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| Annex A: audit tool: psychosocial assessments in line with NICE guidance | |  | |  |
| Psychosocial assessment after self-harm: liaison psychiatry audit proforma\* | | Present | | Notes |
|  | | Yes | No |  |
| Was the patient offered a psychosocial assessment? | |  |  |  |
| Did the patient receive a psychosocial assessment? (Please note if the assessment took place by phone, video call, or in person) | |  |  |  |
| Was the assessment age appropriate? *(e.g., for older adults: explored the presence of depression; cognitive impairment; physical ill health, higher level of suicide risk associated with self-harm). For children and young people: included transitions between services; home and school situation; safeguarding/ child protection issues)* | |  |  |  |
| Was there an assessment of needs? (*e.g., including skills, strengths, coping, mental health problems, social and occupational circumstances, recent life events, personal and financial problems, psychological interventions and treatment needs, and the needs of any dependents)* | |  |  |  |
| Were the reasons/ motives for this individual episode of self-harm explored with the patient? | |  |  |  |
| Risk assessment | |  |  |  |
| Did a risk assessment take place? (*e.g., that included the evaluation and description of previous and current self-harm [e.g. number of tablets, methods], suicidal ideation and intent, plans, depressive and other psychiatric symptoms, precipitating and ongoing risk factors, protective factors, coping strategies, relationships, and immediate/ longer-term risks)* | |  |  |  |
| Were other possible risk-taking or destructive behaviours considered? (*e.g., drug or alcohol misuse, unprotected sexual activity, unnecessary physical risks)* | |  |  |  |
| Was the patient asked about the source of the method and access to means of self-harm*?*  (*e.g., for medication: family members’, carers’ and significant others’)* | |  |  |  |
| Risk tools and scales or stratification (e.g., low, medium, high) should *not be* used to predict risk of self-harm or suicide.  Risk assessment tools or risk stratification (e.g., low, medium, high risk) were NOT used to predict future suicide or repetition of self-harm? | |  |  |  |
| Risk tools and scales or stratification (e.g., low, medium, high) should *not be* used to determine patient treatment or discharge.  Risk stratification were NOT used to determine patient management? *(e.g., treatment offers/ discharge)* | |  |  |  |
| Care plans | |  |  |  |
| Was there evidence of a collaboratively developed care plan?  *(A care plan outlines short- and long-term treatment goals as well as the roles and responsibilities of individual team members)* | |  |  |  |
| Risk management plan |  | | | |
| Was there evidence of a risk management plan? *(a plan that considered short- and long-term risks of further self-harm/other risks - such as self-neglect, risk to others, risk from others - and strategies to mitigate these risks)* | |  |  |  |
| If the person has attended the service on multiple occasions, was there evidence that the risk management plan was updated for each episode? *(e.g., monitoring changes in reasons for self-harm and risk, and evaluating treatment strategies)* | |  |  |  |
| Was there evidence of a collaboratively developed crisis/ safety plan? *(e.g., outlining self-management strategies and how to access services during a crisis)* | |  |  |  |
| Psychosocial assessment after self-harm: liaison psychiatry audit proforma\* | | Present | | Notes |
|  | | Yes | No |  |
| Is there evidence that copies of the care, risk management, and crisis/ safety plans were provided to the patient, and shared with other professional and family members as appropriate? | |  |  |  |
| Overall rating of assessment | |  |  |  |
| Was there evidence that the assessment was carried out collaboratively with  the patient? *(e.g. the contents of the assessment discussed, the patient being asked for their views on the support and care plans)* | |  |  |  |
| Was there evidence of family and carer involvement or discussion of such involvement? | |  |  |  |
| Overall, in your view, was this assessment consistent with the NICE guidelines? *(in general, for an assessment to be consistent, the majority of the items above will have been endorsed as present and risk tools and scales will not have been used to predict outcome or determine management)* | |  |  |  |
| Notes:  \*This audit tool is based on the NICE 2011 clinical guideline for the long-term management of self-harm [CG133]. The new guideline [Self-harm: assessment, management, and preventing recurrence] is out for consultation (<https://www.nice.org.uk/guidance/indevelopment/gid-ng10148/consultation/html-content-2>)  When undertaking any audit and quality improvement activities, services might want to consider some of the additional draft recommendations, such as:   * Psychosocial assessments are carried out at the earliest opportunity (not delayed until after medication treatment, or by the use of breath or blood alcohol levels). * Care plans are checked and followed through where possible. * Personal preferences are considered for the psychosocial assessment (e.g., appropriate adjustments for any physical, mental health, or neurodevelopmental conditions, and the option to have healthcare professionals of the same sex carry out the assessment). * Psychosocial assessments are carried out in private, designated areas. | |  |  |  |



**Annex B: NICE guideline on Self-harm: Comparison between the old/current (2011) and new/proposed (2022) versions of the ‘psychosocial assessment section’**

* Both versions are almost the same (although not word for word – but the message remains the same).
* It looks different as the new/proposed version has been re-written/re-organised but almost all the information from the old/current guidelines are included in the new/proposed version:
  + The highlighted areas below in the old/current guidelines are missing from the new/proposed version.
  + The highlighted areas in the new/proposed version are new additions.

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| Old/current (NICE guideline on Self-harm, published in 23 Nov 2011 | New/Proposed (NICE guideline on Self-harm, Draft for consultation, Jan 2022 |
| **1.3 Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks**  1.3.1 Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations 1.3.2–1.3.5) and risks (see recommendations 1.3.6–1.3.8) to understand and engage people who self-harm and to initiate a therapeutic  relationship.  **Assessment of needs**  1.3.2 Assessment of needs should include:  • skills, strengths and assets  • coping strategies  • mental health problems or disorders  • physical health problems or disorders  • social circumstances and problems  • psychosocial and occupational functioning, and vulnerabilities  • recent and current life difficulties, including personal and financial problems  • the need for psychological intervention, social care and support, occupational  rehabilitation, and also drug treatment for any associated conditions  • the needs of any dependent children.  1.3.3 All people over 65 years who self-harm should be assessed by mental health  professionals experienced in the assessment of older people who self-harm.  Assessment should follow the same principles as for working-age adults (see  recommendations 1.3.1 and 1.3.2). In addition:  • pay particular attention to the potential presence of depression, cognitive impairment and physical ill health  • include a full assessment of the person's social and home situation, including any role they have as a carer, and  • take into account the higher risks of suicide following self-harm in older people.  1.3.4 Follow the same principles as for adults when assessing children and young  people who self-harm (see recommendations 1.3.1 and 1.3.2), but also include a  full assessment of the person's family, social situation, and child protection  issues.  1.3.5 During assessment, explore the meaning of self-harm for the person and take into account that:  • each person who self-harms does so for individual reasons, and  • each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode.  **Risk assessment**  A risk assessment is a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm.  1.3.6 When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into  account:  • methods and frequency of current and past self-harm  • current and past suicidal intent  • depressive symptoms and their relationship to self-harm  • any psychiatric illness and its relationship to self-harm  • the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships  • specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm  • coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm  • significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk  • immediate and longer-term risks.  1.3.7 Consider the possible presence of other coexisting risk-taking or destructive  behaviours, such as engaging in unprotected sexual activity, exposure to  unnecessary physical risks, drug misuse or engaging in harmful or hazardous  drinking.  1.3.8 When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others'4 medications.  1.3.9 In the initial management of self-harm in children and young people, advise  parents and carers of the need to remove all medications or, where possible,  other means of self-harm available to the child or young person.  1.3.10 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**  Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.  1.3.11 Do not use risk assessment tools and scales to predict future suicide or  repetition of self-harm.  1.3.12 Do not use risk assessment tools and scales to determine who should and  should not be offered treatment or who should be discharged.  1.3.13 Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6.  **Developing an integrated care and risk management plan**  1.3.14 Summarise the key areas of needs and risks identified in the assessment (see recommendations 1.3.1–1.3.8) and use these to develop a care plan (see  recommendations 1.4.2 and 1.4.3) and a risk management plan (see recommendations 1.4.4 and 1.4.5) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the  person. Provide printed copies for the service user and share them with the GP.  1.3.15 If there is disagreement between health and social care professionals and the person who self-harms about their needs or risks, consider offering the person  the opportunity to write this in their notes. | **1.5 Psychosocial assessment, risk assessment and care by specialist mental health professionals**  1.5.1 At the earliest opportunity after an episode of self-harm, a specialist mental health professional should carry out a psychosocial assessment to:  • develop a collaborative therapeutic relationship with the person  • begin to develop a shared understanding of why the person has self-harmed  • ensure that the person receives the care they need  • give the person and their family members or carers (as appropriate) information about their condition and diagnosis.  1.5.2 Do not delay the psychosocial assessment until after medical treatment is completed.  1.5.3 If the person who has self-harmed is intoxicated by drug or alcohol use, agree with the person and colleagues what immediate assistance is needed, for example, support and advice about medical assessment and treatment.  1.5.4 Do not use breath or blood alcohol levels to delay the psychosocial  assessment.  1.5.5 If the person is not able to participate in the psychosocial assessment, ensure that they have regular reviews, and complete a psychosocial assessment as soon as possible.  1.5.6 If the person who has self-harmed has agreed a care plan, check this with them and follow it as much as possible.  1.5.7 Carry out the psychosocial assessment in a private, designated area where it is possible to speak in confidence without being overheard.  1.5.8 Take into account the preferences of the person who has self-harmed as much as possible when carrying out the psychosocial assessment, for example, by:  • making appropriate adjustments for any physical, mental health or neurodevelopmental conditions the person may have and  • providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment.  1.5.9 During the psychosocial assessment, explore the meaning of self-harm for the person. Take into account:  • the need for psychological interventions, social care and support, or occupational or vocational rehabilitation  • the person's values, wishes and what matters to them  • the person’s treatment preferences  • that each person who self-harms does so for their own reasons  • that each episode of self-harm should be treated in its own right, and a person's reasons for self-harm may vary from episode to episode  • whether it is appropriate to involve their family and carers; see the section on involving family members and carers.  1.5.10 During the psychosocial assessment, explore the following to identify the person's risk factors and needs:  • historic factors, including:  − vulnerabilities, including those related to age, gender identity, sexual orientation and cultural factors  − past self-harm and/or suicidal behaviours  − adverse childhood events  − history of trauma, if the person feels able to discuss this in the acute context  − family history of suicide  − any mental health and/or neurodevelopmental condition and its relationship to self-harm  − treatments  • changeable and current factors, including:  − recent and current life difficulties  − recent or ongoing trauma  − ability to engage in work or educational activities  − methods and frequency of current self-harm, including their ongoing  access to methods of self-harm  − prescribed medicines  − current suicidal thoughts and behaviours  − significant relationships and changes to them  − threats of abuse or harm; see the section on safeguarding  − the needs of any dependents and any safeguarding issues  − harmful or hazardous use of alcohol or recreational drugs  − any personal, financial, social or other factors preceding self-harm, such as emotional distress  − the benefits and harms of social media and internet resources  • future factors, including specific upcoming events or circumstances  • protective or mitigating factors, including:  − coping strategies (social, psychological, pharmacological) that the person has used to:   limit or avert self-harm or   minimise the impact of personal, social or other factors preceding episodes of self-harm  − supportive personal and family relationships  − support from statutory or third sector services  − the person’s and their family and carers' (as appropriate) perspective about their ability to manage their distress.  1.5.11 For children and young people who have self-harmed, in addition to the topics in recommendations 1.5.9 and 1.5.10, also ask about their social, peer group and home situation, and identify any child protection or safeguarding issues (also see the section on safeguarding).  1.5.12 For people over 65 years who have self-harmed, ensure that a specialist mental health professional experienced in assessing older people who self-harm carries out the psychosocial assessment. In addition to the topics in recommendations 1.5.9 and 1.5.10, they should also:  • pay particular attention to the potential presence of depression, cognitive impairment, and physical ill health  • include an assessment of the person's social and home situation, including any role they have as a carer  • recognise the increased potential for loneliness and isolation  • recognise that people over 65 have a higher risk of suicide after an episode of self-harm.  1.5.13 If a person has self-harmed and presents to services but wants to leave before a full psychosocial assessment has taken place, assess the immediate risks, the person's mental capacity and any mental health problems before they leave.  1.5.14 Conduct a risk formulation as part of every psychosocial assessment. Include the identified risk factors, situations in which the risk of self-harm or suicide might increase, and proposed actions to reduce these risks.  1.5.15 Together with the person who self-harms and their family and carers (if appropriate), develop a care plan using the key areas of needs and risks identified in the psychosocial assessment (see recommendations 1.5.8 to 1.5.14).  1.5.16 Give the person a copy of their care plan and share them as soon as possible with the healthcare professionals involved in the person's care.  1.5.17 If a person presents with frequent episodes of self-harm or if treatment has not been effective, carry out a multidisciplinary review with the person and those involved in their care to agree a joint plan and approach. This should involve:  • identifying an appropriate healthcare professional to coordinate the person's care and act as a point of contact  • reviewing the person's existing care and support, and arranging referral to any necessary services  • developing a care plan  • developing a safety plan for future episodes of self-harm, which should be written with and agreed by the person who self-harms.  **Risk assessment tools and scales**  1.5.18 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.  1.5.19 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.  1.5.20 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.  1.5.21 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged |

