



Royal College of Psychiatrists

Consultation Response

DATE: 8 June 2011

RESPONSE OF: **THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**

RESPONSE TO: SELF HARM – LONGER-TERM MANAGEMENT

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Royal College of Psychiatrists in Wales

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National Institute for Health and Clinical Excellence

**Self-harm (longer term management)
Stakeholder Comments**

Please enter the name of your registered stakeholder organisation below.

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Stakeholder Organisation:		RCPsych in Wales		
Name of commentator:		Manel Tippett		
Order number <i>(For internal use only)</i>	Document Indicate if you are referring to the Full version NICE version or the Appendices	Section Number Indicate number or 'general' if your comment relates to the whole document	Page Number Indicate number or 'general' if your comment relates to the whole document	Comments Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.
<i>Example</i>	<i>Full</i>	<i>3.4.6</i>	<i>45</i>	<i>Our comments are as follows</i>

PROFORMAS THAT ARE NOT CORRECTLY SUBMITTED AS DETAILED ABOVE MAY BE RETURNED TO YOU

1				<p>The Guideline Development Group should be aware of imminent developments in Welsh mental health services. The Mental Health (Wales) Measure will lead to the new primary mental health services separate from primary care and from current community mental health teams and other specialist mental health services. While Welsh policy still supports community mental health teams as the core of the secondary services, it is not necessarily clear that all (or even the majority of) self harm would be managed in future by community mental health teams within secondary mental health services. There is a strong possibility that a significant proportion of patients will be redirected from community mental health teams/ secondary mental health teams to new services. Welsh primary mental health services could, and arguably should, develop expertise to manage much self harm.</p> <p>Part 3 of the Measure enables individuals who have been discharged from secondary mental health services (within three years) to refer themselves directly back to those services, bypassing their GP for a referral altogether.</p> <p>http://www.legislation.gov.uk/mwa/2010/7/contents/enacted</p>
2	Full	General	General	The full guideline is a very useful document covering a wide range of issues in detail. It is a useful summary of current knowledge and will be an important

				reference.
3	Full	General	General	The current guideline needs to clearly dovetail with the recommendations outlined in the previous guidelines concerning treatment of self-harm in the first 48 hours of an accident. There will be areas of overlap between the two documents but how they relate to one another is not always clear. This could be clarified by suggested care pathways amalgamating both guidelines.
4	Full	General	General	The evidence concerning assessment of risk and need is presented in the guideline, and indicates that the specialist assessment will take place in CAMHS/CMHTs within a relatively short period after presentation. However, previous guidance on short-term management rightly highlights the need for specialist assessment, in most cases within 48 hours, often in A&E or medical wards (if admitted). The current guidelines need to reflect this.
5	NICE	General	General	The short guideline contains limited comment on the motives and significance of self harm which is very usefully covered in 2.1.5 of the full guideline. The motive for self harm is an important aspect of the overall risk assessment and should influence any further referrals and interventions.
6	NICE	Introduction (1 st para)	3	This paragraph is confusing; the third sentence is presumably drafted in error as it seems to confuse this guideline with the one on short term management. The third sentence of the third paragraph in the introduction does not read clearly. Presumably the words "and increases" should read "which increase".
7	NICE	Introduction (3 rd para)	3	<i>'Self-harm is associated with a wide range of psychiatric problems'</i> . Self harm is also very much associated with emotional distress and psychosocial problems in addition to a 'psychiatric problem'. Self-harm is a manifestation of emotional distress; an indication that something is wrong rather than a primary disorder. (Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) Therapeutic assessment of patients following self harm in primary care. InnovAiT Vol 4, Num 5, p278 -287)
8	NICE	Introduction (3 rd para)	3	The third sentence of this paragraph does not read clearly. Presumably the words "and increases" should read "which increase".
9	NICE	Introduction (3 rd para)	3	There are two important points to highlight: <ul style="list-style-type: none"> • The incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is among the highest in Europe with rates of around 400 per 100,000 of population (Horrocks and House, 2002). • Although self-harm is associated with a 100 fold increase in completed suicide rate, usually the motivation to self-harm is generally to sustain life as it may be the only mechanism that some people have to cope with their unbearable distress or 'starve off' their suicidal thoughts
10	NICE	Person-	5	<i>'Good communication between health and social care</i>

		centred care		<i>professionals and service users is essential.</i> We suggest the sentence should end with "...the foundation of which is a compassionate, non – judgemental and validating response."
11	NICE	Person-centred care	5	Every contact with an individual who self-harms is a chance to address the unbearable emotional distress that (s)he are feeling. If addressing self-harming behaviours is seen solely as the preserve of specialist mental health services, opportunities for intervention will be missed.
12	NICE	1.1.1	7	Non-disclosure of self-harm Shame and fear of discovery mean that people often keep self-harm a secret. Unless medical treatment is required, self-harm is not usually reported. The reasons why people do not seek help following self-harm are not known but it is assumed that stigma is an important factor. Some may not disclose their self-harming behaviours because the issue is not directly addressed. Therefore, when presented with a patient who is displaying characteristics of depression or emotional distress it may prove valuable to routinely ask about thoughts and acts of self-harm.
13	NICE	[1.3.6]	8	Assessment of self-harm should explore the events leading up to the self-injury in depth. This includes exploring the current situation, recent events and current problems; exploring the patient's emotional and psychological state both leading up to the event and afterwards; exploring how the individual has self-harmed; and determining whether there is an immediate risk of self-harming again. To help GPs assessing patients who have self-harmed, Wadman and Cole-King propose the new mnemonic ' SOS ': <ul style="list-style-type: none"> • Severity: How severe is the situation? Is medical treatment required? Can wounds be managed in-house? Does the patient need to be referred to A&E? (Recommended for all cases of overdose). How severe was the emotional distress when the patient self-harmed? How severe is it now? How severe is any mental illness? How severe are the patient's psychosocial problems/life events and has anything changed? • Outcome: What was the intended outcome of the self harm? Was there a death wish? Did the individual secure the means specifically for the self harm? What was the extent of planning and preparation? Were there any attempts not to be discovered? What was the individual thinking at the moment of self harm? Were any boundaries in place to ensure safety or possibility of rescue? e.g. someone close by, informed someone, did not use all available means, depth of cut, number of cuts etc. Does the individual regret self-harming? • Support systems: Explore the patient's network of supportive family/friends. Beware of social isolation (perceived or real), relationship instability or recent loss e.g. via bereavement. Are there adequate and appropriate support systems in place? <p>It may be useful to consider this process in relation to both self harm and suicide risk as many people may engage in self harm in addition to having suicidal</p>

				<p>thoughts.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care</i>. InnovAiT Vol 4, Num 5, p278 -287)</p> <p>Additionally the risk assessment process should be transparent and understood by the patient.</p>
14	NICE	[1.4.2]	8	<p>Add in: to aim to mitigate against escalation in self harm if the person engaging in self-harm is unable to reduce their self harm.</p>
15	Appendix	General	General	<p>Consider the inclusion of the table of risk factors published in the InnovAiT article as a useful 'aide memoir' within the appendix. (Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care</i>. InnovAiT Vol 4, Num 5, p280-281)</p>
16	NICE	[1.4.3]	9	<p>Consider the addition of the terms in red: 'Care plans should be multidisciplinary and co-developed collaboratively with the person who self-harms and their family, carers or significant others (if appropriate). They should be bio-psychosocial and person centred.'</p> <p>Consider the inclusion of the table taken from the Innovaite paper regarding bio-psychosocial ways to mitigate the immediate risk and longer term risk of self harm.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care</i>. InnovAiT Vol 4, Num 5, p284)</p>
17	NICE	1.1.9	13	<p>Training should also be targeted to increase empathy, compassion and understanding in addition to knowledge and competencies.</p> <p>Training should include an element designed to specifically tackle myths and stigma in addition to identifying and minimising barriers to delivering compassionate responses to people who self –harm.</p>
18	NICE	1.2.1-3	17	<p>The sense of the full guidance is that management of self harm is complex but a function of the whole health system, yet the tone of the short guideline suggests that the locus for assessment and treatment should fall on specialist services. Primary care is specifically covered in the short guideline by only three points [1.2.1. - 1.2.3] covering less than a page. However,</p> <ol style="list-style-type: none"> 1. the short guideline acknowledges that a significant amount of self harm presents to, and can and should be identified in primary care, and further implies that not all such self harm should be referred to specialist/secondary care: page 17 1.2.1 – "If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them..." This is inconsistent with 1.4.1 quoted above. 2. This section of the short guideline also offers guidance for referral to more specialist services. This could also include 1) the presence of significant suicidal thinking or intent, 2) risk of severe physical harm and 3)

				<p>the presence of severe mental disorder.</p> <p>3. The full guideline clearly envisages a range of appropriate interventions for self harm, and acknowledges that some cases can and should be managed in primary care; many of the interventions implied in 1.5.1 of the guideline can be provided in primary care. This is not carried through to the short guideline, which appears to offer more restrictive guidance.</p> <p>It would be helpful if these scattered references could be collated under 1.2.</p>
19	NICE	1.3.10	20	<p><i>'Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.'</i></p> <p>Consider adding the ratio of self harm to completed suicide to highlight this issue.</p>
20	NICE (and FULL)		21	<p>There appears to be inconsistency between the short guideline [page 21] and the full guideline [page 22] in covering assessment and interventions.</p> <ul style="list-style-type: none"> • Full guideline 2.2.2 (Assessment) states that "Subsequent to assessment, the assessing clinician may recommend <i>no follow-up, follow-up in primary care</i>, referral to a Community Mental Health Team, referral for psychological treatment or a recommendation for inpatient admission"; the outcomes in italics do not reflect "community mental health services" – a flexible set of outcomes. It also states that "Assessment for adults most commonly occurs in the context of the community mental health team", again allowing flexibility to address need. • The short guideline 1.4.1 (Provision of care) suggests that "Community mental health services...should be responsible for the routine assessment...and the longer-term treatment and management of self-harm" – a more restrictive pathway. It is not clear why all self harm should be assessed and managed by specialist services.
21	NICE	1.4.3	22	<p>We recommend adding to the final bullet point: "be shared with the person's GP [1] and with other relevant agencies and significant others, [2] with the patient's consent".</p>
22	NICE	4.1	25	<p><i>Effectiveness of training</i></p> <p>Please find below two unpublished audits conducted as part of a Quality Improvement initiative in North Wales related to training and improvements in supervision and documentation:</p> <ol style="list-style-type: none"> 1. Re-audit of junior doctors' assessments following Connecting with People training, enhanced documentation and supervision showed major improvements in care.

				<p>Documentation rates increased as follows:</p> <ul style="list-style-type: none"> • Current suicidal thoughts: 67% to 100% • Method: 40% to 93% • Circumstances: 43% to 93% • Subjective intent: 43% to 80% • Drugs and alcohol during self harm: 30% to 73% • Use of Pierce suicide intent scale: 33% to 63% • Current alcohol/drug use: 47% to 87% • Social history: 77% to 90% • Summary/Opinion of Risk/Clinical Impression: 37% to 66% <p>(All highly significant improvements: 'p' values <0.0002)</p>
23	NICE	4.5	29	<p>Observational study exploring different harm-reduction approaches</p> <p>Hawton et al (1999) in their Cochrane review of psychosocial and pharmacological treatments for self harm, highlighted that despite much research the optimum treatment for self harm remain elusive. We suggest that this may be due to the approach of 'managing self-harm'; focusing on the self-harm itself rather than on the needs of the individual. Furthermore, any treatment strategy relies heavily on an empathic therapeutic relationship and the ability of the practitioner to demonstrate a validating and compassionate approach and this cannot be prescribed. Consider highlighting the importance of therapeutic engagement and a person centred approach rather than 'treating the self harm'.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care</i>. InnovAiT Vol 4, Num 5, p280-281)</p>
24	Full	2.1.1	14	<p>Consider highlighting the extreme importance of language when discussing self harm. There is still a significant amount of stigma regarding self harm. Stigma is a contributing factor to the secrecy regarding experiencing self harm and the difficulty accessing medical care. Even if the practitioner using a possibly offensive term has very compassionate views the distressed person may be offended by the injudicious use of some terms. This is extremely important and services need to assist in the reduction of the stigma and taboo surrounding self harm.</p>
25	Full	2.1.9	19	<p>Recent U.K. evidence suggests that childhood bullying and previous sexual abuse are associated with subsequent risk of attempted suicide in adult life</p> <p>(Bebbington P, Minot S, Cooper C, Meltzer H, Jenkins R, Brugha T, Dennis M. 2009 <i>Suicide attempts, gender and sexual abuse: Data from the British psychiatric morbidity survey 2000</i>. American Journal of Psychiatry, 166, 1135-1140.)</p> <p>(Meltzer H, Vostanis P, Ford T, Bebbington P, Dennis M.S. 2011. <i>Victims of bullying in childhood and suicide attempts in adulthood</i>. European Psychiatry, DOI:10.1016/j.eurpsy.2010.11.006)</p>

26	Full	2.1.9	19	The guideline needs to stress that the people of South-Asian origin living in the U.K. are a heterogeneous group with widely differing cultural and religious backgrounds.
27	Full	2.1.9	20	Lines 4-5: The study of Dennis and colleagues (2005) is misrepresented as it needs to be more specific. The second sentence of this paragraph should ideally read 'They found that two-thirds of older people that who were depressed and had self-harmed had significant suicide intent', rather than, 'They found that two-thirds of this group had significant suicide intent.'
28	Full	2.2.1	21	Consider adding 'when presented with a patient who is displaying characteristics of depression or emotional distress it may prove valuable to routinely ask about thoughts and acts of self-harm.'
29	Full	4.5.1.5	115	The need for providing support to those who do not speak English or for whom English is not their preferred language is paramount. We would recommend that those responsible for translation and interpretation be equally as sensitive and compassionate as practitioners (point 24 above), when using appropriate language. It is also important to take into account cultural attitudes towards self harm and suicide.
30	Full	5.3	128	Consider adding that unpublished work identified an association between GPs and other primary care practitioners attending the Connecting with People suicide and self harm awareness element of the RCGP accredited Primary Mental Health Care Accredited module and an increase in coding of self harm post training. (data available upon request)
31	Full	5.3	129	NICE Guidelines suggest that all patients following self harm have psychosocial assessment by A&E professionals. (Horrocks et al 2003 reported 58% of A&E cases met this) 2009 audit of a North Wales A&E cases (n=64): <ul style="list-style-type: none"> • 94% assessed for immediate risk; • 89% identified previous mental illness; • 81% Mental State Examination
32	Full	5.4	130	Consider the inclusion of the following papers regarding professionals attitude to risk assesments: <ul style="list-style-type: none"> • Cole-King A Lepping, P Suicide mitigation: time for a more realistic approach. 2010. BJGP 3-4 • Cole-King A Lepping P (2010) Personal view: Will the new Government change our approach to risk? <i>British Medical Journal</i>, July. 341: c3890. • Cole-King A Green G, Peake-Jones G, Gask L (2010) The Assessment and Management of Patients with Suicidal Thoughts in Primary Care: An introduction to the concept and practicalities of suicide mitigation. <i>InnovAiT</i> Vol 4, Num 5, 288-295 • Cole-King A Green G, Wadman S, Peake-Jones G, Gask L (2010) Therapeutic assessment of patients

				following self harm in primary care. InnovAiT Vol 4, Num 5, p278-287
33	Full	6.3.1 – 6.3.8	178 - 192	The guideline highlights the difficulties of relying on risk assessment instruments. This correlates with the findings of RCPsych report suggesting that if risk assessment tools are used these are only an adjunct to a skilled clinical assessment. Royal College of Psychiatrists (2010) Self-harm, suicide and risk: helping people who self-harm. College Report CR158. p. 78-80 http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf
34	Full	General	General	Negative attitudes towards self-harm can be associated with a lack of understanding of its complexity. Clinicians are therefore ill-prepared and feel powerless to help a person who is 'assumed' not to want help themselves. Common feelings can be described as "a combination of horrified, guilty, furious, betrayed, disgusted and sad" (Frances, 1987 In Favazza, 1998). Skills and attitudinal training is fundamentally important to engage 'hearts and minds' and to enable practitioners to develop and practice the skills needed to compassionately, safely and effectively engage with patients who self-harm.
35	Full	General	General	STORM now offer a module on self-harm as part of their portfolio of training. http://www.stormskillstraining.co.uk/

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Please email this form to: selfharm@nice.org.uk

Closing date:

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