10.1192/bjp.2019.90

System pressures?



Community Transformation work

Brief psychological intervention

Why are we taking action?

- Improve access to support in timely manner
- Offer targeted interventions for reducing self-harm
- Encourage GPs to support people who self-harm
- \+ Enhance service users understanding of how to manage emotions

What are we planning to do?

- Referral to Mental Health Integrated Community Services (MHICS) by GP
- Offer brief psychological intervention
- 4 sessions by Mental Health practitioner

How will we measure impact?

2020/2021

- Number of patients referred and engaging
- Number of patients signposted
- Feedback (pre and post) wellbeing,satisfaction
- Staff confidence to deliver intervention

Frimley Health and Care Integrated Care System

Digital resources

Why are we taking action?

- Improve the digital offer for people who self-harm
- Increase awareness of support and advice
- Give people hope through videos, poems, art
- \+ Encourage engagement with online resource in the community

What are we planning to do?

- Webpage
- Information & local services
- Self-harm resources
- Stories of hope
- Poster with QR code to webpage

How will we measure impact?

2020/2021

- Website visits
- Stories of hope video views
- User feedback
- QR clicks
- Posters distributed

Somerset STP

https://sites.manchester.ac.uk/mash-project/support-for-improving-community-based-care-for-self-harm/

CQUIN for self-harm

CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm[7] referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with Section 1.3 of CG133 including: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[8]	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %

https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

New opportunities and existing evidence

Outline

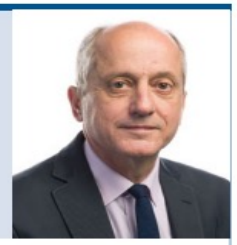
- Context
- **The guideline process**
- The new NICE self-harm guidelines – selected highlights

Historical context

BJPsych The British Journal of Psychiatry (2020)
Page 1 of 2. doi: 10.1192/bjp.2020.85

Editorial

General hospital services in the UK for adults presenting after self-harm: little evidence of progress in the past 25 years



Allan House and David Owens

Summary
Self-harm remains a serious public health concern, not least because of its strong link with suicide. Twenty-five years ago we lamented the deficits in UK services, research and policy. Since then, there has not been nearly enough effective action in any of these three domains. It is time for action.

Keywords
Psychosocial interventions; out-patient treatment; suicide; mental health services; self-harm.

BJPsych The British Journal of Psychiatry (2020)
Page 1 of 2. doi: 10.1192/bjp.2020.104

Editorial

Services for self-harm: progress and promise?

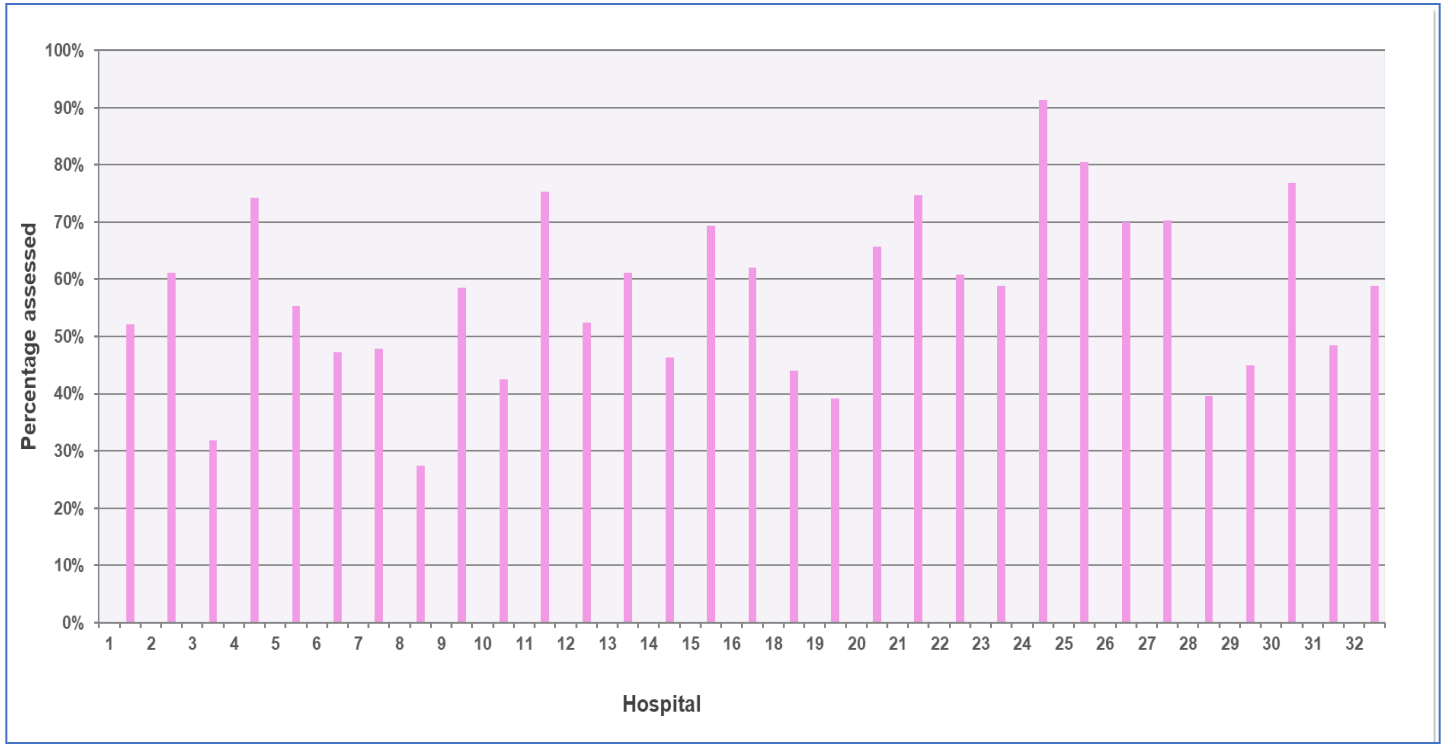
Nav Kapur

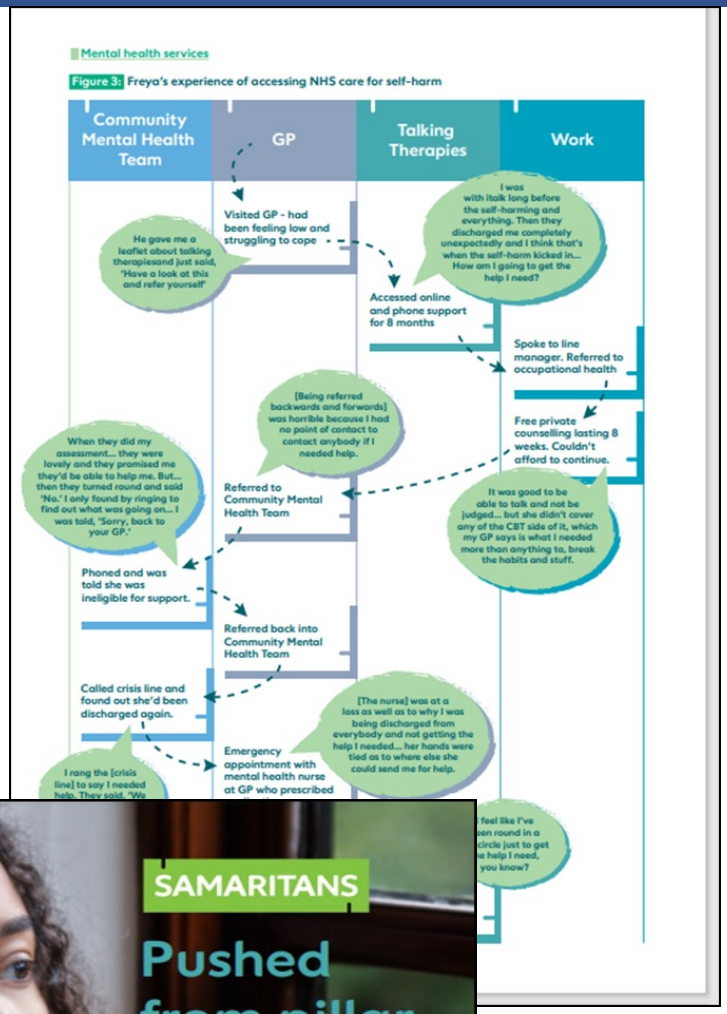
Summary
This editorial considers whether the quality of care for people who present to clinical services in the UK following self-harm has improved or stagnated. Some real progress has been made in the areas of service provision and research, and self-harm has never had a higher priority in policy terms. However, major gaps remain. We need to enhance people's experience of services and improve access to high-quality assessment and aftercare.

Keywords
Self-harm; suicide prevention; mental health services; liaison psychiatry; policy.

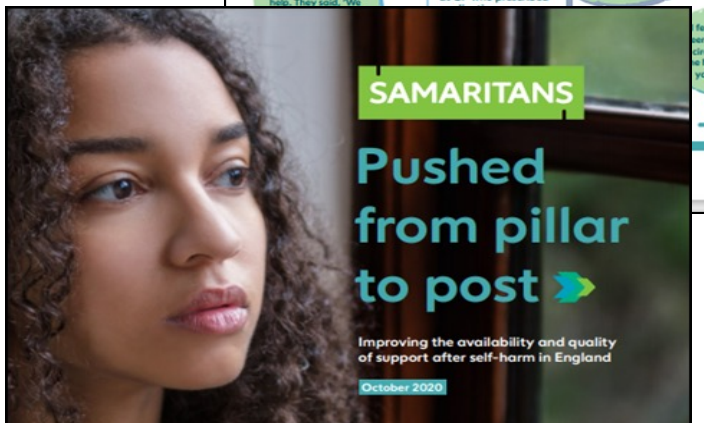
Source: Kapur (2020) https://doi.org/10.1192/bjp.2020.104 ; House & Owens (2020) https://doi.org/10.1192/bjp.2020.85

Why do we need guidelines?





`They wouldn't touch me... they looked at me as if to say ``I'm not touching you in case you flip on me"... they didn't actually say it, it was their attitude...'



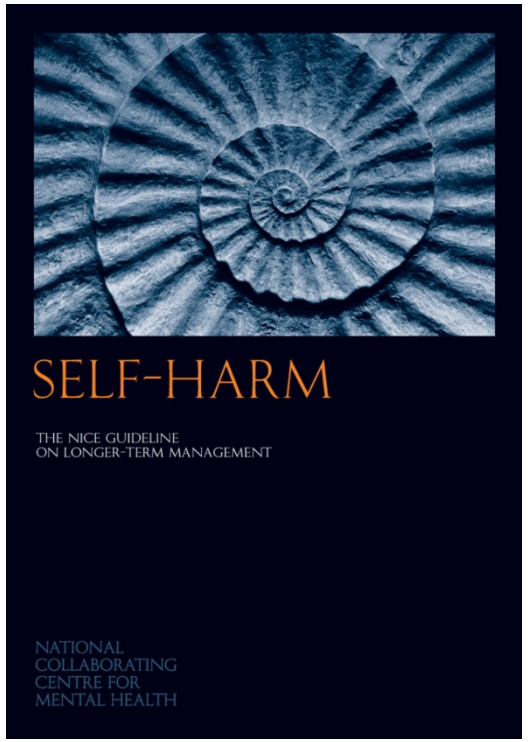
NHS
National Institute for
Health and Clinical Excellence

Self-harm

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

Issued: July 2004

NICE clinical guideline 16
www.nice.org.uk/cg16



NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

Preventing suicide in community and custodial settings

NICE guideline
Published: 10 September 2018
nice.org.uk/guidance/ng105

NICE quality standards for self-harm June 28th 2013

1. People are treated with compassion, respect and dignity
2. They receive an initial assessment of physical health, mental state, social circumstances and risk of suicide.
3. They receive a comprehensive psychosocial assessment
4. They receive the monitoring they need to keep them safe
5. They are cared for in a safe physical environment
6. Collaborative risk management plans are in place.
7. They have access to psychological interventions.
8. There is a transition plan when moving between services.

NICE National Institute for Health and Care Excellence

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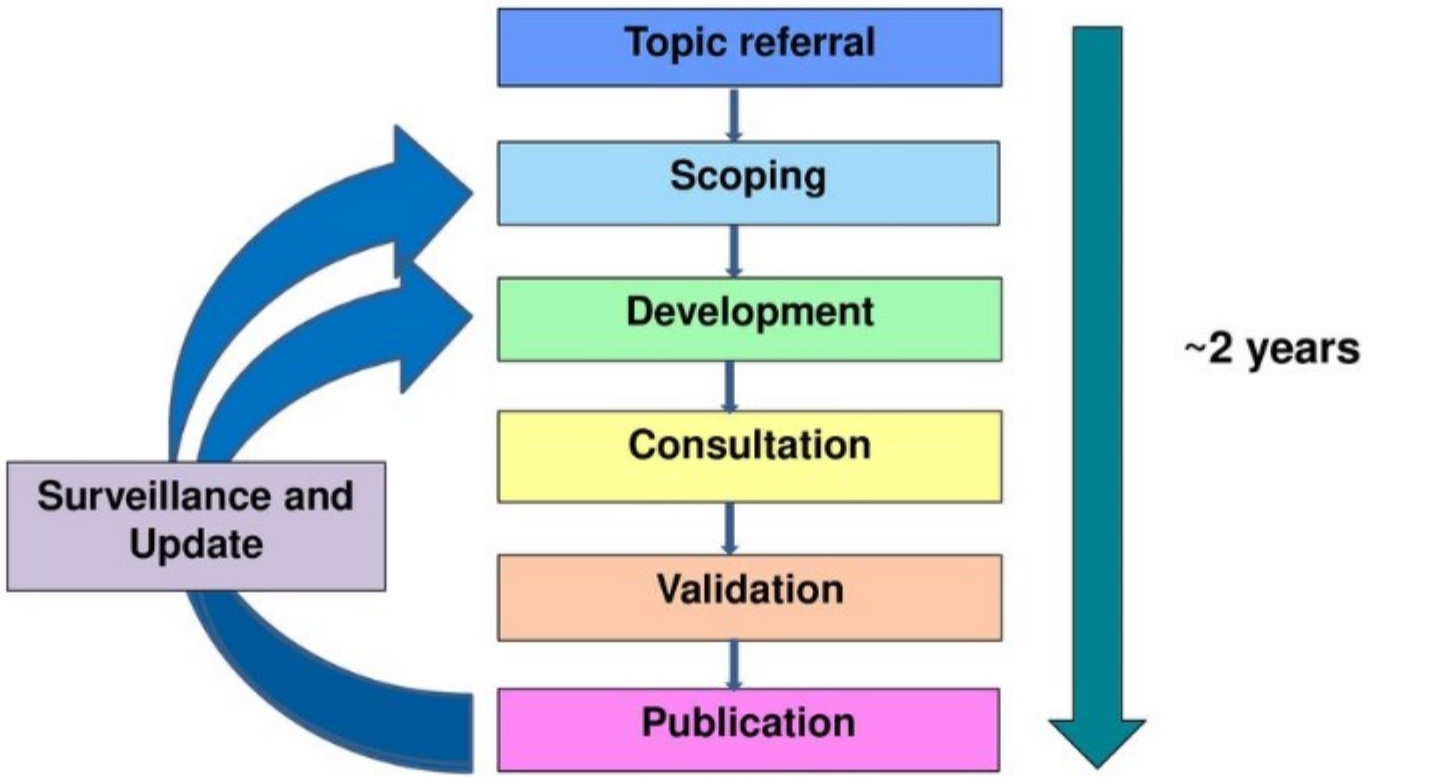
Depression in adults: treatment and management

NICE guideline [NG222] Published: 29 June 2022 Register as a stakeholder

Guideline Development Process

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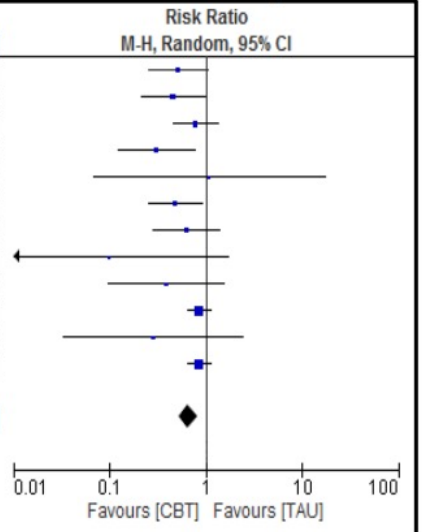
Hard science?

Figure 3: Forest plot for CBT-informed psychological intervention plus TAU *versus* TAU for treatment of RSH in adults: risk ratio at 6 months follow-up.

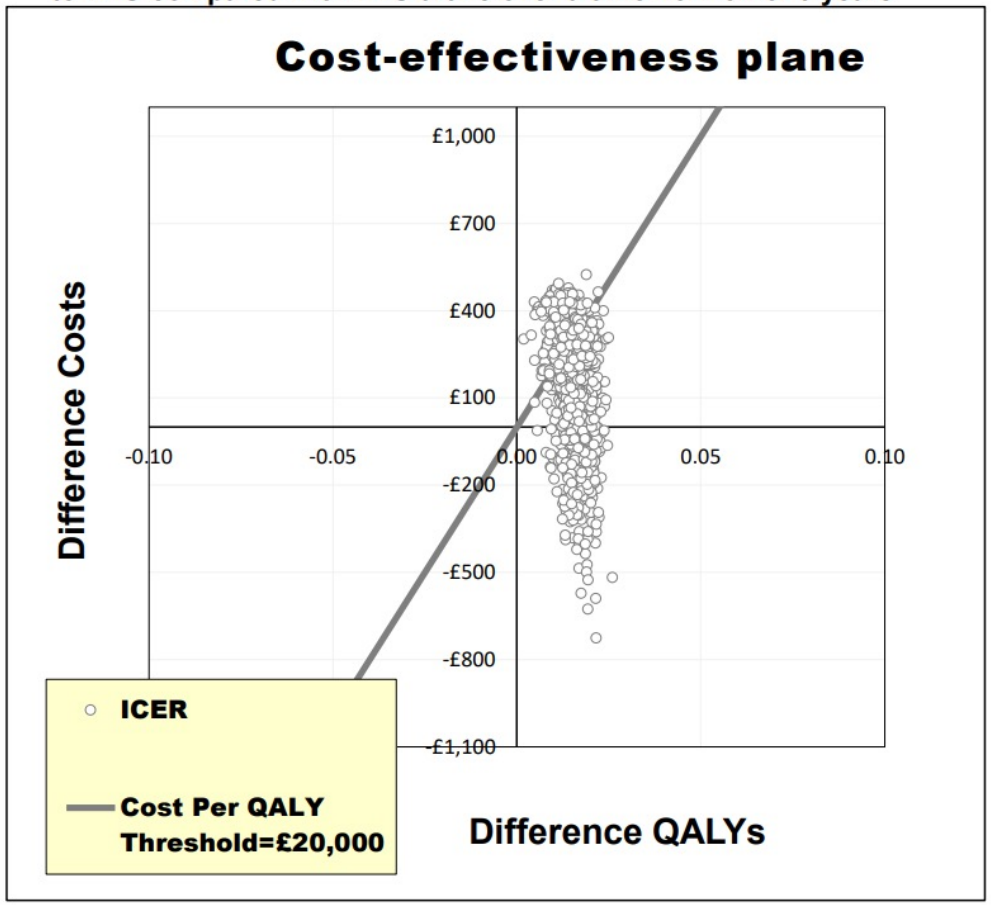
Study or Subgroup	CBT-based therapy Events	Total	TAU Events	Total	Weight	Risk Ratio M-H, Random, 95% CI
Brown 2005	9	50	18	52	7.9%	0.52 [0.26, 1.05]
Davidson 2014	4	10	4	4	6.8%	0.45 [0.21, 0.98]
Evans 1999b	10	18	10	14	12.0%	0.78 [0.46, 1.32]
Guthrie 2001	5	58	17	61	4.9%	0.31 [0.12, 0.78]
Husain 2014	1	102	1	111	0.6%	1.09 [0.07, 17.17]
Lin 2020	11	72	24	75	9.2%	0.48 [0.25, 0.90]
Owens 2020	7	30	12	32	6.5%	0.62 [0.28, 1.37]
Salkovskis 1990	0	12	3	8	0.6%	0.10 [0.01, 1.69]
Tapolaa 2010	2	9	4	7	2.4%	0.39 [0.10, 1.55]
Tyrer 2003	64	213	77	217	24.4%	0.85 [0.64, 1.11]
Wei 2013	1	35	4	40	1.0%	0.29 [0.03, 2.44]
Weinberg 2006	12	15	14	15	23.4%	0.86 [0.64, 1.14]
Total (95% CI)		**624**		**636**	**100.0%**	**0.66 [0.53, 0.82]**
Total events	126		188			

Heterogeneity: Tau² = 0.03; Chi² = 14.79, df = 11 (P = 0.19); I² = 26%
Test for overall effect: Z = 3.71 (P = 0.0002)



CBT: cognitive behavioural therapy; CI: confidence interval; M-H: Mantel-Haenszel; TAU: treatment-as-usual.

Figure 4: Cost effectiveness plane of CBT-informed psychological intervention added to TAU compared with TAU alone over a time horizon of 5 years



£: pound sterling; ICER: incremental cost effectiveness ratio; QALY: quality-adjusted life year

https://www.nice.org.uk/guidance/ng225/evidence/j-psychological-and-psychosocial-interventions-pdf-403069580821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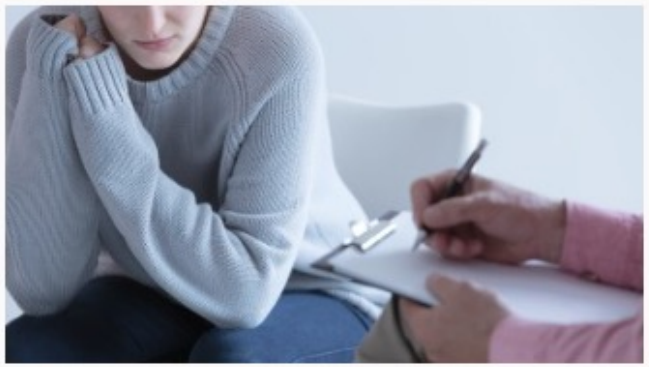
The guideline

https://www.nice.org.uk/guidance/NG225

Self-harm is everyone's business, NICE says in new draft guideline

All professionals working across the health and social care system have a role to play in supporting people who self-harm and the issue should not just be seen as the responsibility of those with mental health expertise, NICE has said in a new draft guideline.

18 January 2022



> Self-harm is a growing problem and should be everyone's business to tackle – not just those working in the mental health sector.
>
> **Dr Paul Chrisp, director of the centre for guidelines at NICE**

> Historically, people who have harmed themselves have had a highly variable experience of services. This new guideline is an opportunity to make things better.
>
> **Professor Nav Kapur, topic advisor for the self-harm guideline**

Self-harm is everyone's business, NICE says in new draft guideline

> Self-harm is a growing problem and should be

Who is it for?

- Healthcare professionals and social care practitioners, commissioners and providers
- Staff in educational settings
- Third sector organisations
- The criminal justice system
- People using self-harm services, their families and carers

This guideline updates and replaces NICE guideline CG16 (published July 2004) and NICE guideline CG133 (published November 2011).

guideline

First contact

1.7.1 When a person presents to a healthcare professional or social care practitioner following an episode of self-harm, the professional should:

- treat the person with respect, dignity and compassion, with an awareness of cultural sensitivity
- establish the means of self-harm and, if accessible to the person, discuss removing this with therapeutic collaboration or negotiation, to keep the person safe
- assess whether there are concerns about capacity, competence, consent or duty of care, and seek advice from a senior colleague or appropriate clinical support if necessary; be aware and accept that the person may have a different view and this needs to be taken into account
- seek consent to liaise with those involved in the person's care (including family members and carers, as appropriate) to gather information to understand the context of and reasons for the self-harm
- discuss with the person and their families or carers (as appropriate), their current support network, any safety plan or coping strategies.

1.7.13 When a person attends the emergency department or minor injury unit following an episode of self-harm, offer referral to age-appropriate liaison psychiatry services, or for children and young people, crisis response service (or an equivalent specialist mental health service or a suitably skilled mental health professional) as soon as possible after arrival, for a psychosocial

Assessments

1.5.1 At the earliest opportunity after an episode of self-harm, a mental health professional should carry out a psychosocial assessment to:

- develop a collaborative therapeutic relationship with the person
- begin to develop a shared understanding of why the person has self-harmed
- ensure that the person receives the care they need
- give the person and their family members or carers (as appropriate) information about their condition and diagnosis.

Psychosocial assessment may reduce the risk of repeat self-harm by **40%**

Source: Kapur et al (2013) https://doi.org/10.1371/journal.pone.0070434

Assessments

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- Don't delay
- Take into account needs and preferences
- Private designated area

Psychosocial assessment may reduce the risk of repeat self-harm by **40%**

Source: Kapur et al (2013) https://doi.org/10.1371/journal.pone.0070434

Assessments

1.5.9 During the psychosocial assessment, explore the functions of self-harm for the person. Take into account:

- the person's values, wishes and what matters to them
- the need for psychological interventions, social care and support, or occupational or vocational rehabilitation
- any learning disability, neurodevelopmental conditions or mental health problems
- the person's treatment preferences
- that each person who self-harms does so for their own reasons
- that each episode of self-harm should be treated in its own right, and a person's reasons for self-harm may vary from episode to episode
- whether it is appropriate to involve their family and carers; see the section on involving family members and carers.

1.5.10 During the psychosocial assessment, explore the following to identify the person's strengths, vulnerabilities and needs:

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

Psychosocial assessment may reduce the risk of repeat self-harm by **40%**

Source: Kapur et al (2013) https://doi.org/10.1371/journal.pone.0070434

Family involvement

1.4 Involving family members and carers

The recommendations in this section should be read alongside the recommendations on consent and confidentiality.

1.4.1 Ask the person who has self-harmed whether and how they would like their family or carers to be involved in their care, taking into account the factors in recommendation 1.4.2, and review this regularly. If the person agrees, share information with family members or carers (as appropriate), and encourage them to be involved.

ZSA

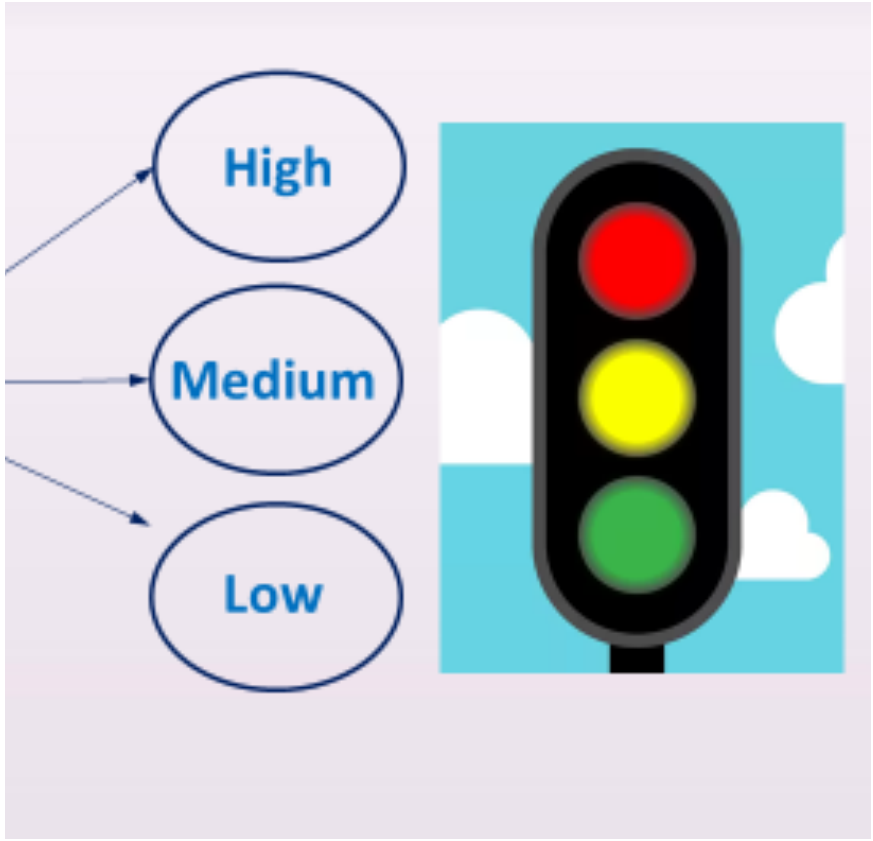
SHARE

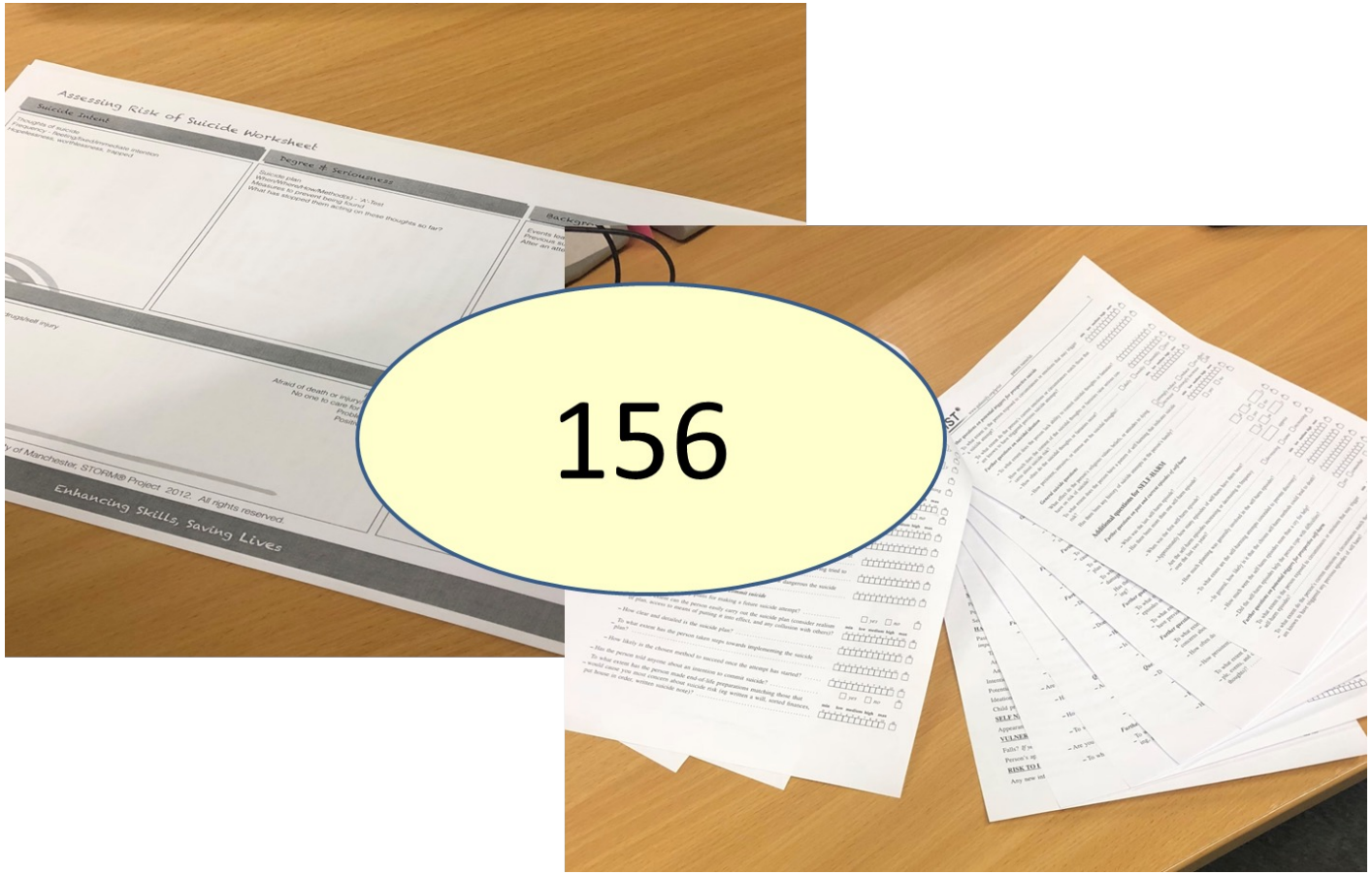
CONSENT, CONFIDENTIALITY & INFORMATION SHARING IN MENTAL HEALTHCARE & SUICIDE PREVENTION

END THE SILENCE
END SUICIDE

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013010/zero-suicide-alliance-share.pdf

Risk assessment





Assessment of risk following self-harm

Risk (N)	n(%) repeating
Low (1721)	165(9.6)
Moderate(1738)	288 (16.6)
High (369)	95(25.7)

(Kapur et al BMJ 2005)

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(Kapur et al BMJ 2005)

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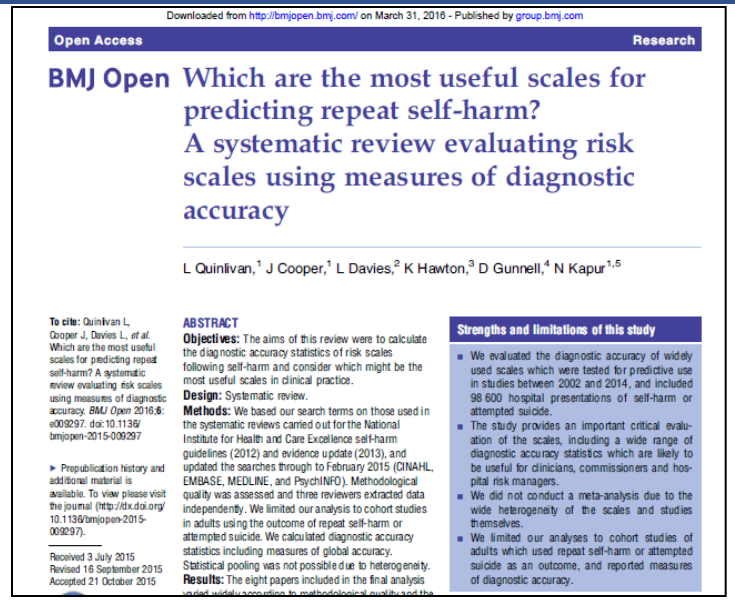
Risk tools and scales

HQIP
Healthcare Quality Improvement Partnership



Open Access Research

BMJ Open

Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating risk scales using measures of diagnostic accuracy

L Quinlivan,[1] J Cooper,[1] L Davies,[2] K Hawton,[3] D Gunnell,[4] N Kapur[1,5]

To cite: Quinlivan L, Cooper J, Davies L, *et al*. Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating risk scales using measures of diagnostic accuracy. *BMJ Open* 2016;**6**: e009297. doi:10.1136/bmjopen-2015-009297

► Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2015-009297).

Received 3 July 2015
Revised 16 September 2015
Accepted 21 October 2015

ABSTRACT

Objectives: The aims of this review were to calculate the diagnostic accuracy statistics of risk scales following self-harm and consider which might be the most useful scales in clinical practice.

Design: Systematic review.

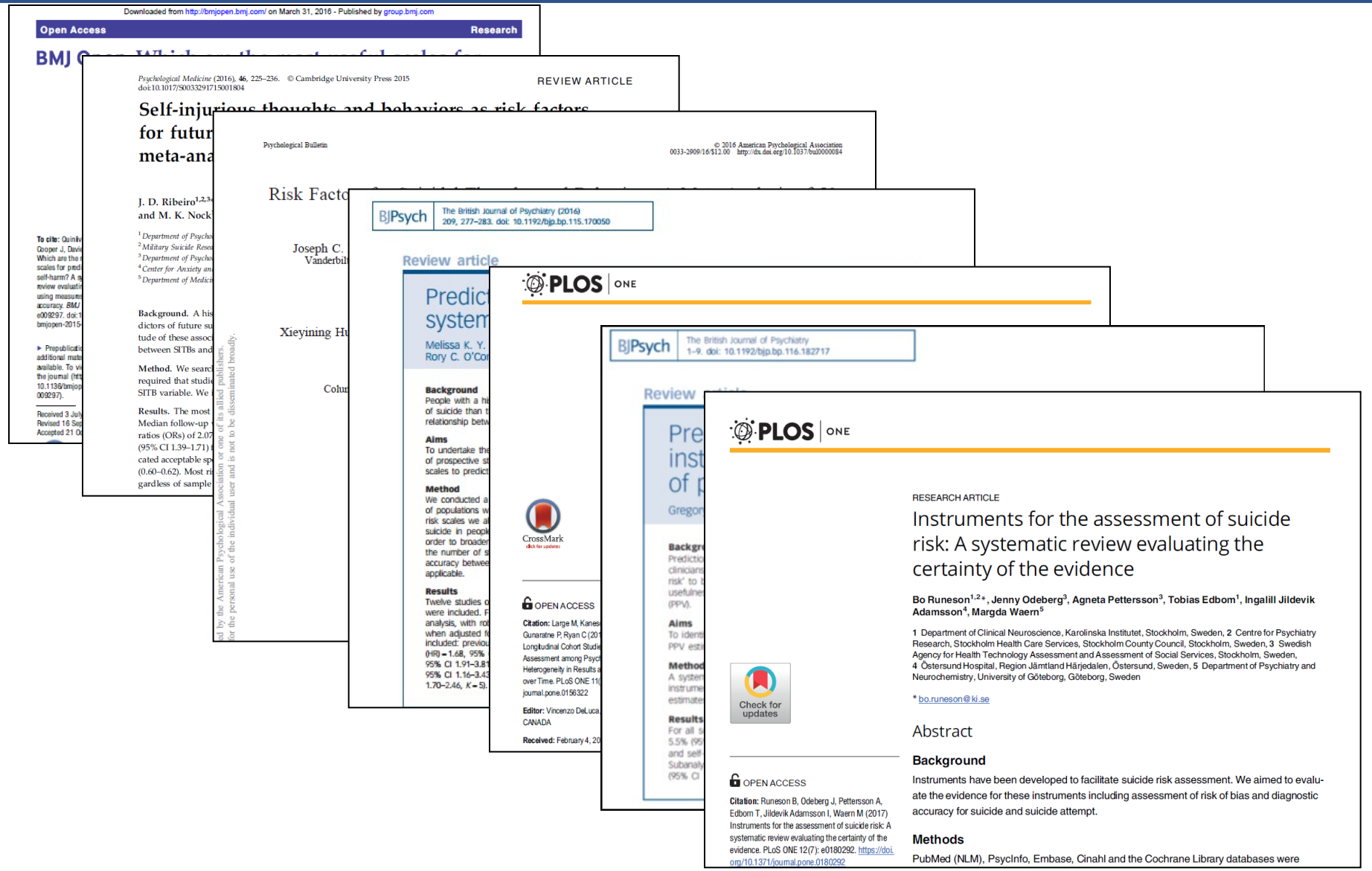
Methods: We based our search terms on those used in the systematic reviews carried out for the National Institute for Health and Care Excellence self-harm guidelines (2012) and evidence update (2013), and updated the searches through to February 2015 (CINAHL, EMBASE, MEDLINE, and PsychINFO). Methodological quality was assessed and three reviewers extracted data independently. We limited our analysis to cohort studies in adults using the outcome of repeat self-harm or attempted suicide. We calculated diagnostic accuracy statistics including measures of global accuracy. Statistical pooling was not possible due to heterogeneity.

Results: The eight papers included in the final analysis

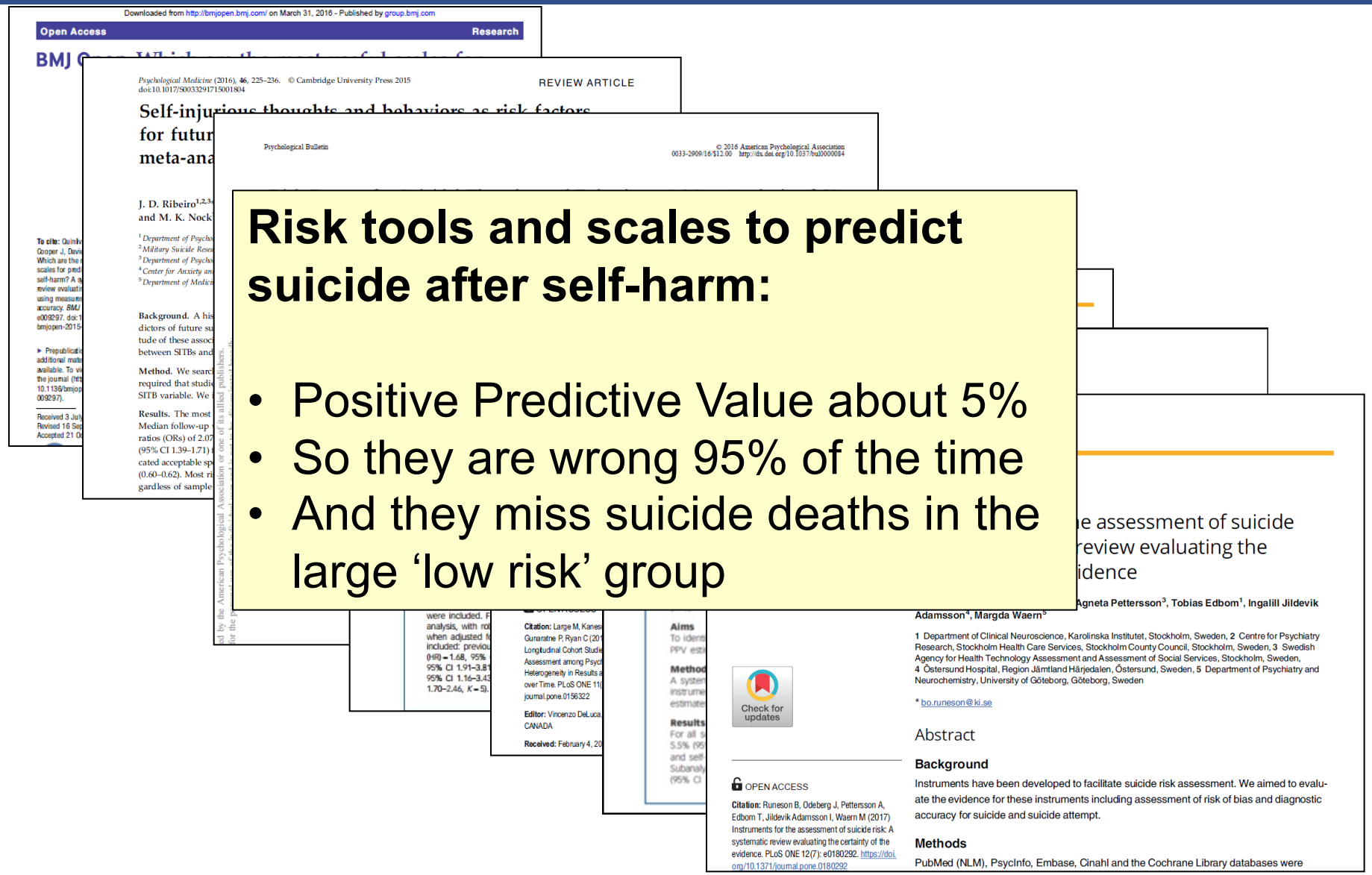
Strengths and limitations of this study

- We evaluated the diagnostic accuracy of widely used scales which were tested for predictive use in studies between 2002 and 2014, and included 98 600 hospital presentations of self-harm or attempted suicide.
- The study provides an important critical evaluation of the scales, including a wide range of diagnostic accuracy statistics which are likely to be useful for clinicians, commissioners and hospital risk managers.
- We did not conduct a meta-analysis due to the wide heterogeneity of the scales and studies themselves.
- We limited our analyses to cohort studies of adults which used repeat self-harm or attempted suicide as an outcome, and reported measures of diagnostic accuracy.

Risk tools and scales



Risk tools and scales



Risk tools and scales to predict suicide after self-harm:

- Positive Predictive Value about 5%
- So they are wrong 95% of the time
- And they miss suicide deaths in the large ‘low risk’ group

Risk tools and scales

BJPsych The British Journal of Psychiatry (2017) 210, 429–436. doi: 10.1192/bjp.bp.116.189993

Predictive accuracy of risk scales following self-harm: multicentre, prospective cohort study†

Leah Quinlivan, Jayne Cooper, Declan Meehan, Damien Longson, John Potokar, Tom Hulme, Jennifer Marsden, Fiona Brand, Kezia Lange, Elena Riseborough, Lisa Page, Chris Metcalfe, Linda Davies, Rory O'Connor, Keith Hawton, David Gunnell and Nav Kapur

Background
Scales are widely used in psychiatric assessments following self-harm. Robust evidence for their diagnostic use is lacking.

Aims
To evaluate the performance of risk scales (Manchester Self-Harm Rule, ReACT Self-Harm Rule, SAD PERSONS scale, Modified SAD PERSONS scale, Barratt Impulsiveness Scale); and patient and clinician estimates of risk in identifying patients who repeat self-harm within 6 months.

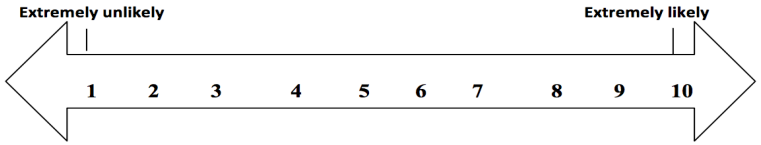
Method
A multisite prospective cohort study was conducted of adults aged 18 years and over referred to liaison psychiatry services following self-harm. Scale *a priori* cut-offs were evaluated using diagnostic accuracy statistics. The area under the curve (AUC) was used to determine optimal cut-offs and compare global accuracy.

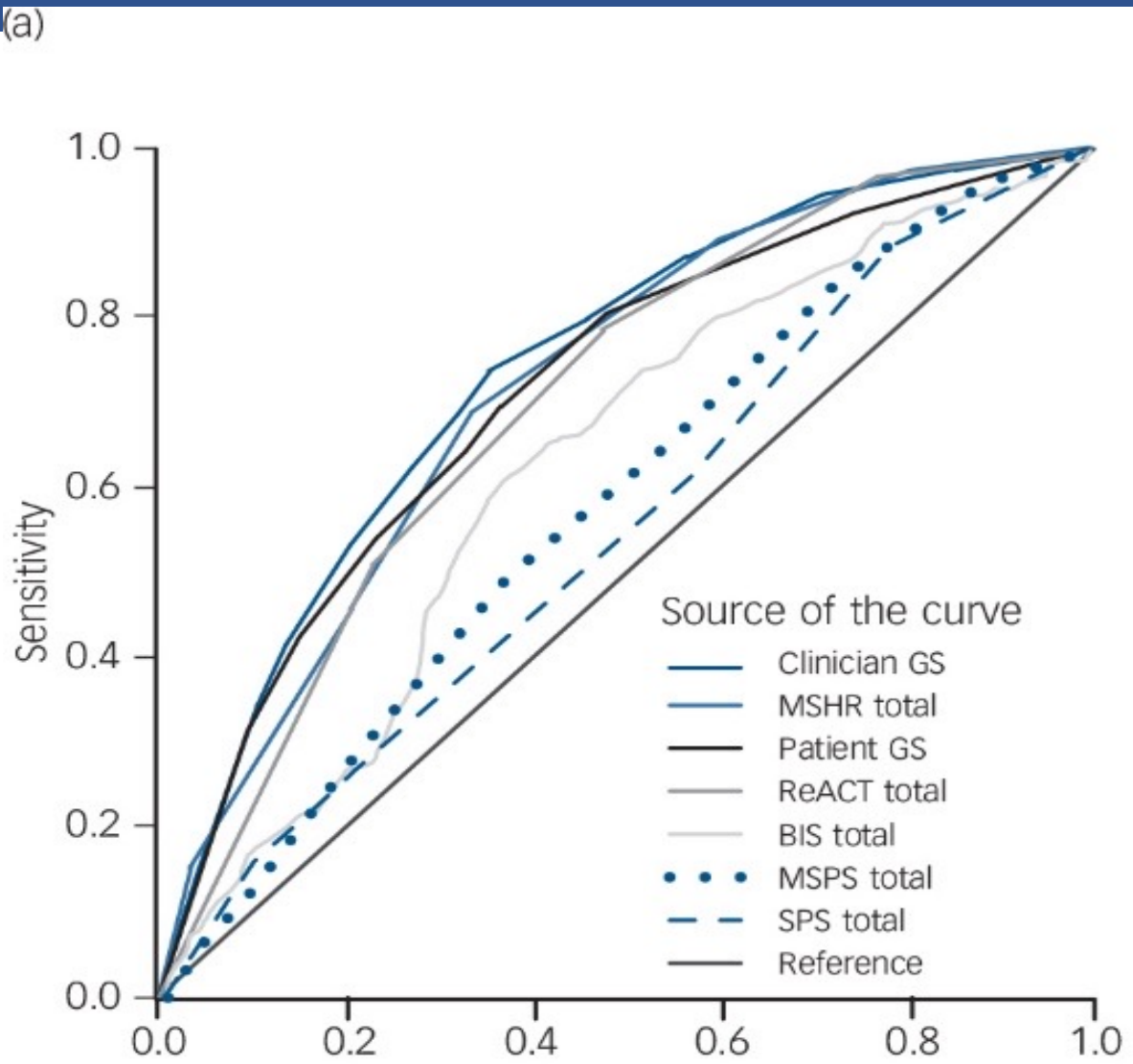
Results
In total, 483 episodes of self-harm were included in the study. The episode-based 6-month repetition rate was 30% (*n* = 145). Sensitivity ranged from 1% (95% CI 0–5) for the SAD PERSONS scale, to 97% (95% CI 93–99) for the Manchester Self-Harm Rule. Positive predictive values ranged from 13% (95% CI 2–47) for the Modified SAD PERSONS Scale to 47% (95% CI 41–53) for the clinician assessment of risk. The AUC ranged from 0.55 (95% CI 0.50–0.61) for the SAD PERSONS scale to 0.74 (95% CI 0.69–0.79) for the clinician global scale. The remaining scales performed significantly worse than clinician and patient estimates of risk ($P<0.001$).

Conclusions
Risk scales following self-harm have limited clinical utility and may waste valuable resources. Most scales performed no better than clinician or patient ratings of risk. Some performed considerably worse. Positive predictive values were modest. In line with national guidelines, risk scales should not be used to determine patient management or predict self-harm.

Declaration of interest
D.G., K.H. and N.K. are members of the Department of Health's (England) National Suicide Prevention Advisory Group. N.K. chaired the NICE guideline development group for the longer-term management of self-harm and the NICE Topic Expert Group (which developed the quality standards for self-harm services). He is currently chair of the updated NICE guideline for depression. R.O.C. was a member of the NICE guideline development group for the longer-term management of self-harm and is a member of the Scottish Government's suicide prevention implementation and monitoring group.

How likely do you think it is, that you will repeat self-harm within the next six months? Please indicate on this scale (with 1 as extremely unlikely and 10 and extremely likely)





https://pubmed.ncbi.nlm.nih.gov/28302702/

Quinlivan et al 2016

Risk tools and scales

1.6 Risk assessment tools and scales

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

1.6.2 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

1.6.3 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.

1.6.4 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

1.6.5 Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

1.6.6 Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales

Improving risk assessment…

Patients' suggestions

- A personalised approach, not based on the completion of a checklist
- Assessment by staff who are better trained and who value the answers given
- To focus on suicidal thoughts, i.e. encourage staff to confidently tackle difficult questions
- Involve carers/families
- Provide information on local support options



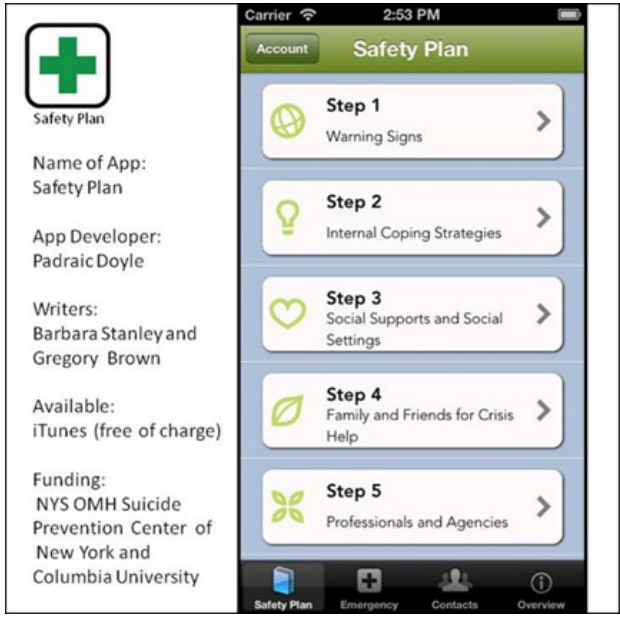


https://pubmed.ncbi.nlm.nih.gov/33189221/

Safety plans

1.11.7 Consider developing a safety plan in partnership with people who have self-harmed. Safety plans should be used to:

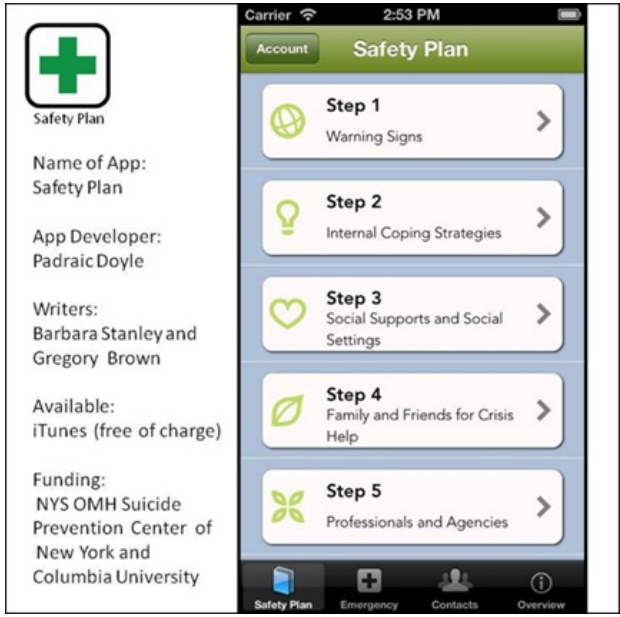
- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.



Safety plans

1.11.8 The safety plan should be in an accessible format and:

- be developed collaboratively and compassionately between the person who has self-harmed and the professional involved in their care using shared decision making (see the NICE guideline on shared decision making)
- be developed in collaboration with family and carers, as appropriate
- use a problem-solving approach
- be held by the person
- be shared with the family, carers and relevant professionals and practitioners as decided by the person
- be accessible to the person and the professionals and practitioners involved in their care at times of crisis.



Good aftercare

1.10 Initial aftercare after an episode of self-harm

The recommendations in this section apply to all healthcare professionals and social care practitioners.

1.10.1 After an episode of self-harm, discuss and agree with the person, and their family members and carers (as appropriate), the purpose, format and frequency of initial aftercare and which services will be involved in their care. Record this in the person's care plan and ensure that the person and their family members and carers have a copy of the plan and contact details for the team providing the aftercare.

1.10.2 If there are ongoing safety concerns for the person after an episode of self-harm, the mental health team, GP, team who carried out the psychosocial assessment or the team responsible for their care should provide initial aftercare within 48 hours of the psychosocial assessment.

Good aftercare

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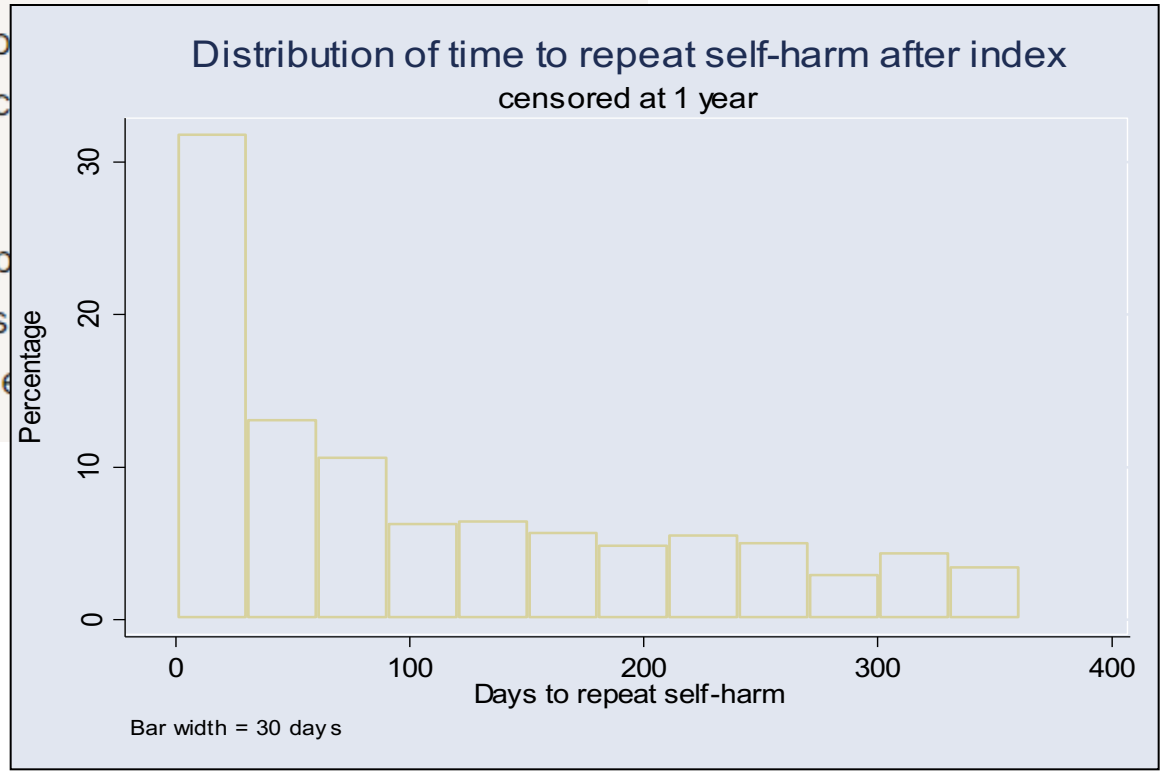


Source: Kapur et al., (2006) https://doi.org/10.4088/jcp.v67n1016 .

Interventions

1.11 Interventions for self-harm

The recommendations in this section apply to all healthcare professionals unless otherwise stated.

1.11.1 When planning treatment following self-harm, take into account any associated coexisting conditions and the psychosocial assessment.

1.11.2 For guidance on how to treat coexisting conditions that may be related to self-harm, also see the NICE guidelines on:

- Alcohol-use disorders
- Autism spectrum disorder in adults
- Autism spectrum disorder in under 19s
- Bipolar disorder
- Borderline personality disorder
- Care and support of people growing older with learning disabilities
- Challenging behaviour and learning disabilities
- Depression in adults
- Depression in children and young people
- Drug misuse in over 16s: opioid detoxification
- Drug misuse in over 16s: psychosocial interventions
- Eating disorders
- Generalised anxiety disorder and panic disorder in adults
- Learning disabilities and behaviour that challenges
- Mental health problems in people with learning disabilities
- Obsessive-compulsive disorder and body dysmorphic disorder
- Psychosis and schizophrenia in adults
- Post-traumatic stress disorder.

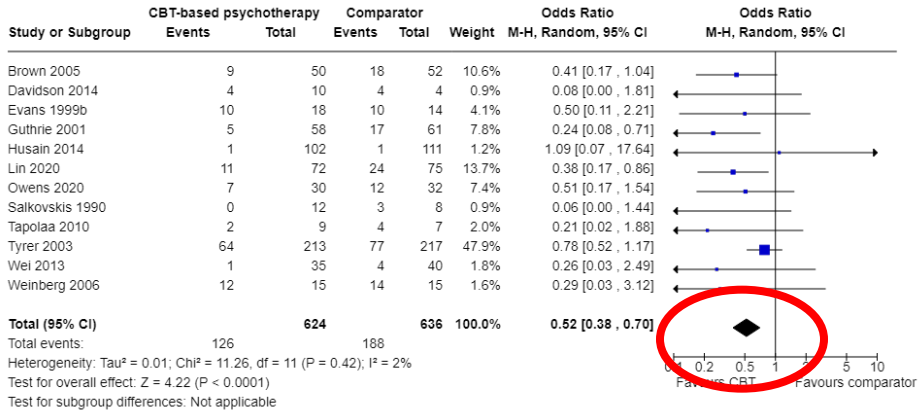
Interventions

1.11.3 Offer a structured, person-centred, cognitive behavioural therapy (CBT)-informed psychological intervention (for example, CBT or problem-solving therapy) that is specifically tailored for adults who self-harm. Ensure that the intervention:

- starts as soon as possible
- is typically between 4 and 10 sessions; more sessions may be needed depending on individual needs
- is tailored to the person's needs and preferences.

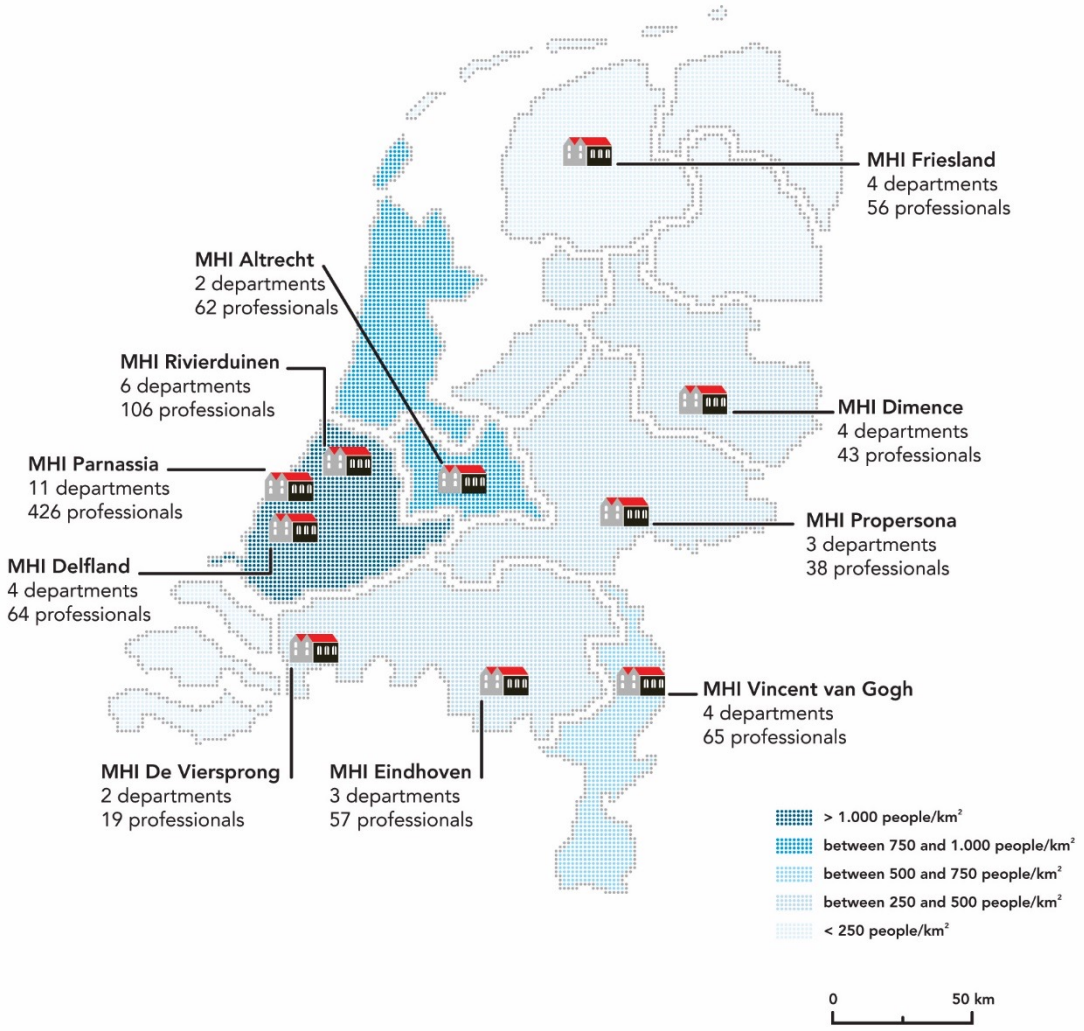
1.11.4 For children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm, consider dialectical behaviour therapy adapted for adolescents (DBT-A). Take into account the age of the child or young person and any planned transition between services.

1.11.5 Healthcare staff should be appropriately trained and supervised in the therapy they are offering to people who self-harm.



https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013668.pub2/references#dataAndAnalyses

A workforce who are trained and supervised



(De Beurs et al 2015)

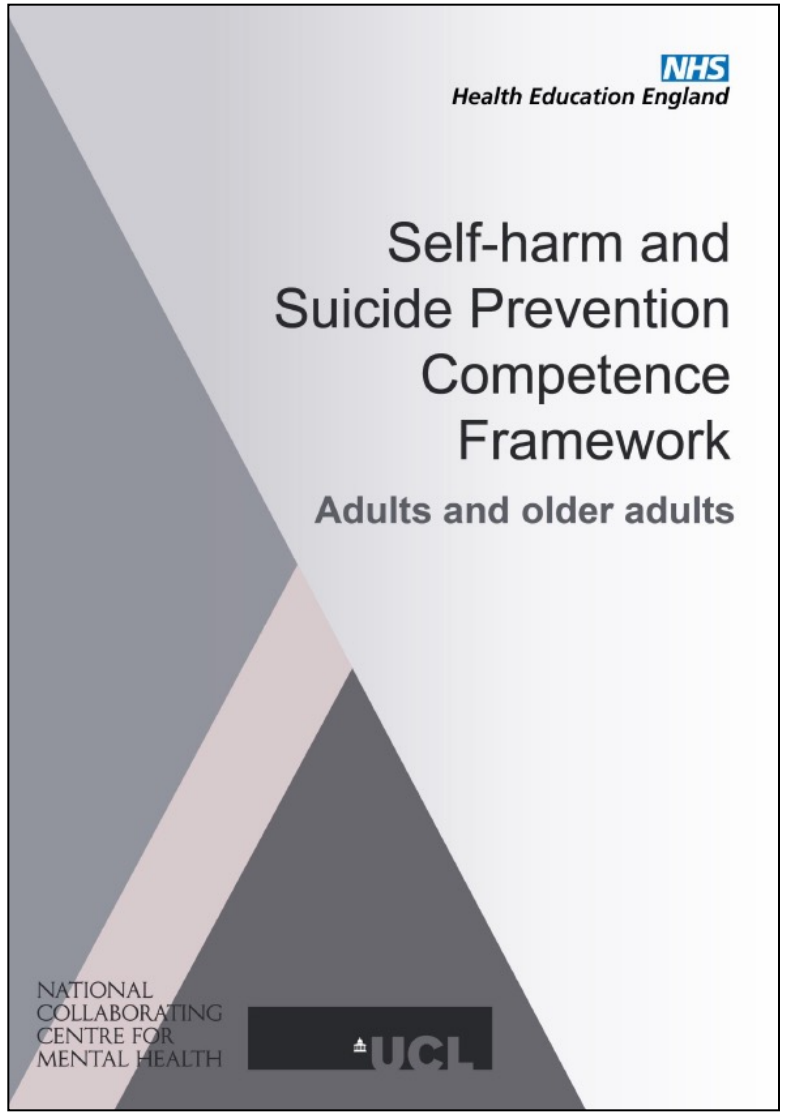
Clinicians

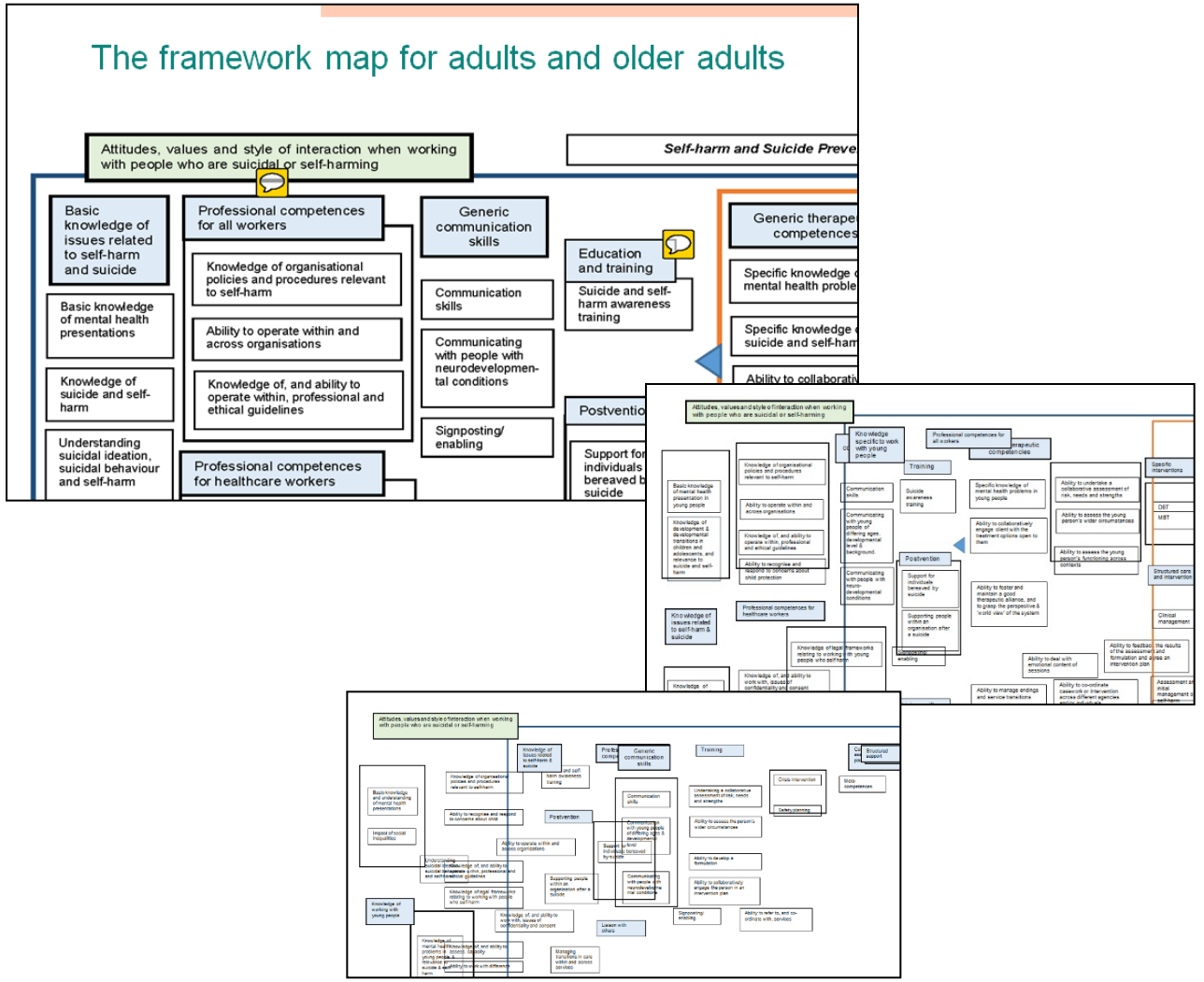
- Better guideline adherence
- Improved knowledge and confidence
- Around a 10% improvement

Patients

- Little effect overall on change in suicidal ideation, future attempts, satisfaction
- A possible effect on patients with depression?

A workforce who are trained and supervised





Source: UCL https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self

Digital interventions

JOURNAL OF MENTAL HEALTH
2020, VOL. 29, NO. 2, 207–216
https://doi.org/10.1080/09638237.2020.1714009

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REVIEW ARTICLE

Check for updates

Are digital interventions effective in reducing suicidal ideation and self-harm? A systematic review

Evgenia Stefanopoulou, Harry Hogarth, Matthew Taylor, Karen Russell-Haines, David Lewis and Jan Larkin

Turning Point, Registered Charity, London, UK

ABSTRACT

Background: There is a significant lack of outcomes research examining the effectiveness of digital interventions for reducing suicidal ideation and self-harm.

Aims: To systematically review the effectiveness of digital interventions for reducing suicidal ideation and self-harm in adult populations. The possible mediating effects of depression are also discussed.

Methods: The databases Pubmed, Medline, PsycInfo, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, IEEEXplore, ACM and CRESP were searched. Only randomised controlled trials (RCTs) were included. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used. Studies were assessed for methodological quality and risk of bias using standard assessment criteria.

Results: Fourteen RCTs were reviewed, reporting data on 3455 participants. Although findings were more consistent for the effectiveness of online Cognitive Behavioural Therapy (CBT), Mindfulness-Based CBT and Dialectical Behavioural Therapy, there was insufficient research to consider any as evidence-based treatments for suicidal ideation and self-harm.

Conclusions: Digital interventions for suicidal ideation and self-harm can be a safe and acceptable option for individuals unwilling or unable to access face-to-face interventions. However, further research is needed to understand the types of interventions that could support people and the risk-benefit ratio of digital interventions for these individuals.

ARTICLE HISTORY
Received 15 March 2019
Revised 24 December 2019
Accepted 28 December 2019
Published online 24 January 2020

KEYWORDS
Online; digital; suicide; self-harm; risk; review

> "further research is needed to understand the types of interventions that could support people and the risk-benefit ratio of digital interventions for these individuals"

> *"Our findings suggest that digital interventions should be promoted and disseminated widely, especially where there is a lack of, or minimal access to, health services."*

Articles

Suicide prevention using self-guided digital interventions: a systematic review and meta-analysis of randomised controlled trials

Michelle Torok, Jin Han, Simon Baker, Aliza Werner-Seidler, Iana Wong, Mark E Larsen, Helen Christensen

Summary

Background Digital interventions that deliver psychological self-help provide the opportunity to reach individuals at risk of suicide who do not access traditional health services. Our primary objective was to test whether direct (targeting suicidality) and indirect (targeting depression) digital interventions are effective in reducing suicidal ideation and behaviours, and our secondary analyses assessed whether direct interventions were more effective than indirect interventions.

Methods In this systematic review and meta-analysis, we searched online databases MEDLINE, PubMed, PsycINFO, and Cochrane CENTRAL for randomised controlled trials published between database inception to May 21, 2019. Superiority randomised controlled trials of self-guided digital interventions (app or web based, which delivered theory-based therapeutic content) were included if they reported suicidal ideation, suicidal plans, or suicide attempts as an outcome. Non-inferiority randomised controlled trials were excluded to ensure comparability of the effect. Data were extracted from published reports, and intention-to-treat data were used if available. The primary outcome was the difference in mean scores of validated suicidal ideation measures (Hedges' *g*) with the associated 95% CI for the analysis of digital intervention effectiveness on suicidal ideation. We also present funnel plots of the primary outcome measure (suicidal ideation) for direct and indirect interventions to assess for publication bias. We calculated I^2 (with I^2 CI) values to test heterogeneity. We used random-effects modelling for the meta-analyses to assess the primary and secondary outcomes. This study is registered with PROSPERO, CRD42018102084.

Findings The literature search yielded 739 articles (including manual searching) for suicidality and 8842 articles for depression. After screening, 14 papers reporting on 16 studies were included in the narrative review and meta-

Lancet Digital Health 2020; 2: e25–36

Published Online
November 28, 2019
https://doi.org/10.1016/S2589-7500(19)30199-2

See Comment page e4

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Correspondence to:
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m.torok@unsw.edu.au

Not all interventions are the same

JAMA

QUESTION Can low-intensity outreach programs, based on effective clinical interventions but delivered primarily online, prevent self-harm or suicidal behavior among outpatients reporting frequent suicidal ideation?

CONCLUSION Compared with usual care, offering care management did not significantly reduce the risk of self-harm, and offering brief online dialectical behavior therapy skills training increased the risk of self-harm among at-risk adults.

POPULATION

12 543 Women
6101 Men

Adults reporting thoughts of death or self-harm on more than half of the days during the past 2 weeks

48% aged 45 years or older

LOCATIONS

4
Integrated health systems in the US

INTERVENTION

18 882 Patients randomized
18 644 Patients analyzed

6230
Care management
Regular outreach to assess suicide risk with guideline-based recommendations for outpatient follow-up

6227
Skills training
Interactive online training on 4 dialectical behavior therapy skills provided by a skills coach

6187
Usual care
Routine mental health visits and structured assessments; safety plans, psychotherapy, and pharmacotherapy if needed

PRIMARY OUTCOME

Nonfatal or fatal self-harm events (nonfatal self-harm ascertained from health system records; fatal self-harm ascertained from state mortality data)

FINDINGS

Self-harm events

Care management: 3.27% (172 patients)

Skills training: 3.92% (206 patients)

Usual care: 3.27% (162 patients)

No significant difference in rate of self-harm for care management vs usual care:
Hazard ratio, 1.07 (97.5% CI, 0.84-1.37)

Significantly higher rate of self-harm for skills training vs usual care:
Hazard ratio, 1.29 (97.5% CI, 1.02-1.64)

Simon GE, Shortreed SM, Rossom RC, et al. Effect of offering care management or online dialectical behavior therapy skills training vs usual care on self-harm among adult outpatients with suicidal ideation: a randomized clinical trial. *JAMA*. Published February 15, 2022. doi:10.1001/jama.2022.0423

Safer prescribing

1.13 Safer prescribing and dispensing

The recommendations in this section apply to all healthcare professionals.

1.13.1 When prescribing medicines to someone who has previously self-harmed or who may self-harm in the future, healthcare professionals should take into account:

- the toxicity of the prescribed medicines for people at risk of overdose (for example, opiate-containing painkillers and tricyclic antidepressants)
- their recreational drug and alcohol consumption, the risk of misuse, and possible interaction with prescribed medicines
- the person's wider access to medicines prescribed for themselves or others
- the need for effective communication where multiple prescribers are involved.

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The University of Manchester

Harm minimisation

HQIP
Healthcare Quality Improvement Partnership

Harm minimisation

Although ways to self-harm safely are often considered a harm minimisation strategy, this guideline does not make any recommendations about the use of safer self-harm.

1.11.11 If a person is engaged in ongoing care and treatment but is not yet in a position to resist the urge to self-harm, only consider harm minimisation strategies:

- in the spirit of hope and optimism, and to reduce the severity and/or recurrence of injury
- as part of an overall approach to the person's ongoing recovery-focused care and support, and not as a standalone intervention **and**
- after being discussed and agreed in a collaborative way with the person and their family members or carers (as appropriate), and the wider multidisciplinary team.

ARCHIVES OF SUICIDE RESEARCH
2020, VOL. 24, NO. 3, 391–401
https://doi.org/10.1080/13811118.2019.1624689

Routledge
Taylor & Francis Group

Open access

"These Things Don't Work." Young People's Views on Harm Minimization Strategies as a Proxy for Self-Harm: A Mixed Methods Approach

Ruth Wadman, Emma Nielsen, Linda O'Raw, Katherine Brown, A. Jess Williams, Kapil Sayal, and Ellen Townsend

ABSTRACT

Although UK clinical guidelines make tentative recommendations for "harm minimization" strategies for repeated self-harm, this is in the absence of empirical evidence supporting their acceptability or effectiveness. We explore young people's views of harm minimization strategies (e.g., snapping elastic bands on skin, drawing on skin with red ink), as a proxy for self-harm. In this mixed methods study we examine data (secondary analysis) from: (1) an online questionnaire ($N = 758$) observing the frequency of these strategies being used as a form of self-harm, and as a form of alternative coping (viewed as distinct from self-harming), and (2) semi-structured interviews ($N = 45$), using thematic analysis to identify themes related to harm minimization. Predominant themes suggest that many young people viewed harm minimization strategies as a proxy for self-harm as ineffective. Where such strategies were reported as helpful, their utility was reported to be short-lived or situation-specific. Findings from both studies indicate that some young people described using harm minimization (e.g., elastic band snapping) as a form of self-harm (e.g., to break the skin). Harm minimization strategies should not be recommended in isolation and their use must be monitored. Further research is urgently needed to develop an evidence base that informs practice.

BJPsych Open (2021)
7, e116, 1–9. doi: 10.1192/bjo.2021.946

CrossMark

Harm minimisation for the management of self-harm: a mixed-methods analysis of electronic health records in secondary mental healthcare

Charlotte Cliffe, Alexandra Pitman, Rosemary Sedgwick, Megan Pritchard, Rina Dutta and Sarah Rowe

Background
Prevalence of self-harm in the UK was reported as 6.4% in 2014. Despite sparse evidence for effectiveness, guidelines recommend harm minimisation; a strategy in which people who self-harm are supported to do so safely.

Aims
To determine the prevalence, sociodemographic and clinical characteristics of those who self-harm and practise harm minimisation within a London mental health trust.

Method
We included electronic health records for patients treated by South London and Maudsley NHS Trust. Using an iterative search strategy, we identified patients who practise harm minimisation, then classified the approaches using a content analysis. We compared the sociodemographic characteristics with that of a control group of patients who self-harm and do not use harm minimisation.

Results
In total 22 736 patients reported self-harm, of these 693 (3%) had records reporting the use of harm minimisation techniques. We coded the approaches into categories: (a) 'substitution' (>50% of those using harm minimisation), such as using rubber bands or using ice; (b) 'simulation' (9%) such as using red pens; (c) 'defer or avoid' (7%) such as an alternative self-injury location; (d) 'damage limitation' (9%) such as using antiseptic techniques; the remainder were unclassifiable (24%). The majority of people using harm minimisation described it as helpful (>90%). Those practising harm minimisation were younger, female, of White ethnicity, had previous admissions and were less likely to have self-harmed with suicidal intent.

Conclusions
A small minority of patients who self-harm report using harm minimisation, primarily substitution techniques, and the large majority find harm minimisation helpful. More research is required to determine the acceptability and effectiveness of harm-minimisation techniques and update national clinical guidelines.

Keywords
Self-harm; non-suicidal self-injury; harm minimisation; harm reduction

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Open access Original research

BMJ Open

Harm minimisation for self-harm: a cross-sectional survey of British clinicians' perspectives and practices

Aishah Madinah Harris, Alexandra Pitman, Faraz Mughal, Evelina Bakanaite, Nicola Morant, Sarah L Rowe

ABSTRACT

Objective Harm minimisation for self-harm is an alternative to preventive strategies and focuses on maximising safety when self-harming. We explored the views of clinicians on harm minimisation for self-harm to describe reported use and acceptability in clinical practice.

Design A cross-sectional study using an online survey consisting of fixed-choice and open-ended questions.

Setting Primary and secondary care practices in England, Scotland and Wales.

Participants Snowball sampling of UK-based clinicians (n=93, 67% female) working with people who self-harm and who have or have not previously recommended harm minimisation methods to patients.

Results Of the 93 clinicians sampled, 76 (84%) reported having recommended harm minimisation techniques to people in their care who self-harm. Commonly recommended techniques were snapping rubber bands on one's wrist and squeezing ice. Other techniques, such as teaching use of crisis instruments when self-harming, were less likely to be recommended. Perceived client benefits included harm reduction and promotion of the therapeutic relationship. Perceived potential limitations of a harm minimisation approach for self-harm were (a) potential worsening of self-harm outcomes; (b) ethical reservations; (c) doubts about its effectiveness and appropriateness; and (d) lack of training and clear policies within the workplace.

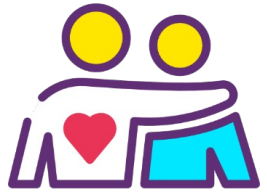
Conclusions In our sample of UK-based clinicians in various settings, harm minimisation for self-harm was broadly recommended for clients who self-harm due to perceived client benefits. However, future policies on harm minimisation must address clinicians' perceived needs for training, well-defined guidelines, and clear evidence of effectiveness and safety to mitigate some clinician concerns about the potential for further harm.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- A wide range of clinical practitioners from different settings participated in this study, but there were very few mental health nurses or managerial staff.
- This study included general practitioners who have not been included in the limited research on harm minimisation for self-harm, despite often being the first point of contact for patients who self-harm.
- The use of an anonymous, online survey may have enhanced disclosure and reduced social desirability bias.
- Snowball sampling may have induced selection and non-response biases.
- We did not specifically ask which self-harm methods respondents had recommended harm minimisation for, so we were unable to capture views on the acceptability of harm minimisation for specific types of self-harm.

Some general principles

1.11.9 Do not use diagnosis, age, substance misuse or coexisting conditions as reasons to withhold psychological interventions for self-harm.



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

1.7.5 Do not use aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes.

1.12.6 Assess the safety of the environment, balancing respect for the person's autonomy against the need for restrictions. Use the least restrictive measures.

1.12.1 Ensure continuity of care, wherever possible, in the staff caring for people who have self-harmed by minimising the number of different staff they see.

Outline

- Context
- The guideline process
- The new NICE self-harm guidelines – selected highlights

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Summary

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- Self-harm is common and increases the risk of suicide.
- Existing care needs to be better
- Clinical guidelines are helpful (↑quality, ↓variability, inform policy, empower patients)
- Assessment should be respectful, kind, and collaborative and not focused on risk
- Aftercare should be well communicated, and timely
- Treatment should take into account underlying conditions and include psychological interventions
- Safer prescribing (and wider access to means) need to be considered
- Care must not exclude people, be solely medication based, or be punitive or unduly restrictive.
- Continuity is important

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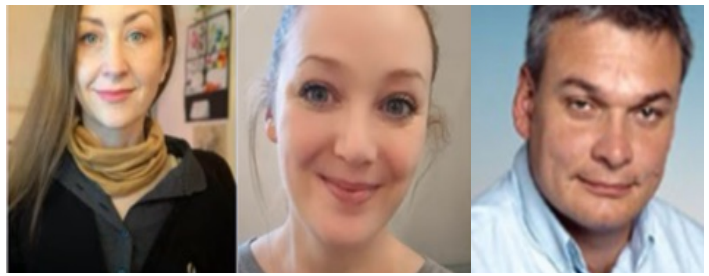

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