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1. Introduction

Staff working in mental health services may come into contact and need to care for people who have self-harmed. Self-harm is a broad term and people may injure or poison themselves by scratching, cutting or burning their skin, by hitting themselves against objects, taking a drug overdose, or swallowing or putting other things inside themselves. It may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs.

Self-harm is poorly understood, even among those working with service users who harm themselves.

Self-harm is defined by 'MIND'¹:

“Self–harm is a way of expressing very deep distress. Often, people don’t know why they self-harm. It’s a means of communicating what can’t be put into words or even into thoughts and has been described as an inner scream. Afterwards, people feel better able to cope with life again, for a while.”

2. Aims and objectives

2.1 The National Institute for Clinical Excellence published a guideline for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed². The recommendations are summarised as follows:

- People who self-harm need to be treated with the respect and understanding given to others who use the health service, taking account of their physical and emotional distress; their needs for support and information; and their right to be properly involved in clinical decision-making.

- Clinical and non-clinical staff who have contact with people who self-harm should be provided with appropriate training.

- Ambulance and emergency department services should ensure that activated charcoal is available.

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage which should determine a person’s mental capacity, their willingness to remain for further (psychosocial assessment), their level of distress and the possible presence of mental illness.

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment. Adequate anaesthesia or analgesia should be offered to individuals who self-harm and require suturing.

¹ Understanding self-harm, for better mental health; MIND, 2010
² The short term physical and psychological management and secondary prevention of self harm in primary and secondary care; NICE Guideline 16; 20
• All people who have self-harmed should be offered an assessment of needs, which should include evaluation of the factors specific to the act of self-harm, current suicidal ideation and hopelessness, as well as a full mental health and social needs assessment.

• Everyone who has self-harmed should have a comprehensive assessment of risk

• All healthcare professionals must be able to understand and assess mental capacity and ensure that someone who has self-harmed is given the opportunity to give properly informed consent before any treatment is initiated

• Referral for further assessment and/or treatment should be based upon a comprehensive assessment

• Following psychosocial assessment, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment.

2.2 The key aims and objectives in the treatment of self-harm should, therefore, include:

• Rapid assessment of physical and psychological need of the service user (triage)

• Effective engagement of service user (and carers where appropriate)

• Effective measures to minimise pain and discomfort

• Timely initiation of treatment, irrespective of the cause of self-harm

• Harm reduction (from injury and treatment; short-term and longer-term)

• Rapid and supportive psychosocial assessment (including risk assessment and comorbidity)

• Prompt referral for further psychological, social and psychiatric assessment and treatment where indicated

• Prompt and effective psychological and psychiatric treatment when necessary

• An integrated and planned approach to the person’s problems

3. Scope of the guidelines

These guidelines apply to all staff working with service users in the Trust.
4. Duties and responsibilities

4.1 The Chief Executive

It is the responsibility of the Chief Executive through the Director of Nursing and People to:

- Promote the aims and objectives of these guidelines.
- Provide resources for putting the guidelines into practice.
- When there is an incident involving the use of CPR for requesting that it is investigated and recommendations made under the Serious Incident Policy.

4.2 Matrons, Ward Managers, Team Leaders and Heads of Services

Matrons, Ward Managers, Team Leaders and Heads of Services are responsible for the implementation of the Self-harm Guidelines in their service area and must ensure that:

- The staff they manage read and understand the Self-harm Guidelines.
- Ensure incident forms are correctly completed and submitted after each self harm/suicide attempt incident.
- Ensure the staff they manage receive supervision which includes support when they have worked with service users who have self-harmed.
- Highlight the need for staff to attend training on self-harms, and ensure that they do.
- Ensure that audits on self-harm/suicide attempts and the implementation of these guidelines are carried out in a timely fashion.

4.3 All staff working with service users

That all staff working with service users who self harm:

- Are able to manage an emergency incident of serious self harm by a service user.
- Have received training to assess mental capacity and to make decisions about when treatment and care can be given without consent.
- Make all efforts necessary to allow someone who has self-harmed the opportunity to give meaningful and informed consent, whilst understanding when and how the Mental Health Act can be used to treat the physical consequences of self-harm.
- Are able to carry out a full risk assessment, devise a care and crisis plan, to meet the specific care needs of the service user.
- Provide regular 1:1 sessions with service users who are at risk of self-harming.
- Receive supervision which includes support when they have worked with service users who self-harm and are given the opportunity to reflect on the impact of this.
5. Definitions

- **Self-harm**: Self-harm is a broad term. People may injure or poison themselves by scratching, cutting or burning their skin, by hitting themselves against objects, taking a drug overdose, or swallowing or putting other things inside themselves. It may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs.

- **Suicide attempt**: an attempt to end one’s life, although the distinction between the two acts may not always be clear cut. For example, a person might take an overdose of prescribed medication to get some sleep or respite from current problems, but not be too bothered if they wake up. They don't plan to kill themselves, but they're too tired to think through the consequences.

Both self-harm and attempted suicide demonstrate that the service user is suffering emotional distress. It is vital that all emotional distress is taken seriously to minimise the chances of self-injury, and suicide. All talk of suicide and warning signs must be taken extremely seriously.

6. The nature of self harm

The methods of self-harm can be divided into two broad groups:

- self-poisoning
- self-injury

Self-poisoning usually involves an overdose of prescribed or over-the-counter medication. A small additional percentage will have intentionally taken a dangerously large amount of an illicit drug or have poisoned themselves with some other substance.

Self-injury is more common than self-poisoning in the population as a whole, perhaps by a ratio of 2:1 in teenagers. Cutting is by far the most common means. Less common methods include burning, hanging, stabbing, swallowing objects, insertion, shooting and jumping from heights or in front of vehicles.

- Self-harm is more common in females than males.
- Rates are highest in young people, especially teenage females and young adult males, two-thirds of patients are under 35 years of age.
- Rates are higher in lower socio-economic groups, the unemployed and those with long-term health problems.
- Repetition of self-harm is common. At least half of self-harm patients have a history of a prior episode; 15-25% will repeat self-harm within a year. Some individuals carry out a large number of self-harm acts.
- The risk of suicide is approximately 1% in the year after a self-harm episode. 40-60% of suicides have a history of self-harm, with 20-25% having an episode of self-harm in the year before death. The risk of suicide for men increases to 10% fifteen years after a single self-harm episode.
- Patients who have self-harmed and who are of no fixed abode are twice at risk of probable suicide as domiciled patients.

**Assessment and treatment for people who self harm**

7. **The Emergency Department (ED)**

The emergency department provides the main services for people who self-harm. Emergency department staff should assess risk and emotional, mental and physical state quickly, and try to encourage people to stay to organise psychosocial assessment.

7.1 **Under 18s**

A child under the age of 18 presenting to the Emergency Department (ED) following an act of self-harm must be referred to the duty Paediatric team. If under the age of 18, they will then be admitted to a teenage ward for further treatment and psychosocial assessment. The psychosocial assessment should be carried out by the Child & Adolescent Mental Health Service (CAMHS) although the Mental Health Liaison Team (MHLT) may be called upon to assess the child in an emergency. If an initial psychiatric assessment is required in the ED before the child is transferred to a medical ward, this should usually be carried out by CAMHS staff. Out of hours, the MHLT duty psychiatrist may be asked to carry out this initial assessment by the on-call CAMHS Specialist Registrar if it is not practical for them to attend. The outcome of an assessment on a child under the age of 18 should always be discussed with CAMHS staff that should make the final decision about disposal and further intervention.

7.2 **Section 136**

The majority of patients brought to the ED by the Police under section 136 of the Mental Health Act will not have self-harmed. In the case of those who have self-harmed, careful assessment is required in order to avoid missing significant self-injury which may have gone unnoticed (e.g. the patient who sustained a minor injury whilst dodging in and out of traffic but has also taken a large overdose). It is important that such patients receive the same standard of medical care as other self-harm patients.

7.3 **Risk Assessment**

All medical and nursing staff with responsibility for the care of self-harm patients should be able to carry out a rapid appraisal of risk. This is because:

- Patients may refuse to see the MHLT or leave abruptly before a full assessment can be undertaken.
- Patients who leave the ED before they receive a psychosocial assessment may be at greater likelihood of repetition of self-harm than those who are assessed\(^3\).

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- Even if patients are admitted for observation to a medical ward, they may decide to leave before the MHLT can assess them.
- Emotional status can fluctuate dramatically following self-harm, and the risk of further self-harm can change.

The objectives of this assessment are to detect immediate suicide risk, identify severe mental illness, and determine whether patients who are refusing treatment or trying to leave the hospital have capacity to decline help. It is essential that when a patient leaves the hospital without either a medical or psychosocial assessment this is rapidly communicated to their GP.

It is advisable to see the patient in a setting that ensures privacy and dignity, and sufficient time should be allowed to make a careful assessment. The interview can start by asking general questions about how the patient is feeling; in particular whether they are feeling low. In relation to the risk of suicide, the key areas of enquiry include:

- The seriousness of intent involved in the self-harm act (e.g. what was going through the patient’s mind when they took the tablets and whether they wanted to die)
- The patient’s view of the survival, if there was suicidal intent (e.g. how they feel still to be alive and whether they have any regrets they didn’t succeed)
- The patient’s current suicidal status (e.g. whether they still have any thoughts of harming themselves and whether they are likely to act upon them)

If there is any evidence from this assessment that the patient wanted to die or that suicidal ideas are still prominent, it is important to try to persuade the patient to stay for further medical treatment and a psychosocial assessment. If this is refused, it will be necessary to assess the patient’s capacity to refuse treatment.

### 7.4 Triage Assessment

The aim of triage assessment for a patient who has self-harmed is to determine the following:

- The nature and severity of the self-harm act
- Whether the patient is willing to accept treatment
- Whether the patient is agitated and distressed
- Suicidal ideation and intent, taking into account what any person accompanying the patient says.
- Whether the patient is so disturbed that they cannot sit in the waiting area even if accompanied
- Whether the patient is a risk to others
- Whether the patient is likely to leave if not observed
- Whether the patient has a history of mental illness
- Whether the patient has any other physical health issues

The triage nurse should record their assessment of risk in the patient’s ED notes, along with the level of observation required. If there are concerns about the risks posed by the patient, an initial psychiatric assessment can be requested from the MHLT. The MHLT will in turn discuss their assessment of risk with the nurse in charge of the ED and the patient’s named nurse. If a patient who has self-harmed is brought to the ED by the Police under section 136 of the Mental Health Act, they will require a parallel assessment from both ED medical staff and the MHLT.
7.5 Initial Psychiatric Assessment

Patients who present at the ED having self-harmed present a particular challenge to staff as they are often emotionally aroused, may have difficulty communicating and may also exhibit varying degrees of compliance with assessment and recommended treatment. Early involvement of the MHLT may be desirable to help with the management of the self-harm patient or in assessing risk during their time in the ED or when being transferred to a medical ward. An initial psychiatric assessment may be particularly useful in determining whether a patient’s mental state affects their capacity to refuse treatment.

7.6 Parallel Assessment

A parallel assessment may be carried out in the Emergency department – an assessment of a patient’s mental health which takes place while a patient is still being medically assessed, i.e. before they are ‘medically fit’. An example of the practice followed at the Whittington Hospital is included at Appendix 3.

7.7 Specialling

Following the triage assessment and/or initial psychiatric assessment, arrangements may be made to secure a Registered Mental Health Nurse (RMN), Health Care Assistant (HCA) or Registered General Nurse (RGN) to remain with the patient (‘specialling’) if this is felt to be appropriate. The funding of this rests with the acute service and the RMN/HCA/RGN is responsible to the nurse in charge of the ED. Any decision to either upgrade or downgrade the category or frequency of observation should be recorded in the ED notes.

Specialling in the ED or on a medical ward would be one of the following two types:

- Within eye-sight at all times
- Within arms-length at all times

In both cases, it is important to specify whether the RMN/HCA/RGN should accompany the patient to the toilet. If a patient has to be actually accompanied into the toilet, this is total observation.

When the RMN/RGN/HCA arrives, they should be given a copy of the Agency Nurse Orientation File (kept in the Mental Health Policy file) to enable the nurse to familiarise themselves with their expected role and responsibilities. A verbal hand-over should be given to the nurse by the patient’s named nurse or MHLT staff and the nurse should sign an agreement that they understand their role and responsibilities. The nurse should read the Close/Total Observations Policy before taking over this task.

7.8 Medical Assessment

It is important that every patient who has self-harmed receives a medical assessment. This includes patients detained under section 136 of the Mental Health Act if they are thought to have self-harmed. Areas to be covered in the medical assessment might include the following:

- Circumstances and antecedents of the self-harm act
- Further risk assessment
- Brief medical history
- Prescribed and non-prescribed medication
- Use of alcohol or drugs
- **Physical examination**
- Brief mental state examination, including cognitive state
- Relevant blood tests, including paracetamol and salicylate levels four hours after ingestion for any drug overdose
- Evaluation of capacity if treatment refused

N.B. Intoxication with alcohol or drugs may complicate the medical assessment of someone who has self-harmed, particularly if the patient is unable to give a coherent history or is not cooperative. Symptoms suggestive of psychiatric disorder may be wholly attributable to the intoxication. An initial psychiatric assessment may be requested from the MHLT but a full psychosocial assessment can only be completed when the patient is no longer under the influence of the ingested substance. In this event, it may be necessary to refer the patient to the Duty Medical Registrar (DMR) for admission until the patient is sober. The MHLT must document the time that they will return to see the patient and advise an RMN/HCA/RGN to remain with the patient until an assessment can take place.

7.9 **Psychosocial Assessment**

Psychosocial assessment should be conducted after the patient has fully recovered from any toxic effects of self-harm and there are no outstanding questions about the patient’s physical health. Staff conducting the assessment should be adequately trained in the procedure. They should also have access to senior psychiatric advice and supervision if they feel this is necessary. The assessment should be conducted in a private setting where other patients cannot overhear what is being said. Gathering information should include interviewing relatives or other informants plus contacting the GP and any other clinicians already involved in the patient’s care.

Areas that should be covered in the psychosocial assessment are shown below:

- Suicidal intent and immediate risk of repetition
- Evidence of current psychiatric disorder
- Events preceding the act
- Problems facing the patient
- Future plans
- Psychiatric history, including previous self-harm (and its consequences)
- Family and personal history
- Alcohol and drug use
- Coping resources and available supports
- Personality traits and disorder
- Mental state examination
- Most appropriate aftercare and patient’s willingness to accept help

It is important to be aware that a patient’s level of distress or intent can change quickly due, for example, to the response of relatives or friends, or other interventions. Self-harm in the context of a severe or chronic physical illness may sometimes appear to be an ‘understandable’ reaction to the condition and its implications. However, depression (which may be treatable) is often present.

7.10 **Security**

Security guards should remain in the vicinity of the patient if requested to do so by the nurse in charge of the ED who will be advised by the MHLT if a patient is not to leave the ED.
Where the patient poses an immediate and unmanageable threat in the ED, the Nurse in Charge should contact the police on **0300 123 1212**.

### 7.11 The Absconding Patient

If the patient leaves the ED before assessment has been completed, an incident form must be completed (see AWOL Policy). Depending on the level of risk identified (e.g., an untreated, potentially fatal, paracetamol overdose), the patient’s details may be circulated to the police. The patient’s GP should also be informed wherever possible.

It must be clearly documented in the patient’s notes if the level of risk is assessed as ‘low’ and a decision is made not to circulate to the Police. It should be remembered that in the case of voluntary patients who have absconded from the ED, the Police have limited powers.

### 7.12 Treatment Plan

Every self-harm patient seen in the ED should have a treatment plan documented in the ED notes. This should take into account the risk assessment and the medical and psychosocial assessments and priority should be given to the most immediate care needs. In some cases, a self-harm patient may be thought to require psychiatric admission. If the patient resides in Camden or Islington, they should be referred to the appropriate Crisis Resolution Team who will assess them in the ED and then decide whether they are appropriate for home treatment. The MHLT will complete a Core Assessment on every patient seen which will be sent to the patient’s GP and other relevant services.

### 7.13 Outcomes

Various outcomes are possible for a patient who has self-harmed:

- Admission to a medical or surgical bed. The MHLT will advise about observation level and the need for a RMN/RGN/HCA. The MHLT will review the patient daily.

- Discharge home with a plan for follow-up documented following discussion between ED staff and the MHLT, and information passed on to the patient’s GP and relevant community services.

- Admission to a psychiatric bed once the patient is deemed medically fit. At UCLH A&E department, he patient can remain in the Transitional Assessment Facility for up to 12 hours. If there is likely to be a lengthy delay in finding a bed (e.g., if the patient lives outside Camden & Islington), they can be admitted temporarily to a medical bed.

- Discharge to the appropriate Crisis Team (gate keepers of Trust inpatient beds) who will document their assessment and an agreed plan for follow-up in the community or admission to an inpatient bed.

### 7.14 Dependents and safeguarding

In cases where the self-harming patient has dependents, details should automatically be logged in the Paediatric Liaison (Social Services) book located in the A&E department. This should be undertaken by A&E staff, but sometimes information about dependents is overlooked. If there are any urgent concerns, an immediate referral should be made to the
hospital social worker. The patient should normally be informed of any referrals, unless doing so would put others at risk.

8. **Referral to mental health services**

When a person is referred to a Crisis team due to a history of self-harm and a risk of repetition, staff will make an assessment. This is appropriate when:

- levels of distress are rising, high or sustained
- the risk of self-harm is increasing or unresponsive to attempts to help
- the person requests further help from specialist services
- levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

The Crisis team will recommend one of the following:

- Treatment by the crisis team
- Referral to a community mental team
- Referral to an inpatient service

**N.B.** If the person is under 18 years, they will consider referral to CAMHS for assessment.

The service user will be offered a comprehensive assessment of needs and risks as detailed below.

If a patient requires a non-urgent referral to one of the local community teams for longer term support, a referral letter should be sent directly to the relevant team.

8.1 **Assessment of needs:**

- skills, strengths and assets
- coping strategies
- mental health problems or disorders
- physical health problems or disorders
- social circumstances and problems
- psychosocial and occupational functioning, and vulnerabilities
- recent and current life difficulties, including personal and financial problems
- the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
- the needs of any dependent children
8.2 Service users over 65

All people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for working-age adults (above) and in addition:

- pay particular attention to the potential presence of depression, cognitive impairment and physical ill health
- include a full assessment of the person’s social and home situation, including any role they have as a carer, and
- take into account the higher risks of suicide following self-harm in older people.

8.3 Risk assessment

Where a risk assessment indicates that a service user has self harmed the clinician should use the following list as a guide to make a more in depth assessment of the self harm which is relevant to future risks including self harm. When assessing the risk of repetition of self-harm or risk of suicide, staff should identify and agree with the service user the specific risks for them, taking into account:

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

The possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking and whether they have access to family members’, carers’ or significant others’ medications should also be included.

Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

Risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm or to determine who should and should not be offered treatment or who should be
discharged. The risk assessment must be recorded in the risk assessment section of the service user’s Electronic Patient Record.

8.4 Developing an integrated care and risk management plan

The key areas of needs and risks identified in the assessment should be used to develop a care plan and also a risk management plan. This should be in conjunction with the service user and with their agreement family, carers or significant others. Printed copies should be given to the service user and their GP.

When caring for people who repeatedly self-harm, 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.

Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes.

With some service users taking a positive risk-taking approach can be beneficial. This is person centred and focuses on developing the service user’s strengths, and supporting them to take a higher level of control over the situation.

In relation to service users who self harm positive risk taking could involve making a decision not to admit someone to an inpatient ward, or to discharge a service user who has had recent episodes of self harm, because the risks of them being on a ward (e.g. an escalation in their self harming) outweigh the risks posed if they are treated in the community. In these circumstances effective management of the short term risks could lead to longer term gains for the service user.

However due to the potential risks of such an approach any decision to proceed must be based on the service user having the capacity to engage in the agreed plan of care, and a detailed knowledge of:

- The service users past history.
- Their current self harming behaviour.
- The service user’s ability to develop alternative coping mechanisms.

In such cases the multidisciplinary team, service user, and their carers (subject to consent) should be involved in the decision, and in agreement with the plan of care.

All discussion which takes place is to be documented in the clinical records along with the details of who was involved. This also includes documenting any phone discussions which take place.

A detailed care plan is to be in place which includes contingency / crisis plans.

Staff should also encourage service users to use advance directives and crisis planning [Advance Decision and Crisis Plan Policy (Sep 2012)].

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

Care plans should be reviewed with the service user regularly, and revised at agreed intervals (more frequent review is necessary for service users in hospital). The aims of longer-term treatment should also be included in the care plan\(^4\), developed with the service user and multidisciplinary team wherever possible. These aims may be to:

• identify realistic and optimistic long-term goals, including education, employment and occupation
• identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
• identify the roles and responsibilities of any team members and the person who self-harms
• include a jointly prepared risk management plan
• include a crisis plan
• be shared with the person's GP.

➢ **Risk management plans** - A risk management plan should be a clearly identifiable part of the care plan and should:

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

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

Staff should update risk management plans regularly for people who continue to be at risk of further self-harm and after all incidents involving the service user. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.

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Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to the ‘Understanding NICE guidance’ booklets for NICE clinical guideline 16 5.

9. Interventions for self-harm

9.1 Psychological intervention

Staff should consider referral to one of the Trust’s Community Mental Health (Non-psychosis Service) services, which offer a range of a psychological interventions that are specifically structured for people who self-harm, with the aim of reducing self-harm.

9.2 Harm reduction

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

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

9.3 Treating associated mental health conditions

Associated mental health conditions must be treated as described in the appropriate NICE Guideline:

- Alcohol-use disorders (NICE clinical guideline 115)
- Depression (NICE clinical guideline 90)
- Schizophrenia (NICE clinical guideline 82)
- Borderline personality disorder (NICE clinical guideline 78)
- Drug misuse (NICE clinical guideline 51 & 52)
- Bipolar disorder (NICE clinical guideline 38).

When prescribing drugs for associated mental health conditions to people who self-harm, prescribers must take into account the toxicity of the prescribed drugs in overdose. For example, with antidepressants medications SSRIs are less toxic than other classes of antidepressants, (tricyclic antidepressants should not be prescribed, because they are more toxic).

9.4 Self harm and enhanced observation

The use of enhanced observations on inpatient wards, for example ‘within eyesight observation’ may be seen by service users as an invasion of privacy and thus an infringement of Article 8 of the Human Rights Act. In fact this is overridden by the Trust’s

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obligation to protect the right to life (Article 2) and where there is a history of self harm including attempted suicide risk takes precedence over the right to privacy.

On inpatient units the use of enhanced observation with service users who self harm must be used with extreme caution. The routine use of placing clients under within eyesight observation tends to make the person more likely to self injure. The client may be supported in avoiding self injury by helping them with problem solving and other techniques such as distraction (see section 8).

If ‘within eyesight observation’ is used, it should be for the shortest possible time and the staff carrying out the 1:1 should endeavour to engage the service user in meaningful activity.

9.5 Action to take following a serious self harm episode

There may be occasions when a service user makes a very serious self harm act. It is essential that clinicians are able to recognise this and take appropriate emergency action to preserve life:

In the event of a serious act of self harm staff must assess the situation:

- ensure an emergency call is made for an ambulance
- apply appropriate emergency first aid
- ensure an emergency call for the site crash team to attend the ward is made

Calls to the London Ambulance Service (LAS) are triaged and the caller needs to convey the seriousness of the injury to the telephonist, and if it is so that ‘there is an immediate threat to life’. The information in Appendix 2 gives the details of information required by LAS and this must be on the wall above the telephone in the ward/unit office.

An incident form must be completed following all acts of self harm.

9.6 Consent to care

Clinicians working with service users who self-harm must be trained to assess Issues of consent and mental capacity as well as mental ill health. Mental capacity should be assumed unless there is evidence to the contrary.

Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

If a person is assessed as being mentally incapable, staff have a responsibility, under the Mental Capacity Act (2005)\(^6\) to act in the service user’s ‘best interest’, to act in that person’s best interests. If necessary, this can include taking the person to hospital, and detaining them to allow assessment and treatment against the person’s stated wishes.

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 explain each new treatment or procedure and obtain consent before it is initiated.

\(^7\) Mental Capacity Act 2005; Code of Practice:
Staff working with people who self-harm should understand when and how the Mental Health Act can be used to treat the physical consequences of self-harm.

Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity and consent at all times. The Trust’s Mental Capacity Act and Deprivation of Liberty Safeguards should be the first reference point for capacity issues.

9.7 An advance decision or crisis plan

In this Trust service users are encouraged to make an advance decision and/or a crisis plan when they are well which relates to the care they will receive if they become mentally unwell in the future (Reference: Advance Decision and Crisis Plan Policy).

An advance decision is made to refuse specified treatment in advance by a person aged 18 or older who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. The exception to this is when a person is detained under the Mental Health Act 1983, when an advance decision to refuse treatment for mental disorder can be overruled.

If possible it would be therapeutic to assist a service user to make an advance decision or crisis plan which describes the therapeutic help they would like should they self harm in the future.

A crisis plan states the wishes of a service user in relation to future treatment and care should they relapse. It is held by the patient and with their CPA, and contains his or her choice of information, including advance agreement for treatment preferences for any future emergency, when he or she might be too unwell to express coherent views.

Although crisis plans, when sensibly done, can be helpful to both the service user and health care professionals, they are not legally binding on health care professionals. This means that they can be disregarded if they are not in the best interest of the service user. It
10. Carers of service users who self harm

There is a lack of information about the views and needs of carers of people who self-harm. Carers may feel isolated, stigmatised and burdened with the anxiety of caring for a family member or friend who repeatedly harms themselves. Their own feelings, especially feelings of shame, may be exacerbated by their cultural environment or their religion.

Friends and relatives can play a crucial role in the care and treatment of people who self-harm. They can provide emotional, practical and financial support and encourage people to seek appropriate support and treatment. They can become involved in treatment plans and, above all, make the person feel wanted, needed and loved.

It is important to recognise that friends and family are not always helpful or healthy in their relationships with service users; however, where carers have been identified and service users are willing to involve them, they should be part of the process from the outset. They should also be offered a carer’s assessment at the first point of contact if the service user agrees.

Professionals should regard it as automatic to enquire about the service user’s carer and the level of involvement that they would like to see from them. If there is a joint agreement that the carer be involved, they should be kept informed on situations that concern them, especially when it directly relates to their care giving. Important issues of confidentiality will apply but aspects of care that will involve the carer should be openly discussed.

Carers bear a lot of responsibility and when the relationships are positive can have a profound impact on good recovery outcomes. As far as possible and appropriate they should be included as part of the team and respected for their expertise and knowledge.

11. Training requirements

Clinical and non-clinical staff who have contact with people who self-harm should be provided with appropriate training. Please refer to the Learning and Development Guide on the Trust intranet at:

http://cift-ap02/sorce/

Support and advice is available for both individual staff and teams working with service users who self-harm from Trust staff who are highly experienced in this type of work:

- The Women’s Mental Health Crisis House and Resource Centre
  
  Tel: Shirley McNicholas on 020 7607 2777
  Email: shirley.mnnicholas@candi.nhs.uk

- PD/CDAT Case Management Team

  Tel: Alan Jones 020 3317 6999
  Email: alan.jones@candi.nhs.uk
• ‘Personality Disorder Knowledge and Understanding’ training which includes self-harm is also available. For more information visit:

http://www.personalitydisorder.org.uk/training/kuf/index.php

12. Dissemination and implementation arrangements

• These guidelines are posted on the Trust Intranet where all staff can access them.

13. Monitoring and audit arrangements

<table>
<thead>
<tr>
<th>Elements to be monitored</th>
<th>Lead</th>
<th>How trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendation and Lead</th>
<th>Change in practice and lessons to be shared</th>
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<tbody>
<tr>
<td>Incidents of self harm</td>
<td>Risk and Patient Safety Manager</td>
<td>Monitor incidents of self-harm &amp; interventions</td>
<td>Annually</td>
<td>Quality Committee</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
<td>Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

14. Review of the policy

This policy will be reviewed in 2 years from date of ratification or earlier should a change in practice is identified or a new national guideline is published.
15. **References**

15.1 Understanding self-harm, for better mental health; MIND 2010

15.2 Self-Harm; The short term physical and psychological management and secondary prevention of self harm in primary and secondary care; NICE Guideline 16; 2004


15.4 Self-harm: longer-term management; Implementing NICE guidance (November 2011).


15.7 Mental Capacity Act 2005; Code of Practice:

16. **Associated documents**

16.1 Advance Decision and Crisis Plan Policy (Sep 2012)

16.2 Observation and Engagement Policy (May 2011).
### Appendix A

**Equality Impact Assessment Tool**

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
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<tr>
<td><strong>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
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<td></td>
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<td>Race</td>
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<td></td>
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<tr>
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<tr>
<td>Age</td>
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<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<td><strong>2. Is there any evidence that some groups are affected differently?</strong></td>
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<td><strong>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
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<td><strong>4. Is the impact of the policy/guidance likely to be negative?</strong></td>
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<tr>
<td><strong>5. If so can the impact be avoided?</strong></td>
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<tr>
<td><strong>6. What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
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<tr>
<td><strong>7. Can we reduce the impact by taking different action?</strong></td>
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</table>
APPENDIX 1A

TREATMENT REFUSAL FOLLOWING SELF-HARM

Occasionally, a patient presents to the ED having taken a potentially lethal overdose, or having harmed themselves in some other way, and refuses to be treated. Their capacity to refuse treatment then needs to be assessed.

For patients who are mentally ill

It should not be assumed that a patient with a mental illness automatically lacks the capacity to consent to treatment. However, if the mental illness is preventing them from ‘comprehending and retaining information which they can weigh in the balance and arrive at a choice’ (legal definition of capacity to consent), e.g. if auditory hallucinations are instructing the patient not to accept treatment, they may lack the capacity to refuse treatment. If urgent treatment is in their best interests, then ED staff may treat under the Mental Capacity Act 2005.

The procedure outlined below will also apply.

For patients who are not mentally ill

Under these circumstances, the following procedure should occur:

- The serious nature of the self-harm must be explained to the patient and the likely consequences of refusing treatment. A third party (member of staff) should be present during this explanation. The discussion should be carefully documented in the patient’s notes.

- A second medical opinion should be obtained. Under normal circumstances, this will involve discussion with the most senior ED doctor available and the consultant liaison psychiatrist (or on-call middle grade psychiatrist if out of hours) who together will decide if the patient should be treated under the Mental Capacity Act.

- The assessment of the patient’s capacity to refuse treatment should be documented in the patient’s notes, e.g. if an overdose was precipitated by an emotionally disturbing event or an event which led to anger. If so, it could be argued that the overdose was taken when the ‘balance of the person’s mind’ was disturbed. Note that the patient’s capacity to consent should be assessed at the time they are refusing treatment, not at the time when they took the overdose.

Under the Mental Capacity Act, a person without capacity to consent can be treated ‘in their best interests’ for a potentially life-threatening condition.

N.B. Any notes made by a patient accompanying a suicide attempt are unlikely to have validity in law.
Appendix 2

999 TELEPHONE CALL TO LONDON AMBULANCE SERVICE (LAS)

In the event of an emergency: the collapse of a patient, serious injury or self inflicted wound staff member must call for an ambulance giving the following information:

Dial:  9 999
Request an emergency 999 ambulance to the following address:

..........................Ward
Highgate Mental Health Centre
Dartmouth Park Hill
London N19 5NX

Ward Telephone Number: ..........................

Name of Patient..........................
Patient’s Date of Birth......................

Injury/ level of response needed...............................................
.........................................................................................
.........................................................................................

In the case of immediate threat to life please make this clear.
Appendix 3

MENTAL HEALTH LIAISON TEAM
PARALLEL REFERRALS

What is a parallel assessment?

- An assessment of a patient’s mental health that takes place whilst a patient is still being medically assessed, i.e., before they are ‘medically fit’

Who can be referred for a parallel assessment?

- Patients in the Emergency Department whose treatment will finish within the 4-hour target time.
- Patients who have taken an overdose but whose bloods are anticipated to be ‘normal’.
- Patients with a medical problem where it is believed they may also have a psychiatric problem.
- In all cases the patient must be assessable.

Who can make a referral for a parallel assessment?

- Doctors in the emergency department.
- Doctors on wards.

When can a patient be referred for a parallel assessment?

- 7 days a week 9am-8pm

Please Note:

Any patient referred for a parallel assessment remains under the care of the Emergency Department or ward clinic team.