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Health and Clinical Excellence

Self-harm: longer-term management

Clinical case scenarios for health and social care professionals

February 2012

Clinical Guideline Implementation Tools

NICE clinical guideline 133

These clinical case scenarios accompany the clinical guideline: 'Self-harm: longer-term management' (available at www.nice.org.uk/guidance/CG133).

Issue date: February 2012

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Introduction

NICE clinical case scenarios

Clinical case scenarios are an educational resource that can be used for individual or group learning. Each question should be considered by the individual or group before referring to the answers.

These six clinical case scenarios have been put together to improve your knowledge of the longer-term management of self-harm and its application in practice. They illustrate how the recommendations from 'Self-harm: Longer-term management' (NICE clinical guideline 133) can be applied to the care of people who self-harm.

The clinical case scenarios are available in two formats: this PDF, which can be used for individual learning, and a slide set that can be used for groups. Slides from the clinical case scenario slide set can be added to the standard NICE slide set (www.nice.org.uk/guidance/CG133/SlideSet/ppt/English) produced for the guideline.

You will need to refer to the NICE clinical guideline to help you decide what steps you would need to follow to manage each case, so make sure that users have access to a copy (either online at www.nice.org.uk/guidance/CG133 or as a printout). You may also want to refer to the self-harm NICE pathway (http://pathways.nice.org.uk/pathways/self-harm) and the specialist library page for self-harm on NHS evidence (www.evidence.nhs.uk/topic/self-harm).

Each case scenario includes details of the person's initial presentation. The clinical decisions about assessment and management are then examined using a question and answer approach. Relevant recommendations from the NICE guideline are quoted in the text (after the answer), with corresponding recommendation numbers.

Self-harm

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

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

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

Clinical case scenarios for health and social care professionals

Case scenario 1: Lucy

Presentation

Lucy is 28 years old and earlier this year took an overdose of paracetamol, necessitating A&E attendance for treatment. Since then she has been superficially scratching her forearms. This is noticed when she presented at the local A&E department because her recent cutting is deep enough to need suturing.

1.1 Question

What steps should the staff in A&E have taken when Lucy first presented after taking an overdose? (For information on the short-term management of self-harm see NICE clinical guideline 16.)

1.1 Answer

The A&E staff caring for Lucy should have referred her to community mental health services for assessment. The staff should have been mindful of the stigma and discrimination that is often associated with people who self-harm and aimed to adopt a supportive and engaging relationship with Lucy.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

A&E refers Lucy to community mental health services for assessment.

1.2 Question

What should Lucy's assessment include?

1.2 Answer

Ask Lucy if she would like her family to be involved in her care, and encourage this. Explore the meaning of Lucy's self-harm to highlight the individual reasons for her actions.

The assessment should be a comprehensive psychosocial assessment of Lucy's needs and risks. The needs assessment should include: skills, strengths, mental health problems, social circumstances, life difficulties, coping strategies and physical health problems.

The risk assessment should include Lucy's specific risk of repetition of self-harm or risk of suicide. This should take into account: methods and frequency of self-harm, suicidal intent, depressive symptoms, risk and protective factors, coping strategies, immediate and longer term risks and significant relationships.

Related recommendations

- Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate. **[1.1.22]**

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

- Assessment of needs should include:
  - skills, strengths and assets
  - coping strategies
  - mental health problems or disorders
  - physical health problems or disorders
  - social circumstances and problems
  - psychosocial and occupational functioning, and vulnerabilities
  - recent and current life difficulties, including personal and financial problems

  - the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
  - the needs of any dependent children. **[1.3.2]**

- During assessment, explore the meaning of self-harm for the person and take into account that:
  - each person who self-harms does so for individual reasons, and
  - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode. **[1.3.5]**

- When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:
  - methods and frequency of current and past self-harm
  - current and past suicidal intent
  - depressive symptoms and their relationship to self-harm
  - any psychiatric illness and its relationship to self-harm
  - the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
  - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
  - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
  - significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
  - immediate and longer-term risks. **[1.3.6]**

1.3 Question

What training might you need to help you care for Lucy?

1.3 Answer

You should be trained in assessing, treating and managing self-harm. They should also be educated about the stigma and discrimination associated with self-harm.

Those who deliver the training should involve people who self-harm in the planning and delivery of training.

If you work with people who self-harm you should have routine access to senior colleagues for supervision, consultation, and support.

Related recommendations

- Health and social care professionals who work with people who self-harm (including children and young people) should be:
  - trained in the assessment, treatment and management of self-harm, and
  - educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes. **[1.1.9]**

- Health and social care professionals who provide training about self-harm should:
  - involve people who self-harm in the planning and delivery of training
  - ensure that training specifically aims to improve the quality and experience of care for people who self-harm
  - assess the effectiveness of training using service-user feedback as an outcome measure. **[1.1.10]**

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

Lucy's assessment established the following points:

- Lucy studied languages at university and lived away from home for 3 years. After completing her course and a relationship breakup she returned home to live with her parents. Once home she started looking for a job but was unable to get one and decided she would like to study further. Lucy struggled to adjust to living with her parents again after living away from home for so long.
- Since her late teens Lucy has found it difficult to manage her emotions. She describes her emotions as labile, with occasions when she expresses them impulsively in an explosive way, mostly as anger. She deals with anger by cutting, burning herself or 'hammering her bones' with the intention to break them or bruise herself. She has successfully concealed this behaviour in the past by wearing long clothes.
- Over the years Lucy has had episodes of mild depression characterised by sleep disturbances, reduced energy, and loss of interests in pleasurable activities. She has had suicidal thoughts on and off but had no plans to act on them until her recent paracetamol overdose.
- Lucy describes her self-harm as being a 'hit', like a shot of a drug that helps her anger to ease away. Lucy feels that if she stops self-harming, her suicidal thoughts will return.

1.4 Question

What strategies should you consider in Lucy's circumstances?

1.4 Answer

Consider strategies aimed at harm reduction, because stopping self-harm is unrealistic in the short-term. Reinforce existing coping strategies and develop new strategies as an alternative to self-harm. Discuss less destructive methods of self-harm and advise Lucy that there is no safe way to self-poison.

Related recommendations

- If stopping self-harm is unrealistic in the short term:
  - consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
  - consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
  - advise the service user that there is no safe way to self-poison. **[1.4.10]**

Case scenario 2: Carly

Presentation

Carly is 14 years old and is brought to the A&E by her mother because she has cut her arms. On examination there are superficial cuts on the outside of both forearms, and some scars elsewhere on her forearm that are of the same pattern as the recent cuts.

2.1 Question

How should you proceed?

2.1 Answer

Provide appropriate physical management for the cuts (see NICE clinical guideline 16). It is important to:

- be sensitive and non-judgmental towards Carly because some people who self-harm feel that medical staff stigmatise their experiences
- carry out a psychosocial assessment and risk assessment, especially because there is evidence that there has been previous self-harm
- ask and understand the reason for self-harm so that this can be included in the psychosocial assessment and so that health and social care professionals can work with Carly to help her to reduce and stop self-harming.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

- When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking

into account:

- methods and frequency of current and past self-harm
- current and past suicidal intent
- depressive symptoms and their relationship to self-harm
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks. **[1.3.6]**

Carly tells you that she has been cutting her arms about twice a week for around 6 months. For around 8 months she has been feeling sad and tired most of the time, finds it hard to get to sleep, finds it hard to concentrate on homework, and has a greatly reduced appetite. She sometimes thinks she would be better off dead, but has never thought of taking her life and does not think she would do so. She is finding it much harder to do schoolwork, and has drifted away from her friends because she has not felt like talking to them or going out.

This started following prolonged bullying at school, and Carly feels isolated with no friends. She is close to her parents. She cuts when she feels very sad and feels that it relieves the mental pain for a few hours. She would like to stop cutting, but thinks she will keep on doing it because she does not know what else to do when she feels so low. She said she has not and would not hurt anyone else.

2.2 Question

What is the likely diagnosis?

2.2 Answer

An 8 month history of low mood, reduced motivation, poor sleep, poor appetite, tiredness and poor concentration, with associated functional impairment at school and withdrawal from friends suggests a likely diagnosis of moderate depressive disorder.

2.3 Question

What does your risk assessment suggest?

2.3 Answer

It is likely Carly will continue to cut herself while her mood remains low, indicating the importance of treating her depression.

Although Carly states that she would not try to take her life, you should consider that patients may not always be honest about suicidal thoughts. Non-suicidal self-harm has been proven to be associated with future suicide attempts so you should maintain a high index of suspicion about her suicidal thoughts[1]. If stopping self-harm is unrealistic in the short term, consider strategies aimed at harm-reduction and reinforce current coping strategies.

Related recommendations

- If stopping self-harm is unrealistic in the short term:
  - consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
  - consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
  - advise the service user that there is no safe way to self-poison. **[1.4.10]**

2.4 Question

What should you tell Carly's mother?

[1] Expert opinion suggests that the strongest predictor of suicide attempts in adolescents with depression is non-suicidal self-harm, and that this is a stronger predictor than suicide attempts. Wilkinson P, Kelvin R, Roberts C et al. (2011) Clinical and Psychosocial Predictors of Suicide Attempts and Nonsuicidal Self-Injury in the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT). The American Journal of Psychiatry 168: 495–50.

Asarnow J et al. (2011) Suicide Attempts and Nonsuicidal Self-Injury in the Treatment of Resistant Depression in Adolescents (TORDIA) Study. Journal of the American Academy of Child and Adolescent Psychiatry 50: 772–81.

2.4 Answer

It is important to let Carly's mother know about the depression and the extent of the self-harm. You should also advise her about the risk of suicide attempts and ways to reduce this risk, including making sure that Carly does not have access to means of self-harm (such as tablets) and that she is not left alone in the house for long periods. Speak jointly to Carly and her mother about what other strategies Carly could use when she feels the urge to self-harm, including talking to her mother. Discuss sources of emergency help with Carly and her mother.

It is important to speak to Carly first about what you need to tell her mother, but you should still inform her even if Carly does not consent, because of the risk issues and Carly's age.

You should also inform Carly's mother about her right to a formal carer's assessment.

Offer Carly and her mother the two 'Understanding NICE guidance' booklets for the short-term and long-term management of self-harm.

You should consider whether Carly should be assed according to local safeguarding procedures.

Related recommendations

- Health and social care professionals who have contact with children and young people who self-harm should be trained to:
  - understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm
  - understand how issues of capacity and consent apply to different age groups
  - assess mental capacity in children and young people of different ages.
  - They should also have access at all times to specialist advice about capacity and consent. **[1.1.18]**

- When families, carers or significant others are involved in supporting a person who self-harms:
  - offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
  - offer contact numbers and information about what to do and whom to contact in a crisis
  - offer information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers or significant others to access these
  - inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this. **[1.1.23]**

- Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to the 'Understanding NICE guidance' booklet for this guideline and for the short-term management of self-harm (NICE clinical guideline 16). **[1.4.7]**

- CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures. **[1.1.19]**

2.5 Question

How should you proceed?

2.5 Answer

Send details of the assessment to Carly's GP. In view of the depression as well as the self-harm, refer Carly to specialist child and adolescent mental health services (CAMHS) for further assessment and treatment.

Different CAMHS services will have different policies on whether they see such cases while still in A&E or arrange a later out-patient appointment. Tier 2 and 3 CAMHS should offer comprehensive treatment including liaison with the school to help deal with the bullying, and specific psychological therapy for depression, preferably interpersonal therapy or cognitive behavioural therapy.

Part of this treatment should address the self-harm. It is likely that the self-harm will stop if Carly recovers from the depression, because the depression preceded (and so is a likely causal factor for) the self-harm.

Related recommendations

- Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8 of the NICE guideline) and use these to develop a care plan (see recommendations 1.4.2 and 1.4.3 of the NICE guideline) and a risk management plan (see recommendations 1.4.4 and 1.4.5 of the NICE guideline) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP. **[1.3.14]**

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

- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing

self-harm. In addition:

- The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
- Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
- Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm. **[1.4.8]**

Related recommendations from 'Depression in children and young people' NICE clinical guideline 28 (2005)

- Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS tier 2 or 3 team. **[1.6.1.1]**
- Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], interpersonal therapy or shorter-term family therapy); it is suggested that this should be of at least 3 months' duration. **[1.6.1.2]**

Case scenario 3: Jenni

Presentation

Jenni is a 14 year old girl and is dealing with the challenges of adolescence, recent home and foster care placement breakdowns and unresolved issues relating to sexual abuse as a young child. Jenni has also been involved in very risky self-harming behaviour at home and at school, including cutting herself. Over the past 2 years these acts have increased in regularity and become more extreme.

Jenni has a statement of special educational needs relating to emotional and behavioural difficulties, first issued when Jenni was 5 years old, following very significant difficulties throughout Key Stage 1 and Key Stage 2, Jenni initially settled at her secondary school, but at the beginning of Year 8 her behaviour deteriorated at home and at school.

She recently started Year 10 at secondary school, and parents and school staff both report that Jenni's behaviour has become increasingly challenging, disruptive, secretive and deceitful. Jenni has started to increase her episodes of self-harm (cutting and opening cuts that were in the process of healing). Jenni's carer noticed her injuries and scars and took her to A&E because some of the cuts were very deep.

3.1 Question

How should A&E staff approach caring for Jenni and what should they do?

3.1 Answer

Treat Jenni's physical wounds (see NICE clinical guideline 16) and care for Jenni in a supportive, non-judgemental manner. Be aware of the stigma and discrimination associated with self-harm and aim to develop an engaging relationship with Jenni.

Because there is evidence of previous self-harm, refer Jenni to CAMHS for assessment.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

3.2 Question

What are the next steps that CAMHS should take to manage Jenni's self-harm?

3.2 Answer

CAMHS should process Jenni's referral in a timely manner and ensure she has access to a full range of treatments and services.

The CAMHS professional caring for Jenni should be trained to assess mental capacity, understand how issues of capacity and consent apply to different age groups and understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm.

CAMHS professionals should balance Jenni's developing autonomy and capacity with perceived risks and the responsibilities and views of Jenni's carer.

CAMHS should carry out a comprehensive and integrated psychosocial assessment of Jenni's needs and risk.

CAMHS should consider whether Jenni should be assessed according to local safeguarding procedures.

CAMHS professionals should adopt an approach which pulls together the concerns of school staff, her parents/carers, social worker and A&E staff so that a comprehensive picture of Jenni's past and present self-harm can be pieced together. This should help with understanding Jenni's self-harm.

Related recommendations

- Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS). **[1.1.3]**

- Health and social care professionals who have contact with children and young people who self-harm should be trained to:
  - understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm

  - understand how issues of capacity and consent apply to different age groups
  - assess mental capacity in children and young people of different ages.

  They should also have access at all times to specialist advice about capacity and consent. **[1.1.18]**

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

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

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

- CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures. **[1.1.19]**

3.3 Question

What should Jenni's assessment of needs include?

3.3 Answer

Jenni's assessment of needs should include; skills strengths and assets, Jenni's coping strategies, the existence of mental or physical health problems, social circumstances, recent and current life difficulties and the need for psychological intervention.

During this assessment, explore the meaning and individual reasons for Jenni's self-harm.

Consider whether Jenni's assessment should be completed according to local safeguarding procedures.

Related recommendations

- Assessment of needs should include:
  - skills, strengths and assets
  - coping strategies
  - mental health problems or disorders
  - physical health problems or disorders
  - social circumstances and problems
  - psychosocial and occupational functioning, and vulnerabilities
  - recent and current life difficulties, including personal and financial problems
  - the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
  - the needs of any dependent children. **[1.3.2]**

- During assessment, explore the meaning of self-harm for the person and take into account that:
  - each person who self-harms does so for individual reasons, and
  - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode. **[1.3.5]**

- CAMHS professionals who work with children and young people who self-

harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures. **[1.1.19]**

Jenni presents as a quite thoughtful young person who is finding it very difficult to meet behavioural expectations in any setting. Jenni's school has reported that although her behaviour has always been difficult to manage, it has become extremely challenging of late; especially with regard to her 'cutting' at any given opportunity. At home and in her recent care placements Jenni was reported as either being mostly 'reclusive and cutting herself' or as being physically and verbally abusive and persistently disrupting the lives of others as a result of her demanding behaviour and constant need for supervision and attention.

Jenni has a diagnosis of attention deficit hyperactivity disorder (ADHD) and has been prescribed medication for this (for guidance on care, treatment and support of people with ADHD see NICE clinical guideline 72). She may not have always taken this and adults have reported that her behaviour is noticeably more difficult to manage when she has not taken it.

Jenni's carer feels that the current situation may have triggered feelings associated with the previous rejections that Jenni has experienced. This may have resulted in Jenni feeling that she needs to assert control over aspects of her life and so is using self-harm to achieve this emotionally and is using challenging behaviour to achieve this socially.

3.4 Question

What should Jenni's risk assessment include?

3.4 Answer

When assessing Jenni's risks of repetition of self-harm, work with her to identify and agree her specific risks. Take into account the method and frequency of self-harm, suicidal intent, depressive symptoms, Jenni's personal and social context, coping strategies, significant relationships and the immediate and longer-term risks.

Consider the existence of coexisting risk-taking behaviour.

Advise Jenni's carer of the need to remove all medications or other means of self-harm.

Do not use risk assessment tools and scales to predict Jenni's risk of future suicide or repetition of self-harm. They may be used to help structure the assessment if they include all the areas mentioned in recommendation 1.3.6.

Related recommendations

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

of risk
  - immediate and longer-term risks. **[1.3.6]**

- Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking. **[1.3.7]**

- In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person. **[1.3.9]**

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm. **[1.3.11]**

- Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6 of the NICE guideline. **[1.3.13]**

3.5 Question

What are the next steps you need to take to manage Jenni's self-harm?

3.5 Answer

Develop a care and risk management plan. This should summarise the key areas of need and risk identified within the psychosocial assessment. Consider treatment and care for ADHD within this plan. From this, develop a care plan in conjunction with Jenni and her carer. Share this with Jenni's GP and give a copy to Jenni and her carer.

Document the aims of Jenni's longer term treatment in the care plan. These aims may be to: prevent escalation of self-harm, reduce harm arising from self-harm or reduce or stop self-harm, stop other risk-related behaviour, improve quality of life and improve any associated mental health conditions. Review the care plan with Jenni at agreed intervals of not more than 1 year.

The risk management plan should form part of the care plan. It should address each of the long-term and more immediate risks, address the specific factors identified in the assessment and include a crisis plan. Update Jenni's risk management plan regularly.

Related recommendations

- Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8) and use these to develop a care plan (see recommendations 1.4.2 and 1.4.3) and a risk management plan (see recommendations 1.4.4 and 1.4.5) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP. **[1.3.14]**

- Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:
  - prevent escalation of self-harm
  - reduce harm arising from self-harm or reduce or stop self-harm
  - reduce or stop other risk-related behaviour
  - improve social or occupational functioning
  - improve quality of life
  - improve any associated mental health conditions.

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. **[1.4.2]**

- A risk management plan should be a clearly identifiable part of the care plan and should:
  - address each of the long-term and more immediate risks identified in the risk assessment
  - address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
  - include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
  - ensure that the risk management plan is consistent with the long-term treatment strategy.

  Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals. **[1.4.4]**

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

Jenni sees her self-harming as “not being naughty or anyone else’s business….unless she shows them”. Jenni adopts a 'matter-of-fact' way of speaking about difficult events in her life, such as being “kicked out of home and foster homes for not doing what I’m told, stealing razors and breaking and hiding bits of glass to cut myself with”, not knowing where she would be living in future because “nobody wants to know me anymore”. At present, Jenni feels “life is not worth living”.

3.6 Question

What interventions should you offer Jenni for the self-harm?

3.6 Answer

Offer 3 to 12 sessions of psychological intervention tailored to Jenni's needs with the aim of reducing her self-harm. This may include CBT, psychodynamic or problem-solving elements.

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

If stopping self-harm is unrealistic in the short term, consider strategies aimed at harm reduction, reinforcing existing coping strategies and consider discussing a less destructive or harmful method of self-harm.

Provide psychological, pharmacological and psychosocial interventions for associated conditions in line with NICE guidance. When prescribing drugs for associated mental health conditions, take into account the toxicity of the drug in overdose.

Related recommendations

- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:
  - The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
  - Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
  - Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm. **[1.4.8]**

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

- If stopping self-harm is unrealistic in the short term:
  - consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible

  - consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
  - advise the service user that there is no safe way to self-poison. **[1.4.10]**

- Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:
  - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115).
  - Depression (NICE clinical guideline 90).
  - Schizophrenia (NICE clinical guideline 82).
  - Borderline personality disorder (NICE clinical guideline 78).
  - Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
  - Bipolar disorder (NICE clinical guideline 38). **[1.5.1]**

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

Case scenario 4: Sarah

Presentation

Sarah is 29 and has been in a general hospital for 5 months after a massive overdose of insulin, which she bought from a friend. She returned to her flat 10 days ago. For the first 2 – 3 days after discharge her mother stayed with her and she has been living alone for the past week.

She presents at the local police station with suicidal thoughts and complains that for the past week her cutting has restarted but she cannot identify the triggers. Staff at the police station informs Sarah that she should visit her GP to discuss her suicidal thoughts and self-harm. They call Sarah's GP to make her a same-day emergency appointment, which Sarah attends.

4.1 Question

Where should Sarah's GP refer her for further assessment and the provision of treatment and how should the GP care for her?

4.1 Answer

Develop a trusting relationship with Sarah and have a non-judgemental and engaging persona. Be aware of the stigma and discrimination associated with self-harm and take into account that Sarah may have had negative experiences with healthcare professionals in the past.

Because Sarah has a history of self-harm, refer her to community mental health services. This should be a priority because her level of distress seems high and she has resumed self-harming.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

4.2 Question

What should community mental health services do initially?

4.2 Answer

Ask whether Sarah would like to have her family involved in her care. If she consents, encourage Sarah's family to be involved when appropriate.

Carry out a comprehensive psychosocial assessment with Sarah. This should include an assessment of needs and risks. During this assessment explore the meaning of Sarah's self-harm, and treat this episode of self-harm in its own right.

The risk assessment element of the psychosocial assessment should consider the possible presence of other coexisting risk-taking or destructive behaviours. You should consider asking whether Sarah has access to family member's medications.

Related recommendations

- Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate. **[1.1.22]**

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

- During assessment, explore the meaning of self-harm for the person and take into account that:
  - each person who self-harms does so for individual reasons, and
  - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode. **[1.3.5]**

- Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking. **[1.3.7]**

- When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others'medications. **[1.3.8]**

During the assessment Sarah acknowledges that discharge from hospital and her inability to use previous coping mechanisms, for example meeting her old friends, may have contributed to her resuming cutting.

She describes hearing ‘lots of voices’ in her head. She describes initial insomnia and nightmares and finds it difficult concentrate. She states that her mood is depressed and rates it at 5 out of 10 (10 being normal). She feels exhausted all day and spends most of her time listening to “death and destruction music”, drinking alcohol and smoking. She usually starts drinking at home in the afternoon and then goes to the pub in the evening.

She states that she has experienced suicidal thoughts over the years but intent has varied. It is generally more when she has been drinking.

4.3 Question

What are the next steps in managing Sarah's self-harm?

4.3 Answer

Work with Sarah to develop an integrated care and risk management plan.

The aims of the care plan may be to prevent the escalation of Sarah's current cutting and to reduce harm by stopping or reducing cutting. You may also include some aims to reduce or stop Sarah's alcohol misuse (For information on the management of harmful drinking see NICE clinical guideline 115). Review these aims with Sarah regularly.

The care plan should be multidisciplinary and should identify realistic long-term goals including education, structure to the day and employment. Identify the roles and responsibilities of any team members and of Sarah herself. Share the plan with Sarah's GP.

The risk management plan should address both the immediate and long-term risks identified in the risk assessment. It should also address the factors that may lead to Sarah's self-harm, such as her inability to use coping mechanisms. A mental health assessment may also be included to address the fact that Sarah has hallucinations. A crisis plan should include details of how to access services if self-management strategies fail.

Update the risk management plan regularly if Sarah continues to be at risk of further self-harm.

Provide Sarah with written and verbal information about the dangers and long-term outcomes associated with self-harm, the available interventions and possible strategies to help reduce this and the treatment of any associated mental health condition.

Related recommendations

- Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8 of the NICE guideline) and use these to develop a care plan (see recommendations 1.4.2 and 1.4.3 of the NICE guideline) and a risk management plan (see recommendations 1.4.4 and

1.4.5 of the NICE guideline) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP. **[1.3.14]**

- Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:
  - prevent escalation of self-harm
  - reduce harm arising from self-harm or reduce or stop self-harm
  - reduce or stop other risk-related behaviour
  - improve social or occupational functioning
  - improve quality of life
  - improve any associated mental health conditions.

  Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. **[1.4.2]**
- Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should:
  - identify realistic and optimistic long-term goals, including education, employment and occupation
  - identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
  - identify the roles and responsibilities of any team members and the person who self-harms
  - include a jointly prepared risk management plan (see below)
  - be shared with the person's GP. **[1.4.3]**

- A risk management plan should be a clearly identifiable part of the care plan and should:
  - address each of the long-term and more immediate risks identified in the risk assessment
  - address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased

risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
  - include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
  - ensure that the risk management plan is consistent with the long-term treatment strategy.

  Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals. **[1.4.4]**

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

- Offer the person who self-harms relevant written and verbal information about, and give time to discuss with them, the following:
  - the dangers and long-term outcomes associated with self-harm
  - the available interventions and possible strategies available to help reduce self-harm and/or its consequences (see recommendations 1.1.1 and 1.4.10 of the NICE guideline)
  - treatment of any associated mental health conditions (see section 1.5 of the NICE guideline). **[1.4.6]**

4.4 Question

What intervention should you offer Sarah for the self-harm?

4.4 Answer

Consider offering Sarah sessions of a psychological intervention tailored to her needs. If stopping cutting is unrealistic in the short-term, consider strategies aimed at harm reduction.

Provide psychological, pharmacological and psychosocial interventions for associated conditions in line with NICE guidance. When prescribing drugs for associated mental health conditions, take into account the toxicity of the drug in overdose.

Related recommendations

- Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:
  - The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
  - Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
  - Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm. **[1.4.8]**

- If stopping self-harm is unrealistic in the short term:
  - consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
  - consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
  - advise the service user that there is no safe way to self-poison. **[1.4.10]**

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

  - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115).
  - Depression (NICE clinical guideline 90).
  - Schizophrenia (NICE clinical guideline 82).
  - Borderline personality disorder (NICE clinical guideline 78).
  - Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
  - Bipolar disorder (NICE clinical guideline 38). **[1.5.1]**

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

Case scenario 5: Gareth

Presentation

Gareth is 33 and first develops depression in his late teens and early twenties, after what he had always assumed was the usual teenage angst and drama become more serious. He becomes withdrawn from friends and family, and has negative thoughts about himself and those around him. He believes that he is worthless, and assumes everyone else agrees. At some point, which he cannot remember, he starts cutting himself. He uses a razor blade to carve increasingly deep and angry wounds into his arms.

At this point his parents intervene and involve Gareth's GP. He is prescribed antidepressants and referred to a specialist within community mental health services.

Gareth visits the psychiatric department of his local hospital as a regular outpatient, and has finally found a person he feels he can really talk to.

5.1 Questions

How should Gareth's GP have reacted and cared for him when he first presented?

From the description of this case what may have gone wrong?

How should primary and secondary care work together?

5.1 Answer

How should Gareth's GP have reacted and cared for him?

Gareth's GP should have aimed to develop a trusting and supportive relationship with him. The GP should have been aware of the stigma and discrimination that Gareth may experience, and have been familiar with local and national resources that may be able to support him. The GP should be able to advise him about how to access these.

What may have gone wrong?

Gareth presented at his GP after self-harming for many years. The fact that Gareth highlights that he 'finally' found someone he could speak to when visiting the psychiatric department may indicate that previously he has had negative experiences with health and social care professionals.

How should primary and secondary care work together?

Services should ensure that they are easily accessible and that access to the full range of treatments is available.

Gareth's GP correctly referred him onto community mental health services where Gareth seems happy with his care. Gareth should be involved with all decisions concerning his care and information about his episodes of self-harm should be communicated to the psychiatric department. Primary and secondary care should ensure they work cooperatively, sharing up-to date risk management plans. Gareth's GP should monitor his physical health and pay attention to the physical consequences of his self-harm.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach

  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- Health and social care professionals who work with people who self-harm should be:
  - familiar with local and national resources, as well as organisations and websites that offer information and/or support for people who self-harm, and
  - able to discuss and provide advice about access to these resources. **[1.1.2]**

- Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS). **[1.1.3]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

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

health and social care professionals should attend CPA meetings. **[1.2.2]**

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

With the support of his family, Gareth's health improves, and he goes on to university – a year older than his peers but more confident in his ability to deal with the stresses and pressures of life. In later years, he is able to identify early warnings of a relapse, and manage the symptoms before he loses control.

Fifteen years later, in his mid-thirties, he becomes depressed again. Now with a wife and child, he finds that his working environment caused severe anxiety and he quickly loses his ability to manage the symptoms. Eventually, he begins cutting himself while at work.

Gareth finds it difficult to say definitively why he cuts himself. There is an element of release involved – immediately after cutting, he feels better, less anxious, and that feeling of relief becomes an incentive to cut again. He also believes he wants to create a physical manifestation of the emotional turmoil – a physical wound is more visible and obvious. However, there is a paradox here because he doesn't want anyone else to see the wounds. Perhaps Gareth is creating this physical evidence to convince himself that there is something wrong.

Gareth goes to see his new GP for the first time, seeking some medication that he believes would make the problem disappear. He is prescribed an antidepressant (mirtazapine), and the doctor also takes time to ask him how he feels during the periods of depression and anxiety, and when he is self-harming. The GP asks what he thinks might be causing the problems. Although Gareth does not have the answers, he appreciates the questions being asked.

5.2 Question

What correct steps has Gareth's current GP carried out and what should she do next given Gareth's medical history?

5.2 Answer

Gareth's current GP has approached the consultation with Gareth correctly. She has adopted a supportive consulting style by asking Gareth how he feels. She also correctly prescribed an antidepressant in line with the NICE clinical guideline 90.

Because Gareth has a history of self-harm and is at risk of repetition, the GP should refer him to community mental health services for assessment. Gareth should remain under the care of his GP for the physical consequences of his self-harm.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:
  - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115).
  - Depression (NICE clinical guideline 90).
  - Schizophrenia (NICE clinical guideline 82).
  - Borderline personality disorder (NICE clinical guideline 78).

  - Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
  - Bipolar disorder (NICE clinical guideline 38). **[1.5.1]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

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

Although Gareth had no previous relationship with his GP, she is patient, understanding and sympathetic. As Gareth's treatment continued, he finds his fortnightly consultations with her to be a useful barometer of his progress.

After several weeks Gareth's referral comes through. He is assessed by the local mental health team and referred to a group CBT course. This is a classroom-based course with around eight other service users. He finds this of limited use; because he is so anxious at the prospect of joining the group he finds it difficult to concentrate on the content. Also, he has no relationship or rapport with the person delivering the content, so he finds what the course leader is saying does not carry much weight.

5.3 Question

What should the community mental health team assessment have included?

5.3 Answer

A comprehensive and integrated psychosocial assessment of needs and risks should have been carried out.

The assessment of needs should have included: skills, strengths, coping strategies, mental health problems, social circumstances and recent and current life difficulties. The meaning of Gareth's self-harm should also have been explored.

When assessing the risk of repetition, Gareth's specific risks should have been identified and agreed with him. This risk assessment should have taken into account: methods and frequency of past and current self-harm, suicidal intent, depressive symptoms, significant relationships and immediate and longer-term risks. The presence of coexisting risk taking behaviour should have been considered.

Risk assessment tools and scales may be used to help structure risk assessment but should not be used to predict suicide or repetition of self-harm. The fact that the initial intervention Gareth was referred to was not useful indicates that some elements of the psychosocial assessment may have been missed.

Related recommendations

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

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

  - psychosocial and occupational functioning, and vulnerabilities
  - recent and current life difficulties, including personal and financial problems
  - the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
  - the needs of any dependent children. **[1.3.2]**

- During assessment, explore the meaning of self-harm for the person and take into account that:
  - each person who self-harms does so for individual reasons, and
  - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode. **[1.3.5]**

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

– immediate and longer-term risks. **[1.3.6]**

- Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking. **[1.3.7]**

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm. **[1.3.11]**

- Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6 of the NICE guideline. **[1.3.13]**

Later, Gareth is seen by an occupational therapist. These sessions are one-to-one and focused specifically on his recovery. Straight away this is more useful and as he builds a rapport with the therapist, Gareth finds himself participating more with the process. Each week they agree clear targets and goals – go to the shops three times, speak to parents, spend time with son – then they review those goals the following week. This follow-up is crucial because it allows Gareth to see what progress he is making

5.4 Question

What should Gareth's care plan include?

5.4 Answer

Gareth's care plan should document the aims of his longer-term treatment. It should include the details of both the group CBT and the one-to one sessions with the occupational therapist. The plan should be multidisciplinary (thus should include notes from Gareth's GP, community mental health professionals and the occupational therapist) and be developed collaboratively with Gareth. It should identify goals and the roles and responsibilities of any team members, include a jointly prepared risk management plan, and be shared with Gareth's GP.

The care plan should be individually tailored to Gareth's needs, taking into account all the information collected throughout assessment. Gareth's first intervention may not have been tailored to his specific needs and that may be why the group CBT course did not work for him.

Related recommendations

- Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:
  - prevent escalation of self-harm
  - reduce harm arising from self-harm or reduce or stop self-harm
  - reduce or stop other risk-related behaviour
  - improve social or occupational functioning
  - improve quality of life
  - improve any associated mental health conditions.

  Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. **[1.4.2]**

- Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should:
  - identify realistic and optimistic long-term goals, including education, employment and occupation
  - identify short-term treatment goals (linked to the long-term goals) and steps to achieve them

  - identify the roles and responsibilities of any team members and the person who self-harms
  - include a jointly prepared risk management plan (see below)
  - be shared with the person's GP. **[1.4.3]**

- A risk management plan should be a clearly identifiable part of the care plan and should:
  - address each of the long-term and more immediate risks identified in the risk assessment
  - address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
  - include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
  - ensure that the risk management plan is consistent with the long-term treatment strategy. **[1.4.4]**

Gradually Gareth starts to feel better. He tries to analyse what made the difference – he thinks it is probably a mix of everything – the drugs, the various therapies, the GP consultations, and the natural cycle of his mental health. The local mental health team invites him to join a reading club (bibliotherapy). Gareth finds this to be a really useful exercise. It helps him get back into the social habits he had lost while he was ill. The timing is important – he wouldn't have been able to participate in the group unless he had already gone through the previous therapies.

Case scenario 6: Robeena

Presentation

Robeena is an 85 year old woman with long standing symptoms of general anxiety and an episode of severe depression 2 years ago. She has always been heavily emotionally dependent on her husband and her supportive family who live nearby.

Robeena has been on antidepressants (maximum doses of mirtazipine and venlafaxine) for the past 25 years with regular outpatient appointments and visits to her GP. Attempts to discharge her in the past have resulted in significant worsening of anxiety and depressive symptoms. She has also been taking 6 mg lorazepam in divided doses and 10 mg nitrazepam at night for many years. There has been no evidence of memory impairment and she remains physically fit for her age. Robeena has made no previous attempts at self-harm.

Robeena's husband died 4 months ago and since then she has become increasingly miserable with more general anxiety symptoms. Over the years she has frequently said she felt suicidal but she says that she is always too frightened to attempt self-harm. She says she feels lonely without her husband, although her family visit her for at least an hour every day and she frequently speaks to them on the telephone as well.

One week after her regular outpatient appointment she takes an overdose of an unknown quantity of coproxamol and is found unconscious in bed by her daughter. Her daughter reports she had become increasingly withdrawn at home, reduced food and fluid intake, had sleep disturbance and expressed suicidal thoughts more frequently.

6.1 Question

What initial steps should the A&E staff take and how should they approach caring for Robeena?

6.1 Answer

Adopt a non-judgemental manner, while being mindful of the stigma and discrimination often associated with self-harm.

Ask Robeena if she would like to have her family involved in her care. Encourage family's involvement if Robeena would like this. If Robeena's family is involved, give them written and verbal information about self-harm and provide contact numbers and information about what to do in a crisis.

If Robeena is at risk of repeating self-harm, refer her to community mental health services for assessment. They should ensure that she has access to the full range of services.

Related recommendations

- Health and social care professionals working with people who self-harm should:
  - aim to develop a trusting, supportive and engaging relationship with them
  - be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
  - ensure that people are fully involved in decision-making about their treatment and care
  - aim to foster people's autonomy and independence wherever possible
  - maintain continuity of therapeutic relationships wherever possible
  - ensure that information about episodes of self-harm is communicated sensitively to other team members. **[1.1.1]**

- Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate. **[1.1.22]**

- When families, carers or significant others are involved in supporting a

person who self-harms:

  - offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
  - offer contact numbers and information about what to do and whom to contact in a crisis
  - offer information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers or significant others to access these
  - inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this. **[1.1.23]**

- If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:
  - levels of distress are rising, high or sustained
  - the risk of self-harm is increasing or unresponsive to attempts to help
  - the person requests further help from specialist services
  - levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help. **[1.2.1]**

- Ensure that children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate. **[1.1.4]**

Following the overdose Robeena is admitted to the general hospital before transfer to the older persons' mental health unit, where she remains withdrawn and suspicious. She tells the ward staff she is frightened they are going to kill her and are talking about her on the ward. She is placed under observation and continues to take her antidepressant and benzodiazepine. Low dose risperidone is also prescribed (for information on the management of depression in adults see NICE clinical guideline 90).

6.2 Question

What steps should the mental health unit staff take to manage Robeena's risk of future self-harm?

6.2 Answer

Carry out an integrated and comprehensive psychosocial assessment of needs and risks.

Robeena should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Consider the higher risk of suicide following self-harm in older people. When carrying out the risk assessment be aware that acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm, but they could help structure the risk assessment.

Provide psychological, pharmacological and psychosocial interventions for Robeena's associated mental health conditions in line with published NICE guidance.

Related recommendations

- Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5 of the NICE guideline) and risks (see recommendations 1.3.6–1.3.8 of the NICE guideline) to understand and engage people who self-harm and to initiate a therapeutic relationship. **[1.3.1]**

- All people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for working-age adults (see recommendations 1.3.1 and 1.3.2 of the NICE guideline). In addition:
  - pay particular attention to the potential presence of depression, cognitive impairment and physical ill health
  - include a full assessment of the person's social and home situation, including any role they have as a carer, and
  - take into account the higher risks of suicide following self-harm in older

people. **[1.3.3]**

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm. **[1.3.11]**

- Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6 of the NICE guideline. **[1.3.13]**

- Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:
  - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115).
  - Depression (NICE clinical guideline 90).
  - Schizophrenia (NICE clinical guideline 82).
  - Borderline personality disorder (NICE clinical guideline 78).
  - Drug misuse (psychosocial interventions or opioid detoxification) (NICE clinical guidelines 51 and 52).
  - Bipolar disorder (NICE clinical guideline 38). **[1.5.1]**

6.3 Question

Who should provide Robeena's longer term treatment and management of self-harm?

6.3 Answer

Mental health services should generally be responsible for the routine assessment and longer-term treatment and management of self-harm.

Related recommendations

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

6.4 Question

What should be included in Robeena's care plan?

6.4 Answer

Discuss and agree the aims of Robeena's longer-term treatment, and document them in the care plan. These aims may be to: reduce self-harm, improve social functioning, improve quality of life and improve Robeena's associated mental health conditions. Review these aims at agreed intervals of not more than 1 year.

The care plan should be multidisciplinary and developed collaboratively.

Risk management plans should be a clearly identifiable part of the care plan.

Related recommendations

- Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:
  - prevent escalation of self-harm
  - reduce harm arising from self-harm or reduce or stop self-harm
  - reduce or stop other risk-related behaviour
  - improve social or occupational functioning
  - improve quality of life
  - improve any associated mental health conditions.
  - Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. **[1.4.2]**

- Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should:
  - identify realistic and optimistic long-term goals, including education, employment and occupation
  - identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
  - identify the roles and responsibilities of any team members and the person who self-harms
  - include a jointly prepared risk management plan (see below)

- be shared with the person's GP. **[1.4.3]**

- A risk management plan should be a clearly identifiable part of the care plan and should:
  - address each of the long-term and more immediate risks identified in the risk assessment
  - address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
  - include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
  - ensure that the risk management plan is consistent with the long-term treatment strategy.
  - Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals. **[1.4.4]**

Robeena remains on combined antidepressants. Because she has always been a sociable outgoing person she is referred to the local social services community innovations team to explore suitable community activities.

The short term outlook is good, although the team are realistic that Robeena will continue to need regular emotional support because she has longstanding anxious and dependent personality traits and is still grieving the loss of her husband.

Other implementation tools

NICE has developed tools to help organisations implement the clinical guideline on self-harm: longer-term management (listed below). These are available on the NICE website (www.nice.org.uk/guidance/CG133).

- Slide set – educational slide set highlighting the key recommendations.
- Costing report and template – a costing report gives the background to the national savings and costs associated with implementation, and a costing template allows you to estimate the local costs and savings involved.
- Clinical audit tool – for monitoring local practice.
- Baseline assessment tool – to help monitor your current practice against the guideline recommendations.
- Risk assessment podcast – a discussion with the guideline development group chair about what should and should not be included within a psychosocial assessment with a person who has self-harmed.
- Service user podcast – a discussion with a service user about their personal experience of self-harm. This podcast also covers harm minimisation.

A practical guide to implementation, 'How to put NICE guidance into practice: a guide to implementation for organisations', is also available (www.nice.org.uk/usingguidance/implementationtools).

Acknowledgements

NICE would like to thank the members of the National Collaborating Centre for Mental Health and the Guideline Development Group. We would specifically like to thank: Shanaya Rathod, Consultant Psychiatrist and Clinical Service Director, Southern Health NHS Foundation Trust; Paul Wilkinson, University Lecturer and Honorary Consultant in Child and Adolescent Psychiatry, University of Cambridge, Cambridgeshire and Peterborough NHS Foundation Trust; David Mclean Thorne, Child and Educational Psychologist; Dr Nicholas Sorby, Consultant Psychiatrist, Southern Health NHS Foundation Trust and Mr Gareth Allen.