



Royal College of
Psychiatrists



Better Services for People who Self-Harm

Quality Standards for Healthcare Professionals

Edited by the 'Better Services for People Who Self-Harm' Project Team and Steering Group, with representatives from:

The British Association for Emergency Medicine and the College of Emergency Medicine.

London Ambulance Service

Mind

NICE National Collaborating Centre for Mental Health

Royal College of Nursing

Royal College of Psychiatrists' Faculty of Liaison Psychiatry

Service User Experts

1st Edition: February 2006

A manual of standards written primarily for:

Emergency department staff
Ambulance services
Mental health teams
Primary care practitioners

Also of interest to:

Service users
Service providers
Commissioners
Policy makers
Researchers

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This document can be downloaded, free of charge, from:
<http://www.rcpsych.ac.uk/cru/auditSelfHarm.htm>

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Foreword

In England, self-harm is one of the most frequent reasons for general hospital admission. It accounts for at least 150,000 presentations to general hospitals each year. Self-harm can occur because of a wide range of psychiatric, psychological, social and physical problems and there are strong associations between self-harm and risk of subsequent suicide. Good clinical care following self-harm is essential. Yet the standards of hospital care for this patient group are highly inconsistent and often very unsatisfactory. In some hospitals, fewer than half of patients who self-harm receive a psychosocial assessment, and aftercare is very patchy indeed.

Thankfully, recognition of this problem has in recent years resulted in concerted efforts to improve care, including guidance from the Royal College of Psychiatrists, and the guideline for the short-term management of people who self-harm produced by the National Institute for Clinical Excellence in 2004. These documents, along with others, have informed this manual of standards. However, ensuring that such standards are implemented in practice is not straightforward, particularly where hospital trusts are facing competing demands for precious resources. This project, which is aimed at rolling out and evaluating the specific advice now available to staff, is therefore most welcome. It should result in improved clinical practice to better meet the needs of a particularly vulnerable patient group. I wish it every success.

***Professor Keith Hawton,
Director, Centre for Suicide Research, University of Oxford
Consultant Psychiatrist, Oxfordshire Mental Healthcare NHS Trust***

I recently accompanied a friend to the Emergency Department after she had self-harmed. This experience, as well as experiences of my own, brought home to me the juxtaposition of supreme excellence with some deeply worrying experience. I cannot praise enough the sensitivity, efficiency and understanding of the key nurse, doctor and psychiatrist who looked after my friend in the first few hours of her visit. Standards set out in this document were met, if not exceeded. However, in the following hours her experiences were such that she felt unable to continue to use the service and was left deeply distressed. There is excellence to be celebrated and shared, and there is work to be done in bringing about more consistent standards of care.

The standards in this document have been developed with significant involvement from service users, as well as medical, nursing, ambulance and mental health professionals. My strong belief is that the way forward is through such dialogue between people using services and those providing them. Both have expertise. This project offers a real and exciting opportunity to make a difference for people who self-harm and those working to support them throughout the UK. The service users on the Central Project Team and Steering Group are looking forward to working in partnership with you to make this a reality.

***Helen Blackwell,
Service User Adviser and Project Team Member, 'Better Services for People who Self-Harm', The Royal College of Psychiatrists Research and Training Unit***

Introduction

The Issue

Self-harm is one of the top five causes of acute medical admission in the UK each year. In the year after attending an emergency department about one in six will self-harm again and nearly 1% will die by suicide.

The quality of care for those who self-harm depends on the quality of joint working between emergency departments and mental health services and this currently varies across the UK. Although there are, of course, areas of good practice, many people who attend an emergency department as a result of self-harm find the experience unpleasant.

In 2004, the National Institute of Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (NCCMH) developed a guideline for the short term management of people who self-harm (see www.nice.org.uk). The guideline concluded that improving staff knowledge and attitudes is the key to better services.

This manual of standards builds on the comprehensive work of NICE and also includes recommendations from other sources. It is intended to be a source of reference for professionals who come into contact with people who self-harm in the emergency setting (primarily ambulance, emergency department and mental health teams).

These standards have been informed by:

- The NICE guideline for the short term management of people who self-harm
- A review of documents from relevant professional bodies such as the Royal College of Nursing, the Royal College of Psychiatrists, the Faculty of Accident and Emergency Medicine and the Joint Royal Colleges Ambulance Liaison Committee
- A review of Department of Health policy and recommendations, including the Emergency Care Checklists
- A written consultation exercise with key stakeholder groups. These included healthcare professionals from emergency care, mental health and ambulance, service users, voluntary organisations and other experts in the field.
- The ideas and discussions of a Standards Teleconference held with service users, researchers and carers
- Consultation with experts from other quality improvement programmes

All of the standards and criteria are referenced with links to source documents so that readers can see where each criterion has derived from and explore related documents in more detail.

The policy context

These standards are mapped against *The Healthcare Commission's 'Standards for Better Health'*, with clear references to their core standards, helping services to demonstrate compliance against both sets of standards. The core standards in the Standards for Better Health represent a level of service that all patients should be able to expect. Visit this website for a full list of the Healthcare Commission's standards:

<http://www.healthcarecommission.org.uk/informationforserviceproviders>

The 'Better Services for People who Self-Harm' project

This is a national quality improvement project which uses well established audit, service evaluation and quality improvement methods to bring about positive changes to the quality of healthcare.

Local teams have been established throughout the UK comprising of local service users, practitioners and managers from emergency departments, local ambulance services and their associated mental health services. These teams have been grouped with neighbouring teams to form 6 regional collaboratives throughout the UK.

Local teams measure their performance against the standards using the following methods:

- A comprehensive survey of service users to seek their views on the quality of care provided by emergency services
- A staff survey focussing on training, support, supervision and interagency communication
- A staff survey focussing on staff attitudes and opinions towards working with people who self-harm
- An audit of joint working arrangements and policy documents
- A 'case flow audit' focussing on waiting times and patient outcomes

All of the data being measured relate to standards contained in this document.

Results will be collated and each local team will receive a report summarising activity data and the responses of staff and service users in this area. The summary will include details of achievements, as well as ideas for future developments, as suggested by staff and service users.

Regional and national reports will allow services to benchmark their performance against other services participating in the quality improvement programme. In some cases, this may help local services argue for better resources.

Teams will be given time to digest the report and will then be expected to undertake a period of action planning and applying interventions. The central project team will provide local teams with training in the 'Plan-Do-Study-Act' (PDSA) model for improvement and will then be given time to apply interventions before being re-audited to test for improvement.

Local teams will be supported in learning and information sharing with other services by:

- Peer-reviews – each team will visit another service in their region to discuss key issues in more detail, exchange ideas, offer advice and tour the premises. The central project team will offer support and training in this beforehand.
- Regional and national learning events will be provided, with presentations on best practice from local teams
- An email discussion group to ask for advice and exchange ideas and policy documents
- Regular newsletters

By providing staff and service users with this platform for information sharing, teams will have the opportunity to quickly learn about innovative work taking place elsewhere and use this knowledge to apply better practice to their own organisations.

To enquire about joining future waves of the project, please contact Philippa Strevens, email selfharmproject@cru.rcpsych.ac.uk, Tel: 020 7997 6643/6642.

The project team and partners

The central project team is based at the Royal College of Psychiatrists' Centre for Quality Improvement and consists of two full time and two part-time staff, one of which is a service user advisor. Other partners include:

- The Faculty of Accident and Emergency Medicine and the College of Emergency Medicine.
- The Royal College of Nursing
- London Ambulance Service
- The Royal College of Physicians
- Mind
- The NICE National Collaborating Centre for Mental Health
- Service Users

The project team has also sought input from the National Poisons Information Service and various service users and self-harm groups.

This project is funded by the Health Foundation, an independent charity.

How to use this document

Section 1 concentrates on core principles that all staff should take into account, regardless of their profession. Sections 2 and 3 describe best practice along a common care pathway, allowing professionals to apply these standards directly to patient care. Sections 4 and 5 refer to staffing, training, service organisation and aspects of joint working that all teams should aspire to. Special issues relating to the responsibility of ambulance services and primary care are listed in sections 6 and 7. Issues relating to the care and treatment of children and young people, and older service users are listed in sections 8 and 9. These two sections are primarily based on the NICE recommendations and will be expanded further in the second edition of this document with extensive input from specialists in these areas.

This document is not intended to be a definitive guide to specific clinical and medical practice. However, recommendations from the NICE guideline on the physical, pharmacological and psychosocial interventions are listed in Appendix 1.

Each standard appears in bold, followed by a table of criteria. **A standard** can be defined as "An authoritative statement of a level of performance". **A criterion** can be defined as "a variable against which specific activity can be compared" or "an operational definition of a standard".

The table below shows how each criterion is laid out.

No.	Criterion statement	R	S
The unique criterion number given to each item	Describes what needs to take place	Describes the rating for each criterion: E = Essential D = Desirable	Provides a code to the original source (see page 47 for full list) <u>Please note that GPP = 'good practice point'</u> <i>Recommended good practice based on the experience of the experts consulted</i>

Important Note

Many of the criteria listed represent best practice and consequently we would not expect services to meet every standard. While some statements are based upon legal requirements, this document is not intended to act as a legal guide. These standards do not override the individual responsibility of a healthcare professional to make appropriate decisions in the circumstances of the individual service users, in consultation with the patient and/or guardian or carer.

1. CORE PRINCIPLES FOR ALL STAFF

“Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers, with dignity and respect. Healthcare organisations should challenge discrimination, promote equality and respect human rights”

(Healthcare Commission, Standards for Better Health 2004, Core standards C7 and C13)

1. People who have self-harmed should be treated with the same care, respect and compassion as any patient

No.	Criterion statement	R	S
1.1	Healthcare professionals should take full account of the likely emotional distress associated with self-harm, additional to the injury itself; in particular, immediately following injury and at presentation for treatment	E	NICE
1.2	People who have self-harmed should be offered the same quality of care and range of treatments as any other patient, without unnecessary delay, and regardless of their willingness to accept psychosocial assessment or psychiatric treatment	E	NICE
1.3	Staff should not behave in a punitive, threatening, dismissive or judgmental manner towards people who self-harm	E	GPP
1.4	Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments	E	NICE
1.5	Staff should ask service users if there are any specific personal, cultural, religious or other factors that need to be considered when examining or treating the individual, and make reasonable efforts to accommodate this	E	GPP
1.6	When the physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance	E	NICE
1.7	Healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion, and therefore each episode needs to be treated in its own right	D	NICE
1.8	If an individual presents to services alone, staff should ask if there is anyone the service user would like to contact, and offer to make contact or provide access to a phone	D	GPP
1.9	People who self-harm should be <i>given the choice</i> of having a friend, relative or advocate present during assessment and treatment	E	GPP
1.10	Healthcare professionals should provide emotional support and help if necessary to any relatives/friends/carers present	D	NICE

2. People who self-harm (and their relatives/carers) should be provided with up to date and relevant information

(Healthcare Commission C14, C16, D8)

2.1	Service users should be provided with clear and understandable information about the care process	E	DH1
2.2	Service users should be allocated a named member of staff and informed if the shift ends and the named member of staff changes	D	GPP
2.3	A member of staff (preferably the named staff member) should keep in regular contact with the service user to ensure their safety and update them on waiting times and progress	E	GPP
2.4	When necessary, information should be provided in languages other than English, and for people with sight, learning or literacy difficulties	E	DH1
2.5	There should be access to face to face interpreter services and, where appropriate, the person's preferred language should be recorded in notes. When face to face interpreters are not available, staff should use telephone interpreters, such as www.languageline.co.uk . Staff should not use patients' relatives as interpreters	E	DH2
2.6	Staff should have access to the multilingual phrasebook developed by the Department of Health and the Red Cross	D	DH2
2.7	Information on crisis and advice organisations, social services departments, independent advocacy services, service user/carer's support groups etc. should be prominently displayed in foyers, waiting areas and resource areas	D	GPP
2.8	Information should be available on how to complain or ask questions if a service user is unhappy with their treatment	E	DH1

3. Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care

(Healthcare Commission C17)

3.1	Staff should engage service users in a therapeutic alliance and promote joint clinical decision-making on the basis of understanding and compassion	E	NICE
3.2	Staff should take into account that a person's capacity to make informed decisions may change over time. Whether it has been possible to obtain consent or not, attempts should be made to obtain consent before each treatment is initiated.	E	NICE
3.3	Information should be provided on the perceived risks and benefits of treatment, as well as any side effects	E	GPP
3.4	Written material and time to talk over preferences should be provided for all service users, with staff checking that the service user has been given sufficient information to make a decision	E	NICE
3.5	Staff should consider carefully the content of any crisis card or advance directive when deciding when and how to intervene	D	NICE

4. Personal information about the person who has self-harmed should remain confidential, unless this is detrimental to their care

(Healthcare Commission C9, C13c and C16)

4.1	Confidentiality and its limits are explained to service users and their relatives/carers, e.g. it is made clear that confidentiality is extended beyond the clinical team only if the quality of their care and/or the safety of another depends on this, and then only to those who need to know	E	RCP2
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4.2	The healthcare service holds data in compliance with the Data Protection Act (1984) to ensure maintenance of confidentiality	E	RCP2
4.3	Information about the service user should only be sought from others if the patient gives consent, unless the individual lacks the capacity to make that decision and their safety is at risk	E	RCP2
4.4	Service users should be told to whom information has been passed on	E	RCP2

5. Environment and facilities should provide a level of safety, dignity and comfort to service users and staff
(Healthcare Commission C20)

WAITING AREAS IN THE EMERGENCY DEPARTMENT

5.1	The waiting environment should be safe	E	RCP1
5.2	The waiting environment should be comfortable and designed to minimise any distress	D	RCP1
5.3	The individual should be given the choice of waiting in a separate, quiet room with supervision	D	RCP1

RECOVERY FACILITIES IN THE EMERGENCY DEPARTMENT

5.4	There should be facilities in the emergency department to allow patients a degree of recovery time	D	RCP1
5.5	There should be access to a 'detoxification room' in emergency departments to enable people intoxicated by alcohol/drugs to be treated and nursed in a safe, secure environment over a short period of time	D	RCP3

ASSESSMENT FACILITIES IN THE EMERGENCY DEPARTMENT

5.6	There should be a designated private room that can be used for assessments	E	RCP1
5.7	The assessment room should be close to, or part of, the main department's receiving area	E	RCP1
5.8	The door to the assessment room must open both ways and must not be lockable from the inside	E	RCP1
5.9	There should be a telephone with access to an outside line	E	RCP1
5.10	There should be a 'panic button', with connection to staff nearby, or another suitable security system	E	RCP1
5.11	The assessment room should have comfortable seats	D	GPP
5.12	There should be access to tissues	D	GPP
5.13	Furniture and fittings should be selected so that they are not likely to be used to cause harm to the individual	E	RCP1
5.14	All psychosocial self-harm assessments should take place in such a room unless it is inappropriate (for example, if the service user feels unable to be interviewed in that setting or if a patient is threatening and abusive)	E	RCP1

2. TRIAGE, PRELIMINARY AND SPECIALIST PSYCHOSOCIAL ASSESSMENTS

FOR ALL ASSESSMENTS

6. Staff should make efforts to ensure that service users have the opportunity to be fully engaged in the assessment process (Healthcare Commission C17)

6.1	Assessment should be conducted in a respectful and supportive manner, with the individual's views taken into account throughout	E	NICE
6.2	When assessing people, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words	E	NICE
6.3	Wherever possible, service users and the assessor should both read through the written assessment to mutually agree the assessment	D	NICE
6.4	Agreement regarding the assessment should be written into the service user's notes	D	NICE
6.5	Where there is significant disagreement over the assessment, the service user should be offered the opportunity to write his or her disagreement in the notes	D	NICE
6.6	A copy of the assessment should be given to the service user	D	GPP

7. Issues of mental capacity and mental ill health in the assessment and treatment of people who self-harm should be understood and addressed by all healthcare professionals (Healthcare Commission C7c) For a detailed algorithm see page 43

7.1	In the assessment and treatment of people who have self-harmed, mental capacity should be assumed unless there is evidence to the contrary	E	NICE
7.2	If a person wishes to leave before psychosocial assessment has been undertaken, assessment of mental capacity and the presence of mental health problems should be undertaken before the person leaves the service	E	NICE
7.3	People who wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental health problem is established, should be referred for urgent mental health assessment	E	NICE
7.4	Appropriate measures should be taken to prevent people who wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental health problem is established, from leaving the service	E	NICE
7.5	When a person has the capacity to discharge themselves against medical advice, staff should make efforts to point out any alternative care available (e.g. secondary mental health services, crisis teams)	E	IMH1
7.6	When a person <u>with capacity</u> self-discharges, staff should inform the care co-ordinator (where there is one) and ask them to contact the service user within 24 hours	E	GPP

7.7	When a person <u>lacking</u> in mental capacity is actively opposed to the course of action favoured by staff, the benefits which it holds for the person should be carefully weighed against the disadvantages of going against his or her wishes	E	NICE
7.8	The use of force or restraint should always be a last resort, when all other negotiation has been exhausted. Force or restraint should only be used when immediately necessary and should always be the minimum possible in the circumstances	E	RCP2
7.9	If restraint or detention is employed, efforts should be made to explain to the service user why this is happening, and to inform them about their rights under the Mental Health Act	E	GPP
7.10	A copy of the assessments of capacity and mental ill health should be recorded in the notes	E	NICE
7.11	The mental capacity assessment should be passed on to the person's GP and to the relevant mental health services as soon as possible, to enable rapid follow-up	E	NICE

INITIAL CONTACT WITH EMERGENCY SERVICES

8. When a person who has self-harmed first comes into contact with services (emergency department or ambulance), a staff member should instantly evaluate immediate risk, including: (Healthcare Commission C7)

8.1	The physical severity of the self-harm	E	RCP1
8.2	Is there obvious severe distress?	E	RCP1
8.3	Is the person actively suicidal?	E	RCP1
8.4	Is there a risk that the person will leave before assessment and treatment is provided?	E	RCP1

TRIAGE

9. Emergency department staff responsible for triage should take physical and psychological factors into account when making decisions about priority for treatment (Healthcare Commission C7)

9.1	Triage staff should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment	E	NICE
9.2	Where physical and emotional distress co-exist, the highest appropriate triage category based on the combined scores should be applied, as per the Australian Mental Health Triage Scale	E	NICE
9.3	All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm	E	NICE
9.4	Triage should take account of information provided by the ambulance staff if they were involved in conveying the person to hospital	E	DH3

10. During the preliminary assessment, staff should establish:

(Healthcare Commission C7)

10.1	The likely physical risk of the injury	E	RCP1
10.2	Emotional and mental state e.g. depression, hopelessness, distress, and previous or continuing suicidal intent (consider using a tool such as Beck's Suicide Intent Scale)	E	RCP1
10.3	A brief history of the course of any mental health problems (e.g. any diagnoses and intervention encountered so far)	E	NICE
10.4	The general physical health of the person who has self-harmed	E	GPP
10.5	Recent major stress	E	GPP
10.6	Alcohol or substance misuse	E	RCP1
10.7	Cultural needs (faith, language etc.)	E	GPP
10.8	Mental capacity	E	NICE
10.9	The person's willingness to stay for further psychosocial assessment	E	NICE

11. All available information should be used in making preliminary assessments. If necessary, emergency department staff should have access to (if the patient consents):

(Healthcare Commission C7)

11.1	The patient's GP	D	DH3
11.2	Community psychiatric nurse	D	DH3
11.3	Information from significant others such as family or friends	D	RCP1

SPECIALIST PSYCHOSOCIAL ASSESSMENT

12. Specialist Psychosocial assessment and treatment should be offered without unacceptable delay

(Healthcare Commission C7)

12.1	Psychosocial assessment should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed, or the patient is unconscious	E	NICE
12.2	Response times should be agreed locally for referrals for mental health assessment. These should be no greater than the response times recommended by the Royal College of Psychiatrists and the British Association for Accident and Emergency (BAEM). These are:	D	RCP1 BAEM
	Urban areas		Rural areas
First line attendance	30 minutes from the time of referral		90 minutes from the time of referral
Section 12-approved doctor attendance	60 minutes from the time of referral		120 minutes from the time of referral

13. A specialist mental health professional should assess the needs of the person who has self-harmed by evaluating: (Healthcare Commission C7)

13.1	The <i>social</i> factors specific to the act of self-harm	E	NICE
13.2	The <i>psychological</i> factors specific to the act of self-harm	E	NICE
13.3	The <i>motivational</i> factors specific to the act of self-harm	E	NICE
13.4	A history of the course of any mental health problems (e.g. any diagnoses and interventions encountered so far)	E	NICE
13.5	Details of any medication being taken	E	NICE
13.6	The general physical health of the person who has self-harmed	E	NICE
13.7	Family history (both physical and psychological)	E	NICE
13.8	Family/social network	E	NICE
13.9	Home environment	E	NICE
13.10	Employment status	E	NICE
13.11	Recent major stress	E	NICE
13.12	Alcohol or substance misuse	E	NICE

14. A specialist mental health professional should assess the person who has self-harmed for risk by evaluating: (Healthcare Commission C7c)

14.1	Current emotional and mental state	E	NICE
14.2	Previous suicidal intent	E	NICE
14.3	<i>Current</i> suicidal intent, hopelessness and depression	E	NICE

15. Standardised risk assessment tools should be used appropriately

(Healthcare Commission C7c)

15.1	If a standardised risk assessment scale is used to assess risk, this should be used only to aid in the identification of people at high risk of repetition of self-harm or suicide	D	NICE
15.2	Standardised risk-assessment scales should <i>not</i> be used as a means of identifying service users at supposedly low risk who are then not offered services	E	NICE
15.3	Consideration should be given to combining the assessment of risks into a needs assessment framework to produce a single integrated psychosocial assessment process	D	NICE
15.4	Service users should also be asked to rate their own level of risk and asked what might help them feel more safe	E	GPP

16. Professionals should maintain accurate and informative notes on the assessment

(Healthcare Commission C7c)

16.1	The assessment of risk should be written clearly in the service user's notes	E	NICE
16.2	The assessment of needs should be written clearly in the service user's notes	E	NICE

17. Professionals should share notes on the assessment with other relevant agencies where appropriate (Healthcare Commission C7c)

17.1	The assessment should be passed on to the patient's GP and to any relevant mental health services as soon as possible to enable follow-up	E	NICE
17.2	The assessment should be passed on to the relevant mental health services promptly to enable rapid follow-up	E	NICE
17.3	Service users should be told where the assessment notes are being sent and what will happen next	E	GPP

3. REFERRAL AND AFTERCARE

18. The psychosocial assessment should inform any decisions made about any referrals to future care (Healthcare Commission C7, C18)

18.1	Referral for further assessment and treatment should be based upon the combined assessment of needs and risk	E	NICE
18.2	The decision to discharge a person <u>without</u> follow-up following an act of self-harm should be based upon the combined assessment of needs and risk	E	NICE
18.3	The decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the <u>presence of low risk and the absence of a mental illness</u>	E	NICE
18.4	Social and personal factors that may later increase risk should be considered when making decisions about follow-up	E	NICE

19. The decision to refer or to discharge the patient should be taken jointly by the service user and the healthcare professional whenever this is possible

(Healthcare Commission C13, C17)

19.1	Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, in a spirit of collaboration, before treatments are offered	E	NICE
19.2	Service users should be encouraged to express their needs and preferences	E	SKH
19.3	Service users should be encouraged to draw up a realistic and achievable plan for accessing and using services	D	SKH
19.4	Service users should be encouraged to draw up a list of people and resources from whom they will seek support	D	SKH
19.5	If the service user is unable to engage with the decision making process, this should be explained to the service user and written in their notes	E	NICE
19.6	'Aftercare sheets' should be given to patients who are being discharged	D	DH1
19.7	The mental health professional making the assessment should inform mental health services (if they are involved already) and the service user's GP, in writing, of the treatment plan within 24 hours	E	NICE GPP

20. Temporary admission, which may need to be overnight, should be considered where necessary, for example:

(Healthcare Commission C19)

20.1	For people who are very distressed	E	NICE
20.2	For people for whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication	E	NICE

20 (continued). Temporary admission, which may need to be overnight, should be considered where necessary, for example: (Healthcare Commission C19)

20.3	For people who may be returning to an unsafe or potentially harmful environment	E	NICE
20.4	When temporary admission occurs, reassessment should be undertaken the following day or at the earliest opportunity thereafter	E	NICE
20.5	Consideration should be given to developing a dedicated unit or general observation/assessment ward attached to the emergency department	D	DH4

21. People who repeatedly self-harm should, where appropriate, be offered advice on the risks of self-harm and advice on minimisation, self-management and coping strategies (Healthcare Commission)

21.1	Staff should consider offering advice and instructions on the self management of superficial injuries, including the provision of tissue adhesive and harm minimisation issues/techniques	D	NICE
21.2	Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss appropriate alternative coping strategies	D	NICE
21.3	Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue	D	NICE
21.4	Where service users are likely to repeat self-poisoning, clinical staff (including pharmacists) may consider discussing the risks of self-poisoning with service users, and carers where appropriate	D	NICE
21.5	Harm minimisation strategies should NOT be offered for people who have self-harmed by poisoning. There are <u>no</u> safe limits in self-poisoning	E	NICE
21.6	If staff are unsure about whether or not to offer advice on self-management, minimisation or coping strategies, they should seek advice from the appropriate mental health worker	E	GPP

22. For people deemed to be at risk of repetition, consideration may be given to offering an intensive therapeutic intervention combined with outreach. The intensive intervention should allow: (Healthcare Commission C18)

22.1	Frequent access to a therapist when needed	E	NICE
22.2	Home treatment when necessary	D	NICE
22.3	Telephone contact	E	NICE

23. Outreach should meet the needs of the patient: (Healthcare Commission C18)

23.1	Staff should actively follow up the service user when an appointment has been missed	E	NICE
23.2	The therapeutic intervention should be agreed with the service user and recorded as part of the care plan	E	GPP
23.3	The duration of the intervention should meet individual needs, but should be set at a minimum of 3 months	D	GPP NICE
23.4	For people who self-harm and have psychological problems, consideration should be given to the use of psychological treatments	E	GPP

4. STAFFING AND TRAINING

24. There should be a sufficient number of skilled and varied staff available

(Healthcare Commission C8 b, C19)

24.1	Services should be staffed according to the relevant agreed guidelines for that organisation or service	E	DH3
24.2	In emergency departments, staffing levels should reflect assessed hourly workloads	D	DH3
24.3	There should be 24-hour access to a psychiatrist or another designated self-harm mental health specialist who is equipped to undertake psychosocial assessment and management	E	RCP1 DH3
24.4	Social services assistance should be available for individuals who have significant social difficulties	D	RCP1
24.5	Approved psychiatric and social workers for Mental Health Act assessments (section 12 doctors and approved social workers) should be explicitly provided and not left to a default on-call adult psychiatry service	E	RCP1
24.6	Staff responsible for assessment should have sufficient time to conduct assessment thoroughly	E	DH3
24.7	In larger emergency departments (more than 70,000 new emergency admissions per annum), there should be a psychiatric/liaison nurse on duty at all times	E	NSF1
24.8	Where possible, emergency department staff should have access to a liaison nurse who has protected time dedicated to conducting assessments	D	DH3
24.9	Where possible, the staff group should reflect the age, gender and ethnicity of the local community	D	GPP

25. All staff who have contact with people who self-harm (including receptionists, domestic, security personnel etc) should be provided with basic training/education in:

(Healthcare Commission C11)

25.1	A basic awareness of mental health	E	GPP
25.2	A basic awareness of risk	E	GPP
25.3	Safety issues relating to the hospital environment (e.g. ensuring that individuals are not isolated for long periods if they are feeling unsafe and staff knowing when to alert colleagues to potential hazards)	E	GPP

26. In addition to the above, all staff involved in immediate emergency contact with people who self-harm should be provided with intermediate training/education in:

(Healthcare Commission C11)

26.1	Assessing mental health needs	E	RCP1
26.2	Assessing risk, hopelessness and suicidal intent	E	RCP1
26.3	Basic understanding of the Mental Health Act and relevant common law	E	RCP1
26.4	Assessing mental capacity	E	GPP
26.5	Understanding why people self-harm (precipitating feelings and functions served) and the difference between self-harm and acts of suicidal intent	E	GPP
26.6	The impact of cultural differences on self-harm	E	GPP
26.7	The basis of the Care Programme Approach (CPA)	D	GPP
26.8	The fact that a service user's initial contact with services and the manner in which that contact is experienced can have a significantly positive or negative impact on that person	E	GPP
26.9	What it means to live with mental health problems and, in particular, self-harm	D	GPP
26.10	Staff involved in the emergency treatment of self-poisoning should be given training in human toxicology, in order to make best use of TOXBASE and the NPIS telephone service	E	NICE
26.11	Ambulance crews should receive regular update training on the management of poisoning	E	NICE

27. In addition to the above, all staff involved in advanced care (e.g. conducting specialist assessments and referrals) should be provided with advanced training in:

(Healthcare Commission C11)

27.1	Assessing the social, psychological and motivational factors specific to the act of self-harm, and the associated needs of the individual	E	GPP
27.2	The use of standardised risk assessment tools	E	GPP
27.3	Emergency department doctors should have sufficient training so that they feel confident in making a mental health assessment and in making a referral	E	RCP3
27.4	Staff involved in making referrals should have a knowledge of local services; e.g. psychiatric services, self-harm support agencies in the voluntary sector, social work services, culturally specific services and crisis intervention services	E	RCP1
27.5	Mental health professionals who are likely to assess children and young people should receive specific training relating to assessing this age group and access to advice from a senior specialist	E	GPP
27.6	Mental health professionals who are likely to assess older adults (over 65 years of age) should receive specific training relating to assessing this age group and access to advice from a senior specialist	E	GPP

28. Training should be planned and delivered in conjunction with all relevant stakeholders
(Healthcare Commission C11)

28.1	People who self-harm should be involved in the planning and delivery of training for staff	E	NICE
28.2	Mental health services, service users and emergency department services should jointly develop regular training programmes in the psychosocial assessment and early management of people who self-harm	D	NICE
28.3	Managers should ensure that continuing training and development for emergency care staff with an interest in mental health takes place; for example, learning sets	D	DH3
28.4	Training should be needs-led, in response to feedback from staff, and incorporating issues raised in appraisals and personal development plans	E	RCP2
28.5	GPs should have ready access to training and advice about the assessment and management of people who self-harm	E	NHS1

29. All staff should have access to the appropriate advice, supervision and support
(Healthcare Commission C5b)

29.1	All staff providing treatment and care for people who have self-harmed should have regular clinical supervision to discuss and understand the emotional impact of working with people who self-harm	E	GPP
29.2	Staff should be able to discuss, with an appropriately qualified person, a specific incident of self-harm that has caused them distress	E	GPP
29.3	Staff should be provided with opportunities for exploring general negative attitudes towards people who self-harm, in a supportive and non-reproachful manner, with an outside facilitator if necessary	D	GPP
29.4	Active policies should be developed to help prevent 'burnout'	D	RCP3
29.5	The psychological effects experienced by staff should be a component of all major incident plans	D	RCP3
29.6	Service providers should work to improve attitudes towards people who self-harm, for example through training aimed at increasing knowledge	E	NHS1

5. SERVICE ORGANISATION AND JOINT WORKING

30. The planning of services should involve all relevant stakeholders

(Healthcare Commission C6, C17)

30.1	Strategic Health Authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm	D	NICE
30.2	Emergency departments, PCTs and local mental health services, in conjunction with local service users and carers wherever possible, should jointly plan the configuration and delivery of integrated physical and mental healthcare services within emergency departments	D	NICE
30.3	In jointly planning an integrated emergency department service for people who self-harm, service managers should consider integrating mental health professionals into the emergency department	D	NICE
30.4	Emergency departments and local mental health services should jointly plan effective liaison psychiatric services, available 24 hours a day	D	NICE

31. Joint protocols should be agreed between the services that treat people who self-harm, including:

(Healthcare Commission C6)

31.1	Rapid response to referrals to the ambulance service by out-of-hours GPs	E	DH3
31.2	Initial assessment by emergency department staff and referral to mental health services	E	DH3
31.3	Referral from the emergency department to the mental health unit, including response times	E	DH3
31.4	A policy regarding the availability of the mental health trust's IT system in the emergency department	D	RCP1
31.5	Protocols allowing acute wards and community mental health teams to deal proactively with potential delays in discharging patients from short-stay units	D	DH3
31.6	Assessment checklists, risk matrices or a pro-forma for telephone referrals from the emergency department to community mental health teams	E	DH3
31.7	A liaison group, with representatives from the emergency department and from mental health services, should review issues of joint working	E	DH3
31.8	Ambulance services should work with other organisations to develop care pathways for patients already known to the service, including service users being taken directly to mental health units, primary care, crisis intervention teams or to social services	D	DH3
31.9	A policy to ensure that TOXBASE is available to all clinical staff involved in the emergency treatment of self-poisoning	E	NICE

32. Staff should be equipped to work across boundaries, for example:

(Healthcare Commission C6)

32.1	Technicians and paramedics working in primary care and in hospitals	D	DH5
32.2	Emergency care practitioners working across pre-hospital, primary and secondary care	D	DH5
32.3	Nurse practitioners working in ambulance services and emergency departments	D	DH5

33. Services should have access to a dedicated self-harm services planning group

(Healthcare Commission C6)

33.1	Large emergency departments (e.g. those with over 70,000 new emergency admissions per year) should have an established self-harm planning group. Smaller departments should have access to a regional planning group	E	RCP1
33.2	It is the responsibility of the acute trust, in liaison with the mental health trust, to set the standards of assessment and care for people who self-harm	E	RCP1
33.3	Staff from accident and emergency, medicine and psychiatry should work together to implement the standards for self-harm services	E	RCP1
33.4	The training and mechanisms for supervision of the self-harm team, or those individuals carrying out self-harm assessments, should be regularly reviewed by the self-harm services planning group or the self-harm services coordinator	D	RCP1
33.5	Ambulance trusts, the emergency department and mental health trusts should work in partnership to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self-harmed, where this is appropriate and does not increase the risks to the service user	D	RCP1

34. Services should audit the treatment of people of who self-harm

(Healthcare Commission C5d, C1a)

34.1	All cases of people with mental health needs who spend longer than four hours in the emergency department should be subject to individual review by both emergency and mental health professionals	D	DH3
34.2	Feedback from service users and carers should be used to inform improvements to the delivery of care and treatment	E	GPP
34.3	NHS trusts responsible for emergency services should undertake regular monitoring of clinical care, including paracetamol overdose	E	HC
34.4	All staff should participate in clinical audits	D	DH5
34.5	Where discharges are delayed for non-clinical reasons, aggregated information should be used to review service provision across the network	D	DH4
34.6	Results of local patient surveys should be used to stimulate patient involvement, e.g. by sharing them with the PALS team, informing A & E PEAT inspections or establishing user forums	D	DH8

6. SPECIAL ISSUES FOR AMBULANCE SERVICES

(See page 40 for more detailed information on medical care provided by ambulance crews)

35. Ambulance staff should collect information and, where appropriate, drug samples from the scene of the emergency call

(Healthcare Commission C6, C13c)

35.1	In cases of self-poisoning, ambulance staff should obtain all substances and/or medications found at the scene of an emergency call, whether thought to be involved in the overdose or not	E	NICE
35.2	All substances and/or medications obtained at the scene should be passed to staff upon arrival at the emergency department	E	NICE
35.3	Unless the service user's clinical condition requires urgent treatment that should not be delayed, ambulance staff should record relevant information about the service user's home environment	D	NICE

36. If emergency treatment is not required, ambulance staff should consider other treatment options

(Healthcare Commission C18c)

36.1	If the service user does not require treatment in the emergency department, ambulance staff should consider taking the service user to an alternative appropriate service, such as a specialist mental health service	D	NICE
36.2	The decision to take the individual to an alternative service should be taken jointly between the ambulance staff, the service user and the receiving service	E	NICE
36.3	If a person with mental capacity declines treatment, or emergency treatment is not required, this should be recorded in the patient report	E	JRC1

37. When transporting people who have self-harmed to an emergency department, the service user's views, confidentiality and rights should be taken into account wherever possible

(Healthcare Commission C18c, c20b, c13b)

37.1	Where possible, ambulance staff should take into account the service user's preferences when more than one emergency department facility exists within a reasonable distance, unless doing so significantly increases the risk to the service user, or when one department specialises in the treatment of people who have self-harmed	D	NICE
37.2	An individual's personal details or any information about their condition or injuries must not be revealed to the press or a member of the public	E	JRC1
37.3	Before passing confidential information over the air, the radio channel should be secured wherever possible	E	JRC1
37.4	Patient report forms are strictly confidential and should not be left lying around in the vehicles, ambulance stations, standby points or in hospital	E	JRC1

38. Ambulance staff should have access to advice and information at all times

(Healthcare Commission C6)

38.1	The ambulance services should ensure that there is rapid access to TOXBASE and the National Poisons Information Service (http://www.npis.org) so that their crew can gain additional information on substances and/or drugs ingested in cases of self-poisoning	E	NICE
38.2	Ambulance staff should have access to telephone advice from crisis resolution teams	D	NICE
38.3	Ambulance staff should have access to telephone advice from approved social workers	D	NICE
38.4	Ambulance staff should have access to telephone advice from approved doctors, regarding the assessment of mental capacity and the possible use of the Mental Health Act in the urgent assessment of people who have self-harmed	E	NICE
38.5	Ambulance trusts should regularly update ambulance staff about any change in local arrangements for services available for the emergency treatment of people who have self-harmed	E	NICE

39. Adequate local support should be available to the ambulance service

(Healthcare Commission C18c)

39.1	Ambulance trusts should agree local response guidelines (comparable to those in emergency departments) when mental health teams are required at a person's home	E	DH3
39.2	Ambulance trusts should ensure that ambulance crews have access to advice about mental ill health in general and, when appropriate, access to advice about individual patients	E	DH3

7. SPECIAL ISSUES FOR PRIMARY CARE

40. The service user's preferred place of treatment should be taken into account and granted where possible (Healthcare Commission C18c)

40.1	When a person who has self-injured expresses a preference for physical treatment in primary care without referral to the emergency department, this should be supported if primary healthcare professionals have the facilities and training to provide appropriate treatment	E	NICE
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41. After assessment in primary care, healthcare professionals should refer the individual to the appropriate service (Healthcare Commission C18, C20)

41.1	If the assessment suggests there is a significant risk to the individual who has self-injured, they must be admitted for urgent treatment in an emergency department	E	NICE
41.2	People who have self-poisoned should be urgently referred to the nearest emergency department	E	NICE
41.3	If there is any doubt about the seriousness of an episode of self-harm, the general practitioner should discuss the case with the nearest emergency department consultant	E	NICE
41.4	Consideration should be given to the service user's welfare during transportation to any referral organisation and, if necessary, this should be supervised by an appropriate person where there is a risk of further self-harm or reluctance to attend other care centres, or the service user is very distressed	E	NICE
41.5	If urgent referral to an emergency department is not considered necessary, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services	E	NICE
41.6	Following assessment and treatment of self-harm in primary care, the outcome of the risk and needs assessment, and full details of the treatment provided, should be forwarded to the appropriate secondary mental health team at the earliest opportunity	E	NICE

42. Healthcare professionals should take into account the risk of deliberate overdose when prescribing drugs (Healthcare Commission C5)

42.1	In service users who are considered at risk of self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose, and should consider prescribing fewer tablets at any one time	D	NICE HC C4
42.2	Consideration should be given to preventing or reducing the prescription of co-proxamol, especially for people who are at risk of self-poisoning	D	NICE
42.3	When prescribing medication to those who live with a person who is considered at risk of self-poisoning, healthcare professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose, and should also consider prescribing fewer tablets at any one time	D	NICE

43. In remote areas with a lack of local, accessible emergency departments, alternative provision should be available (Healthcare Commission C6)

43.1	Where there is no local emergency department or where access is likely to be delayed, consideration should be given to initiating assessment and treatment of self-harm in the primary care setting	E	NICE
43.2	Any treatment given in the primary care setting should follow discussion with the nearest emergency department consultant	D	NICE
43.3	Any treatment for overdose given in the primary care setting should include taking samples to test for paracetamol and other drugs, as indicated in TOXBASE	E	NICE
43.4	Access to TOXBASE should be readily available for primary care teams in remote settings	E	NICE

8. SPECIAL ISSUES FOR CHILDREN AND YOUNG PEOPLE (UNDER 16 YEARS)

(This section will be expanded further in the second edition of these standards)

44. Appropriately trained children's doctors or nurses should be available to ensure that young people who have self harmed are: (Healthcare Commission C5)

44.1	Triaged by appropriately trained children's nurses	D	NICE
44.2	Assessed by appropriately trained children's nurses or doctors	D	NICE
44.3	Treated by appropriately trained children's nurses and doctors	D	NICE

45. Young people should be provided with child-friendly facilities and information (Healthcare Commission C20)

45.1	Young people should be triaged, assessed and treated in a separate children's area of the emergency department	D	NICE
45.2	Written information provided to young people should be written in a child-friendly language	E	RCP2

46. Young people who self-harm should be admitted to an appropriate environment (Healthcare Commission C20)

46.1	Young people who have self-harmed should normally be admitted overnight to a paediatric ward	E	NICE
46.2	Young people should be assessed fully the following day, before discharge or further treatment is initiated	E	NICE
46.3	Alternative placements should be available depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child. This might include a child or adolescent psychiatric inpatient unit where necessary	D	NICE
46.4	For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person	D	NICE
46.5	A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm	D	NICE

47. All assessment and treatment of young people should be conducted with the appropriate consent (Healthcare Commission C13c)

47.1	Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for the mental health assessment of the child or young person	E	NICE
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48. Staff who have emergency contact with young people who have self-harmed should have received training in: (Healthcare Commission C2, C8b)

48.1	Assessing mental capacity in children of different ages and understanding how issues of mental capacity and consent apply to this group	E	NICE
48.1	The concept of Gillick competence	E	NICE
48.2	Child Protection (repeated at least annually)	E	PCH
48.3	Recognition of abuse	E	RCP2
48.4	Confidentiality issues relating to children and young people	E	NICE
48.5	The use of the Mental Health Act in young people	E	NICE
48.6	The Children's Act	E	NICE
48.7	Assessing risk in young people	E	GPP

49. Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should: (Healthcare Commission C6)

49.1	Work specifically with children and young people, and their families, after self-harm	E	NICE
49.2	Have regular supervision	E	NICE
49.3	Have access to consultation with senior colleagues	E	NICE

50. Children and young people admitted to a paediatric ward following self-harm should be assessed appropriately (Healthcare Commission C2, C11)

50.1	All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm	E	NICE
50.2	Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues	E	NICE

51. Young people who have self-harmed (and their carers) should be offered the appropriate advice and treatment (Healthcare Commission C18, C19)

51.1	Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed	E	NICE
51.2	For young people who have self-harmed several times, consideration may be given to offering developmental group psychotherapy with other young people who have repeatedly self-harmed. This should include at least six sessions. Extension of the group therapy may also be offered. The precise length of this should be decided jointly by the clinician and the service user	D	NICE

9. SPECIAL ISSUES FOR OLDER PEOPLE (OVER 65 YEARS)

(This section will be expanded further in the second edition of these standards)

52. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to: (Healthcare Commission C7c)

52.1	The potential presence of depression	E	NICE
52.2	Cognitive impairment	E	NICE
52.3	Physical ill health	E	NICE
52.4	Social situation	E	NICE
52.5	Family/social support	E	NICE
52.6	Accommodation (including type, tenure and suitability)	D	SAP
52.7	Local provisions available in the community to support independent living	D	BGS

53. Professionals should be aware of the risk associated with self-harm in older adults (Healthcare Commission C7c)

53.1	All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults	E	NICE
53.2	Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessments, and time given to monitor changes in mental state and levels of risk	E	NICE
53.3	All older adults who have self-harmed should be assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm	E	NICE
53.4	Where possible, all older adults who have self-harmed should be referred for a specialist old age psychiatry assessment	D	RCP
53.5	Mental health professionals who are not specialists in old age psychiatry but work with this age group, should be provided with <i>supervision</i> from a qualified professional such as a psychiatrist specialising in old age	D	GPP
53.6	Mental health professionals who are not specialists in old age psychiatry but work with this age group should be provided with <i>training</i> regarding self-harm in older people	E	GPP
53.7	Mental health professionals who are not specialists in old age psychiatry but work with this age group should be able to discuss all cases of older people that have self-harmed with a specialist	E	GPP

In all other respects, the assessment and treatment of older adults who have self-harmed should follow the recommendations given for other adults.

APPENDIX 1: PSYCHOLOGICAL, PSYCHOSOCIAL AND PHARMACOLOGICAL INTERVENTIONS

The following is taken from the NICE guideline for the management of people who self-harm, available at www.nice.org.uk

Medical and surgical management of self-harm

Self-poisoning can be treated by reducing absorption, increasing elimination and/or countering the biological effects of the poison, depending upon the nature of the poison and the route of intake. Superficial uncomplicated wounds can be closed with tissue adhesive, whilst more complicated injuries will need surgical assessment and possibly exploration.

General treatment for ingestion

Gastrointestinal decontamination should be considered only for people who have self-harmed by poisoning who present early, are fully conscious with a protected airway, and are at risk of significant harm as a result of poisoning.

When a person who has self-poisoned presents to the emergency department within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, emergency department staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

When a person who has self-poisoned is fully conscious and able to protect his or her own airway, activated charcoal may also be considered between 1 and 2 hours after ingestion, as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

Multiple doses of activated charcoal should not be used in the management of self-poisoning to reduce absorption, or to promote elimination of poisons, unless specifically recommended by TOXBASE or following consultation with the National Poisons Information Service (NPIS).

Emetics, including ipecac (ipecacuanha), should not be used in the management of self-poisoning.

Cathartics as a specific treatment should not be used in the management of self-poisoning.

Gastric lavage should not be used in the management of self-poisoning unless specifically recommended by TOXBASE or following consultation with the NPIS.

Whole bowel irrigation should not be used in the management of self-poisoning, unless specifically recommended by TOXBASE or following consultation with the NPIS.

Collecting samples and interpreting results

Staff involved in the emergency treatment of self-poisoning should collect appropriate samples for analysis; usually this will be a sample of blood, although samples of urine, vomit or sometimes gastric contents may be indicated following discussion with the NPIS. If possible, samples of the suspected poison should also be collected.

Hospital laboratory staff should provide emergency department staff with regular updates about which toxicology tests are available, both locally and at the nearest specialised toxicology laboratory. These should include information on the correct methods of collecting, handling and storing samples, and how samples should be transferred to the laboratory.

Where emergency department staff are unsure about the value of undertaking a toxicology assay or about whether an assay is available locally, advice should be sought from TOXBASE, the local hospital laboratory, a specialised toxicology laboratory or the NPIS.

When emergency department staff are unsure about the interpretation of assay results, advice should be sought from the local hospital laboratory, specialised toxicology laboratory or the NPIS.

Information and laboratory services available to clinicians treating self-poisoning

Emergency department staff should have easy access to TOXBASE, be fully trained in its use, and know how and when to contact the NPIS.

TOXBASE should be available to all clinical staff involved in the emergency treatment of self-poisoning. TOXBASE should be the first point of call for poisons information.

The NPIS telephone number should be permanently and easily available to clinical staff involved in the emergency treatment of self-poisoning. The NPIS should normally be contacted only directly after clinicians have accessed TOXBASE or if there is concern about the severity of poisoning in a particular case.

Clinical staff involved in the emergency treatment of self-poisoning should be given training to better understand human toxicology, in order to make best use of TOXBASE and the NPIS telephone service. Emergency departments, in conjunction with local hospital laboratories or regional toxicology units, or NPIS units, should ensure all staff receive regular training.

In cases where the suspected poison is a substance for which little toxicology data exists, clinical and laboratory data about exposure and absorption should be passed to the NPIS to help in the development of TOXBASE and other poisons information databases.

For further information about the management of overdose with substances covered by this guideline and for the specific management and treatment of overdose with substances not covered in this guideline, clinicians should consult TOXBASE or discuss the individual case with the NPIS.

Paracetamol screening

Plasma paracetamol concentrations should be measured in all conscious patients with a history of paracetamol overdose, or suspected paracetamol overdose, as recommended by TOXBASE. They should also be taken in patients with a presentation consistent with opioid poisoning, and in unconscious patients with a history of collapse where drug overdose is a possible diagnosis. Plasma paracetamol levels should be measured for risk assessment no earlier than 4 hours and no later than 15 hours after ingestion, as results are not reliable outside this time period.

Management of paracetamol overdose

Following gut decontamination with activated charcoal as recommended in this guideline, TOXBASE should be used to guide the further management of paracetamol poisoning. TOXBASE should be easily available to all clinicians treating paracetamol poisoning.

Intravenous acetylcysteine should be considered as the treatment of choice for paracetamol overdose (although the optimum dose is unknown). If acetylcysteine is not available or cannot be used, for example in people who abuse intravenous drugs where intravenous access may be difficult, or for people with needle phobia, then TOXBASE should be consulted. In the event of an anaphylactoid reaction following administration of intravenous acetylcysteine, procedures outlined in TOXBASE should be followed.

In cases of staggered ingestion of paracetamol, the procedures outlined in TOXBASE should be followed in conjunction with discussion with the NPIS.

Flumazenil in benzodiazepine overdose

If poisoning with benzodiazepines is suspected, flumazenil, given cautiously, can help reduce the need for admission to intensive care. Although widely used, flumazenil is not currently licensed for the treatment of benzodiazepine overdose in the UK.

When a positive diagnosis of self-poisoning with a benzodiazepine has been made, the possibility of mixed overdose should be considered, and investigated if necessary, at the earliest opportunity, especially if the patient's clinical progress suggests that he or she may later require admission to intensive care.

In patients who are unconscious or showing marked impairment of consciousness, with evidence of respiratory depression likely to lead to admission to intensive care with endotracheal intubation, and in whom self-poisoning with a benzodiazepine is suspected, flumazenil should be considered as a therapeutic option to avoid intubation and artificial ventilation. The decision to administer flumazenil should be based upon a comprehensive assessment including a full clinical and biochemical assessment of the patient's respiratory status, and his or her ability to protect his or her own airway. Clinicians should, however, avoid the use of flumazenil in: patients who may have ingested proconvulsants, including tricyclic antidepressants; those who have a history of epilepsy; and patients who are dependent upon benzodiazepines.

When using flumazenil in the treatment of benzodiazepine poisoning, clinicians should use small doses, comparable to those used in other contexts, and administer slowly, to avoid the emergence of the more serious adverse reactions associated with the use of flumazenil.

Given the relatively high incidence of adverse psychological events experienced by patients following administration of flumazenil, the minimum effective dose should be used and only for as long as it is clinically necessary.

When using flumazenil in the treatment of benzodiazepine poisoning, care should be taken to ensure that patients who become agitated should be closely monitored and warned of the risk of re-sedation, especially if the patient expresses the desire to leave the treatment setting.

Flumazenil should be used in the treatment of benzodiazepine overdose only when full resuscitation equipment is immediately available.

Only clinicians who have been explicitly trained in the use of flumazenil for the treatment of benzodiazepine poisoning, as described in this guideline, should undertake to administer flumazenil in this context.

Treatment and management of poisoning with salicylates

Following gut decontamination with activated charcoal, where this is indicated by this guideline, the further treatment of self-poisoning with salicylates should follow the current guidance outlined in TOXBASE.

Treatment of opioid overdose

Naloxone should be used in the diagnosis and treatment of opioid overdose associated with impaired consciousness and/or respiratory depression.

The minimum effective dose of naloxone should be used to reverse respiratory depression caused by opioids without causing the patient to become agitated. This is especially important in people who are dependent upon opioids.

When reversing the effects of opioids, especially long-acting opioids such as methadone, the use of an intravenous infusion of naloxone should be considered.

When reversing the effects of opioid overdose using naloxone in people who are dependent upon opioids, naloxone should be given slowly. Preparations should be made to deal with possible withdrawal effects, especially agitation, aggression and violence.

When using naloxone in the treatment of opioid poisoning, regular monitoring of vital signs (including the monitoring of oxygen saturation) should be undertaken routinely until the patient is able to remain conscious with adequate spontaneous respiration unaided by the further administration of naloxone.

Ambulance staff

When a person who has self-poisoned presents to the ambulance service within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, ambulance staff should consider offering activated charcoal at the earliest opportunity. Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

Activated charcoal may also be considered between 1 and 2 hours after ingestion as there is some evidence that activated charcoal may still be effective in reducing absorption, especially if the ingested substance delays gastric emptying, such as tricyclic antidepressants.

Activated charcoal should be offered only when the substance(s) ingested are likely to be adsorbed by activated charcoal and when the person is considered to be at risk of significant harm.

In the emergency treatment of opioid overdose when using intravenous naloxone, ambulance staff should adhere to the guidelines established by the Joint Royal Colleges Ambulance Liaison Committee. Particular attention should be given to the possible need for repeated doses of naloxone and frequent monitoring of vital signs, because the effects of naloxone are short-lived in comparison with the effects of most opioids and service users frequently relapse once the effect of naloxone has worn off. All people who have overdosed with opioids should be conveyed to hospital, even if the initial response to naloxone has been good.

When a person who has self-poisoned presents to the ambulance service within 1 hour of ingestion and is fully conscious and able to protect his or her own airway, ambulance staff should consider offering activated charcoal at the earliest opportunity

General treatment for self-injury

The treatment of self-injury should be the same as for any other injury, although the level of distress should be taken into account, and therefore delays should be avoided. Tissue adhesive is effective and simple to use for small superficial wounds.

In the treatment and management of injuries caused by self-cutting, appropriate physical treatments should be provided without unnecessary delay irrespective of the cause of the injury.

In the treatment and management of people with self-inflicted injuries, clinicians should take full account of the distress and emotional disturbance experienced by people who self-harm additional to the injury itself, in particular, immediately following injury and at presentation for treatment.

In the treatment and management of superficial uncomplicated injuries of greater than 5 cm in length, or deeper injuries of any length, wound assessment and exploration, in conjunction with a full discussion of preferences with the service user, should determine the appropriate physical treatment provided.

Superficial wound closure

In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, the use of tissue adhesive should be offered as a first-line treatment option.

In the treatment and management of superficial uncomplicated injuries of 5 cm or less in length, if the service user expresses a preference for the use of skin closure strips, this should be offered as an effective alternative to tissue adhesive.

APPENDIX 2: CONSENT AND CAPACITY

The following guidance is taken directly from the NICE guideline

Staff often face difficult decisions about whether they should intervene to provide treatment and care to a person who has self-harmed and then refuses help. This might happen when a person refuses to be conveyed to an emergency department by ambulance, indicates a wish to leave an emergency department before a full assessment has been made or refuses treatment for the physical effects of self-harm. Not only are these decisions difficult but they can provoke disagreements between staff who may interpret differently the legal framework that underpins them (Hassan *et al.*, 1999a and 1999b). The Department of Health's *Reference Guide to Consent for Examination or Treatment* has helped to clarify the issues involved (Department of Health, 2001a).

This guideline cannot offer specific advice about every possible scenario, but can give general guidance that, if applied, should allow staff to reach a decision that ensures both that the best interests of the patient are served and that the actions of staff are defensible if subsequently challenged. Flowchart 1 shows an algorithm intended to support decision-making about treatment for the physical effects of self-harm.

Mental capacity

Except in situations where mental health legislation applies, the concept of **mental capacity** is central to determining whether treatment and care can be given to a person who refuses it. The starting point for decision-making is the presumption that a person has capacity. For the person's wishes to be overridden, there must be evidence that some impairment or disturbance of mental functioning renders the person unable to make an informed decision whether to accept or refuse the treatment that is being offered.

In order to demonstrate capacity to give or withhold consent for medical treatment, an individual should be able to:

- Understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed
- Understand its principal benefits, risks and alternatives
- Understand in broad terms what will be the consequences of not receiving the proposed treatment
- Retain the information for long enough to make an effective decision
- Believe the information
- Weigh the information in the balance
- Make a free choice (i.e. uncoerced).

Testing for capacity

A test of capacity requires that the person has received sufficient information about the specific treatment being offered, in a form that he/she could be expected to understand. This would also include information about the seriousness and nature of the problems associated with the episode of self-harm and the consequences of not being treated.

The giving of information, and attempts to obtain consent, should be repeated and continue throughout the process of assessment and treatment. It is important that a person is not judged to be incapable of making a decision simply because they have communication difficulties. Communication support should be offered if needed.

Factors that can affect capacity

A person may be mentally incapable of making the decision in question either because of a long-term mental disability or because of temporary factors such as unconsciousness, confusion or the effects of fatigue, shock, pain, anxiety, anger, alcohol or drugs or drug withdrawal. When possible, attempts should be made to enhance capacity by, for example, pain management.

If the mental capacity of a person who has self-harmed has been impaired by the effects of alcohol or drugs, or by that person's emotional distress, staff must be satisfied that these temporary factors are operating to such a degree that the assumption of mental capacity is overridden. In such a case, where incapacity is temporary, staff should decide whether it is safe to defer treatment decisions until capacity is regained.

If a person appears to be calm but refuses potentially life-saving treatment, or expresses the wish to die by suicide, the assumption of capacity could be rebutted by evidence that the person does not truly comprehend the consequences of his or her decision, that the person is acting under the undue influence of another, that the person's emotional distress associated with the stated reason for wishing to be dead is impairing his or her judgment, or that the person's behaviour shows that he or she is deeply ambivalent about the decision (for example if the person initially sought help for the effects of the self-harm).

Assessments of capacity are 'functional'

It may not be a question of capacity or no capacity. It may be a case of reduced capacity. Assessments of capacity are 'functional', that is they are related to the individual decision that needs to be made. The graver or more serious the decision, the higher the level of capacity required. Refusals of treatment can vary in importance. Some may involve a risk to life or of irreparable damage to health; others may not. What matters is whether, at that time, the patient's capacity is reduced below the level needed in a case of refusal of that importance. If there is uncertainty as to the consequences of the act of self-harm, then it should be assumed that the consequences will be serious.

What should be done if a person who has self-harmed lacks capacity?

If a person is mentally capable of making the decision, then his or her decision about whether to receive treatment or care must be respected; even if a refusal may risk permanent injury to that person's health or even lead to premature death (unless he or she is mentally disordered and can be treated under the Mental Health Act – see below).

If a person is assessed as being mentally incapable, the common law doctrine of necessity will apply and staff must act in the person's best interests in a manner that is consistent with good medical practice. The doctrine of necessity could provide authority for healthcare workers to intervene, even if the person does not wish to comply. This might include ambulance staff conveying the person to hospital, emergency department staff detaining him or her for the purposes of medical assessment or medical staff administering treatment. When a mentally incapacitated person is actively opposed to the course of action favoured by

staff, the benefits which it holds for the person will have to be carefully weighed against the disadvantages of going against his or her wishes, especially if force is required to do this. The use of force or restraint should be a matter of last resort, should be used only when immediately necessary and should always be the minimum possible in the circumstances.

Advance directives

Valid advance directives are binding under common law and there are plans to put them on a statutory footing in the forthcoming capacity legislation. A valid advance refusal of treatment should be respected regardless of the consequences for the person concerned.

However, for people who self-harm, it is often difficult to decide the validity of such advance directives. In an emergency, if a person lacks capacity and there is any doubt, staff should take whatever steps are necessary to prevent deterioration of the person's condition while the validity of the advance refusal of treatment is assessed. A person who has self-harmed might have made a broader advance statement about preferred treatment options, perhaps carried in the form of a 'crisis card'. Although such advance statements are not legally binding on the treating clinician, they should be taken into account.

Under the common law, an advance refusal of treatment is valid if:

- The patient is an adult and was competent when the directive was made, and
- The patient has been offered sufficient accurate information to make an informed decision, and
- The circumstances that have arisen were those envisaged by the patient, and
- The patient was not subject to any undue influence in making the decision, and
- The patient has not subsequently changed his/her mind or done anything to indicate that he/she disagrees with the terms of the advance directive.

Who should assess capacity?

The health professional carrying out the treatment or care intervention has the legal responsibility to obtain informed consent. He or she is also best placed to assess capacity because he or she has the clearest understanding of what is involved and can best present the proposed intervention in the clearest terms. For this reason, all staff who have emergency contact with people who have self-harmed should understand the test of capacity and know how to apply it. In particularly complex cases, it may be necessary to request an opinion from a specialist, such as a psychiatrist who has expertise in assessing capacity and who is independent of the treating team. Staff should also have ready access to legal advice at all times.

The role of the Mental Health Act

The fact that a person has a mental disorder is not sufficient to override the assumption of mental capacity. However, a mentally capable person who suffers from a mental disorder could be detained under the Mental Health Act if the relevant criteria under that Act are satisfied. The Court of Appeal has held that the compulsory treatment for the mental disorder of a person who has been detained under Section 2 or 3 of the Act can involve treatment for the consequences of the mental disorder and for the symptoms of the disorder (*B. v. Croydon Health Authority* [1995] 1 All ER 683). In this case, one of the judges ruled that ‘it would seem strange to me if a hospital could, without the patient’s consent, give him treatment directed at alleviating a ... disorder showing itself in suicidal tendencies, but not without such consent be able to treat the consequences of a suicide attempt. In my judgment the term “medical treatment for mental disorder” in s.63 includes such ancillary acts’ (*ibid.*, pp. 686–7). Therefore, although it is not a common occurrence, compulsory treatment can include medical and surgical treatment for the physical effects of self-harm if the self-harm can be categorised as either the consequence of or a symptom of the patient’s mental disorder. If, in a particular case, staff are in doubt about the extent of treatment permissible under the Mental Health Act, they should consider seeking legal advice and, when necessary, a court ruling.

Intoxication

If a person who has self-harmed is incapable through drink (or drugs or any other cause), and staff believe there is a real risk that they will come to harm, staff should stop them if they attempt to leave the emergency department or treatment setting. Intoxication alone cannot be grounds for making an application under the Mental Health Act. Furthermore, it is often difficult to make a proper Mental Health Act assessment if a person is intoxicated. In this situation, necessary treatment and care can be given under the common law on the grounds that the person is mentally incapacitated. This will include holding a person who is incapable in the emergency department until a Mental Health Act assessment can proceed once their mental abilities are no longer impaired by alcohol or drugs.

Young people

This section contains only a brief introduction to consent in young people. Fuller guidance, for both staff and young people, is available from the Department of Health (www.doh.gov.uk/consent). Although staff who have contact with young people who self-harm should understand issues relating to capacity and consent in young people, including the role of the Mental Health Act and Children Act, they should always seek expert advice in difficult or complex situations unless they have to act immediately to save life.

Consent

Mentally capable young people aged 16 and 17 have the same right to consent to medical treatment as adults. A child under the age of 16 has a right to consent to treatment if he or she is assessed as being mentally competent (‘Gillick competence’). The refusal of a competent young person, under the age of 18, to receive treatment or to enter hospital, can be overridden by a person or body that has parental responsibility. However, this power to overrule a competent young person’s refusal should be used only in exceptional cases. If a young person under the age of 18 lacks mental capacity, the consent of a person or body that has parental responsibility for that child should be obtained before treatment is given. However, if it is not possible to contact a person with parental responsibility, emergency treatment can be given if it is in the young person’s best interests. Those with parental responsibility should be informed as soon as possible.

In cases where there is disagreement between parents and doctors, every attempt must be made to resolve this and, if unsuccessful, legal advice should be sought. The court’s decision is determinative. Only in exceptional cases, where the doctor believes the treatment to be vital to the survival or health of a child, can emergency treatment be given in the face of parental opposition. It is good practice to encourage competent young people to involve their

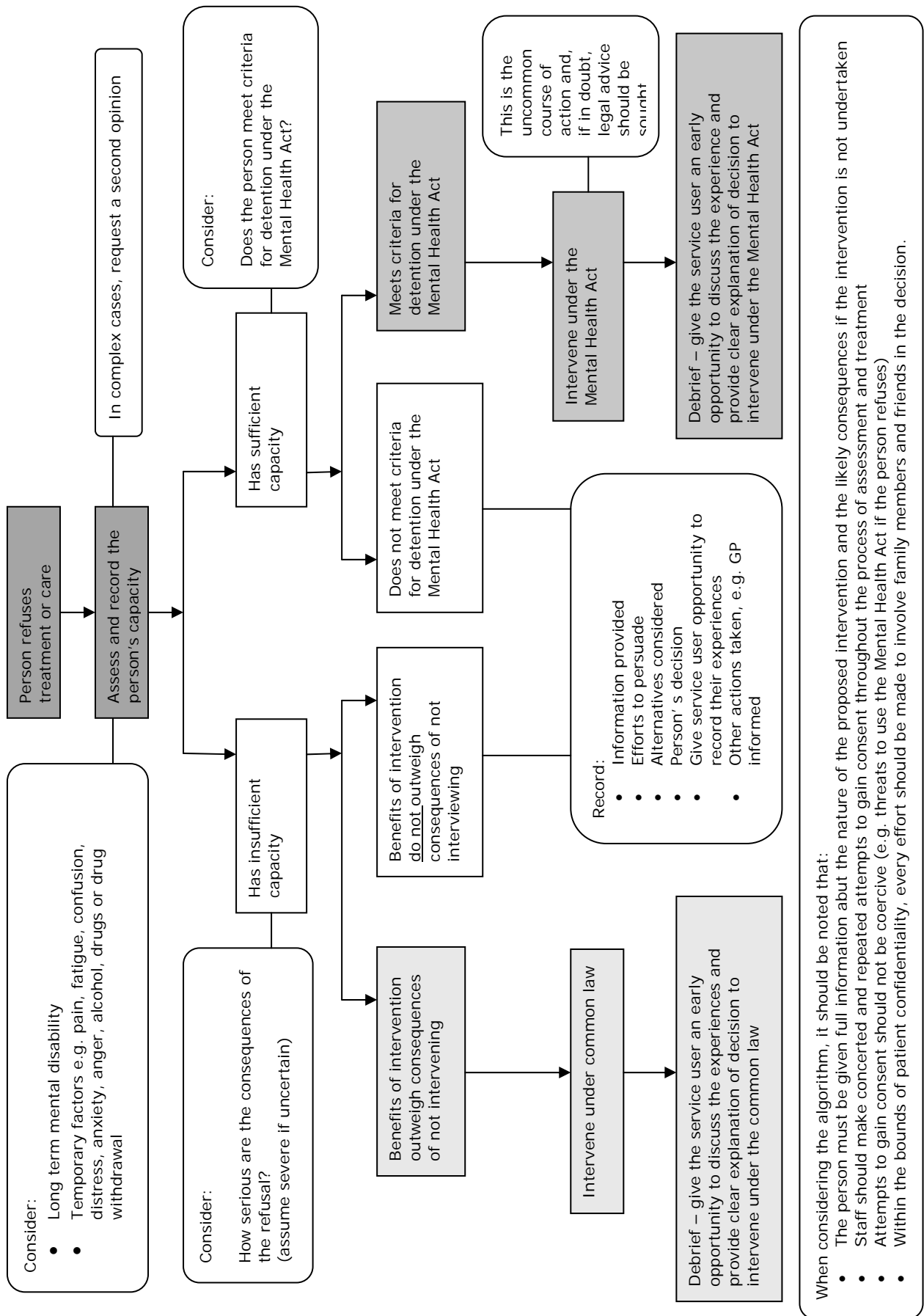
families in decision-making. However, if such a young person does not wish this, disclosure can be justified if it is decided that the young person is suffering, or is likely to suffer, significant harm.

Putting these principles into practice

Flowchart 1 shows an algorithm intended to support decision-making. When considering the algorithm, it should be noted that:

- The person must be given full information about the nature of the proposed intervention and the likely consequences if the intervention is not undertaken
- Staff should make concerted and repeated attempts to gain consent throughout the process of assessment and treatment
- Attempts to gain consent should not be coercive (e.g. threats to use the Mental Health Act if the person refuses)
- Within the bounds of confidentiality, every effort should be made to involve family members and friends in the decision. If staff are refused permission to interview a third party who might have important information, they must decide whether the risk to life is such that they should override that refusal
- Staff should consider carefully the content of any crisis card or advance directive when deciding when and how to intervene
- Staff should carefully record their actions and the reasons for them

Flowchart 1. Algorithm to support decision-making in the event of a person refusing treatment for the physical effects of self-harm (NICE)



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