

Self-harm

Quality standard

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This standard should be read in conjunction with QS8, QS14, QS15, QS48, QS88, QS102, QS95, QS115, QS159 and QS175.

Introduction and overview

Introduction

The term self-harm is used in this quality standard to refer to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

A wide range of mental health problems are associated with self-harm, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders. People who self-harm have a 50- to 100-fold higher likelihood of dying by suicide in the 12-month period after an episode than people who do not self-harm.

This quality standard covers the initial management of self-harm and the provision of longer-term support for children and young people (aged 8 years and older) and adults (aged 18 years and older) who self-harm. For more information see the [scope](#) for this quality standard.

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. The quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- [NHS Outcomes Framework 2013/14](#)
- [A Public Health Outcomes Framework for England 2013–2016](#)

The table below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

NHS Outcomes Framework 2013/14

<p>Domain 1: Preventing people from dying prematurely</p>	<p>Overarching indicator</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>Improvement areas</p> <p><i>Reducing premature death in people with serious mental illness</i></p> <p>1.5 Excess under 75 mortality rate in people with serious mental illness</p>
<p>Domain 4: Ensuring that people have a positive experience of care</p>	<p>Overarching indicator</p> <p>4a Patient experience of primary care</p> <p>4b Patient experience of hospital care</p> <p>Improvement areas</p> <p>4.2 Responsiveness to in-patients' personal needs</p> <p>4.3 Patient experience of A&E services</p> <p>4.7 Patient experience of community mental health services</p>
<p>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p>Overarching indicator</p> <p>5a Patient safety incidents reported</p> <p>5b Safety incidents involving severe harm or death</p>
<p>A Public Health Outcomes Framework for England 2013–2016</p>	
<p>Domain 2: Health improvement</p>	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.10 Hospital admissions as a result of self-harm</p>

<p>Domain 4: Healthcare public health and preventing premature mortality</p>	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators</p> <p>4.9 Excess under 75 mortality in adults with serious mental illness</p> <p>4.10 Suicide</p>
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Overview

The quality standard for self-harm requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. A person-centred approach to provision of services is fundamental to the delivery of high-quality care to people who self-harm.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of healthcare should cross-refer across the library of NICE quality standards when designing high-quality services.

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people who self-harm should be sufficiently and appropriately trained and competent to deliver the actions and interventions described in the quality standard.

List of quality statements

Statement 1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

Statement 2. People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

Statement 3. People who have self-harmed receive a comprehensive psychosocial assessment.

Statement 4. People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.

Statement 5. People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.

Statement 6. People receiving continuing support for self-harm have a collaboratively developed risk management plan.

Statement 7. People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Statement 8. People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Other quality standards that should also be considered when choosing, commissioning or providing a high-quality service for people who self-harm are listed in [Related NICE quality standards](#).

Quality statement 1: Compassion, respect and dignity

Quality statement

People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

Rationale

Everyone who uses healthcare services should be treated with compassion, respect and dignity. For people who have self-harmed, however, staff attitudes are often reported as contributing to poor experiences of care. Punitive or judgemental staff attitudes can be distressing for people who have self-harmed and may lead to further self-harm or avoidance of medical attention.

Quality measure

Structure: Evidence of local arrangements to provide staff training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Process: Proportion of staff in contact with people who have self-harmed who have received training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Numerator – the number of staff in the denominator who have received training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Denominator – the number of staff in contact with people who have self-harmed.

Outcome: Evidence from feedback that people who have self-harmed feel treated with compassion and the same respect and dignity as any service user.

What the quality statement means for each audience

Service providers ensure that training is provided on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

All staff ensure that they treat people who have self-harmed with compassion and the same respect and dignity as any service user.

Commissioners ensure that they commission services in which all staff who come into contact with people who have self-harmed are trained in treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

Source guidance

NICE clinical guideline 16 recommendations 1.1.1.1 (key priority for implementation) and 1.1.2.1 (key priority for implementation).

NICE clinical guideline 133 recommendations 1.1.1 (key priority for implementation), 1.1.9 and 1.1.10.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: Local data collection. NHS Surveys ask questions about dignity when using services; however, data on diagnosis are not collected.

Definitions

People who have self-harmed

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation.

Staff

Everyone employed by or working in a service that provides care and support for people who have self-harmed. It is not restricted to qualified healthcare professionals, and could include reception staff, administrative staff and others. It applies to primary care, ambulance services, emergency departments, community services and inpatient settings.

Quality statement 2: Initial assessments

Quality statement

People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

Rationale

An initial assessment can identify whether a person who has self-harmed is at immediate physical risk so that steps can be taken to reduce this risk, including referral for more urgent care if indicated.

Quality measure

Structure: Evidence of local arrangements to ensure that initial assessments of people who have self-harmed include physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

Process: Proportion of people who have self-harmed who have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

Numerator – the number of people in the denominator with an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.

Denominator – the number of people with a new episode of self-harm.

What the quality statement means for each audience

Service providers ensure that people who have self-harmed have an initial assessment after an episode of self-harm that includes physical health, mental state, safeguarding concerns, social circumstances and risk of further self-harm or suicide.

Healthcare professionals ensure that people who have self-harmed have an initial assessment after an episode of self-harm that includes physical health, mental state, safeguarding concerns, social circumstances and risk of further self-harm or suicide.

Commissioners ensure that they commission services that undertake an initial assessment of

physical health, mental state, safeguarding concerns, social circumstances and risk of further self-harm or suicide for people after an episode of self-harm.

People who have self-harmed have their physical health, mental state, social circumstances and risks of repetition or suicide assessed after an episode of self-harm.

Source guidance

NICE clinical guideline 16 recommendations 1.2.1.1, 1.2.1.2, 1.3.1.1 and 1.4.1.1.

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

People who have self-harmed

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation.

Initial assessment

The first assessment by a healthcare professional after an episode of self-harm. It applies to people first seen in primary care, ambulance services or emergency departments. It also applies to the first assessment of episodes of self-harm in inpatient settings. An initial assessment should be undertaken each time a person presents with an episode of self-harm.

Physical health

Factors that should be recorded in an initial assessment of physical health include, but are not limited to:

- level of consciousness
- physical injuries
- level of pain

- details of the nature and quantity of any overdose.

Mental state

Factors that should be recorded in an initial assessment of mental state include, but are not limited to:

- mental capacity
- level of distress
- presence of mental health problems
- willingness to remain for further psychosocial assessment.

Safeguarding

The protection of vulnerable people from harm. It can apply to people of all ages, including adults, older people, children and young people. It includes consideration of risks to the person who has self-harmed, any children or adults in the person's care and to other family members or significant others.

Social circumstances

Factors that should be recorded in an initial assessment of social circumstances include, but are not limited to:

- family members, significant others or carers who can provide support
- dependants
- housing
- personal or financial problems.

Equality and diversity considerations

NICE clinical guideline 16 recommendation 1.9.1.1 states that children and young people under 16 years who have self-harmed and present at the emergency department should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

Quality statement 3: Comprehensive psychosocial assessments

Quality statement

People who have self-harmed receive a comprehensive psychosocial assessment.

Rationale

A comprehensive psychosocial assessment is aimed at identifying personal factors that might explain an act of self-harm. It should be carried out each time a person presents with an episode of self-harm. It can start a therapeutic relationship with the healthcare professional and be used to form an effective management plan.

Quality measure

Structure: Evidence of local arrangements to ensure that healthcare professionals either undertake comprehensive psychosocial assessments with people who have self-harmed or refer them to a specialist mental health professional for the assessment.

Process:

a) Proportion of people who have self-harmed who either receive a comprehensive psychosocial assessment or are referred to a specialist mental health professional for the assessment.

Numerator – the number of people in the denominator receiving a comprehensive psychosocial assessment or referred to a specialist mental health professional for the assessment.

Denominator – the number of people with a new episode of self-harm.

b) Proportion of people who have self-harmed and are referred to a specialist mental health professional for a comprehensive psychosocial assessment who receive a comprehensive psychosocial assessment.

Numerator – the number of people in the denominator receiving a comprehensive psychosocial assessment.

Denominator – the number of people who have self-harmed and are referred to a specialist mental health professional for a comprehensive psychosocial assessment.

What the quality statement means for each audience

Service providers ensure that systems are in place for healthcare professionals to undertake comprehensive psychosocial assessments for people who have self-harmed or refer them to a specialist mental health professional for the assessment.

Healthcare professionals ensure that people are offered a comprehensive psychosocial assessment or are referred to a specialist mental health professional for the assessment after an episode of self-harm.

Commissioners ensure that they commission services that provide comprehensive psychosocial assessments for people after an episode of self-harm.

People who have self-harmed are offered a comprehensive psychosocial assessment that considers their needs, social situation, psychological state, reasons for harming themselves, feelings of hopelessness, depression or other mental health problems and any thoughts of suicide.

Source guidance

NICE clinical guideline 16 recommendations 1.7.2.1 (key priority for implementation) and 1.7.3.1 (key priority for implementation).

NICE clinical guideline 133 recommendations 1.3.1 to 1.3.6.

Data source

Structure: Local data collection.

Process: a) and b) Local data collection.

Definitions

People who have self-harmed

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation.

Specialist mental health professional

A health professional employed to provide expertise in mental healthcare.

Comprehensive psychosocial assessment

[NICE clinical guidelines 16](#) and [133](#) state that a psychosocial assessment is the assessment of needs and risks to understand and engage people who self-harm and initiate a therapeutic relationship. Recommendations 1.3.1 to 1.3.6 in [NICE clinical guideline 133](#) give further details on undertaking comprehensive psychosocial assessments. The comprehensive psychosocial assessment should be offered to people being treated in primary care, emergency departments and inpatient settings, and may require referral to a specialist mental health professional.

Equality and diversity considerations

[NICE clinical guideline 16](#) recommendation 1.9.1.10 states that children and young people should be assessed by professionals experienced in the assessment of children and young people who self-harm.

[NICE clinical guideline 16](#) recommendation 1.9.1.10 and [NICE clinical guideline 133](#) recommendation 1.3.4 state that assessment of children and young people should follow the same principles as for adults, but should also include a full assessment of the family, their social situation and child protection issues.

[NICE clinical guideline 16](#) recommendation 1.10.1.1 and [NICE clinical guideline 133](#) recommendation 1.3.3 state that older people (over 65 years) should be assessed by professionals experienced in the assessment of older people who self-harm.

[NICE clinical guideline 16](#) recommendation 1.10.1.1 states that assessment of older people should follow the same principles as for adults, but should also pay attention to the potential presence of depression, cognitive impairment or physical ill health, and include a full assessment of their home and social situation.

Quality statement 4: Monitoring

Quality statement

People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.

Rationale

Monitoring people who have self-harmed when they are in a healthcare setting can reduce distress, ensure that the person feels supported and help reduce the risk of further self-harm while in the healthcare setting.

Quality measure

Structure: Evidence of local arrangements to ensure that people who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm while in the healthcare setting.

Process: Proportion of people who have self-harmed who have a record of monitoring arrangements while in the healthcare setting, in order to reduce the risk of further self-harm.

Numerator – the number of people in the denominator with a record of monitoring arrangements while in the healthcare setting, in order to reduce the risk of further self-harm.

Denominator – the number of people with a new episode of self-harm.

Outcome: Number of episodes of self-harm occurring in healthcare settings.

What the quality statement means for each audience

Service providers ensure that staff carry out monitoring in the healthcare setting according to the needs of people who have self-harmed, in order to reduce the risk of further self-harm.

Healthcare professionals ensure that people who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.

Commissioners ensure that they commission services that monitor people who have self-harmed

according to their needs while in the healthcare setting, in order to reduce the risk of further self-harm.

People who have self-harmed are checked regularly by healthcare staff, and are accompanied when required, when they are in hospital or another part of the health service, to make sure they are safe.

Source guidance

NICE clinical guideline 16 recommendation 1.4.2.3 (key priority for implementation).

Data source

Structure: Local data collection. NHS Litigation Authority risk management standards assess the process for managing the risks associated with the observation and engagement of patients.

Process: Local data collection.

Outcome: Local data collection. The National Reporting and Learning System contains national and local figures on patient safety incidents including self-harm.

Definitions

People who have self-harmed

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation.

Monitoring

Includes observation and accompaniment of people who have self-harmed, either by healthcare professionals or by their families or carers with support from healthcare professionals.

Monitoring applies to people being treated in primary care, ambulance services, emergency departments and inpatient settings.

Equality and diversity considerations

NICE clinical guideline 16 recommendation 1.9.1.1 states that children and young people under

16 years who have self-harmed should be assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

Quality statement 5: Safe physical environments

Quality statement

People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.

Rationale

Caring for people who have self-harmed in a safe physical environment within the healthcare setting can reduce distress, help them to feel supported and reduce the risk of further self-harm in the healthcare setting.

Quality measure

Structure: Evidence of local arrangements to undertake environmental assessments of healthcare settings, including assessing the risks to people who have self-harmed.

Outcome: Number of episodes of self-harm occurring in healthcare settings.

What the quality statement means for each audience

Service providers ensure that they undertake environmental assessments to ensure that healthcare settings are safe for people who have self-harmed and to reduce the risk of further self-harm while in the healthcare setting.

Healthcare professionals ensure that people who have self-harmed are cared for in a safe physical environment while in the healthcare setting to reduce the risk of further self-harm.

Commissioners ensure that they commission services that provide safe physical environments in healthcare settings for people who have self-harmed to reduce the risk of further self-harm.

People who have self-harmed are cared for in a safe physical environment that reduces the risk of harming themselves further while in hospital or another part of the healthcare service.

Source guidance

[NICE clinical guideline 16](#) recommendation 1.4.2.3 (key priority for implementation).

Data source

Structure: Local data collection. [NHS Litigation Authority risk management standards](#) assess the process for managing the risks associated with the physical security of premises and assets.

Outcome: Local data collection. [NHS Surveys](#) ask questions about the environment of services; however, data on diagnosis are not collected. The [National Reporting and Learning System](#) contains national and local figures on patient safety incidents, including self-harm.

Definitions

People who have self-harmed

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation.

Safe physical environment

People who have self-harmed should be offered an environment that is safe, supportive and minimises any distress.

Examples of environmental risks to people who self-harm include, but are not limited to:

- ligature points
- open windows
- access to sharps
- access to medication.

Consideration should be given to the individual needs and safety requirements of each service user.

A safe physical environment refers to primary care settings, ambulance services, emergency departments and inpatient settings where people who have self-harmed are being cared for.

Equality and diversity considerations

[NICE clinical guideline 16](#) recommendation 1.9.1.1 states that children and young people under 16 years who have self-harmed should be assessed and treated by appropriately trained children's

nurses and doctors in a separate children's area of the emergency department.

Quality statement 6: Risk management plans

Quality statement

People receiving continuing support for self-harm have a collaboratively developed risk management plan.

Rationale

A risk management plan can help people who self-harm reduce their risk of self-harming again. It should be based on a risk assessment and developed with the person who has self-harmed, who should have joint ownership of the plan. They should fully understand the content of the plan, including what can be done if they are at risk of self-harming again and who to contact in a crisis.

Quality measure

Structure: Evidence of local arrangements to ensure that people receiving continuing support for self-harm have a collaboratively developed risk management plan.

Process: Proportion of people receiving continuing support for self-harm who have a collaboratively developed risk management plan.

Numerator – the number of people in the denominator who have a collaboratively developed risk management plan.

Denominator – the number of people receiving continuing support for self-harm.

What the quality statement means for each audience

Service providers ensure that collaboratively developed risk management plans are in place for people receiving continuing support for self-harm.

Healthcare professionals ensure that people receiving continuing support for self-harm have a collaboratively developed risk management plan.

Commissioners ensure that they commission services that have collaboratively developed risk management plans in place for people receiving continuing support for self-harm.

People who are having long-term support after self-harming have a risk management plan developed with their healthcare professional that helps them reduce their risk of harming themselves again.

Source guidance

NICE clinical guideline 133 recommendations 1.4.3 (key priority for implementation) and 1.4.4 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

People receiving continuing support for self-harm

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation, and are receiving longer-term psychological treatment and management. It includes people with both single and recurrent episodes of self-harm. It does not include people having immediate physical treatment or management for self-harm in emergency departments.

Risk management plan

NICE clinical guideline 133 recommendation 1.4.4 states that a risk management plan 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.

Equality and diversity considerations

NICE clinical guideline 133 recommendation 1.3.3 highlights the higher risks of suicide following self-harm in people aged over 65 years. These risks should be reflected in risk management plans.

Quality statement 7: Psychological interventions

Quality statement

People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Rationale

There is some evidence that psychological therapies specifically structured for people who self-harm can be effective in reducing repetition of self-harm. The decision to refer for psychological therapy should be based on a discussion between the service user and healthcare professional about the likely benefits.

Quality measure

Structure: Evidence of local arrangements to provide psychological interventions specifically structured for people who self-harm.

Process:

a) Proportion of people receiving continuing support for self-harm who have a record of a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Numerator – the number of people in the denominator who have a record of a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Denominator – the number of people receiving continuing support for self-harm.

b) Proportion of people who self-harm who accept referral for psychological intervention and receive at least 3 sessions of a psychological intervention specifically structured for people who self-harm.

Numerator – the number of people in the denominator receiving at least 3 sessions of a psychological intervention specifically structured for people who self-harm.

Denominator – the number of people who self-harm who accept referral for psychological intervention.

What the quality statement means for each audience

Service providers ensure that systems are in place for healthcare professionals to refer people receiving continuing support for self-harm for 3 to 12 sessions of a psychological intervention specifically structured for people who self-harm.

Healthcare professionals ensure that they discuss with people receiving continuing support for self-harm the potential benefits of psychological interventions specifically structured for people who self-harm.

Commissioners ensure that they commission services that discuss potential benefits of psychological interventions specifically structured for people who self-harm with people receiving continuing support for self-harm and can refer them for 3 to 12 sessions.

People who are having long-term support after self-harming discuss the possible benefits of psychological treatments for self-harm with their healthcare professional.

Source guidance

NICE clinical guideline 133 recommendation 1.4.8 (key priority for implementation).

Data source

Structure: Local data collection.

Process: a) and b) Local data collection.

Definitions

People receiving continuing support for self-harm

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation, and who are receiving longer-term psychological treatment and management. It includes people with both single and recurrent episodes of self-harm. It does not include people having immediate physical treatment or

management for self-harm in emergency departments.

Lead healthcare professional

The professional with overall responsibility for the care and support of a person who has self-harmed. This could include, but is not limited to, professionals from primary care and community mental health services.

Psychological interventions

NICE clinical guideline 133 recommendation 1.4.8 states:

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

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

Quality statement 8: Moving between services

Quality statement

People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Rationale

Moving to different mental health services (for example, from services for young people to services for adults) can be a difficult period for people who self-harm. Unless there are plans to manage these transitions, service users can feel isolated and unsupported, and be at increased risk of further self-harm. It is important that service users are involved in agreeing how their support will be managed and understand who they can contact in a crisis.

Quality measure

Structure: Evidence of local arrangements to ensure that providers collaboratively plan in advance and coordinate effectively when people who have self-harmed move between mental health services.

Process: Proportion of people receiving continuing support for self-harm and moving between mental health services who have a collaboratively developed plan describing how support will be provided during the transition.

Numerator – the number of people in the denominator with a collaboratively developed plan describing how support will be provided during the transition.

Denominator – the number of people receiving continuing support for self-harm and moving between mental health services.

What the quality statement means for each audience

Service providers ensure that systems are in place to coordinate effectively with other providers when people who have self-harmed move between mental health services.

Healthcare professionals ensure that people receiving continuing support for self-harm and

moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Commissioners ensure that they commission services that provide people receiving continuing support for self-harm and moving between mental health services with a collaboratively developed plan describing how support will be provided during the transition.

People who are having long-term support after self-harming and are moving between mental health services agree a plan with their healthcare professionals that describes how they will be supported while they move from one service to another.

Source guidance

NICE clinical guideline 133 recommendation 1.1.25.

Data source

Structure: Local data collection.

Process: Local data collection.

Definition

People moving between mental health services for continuing support for self-harm

Children or young people (aged 8 years and older) and adults who have carried out an act of self-poisoning or self-injury, irrespective of motivation, who are receiving longer-term psychological treatment and are moving from child and adolescent to adult mental health services, or from one adult mental health service to another. Continuing support refers to longer-term psychological treatment and management. It includes people with both single and recurrent episodes of self-harm. It does not include people having immediate physical treatment or management for self-harm in emergency departments.

Using the quality standard

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, health and social care professionals, patients, service users and carers alongside the documents listed in [Development sources](#).

NICE has produced [commissioning support](#) that considers the commissioning implications and potential resource impact of this quality standard. [Information for the public](#) using the quality standard is also available on the NICE website.

The quality measures accompanying the quality statements aim to improve structures, processes and outcomes of care in areas identified as requiring quality improvement. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice when taking account of safety, choice and professional judgement and so desired levels of achievement should be defined locally.

We have illustrated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their [Indicators for Quality Improvement Programme](#). If national quality indicators do not exist, the quality measures should form the basis of audit criteria developed and used locally to improve the quality of care.

For further information, including guidance on using quality measures, please see [What makes up a NICE quality standard?](#)

Diversity, equality and language

During the development of this quality standard, equality issues have been considered. [Equality assessments](#) are available.

Good communication between healthcare services and people who self-harm is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning

disabilities, and to people who do not speak or read English. People who self-harm (or their parents or carers) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

NICE clinical guideline 133 recommendation 1.1.22 states that the service user should be asked whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved if appropriate.

Development sources

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE accredited sources that were used by the Topic Expert Group to develop the quality standard statements and measures.

Self-harm: longer-term management. NICE clinical guideline 133 (2011)

Self-harm. NICE clinical guideline 16 (2004).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

Department of Health (2012) Preventing suicide in England – a cross-government outcomes strategy to save lives.

Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.

Definitions and data sources for the quality measures

References included in the definitions and data sources sections:

NHS Commissioning Board National Reporting and Learning System.

NHS Litigation Authority Risk management standards.

Picker Institute NHS Surveys.

Related NICE quality standards

Published

- [Patient experience in adult NHS services](#). NICE quality standard 15 (2012).
- [Service user experience in adult mental health](#). NICE quality standard 14 (2011).
- [Depression in adults](#). NICE quality standard 8 (2011).

In development

- [Depression in children and young people](#). NICE quality standard. Publication expected September 2013.
- [Anxiety](#). NICE quality standard. Publication expected March 2014.

Future quality standards

- Managing the transition from children's to adult services

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About this quality standard

This quality standard covers the following quality standard referrals in the [core library](#):

- Self-harm (vulnerable groups, children and young people).
- Self-harm (adults).

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, describing high-priority areas for quality improvement in a defined care or service area. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

This quality standard has been incorporated into the [NICE pathway for self-harm](#).

We have produced a [summary for patients and carers](#).

Changes after publication

May 2015: Minor maintenance.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [College of Emergency Medicine](#)
- [Royal College of Psychiatrists](#)