

NON-SUICIDAL SELF-INJURY RESEARCH NETWORK

Clinical Guidelines for Deliberate Self-Harm, Non-Suicidal Self-Injury and Borderline Personality Disorder

Prepared for: Region Skåne

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TABLE OF CONTENTS

LIST OF TABLES	3
Executive Summary	4
Common Themes in Clinical Guidelines	4
Introduction.....	6
Inclusion criteria	6
Exclusion criteria	6
Search Strategy and Source.....	7
Deliberate Self-Harm Guidelines: Description and Summary.....	9
Australia and New Zealand.....	9
The United Kingdom	11
Canada & United States of America	22
Non-Suicidal Self-Injury: Description and Summary.....	23
The United Kingdom	23
Borderline Personality Disorder: Description and Summary.....	25
The United Kingdom	25
Integration of Common Themes in Clinical Guidelines	28
Treatment	28
Program Development	29
Research.....	30
References.....	32
Appendix A.....	35

LIST OF TABLES

Table 1: Deliberate Self-Harm Treatment Guidelines in Australia and New Zealand 10

Table 2: Deliberate Self-Harm Treatment Guidelines in the United Kingdom 20

Table 3: Deliberate Self-Harm Treatment Guidelines in Canada via the United States of America 22

Table 4: Non suicidal Self-Injury Clinical Guidelines in the United Kingdom..... 24

Table 5: Borderline Personality Disorder Clinical Guidelines in the United Kingdom..... 27

Table 6: Treatment Guidelines for the Layperson Responding to Self-Injury in Australia and New Zealand
..... 37

Executive Summary

This report is a component of a collaborative initiative involving members of Lund University's Non-Suicidal Self-Injury (NSSI) Research Network, experts in the area, and individuals representing related community initiatives. This report is dedicated to the review of clinical guidelines for individuals who engage in deliberate self-harm (DSH), NSSI, or have been diagnosed with borderline personality disorder (BPD).

Worldwide interest in DSH, particularly amongst youth has been increasing over the past several years (Muehlenkamp et al., 2012). Consequentially, there is a substantial volume of information dedicated to examining various treatments for NSSI, DSH, and associated behaviours and disorders. Information dedicated to treatment is available and abundant, although substantially less exists to critically evaluate this information or organize it within treatment and clinical guidelines¹.

There were three principle objectives of this report:

1. To determine what comprised an evidence-based clinical guideline.
2. To summarize existing evidence-based clinical guidelines for DSH and related concerns.
3. To integrate common themes arising across various evidence-based clinical guidelines.

A total of 210 treatment guidelines were retrieved and reviewed. Inclusion criteria were developed to distinguish which guidelines were evidence-based, and had benefitted from a review process. From the 13 comprehensive guidelines that were retained, a number of common themes emerged with respect to all aspects of treatment, program development, and research.

Common Themes in Clinical Guidelines

Common themes emerged through the course of reviewing clinical guidelines that met inclusion criteria for this report. These were recommendations that were similar, despite originating from different research groups. These unified recommendations are grouped into domains related to treatment, program development, and research as follows:

Treatment

- Validating and collaborative therapeutic relationships across the continuum of care, including support staff.

¹ An internet search for “deliberate self-harm clinical guidelines” yielded 21,100,000 results that contained fact sheets, community resources, descriptions of treatment programs, and recommendations. These documents were based largely on single programs, presentations, opinions, or testimonials.

- Developmental and cultural considerations in assessment and treatment.
- Comprehensive assessments for:
 - Risk management
 - Clinical formulation and treatment planning.
- Pharmacotherapy: Position statements and cautions.
- Treatment plans: Aspects to include and recommendations to enhance collaboration.
- Inter-professional and multi-site professional communication for specialized services in the community/outside of primary care.
- Collaborative selection of psychological and pharmacological treatments.

Program Development

- Developing specialized programs for DSH and related concerns.
- Involvement of people with lived experience of DSH and related concerns in all aspects of staff training, program development, and implementation.
- Adapting evidence-based best practice models for program development.
- Development of DSH services for children and youth.
- Coordinating DSH assessment and treatment for prisoner populations.
- Availability of 24-hour support from professionals with specialized training to respond to DSH and related concerns.
- Ongoing support, training and consultation for clinical staff.
- Free internet resources with health-promoting content relating to DSH.

Research

- Research examining the functions of self-harm amongst various vulnerable populations.
- Large-scale randomized control trials to examine outcomes associated with DSH.
- Clinical trials testing the efficacy and of various psychological and pharmacological treatments for DSH and related concerns.
- Client satisfaction studies rating experiences of various psychological and pharmacological treatments for DSH and related concerns.
- Intervention and prevention studies to determine factors that effectively reduce or prevent DSH and related concerns in vulnerable populations.

Based upon the objectives of this report, clinical guidelines will be operationally defined, and described in summary. Common themes in clinical guidelines will be integrated following the presentation of the guidelines from which they are derived.

A separate section on clinical guidelines for the layperson responding to DSH is presented in the Appendix.

Introduction

The purpose of this report was to define, present, and integrate clinical guidelines for deliberate-self harm (DSH), non-suicidal self-injury (NSSI), and Borderline Personality Disorder (BPD) across the lifespan. Nosological distinctions between NSSI and DSH are reviewed by others within the group. For classification purposes, children and youth were individuals 18 years old and younger, and adults were individuals 19 years old and older.

Inclusion criteria

For the current contribution, English language clinical and treatment guidelines published in paper or electronic format were considered. Parameters for inclusion were clinical and treatment guidelines that had been peer reviewed, prepared by professional regulatory bodies, task forces, mental health commissions or research groups focused on DSH, NSSI and BPD. Ideally they would also have been developed or reviewed in consultation with members of the public, and individuals with lived experience, although this was the exception rather than the norm. These inclusion criteria also operationally define clinical guidelines for the purpose of this report.

Exclusion criteria

1. Guidelines in which the authors stated that the data comprising the guideline would be redundant after a certain number of years, and the date of redundancy had passed by a considerable margin (>3 years).
2. Guidelines in which consideration of DSH, NSSI or BPD was secondary, and cursory in nature. Examples were situations in which DSH and related concerns were part of formulation for other problems (e.g., indicators of possible child maltreatment in maltreatment clinical guidelines).
3. Guidelines related to practice parameters that were non-generalizable outside of a specific jurisdiction (e.g., ethical decision-making with respect to informed consent amongst primary care physicians in England and Wales).
4. Guidelines with reference to DSH, NSSI or BPD only in the citation of a previously summarized guideline. This was encountered frequently with secondary sources citing the NICE clinical guidelines for management and longer term care of self-harm (NICE 2004; 2011).
5. Guidelines removed from the published source and could not otherwise be retrieved.
6. Guidelines withdrawn since publication.

Search Strategy and Source

For its storage and retrieval capacity of clinical guidelines, the clinical search engine TRIP Database was used as the principal database (<http://www.tripdatabase.com/>). On June 10, 2012 the TRIP database was searched for clinical guidelines.

Search Terms: 1. Deliberate self-harm; deliberate self harm. 2. Non-suicidal self-injury; non suicidal self injury, non-suicidal self-injury². 3. Borderline Personality Disorder. Results were:

- i. Deliberate self-harm: 11 records included
Australia and New Zealand: 4 retrieved, 0 excluded; Canada 0; United Kingdom 28 retrieved, 22 excluded, United States of America: 5 retrieved, 4 excluded, Other Country: 0.
- ii. Deliberate self harm: No new records included
Australia and New Zealand: 8 retrieved (3 previously included, 5 excluded), United Kingdom: 43 retrieved (6 previously included, 37 excluded), United States of America: 8 retrieved (1 previously included, 7 excluded), Other Country: 0.
- iii. Non suicidal self injury³: 1 new record included
Australia and New Zealand: 21 retrieved, (18 excluded, 3 previously included); Canada: 4 retrieved, 4 excluded; United Kingdom: 25 retrieved (5 previously included, 19 excluded), United States of America: 27 retrieved (1 previously included; 26 excluded), Other Country: 0.
- iv. Non suicidal self-injury: No new records included
Australia and New Zealand: 8 retrieved, (6 excluded, 2 included); Canada (0); United Kingdom: 5 retrieved (4 previously included, 1 excluded), United States of America: 6 retrieved (2 previously included, 4 excluded), Other Country (0).
- v. Borderline Personality Disorder: 1 new record included
Australia and New Zealand: 3 retrieved (1 previously recorded, 2 excluded); Canada (0); United Kingdom: 11 retrieved (3 previously recorded, 7 excluded), United States of America: 5 retrieved, (1 previously recorded, 4 excluded), Other Country (0)

Acronyms:

BPD: Borderline Personality Disorder

CBT: Cognitive Behavioural Therapy

² All (4) records retrieved in this search had already been reviewed.

³ Previously reviewed records retrieved in searches for deliberate self-harm were also retrieved in searches for non-suicidal self-injury and borderline personality disorder.

DBT: Dialectical Behaviour Therapy
NSSI: Non-suicidal self-injury

DSH: Deliberate self-harm

Deliberate Self-Harm Guidelines: Description and Summary

Australia and New Zealand

Clinical guidelines summarized in Table 1 were retrieved from Australia and New Zealand. The first set of guidelines were published by The Victorian Government Department of Human Services, who created an E-book to respond to “suicidal behaviour,” including self-injury. This E-book was developed in consultation with multidisciplinary mental health professionals and consumers of mental health services (State of Victoria, Department of Health, 2010). Best practice guidelines were generated from a review of the literature on evidence-based practice for behaviours ranging in lethality from self-injury to completed suicide⁴. Guidelines were graded by technical experts and clinical consensus, with grades ranging from A to D. Grades were based on consistency of recommendations supporting the guideline within the field, and rigour of supporting evidence (State of Victoria, Department of Health, 2010). A summary of recommendations relating to self-injury were:

1.a. *Effective and validating communication.* There was an emphasis on careful listening and mindfulness of demographic variables (e.g. adolescents; older adults; Aboriginal Australians) influencing verbal and non-verbal expression of distress among self-injuring individuals.

1.b. *Comprehensive assessment.* In addition to presenting concerns, it was recommended that data should also be collected to assist determining appropriate referrals. Intoxication should be noted as a risk-factor for impulsivity with respect to attempting suicide.

1.c. *Supervision:* Where the front-line clinician does not have expertise in assessing self-injury, consultation and supervision should be sought by senior clinicians with this training and experience.

1.d. *Crisis planning:* Identifying supports in the professional community, and developing a plan detailing when and how to access clinical resources was encouraged. Involving the natural environment (family members, significant others) to support the individual was described, based on presenting problems and individual circumstances (State of Victoria, Department of Health, 2010).⁵

⁴ Only guidelines for self-injury are included here.

⁵ These guidelines also included peer reviewed practice tips which included topics such as developmental and cultural considerations; aspects of formulation in clinical assessment, remaining empathic with affectively dysregulated individuals in crisis, etc.

The guidelines in Table 1.2 were published by MH-Kids, New South Wales Health (MH-KIDS, NSW Health, 2008). They were published within an adolescent eating disorders toolkit to facilitate timely and consistent clinical care for youth in New South Wales. The toolkit is divided into sections based on aspects of inpatient treatment. A section on *Psychological Issues* was presented, in which associated features sometimes presenting alongside eating disorders described, amongst other things, DSH. DSH was defined behaviourally and clinically, providing information about the forms it may take and the functions it may serve (MH-KIDS, NSW Health, 2008). The authors disputed the notion that DSH was necessarily indicative of personality pathology. Developmentally, youth have less experience and ability to express their emotions compared to adults, making self-harm a means of communicating distress more likely. Implementation of strategies to manage DSH was encouraged in the toolkit, although no strategies to do so were mentioned specifically (MH-KIDS, NSW Health, 2008).

Table 1: Deliberate Self-Harm Treatment Guidelines in Australia and New Zealand

Authors / Developers	a. Description of treatment guideline(s) b. Modality	Focus	Age
1.1 State of Victoria, Department of Health (2010)	a. Clinical best practice guidelines for staff in emergency room, mental health triage, crisis teams and community services. b. E-book containing treatment guidelines (graded A – D) and summary recommendations developed through extensive consultation and peer review.	“Suicidal behaviours.”	Lifespan
1.2 MH-Kids, NSW Health (2008)	a. A toolkit for non-specialist clinicians treating adolescents referred for the inpatient treatment of eating disorders who may also engage in DSH. b. Electronic manual with practice-based guidelines developed from clinical practice and consultation with international experts.	DSH in youth with eating disorders	Adolescent

The United Kingdom

Clinical guidelines for DSH and related concerns in the United Kingdom are summarized in Table 2. The National Institute for Health and Clinical Excellence (2004) published multi-component aspects of guidance within Clinical Guideline 16, dedicated to the short-term (48 hour) management of self-harm in individuals age 8 years old and older. An additional merit of this clinical guideline was documented consultation with individuals that had lived experience of self-harm in formulating recommendations. In summary form, the guidance covered:

2.a. Inter-professional issues for all service providers: The experience of individuals presenting for care of self-harm was described as “often unacceptable.” Correcting the treatment experience for self-harming individuals was expressed as a priority, with numerous examples of responding mindfully, collaboratively, and non-judgmentally (NICE, 2004). All service providers were to have received training to assess capacity for consent as well as legislation and parameters for giving treatment without consent. Practice parameters for emergency interventions were presented alongside guidance for relevant training in relation to these interventions (NICE, 2004).

Within this guidance were specific treatment issues and recommendations (e.g., offering treatment for physical self-harm consequences regardless of whether the individual was willing to accept mental health services). Guidelines also existed for clinical and non-clinical staff training in management of self-harm and related mental health concerns, and integrated planning of services in consultation with multiple stakeholder groups (NICE, 2004).

2.b. Self-harm management in primary care: This outlined clinical decision-making and treatment parameters for minimizing risk, determining lethality of self-harm, and describing effective emergency response (NICE, 2004). Specific pharmacological practices to off-set ongoing risk were presented. An example was limiting tablets sent home with individuals who have self-poisoned and being mindful of prescriptions available in the household; choosing medicines that are not toxic if taken in excess of the prescribed dose (NICE, 2004). Resources for determining a risk index were presented, such as consulting with national information systems for fast information regarding poisons, or consulting with emergency services if the lethality of self-harm was unclear. Guidance for responding to self-harm in remote settings, and making specialist referrals for non-urgent cases were also presented (NICE, 2004).

2.c. Initial assessment by ambulance services: Guidance contained suggestions for protocols to follow in specific instances of poisonings (e.g., how to respond to opioid overdose versus tricyclic antidepressant overdose) in ambulatory care (NICE, 2004). Guidelines for transportation of individuals presenting for self-harm to emergency departments and specialist services, including collaborating with the individual to provide care in a manner as consistent with their preferences were presented. Guidance on auditing overdose and adverse events in ambulatory care was provided (NICE, 2004).

2.d. *Treatment in emergency departments:* This guidance was focused on quickly establishing the cognitive, physical and emotional functioning of an individual presenting for self-harm in emergency department triage, which was reported to be the principal first line of contact for care (NICE, 2004). The Australian Mental Health Triage Scale was referenced as being helpful in determining urgency and timing of interventions, the options for which were to be explained in an empathic manner (NICE, 2004). Thorough assessment at triage was to be carried out whenever possible, to accurately shape the following treatment plan. This assessment was prioritized, with the only acceptable delay being delivery of life-saving physical interventions (NICE, 2004). Therapeutic supervision of individuals presenting for care for self-harm was encouraged, to minimize the likelihood of them leaving prior to full assessment or treatment. Follow-up with the General Practitioner (GP) and relevant mental health services was to be initiated to facilitate further care should individuals leave abruptly. Thorough understanding of the Mental Health Act and when its use would be therapeutically indicated was also encouraged (NICE, 2004).

2.e. *Medical and surgical management:* This guidance outlined general protocols for responding to self-harm involving ingestion and self-cutting resulting in wounds (NICE, 2004).

2.f. *Guidance for individuals who repeatedly self-harm:* This guidance was concerned with sharing information and giving advice to individuals and others presenting with them regarding the risks and consequences associated with the specific method of repetitive self-harm (NICE, 2004). Alternative coping strategies were to be introduced, with information shared about these supports with the individual and others presenting with them. Case-by-case decisions were to be made in consultation with a mental health worker to determine who should be coached for self-management of injuries at home. Offering resources to manage significant scarring was also encouraged (NICE, 2004).

2.g. *Assessment:* This guidance was focused on carrying out a thorough assessment of risks and service needs with an individual presenting for care of DSH (“psychosocial assessment,” NICE, 2004). Elements to include in a therapeutic assessment were listed (NICE, 2004). Every member of the clinical team was to have training in conducting and documenting a self-harm assessment. Notes from the assessment were to be shared with the individual, with the invitation extended to the individual to disagree in writing with the assessment prior to having results sent to other service providers (NICE, 2004). Some guidelines within this group have been withdrawn since publication and are not summarized here (specifically: Clinical guidelines 1.7.3.3 and 1.7.3.4, NICE, 2012).

2.h. *Planning care:* This guidance was concerned with managing treatment, referral, admission and discharge when appropriate, which was to be conducted in collaboration with the individual presenting for care of self-harm whenever practically possible (excluding incapacity due to significant distress or mental illness, NICE, 2004). Referral and discharge without follow-up

were decisions to be based on the results of assessment. Temporary overnight admission was to be considered for individuals whose complex presentation precluded their ability to complete the assessment (NICE, 2004).

2.i. Special considerations for children and youth under 16 years of age: This guidance had to do with recommendations to involve clinicians with specialty training in child, youth, and family mental health to comprehensively assess, treat, and potentially follow up with children and youth who present for care of self-harm (NICE, 2004). The role of confidentiality and consent, involvement of child protective services where indicated, and advice to parents, such as removing means of self-harming in the home were presented. Regular clinical supervision to front-line staff from senior colleagues experienced with treating self-harm was encouraged (NICE, 2004). Guidelines within this group have been withdrawn since publication and is therefore not summarized (specifically: Clinical guideline 1.9.1.13, NICE, 2012).

2.j. Special considerations for older adults (age 65 plus): This guidance began with the observation that self-harm in older adults has been associated with greater likelihood of completing suicide, of which clinicians should be mindful in the context of assessment, treatment, and discharge planning (NICE, 2004). Assessments were to include clinical consideration of cognitive decline, failing health, social and living situation, as well as all other components of need and risk assessments for adults, outlined in previous guidance (NICE, 2004).

2.k. Psychological, social and pharmacological treatments: This guidance was concerned with follow-up referral after assessment and treatment for self-harm had been carried out in primary care. Decisions regarding referrals for specialist services were to be made not solely based on the fact the individual engaged in self-harm. Rather, referrals were to be formulated to treat the reasons leading to self-harm as well as to support the individuals' mental health functioning and global well-being (NICE, 2004). Individuals were to be given a description of available services, referral to which was to be planned and documented collaboratively, and shared with the General Practitioner. Some guidelines within this group have been withdrawn since publication and were therefore not summarized here (specifically: Clinical guidelines 1.11.1.4 , and 1.11.1.5, NICE, 2012).

The guideline summarized in Table 2.2 was a second set of guidance published by The National Institute for Health and Clinical Excellence (NICE). Clinical Guideline 133 (2011) was concerned with longer-term care of self-harm, excluding recommendations for physical injuries and clinical aspects of emergency department care that were summarized in Guideline 16. In summary:

2.2.a. General guidance for those providing care: These reiterated the principles expressed in Guideline 16 with respect to specialized, professional, ethical, empathic, and non-judgmental caring, and added that care should ideally be directed towards maximizing the strengths and

autonomy of the individual (resilience). Feedback from individuals using self-harm services was to be used as an outcome measure (NICE, 2011). All staff members were directed to speak and conduct themselves with sensitivity regarding the stigma surrounding self-harm, and to be familiar with local and national Acts, parameters of consent, organizations, websites, guidelines, and other resources to inform their work with individuals for whom they care (NICE 2011). Children and youth requiring treatment for self-harm were to have full access to services described within Clinical Guideline 16. These were to be conducted in the context of specialized child and youth mental health services, and related social agencies including child protection where indicated (NICE, 2011a). When presenting with family or “carers” these individuals were to be offered information on managing self-harm, the option of being part of future crisis planning (if agreed to by the individual presenting for DSH care), and their own assessment to support their needs (NICE, 2011).

For longer term services, continuity of care with the same provider and team was described as ideal. Where there was a possibility of youth “dropping out” of care upon their 18th birthday rather than transitioning to adult services, they were to be given the option of continuing care within child and youth mental health services (NICE, 2011). Ethnicity was not to influence access to care. Treatment was to be offered in language of choice, wherever possible, including the use of an interpreter as needed. Programming guidance was provided for delivering services to those with learning disabilities across the spectrum of severity (NICE, 2011).

2.2.b Primary care treatment and referral: Referral to mental health service for adults and child and youth mental health services for younger individuals was to be made for those with a history of self-harm presenting to primary care. This was to be done with priority in situations of treatment-resistant and escalating self-harm, with ongoing communication encouraged between care providers in primary and specialist settings. Primary care’s principal role was assessment, physical care, and referral (NICE, 2011).

2.2.c. Risk and needs assessment in secondary care: This guidance provided a protocol for conducting needs and risk assessments that were more comprehensive than guidance assessments in Guideline 16 (NICE 2004; 2011). Detailed guidance was presented for children and youth, as well as adults in later life, with the recommendation that these services are delivered by professionals with training in these developmental periods (NICE, 2011). All aspects of the needs assessment protocol, to be adapted developmentally based on age of the individual presenting for care of self-harm were presented, as were all aspects of the risk assessment protocol, also presented with developmental specifications (NICE, 2011). The guidance included recommendations to query other impulsive behaviours that were potentially self-damaging outside the NICE defined scope of self-harm (2004; 2011), (NCCMH, 2004). Results of multicomponent assessments were to be presented in risk management and treatment plans, shared with the individual, their family or “carer” with appropriate consent, and a paper copy sent to the general practitioner (NICE, 2001). Checklist-based risk assessment tools were to be used sparingly and with caution. Guidance discouraged predicting risk of completing suicide,

need for admission, or discharge based on risk assessment checklists in the absence of integrating feedback from the comprehensive clinical assessment guidelines presented above (NICE, 2011).

2.2.d. Longer term self-harm treatment & management: This guidance designated responsibilities for provision of care of longer-term ongoing assessment and treatment of self-harm. Service delivery was to be carried out via community-based mental health services, with specialist services based on developmental considerations (child and youth; older adult) (NICE, 2011a). A protocol of developing treatment and risk management plans, and the purpose of these plans, and timelines for updates were presented in detail, as were suggestions of appropriate parties with whom to share these plans. Guidance was also given on psychoeducation for the individuals regarding harm reduction strategies, long-term outcomes of self-harm and related mental health issues, as well as available interventions, and other self-harm resources, such as NICE Clinical Guidelines related to self-harm (NICE, 2011). It was noted that psychological treatments available to date have had limited data on efficacy.

2.2.e. Treating mental health related to self-harm: This guidance pertained to treating mental health issues co-occurring with self-harm. These were most often alcohol and substance use disorders; mood disorders (unipolar and bipolar depression); schizophrenia and borderline personality disorder (NICE, 2011). It was noted that self-harm is a not a diagnosis, but rather a “heterogeneous set of behaviours that can have different meanings in different contexts.” Holistic treatment would encompass biological, cognitive, emotional, behavioural and social aspects of self-harm, and indicate where underlying mental health concerns were ongoing vulnerability factors to continued self-harm (NICE, 2011).

The guidance summarized in Table 2.3 was derived from the fourth edition of guidelines for clinical management of self-harming substance use detainees (Royal College of Psychiatrists, 2011). This guidance contained procedures for managing individuals for whom self-harm is a risk while in custody. The procedures cite the empirical literature reporting that self-harm increases shortly after arrest, particularly for those who with a history of the behaviour. Risk was noted to be elevated for those who have addictions and mental health concerns, females in detention, and young people with comorbid mental illnesses (Royal College of Psychiatrists, 2011).

The guidance encouraged mental state exam as well as assessment to rule out referral to emergency services on the basis of serious injury resulting from self-harm, or fatality from recent self-poisoning. Following this, a needs and risk assessment was to be conducted, to determine appropriate referral for mental health needs excluding crisis intervention (Royal College of Psychiatrists, 2011). Previous suicide attempts and a history of self-harm were described as risk factors to be considered while conducting the secondary assessment. With respect to responsible caring, confidentiality and its limits were discussed within the context of the forensic physician conferring a referral via the custody officer. Sharing relevant but limited personal health

information was encouraged in order to facilitate the referral to appropriate mental health services (Royal College of Psychiatrists, 2011).

The guidance summarized in Table 2.4 represented a joint initiative between The Royal College of Physicians and the Royal College of Psychiatrists (2003). These two regulatory bodies created a manual for the psychological care of individuals presenting for treatment of physical illness in hospital settings (2003). A 10-part section on DSH had contained evidence-based practices in the form of guidance for all aspects of care for the individual presenting due to DSH.

The epidemiology of DSH as the primary purpose for hospital presentation in England was presented (140,000 per year) alongside a description of vulnerable populations (under age 35; females; a history of self-harm; chronically ill; socio-economically disadvantaged) (The Royal College of Physicians and the Royal college of Psychiatrists, 2003). In the year following an incident of DSH, the risk of suicide was noted to increase by 100 times compared to the general population. This statistic was presented alongside England's national target for suicide reduction, which aimed to reduce completed suicides by 20% from 1995/97 to 2010. The authors articulated England's national suicide prevention strategy, which included the effective management of DSH. The authors note: "All large general hospitals should have a specific DSH service" (p. 66).

2.4.a. Guidance on DSH assessment and formulation (The Royal College of Physicians and the Royal college of Psychiatrists, 2003): To assess those presenting to emergency services within 3 hours, and to assess non-urgent hospitalized individuals within 24 hours. An algorithm to support decision-making among hospital staff to assess risk and encourage individuals to stay for thorough assessment was presented. Determining mental status was also encouraged, detaining those refusing to participate and deemed to require care, or involving the General Practitioner for individuals presenting with DSH who leave prior to assessment.

Guidance also encouraged identifying those with a history of DSH, those in suicidal crisis, and those with untreated mental illness requiring mental health services. Creating a treatment plan including either hospital or community-based services was recommended. Examples of questions to include in suicide risk assessment were presented, as were 11 specific topics to include in comprehensive DSH assessment⁶.

⁶ These topics included antecedents to DSH; degree of suicidality associated with DSH; querying a list of current stressors; determining the presence of alcohol and substance use; mental health status for Axis 1 and Axis 2 disorders; individual and family functioning; mental health history, including DSH history and consequences therein; suicide risk at time of assessment; internal and external resources (coping and support); treatment plan, including the individual's commitment to the plan (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

2.4.b. *Developmental considerations:* For assessment of adolescents presenting with DSH, clinical consultation with child and youth mental health services was encouraged. With respect to treatment, problem-solving family therapy was recommended. Similarly, consultation with geriatric mental health services was encouraged in the assessment of older adults presenting with DSH. DSH was reported to be less frequent in later life, but associated with greater mortality (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

2.4.c. *Treatment guidance for repetitive DSH (defined as DSH on 5 or more occasions):* Dialectical Behavior Therapy (DBT) was recommended for those who met criteria for BPD. For those with concurrent disorder (co-occurring mental illness and substance use disorder), multi-component and possibly multi-agency treatment was recommended, alongside regular consultation amongst treatment providers. Pharmacotherapy was recommended to reduce DSH frequency in some cases (low dose antipsychotics), as were SSRIs, although the later was indicated with caution (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

2.4.d. *Guidance on caregiver attitudes influencing care:* The authors note that negative attitudes amongst caregivers are prevalent towards DSH, particularly repetitive DSH. When individuals presenting with DSH experience negative caregiver attitudes, it which may serve as a barrier to seeking required services in the future (The Royal College of Physicians and the Royal College of Psychiatrists, 2003). Consideration of the individual's circumstance, including family history, genetics, and early experience was recommended to offset the view that problems are "self-inflicted." Careful listening and empathy, alongside good communication with the individual and their treatment team was encouraged (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

2.4.e *Guidance on DSH staffing and service:* Having an inter-professional DSH service within a general hospital setting available for consultation to the Emergency Department, and the rest of the hospital was encouraged. The capacity for rapid response was recommended, such that a DSH team member could respond to a request from the emergency department within 1 hour (The Royal College of Physicians and the Royal College of Psychiatrists, 2003). Nurses with specialty training, clinical psychologists, social workers and psychiatrists would comprise the team, with liaison psychiatry nurses traditionally in a leadership position. Availability of these staff was cited as reducing duration of inpatient admissions.

The DSH services' role included assisting with treatment planning, collaborating with other agencies and services outside the hospital. Further they would be stakeholders within the hospital to communicate policy, access, and staffing requirements. A drafted template of members of a

DSH planning group was presented for hospitals considering implementing a DSH service⁷ (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

2.4.f. *Guidance on evaluation and research of DSH services*: DSH services were encouraged to track the number of cases they saw, to estimate their workload, track the proportion of thorough assessments completed, and evaluate the experiences of those who received care including aftercare. A need for research on DSH treatment was articulated (The Royal College of Physicians and the Royal College of Psychiatrists, 2003).

The guidance presented in Table 2.5 represents best practice guidance on personality disorders published by The National Institute for Mental Health in England (NIME: 2003). It included a description of personality disorders and their characteristics, including DSH, examined the evidence for treatments, and presented recommendations. A number of psychological treatments were presented for various aspects of personality disorders. Dialectical Behaviour Therapy (DBT) was described and recommended as an intervention to reduce self-harm (NIME, 2003). Helpful and unhelpful features of mental health services were presented from those with lived experience of DSH, and recommendations were presented therein, including early intervention and public education to de-stigmatize personality disorders (NIME, 2003).

The guidance presented in Table 2.6 reflects England's national Department of Health (DH) publication of a suicide prevention strategy in (2002). Within it were goals and implementation strategies to reduce suicide by 20% by the year 2010⁸. Initiating activities related to the goals of the suicide prevention strategy was to be directed by the National Institute of Mental Health in England and the National Institute for Clinical Excellence (DH, 2002).

Goals of the strategy related to DSH were:

2.6.a. To reduce risk of suicide in this population, who were noted to be particularly vulnerable.
2.6.b. To improve the mental health of at-risk, socially excluded, and cultural minority populations, as well as men under age 35 who engage in DSH and have addictions.

2.6.c. To reduce access to lethal methods of harming oneself. Each goal had a number of specific objectives within it, specifying directions in which the goal was to be implemented (DH, 2002).

⁷ Potential members would include: Medical and non-medical staff from the DSH service; medical and non-medical staff from the emergency department; general medical staff; child and youth mental health services staff; geriatric mental health services staff, addictions treatment staff; a member from hospital management; front-line staff; staff from community crisis services; individuals with lived experience (The Royal College of Physicians and the Royal College of Psychiatrists, 2003)

⁸ Although England did not reach their national suicide prevention goal in 2010, they met their objectives during the first five years of the strategy, and maintained a trend of reduction while other countries observed increases in completed suicide nationally (Martin & Page, 2009).

Implementation plans within the prevention strategy outlined required actions to achieve specific goals (DH, 2002). The authors acknowledged that self-harming individuals are significantly more likely to complete suicide within the year of having engaged in DSH. Accordingly, individuals presenting for care of DSH or with a recent (one-year) DSH history were to be given the most timely and intensive level of services when presenting to mental health service settings (DH, 2002). Where mental health services were involved, crisis outreach teams were to maintain contact in situations where risk of drop-out was high. Specialty services were to be arranged for individuals struggling with DSH alongside co-occurring mental illness and addictions. Hospitalized individuals presenting for DSH (or individuals who had engaged in DSH over the past 3 months) were to be revisited within 7 days following discharge. Prescribed medication was to be given for no more than a 2-week period (DH, 2002).

DSH interventions were to be inter-professional and comprehensive, with communication across the individual's continuum of care, including appropriate services to families in the event of "incidents" (DH, 2002). Plans for national monitoring of DSH and related suicide were reported, as were national scholarly initiatives to examine the frequency and scope of DSH in school-attending young people (DH, 2002).

Table 2: Deliberate Self-Harm Treatment Guidelines in the United Kingdom

Authors / Developers	a. Description of treatment guideline(s) b. Modality	Focus	Age
2.1 National Institute for Health and Clinical Excellence (NICE: 2004)	a. National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 16 (Self-Harm). Multiple points of guidance were published within a larger framework that included key priorities for implementation, scope of guidance, implementation considerations, research recommendations, various versions and review dates of the guideline, the grading scheme used to evaluate guidelines, and author and reviewer appendices (NCCMH, 2004) b. NICE Guideline (e-publication)	Short-term (48 hour) assessment and intervention of “self-harm.”	Child, youth, and adult.
2.2 Update to Clinical Guideline 16 in (NICE, 2011)	a. NICE Clinical Guideline 133 dedicated to guidance for longer term care of self-harm (NICE, 2011a). b. NICE Guideline (e-publication)	Longer-term (=>72 hour) mental health services for self-harm in individuals 8 years old and older	Child, youth and adult.
2.3 Royal College of Psychiatrists (2011)	a. A procedure for managing risk of DSH and suicide in detainees apprehended for substance misuse. b. Medico-legal guidelines of clinical management e-report.	Detained, possibly intoxicated individuals at risk of self-harm or suicide.	Lifespan
2.4 Royal College of Physicians & Royal College of Psychiatrists (2003)	a. A framework for doctors highlighting the psychological aspects of physical health and illness. A section dedicated to DSH included recommendations for assessment, intervention, inter-professional collaboration and evaluation of services. b. E-manual dedicated to the psychological care of medical patients.	Individuals with physical conditions impacted by mental health functioning	Lifespan
2.5 The National Institute for Mental Health in England (NIME: 2003)	a. National Institute for Mental Health in England (NIME) best practice guideline. Guidance existed for treatments targeting personality disorders, DSH, and related public policies and education. b. National policy implementation guideline for personality disorders (e-document).	Personality disorders and their traits, including DSH.	Adult

Table 2: (Continued)

2.6 Department of Health (2002)	<p>a. England's national suicide prevention strategy, which was dedicated to reducing completed suicide by 20% by 2010. Goals were formulated to support this outcome, and implementation guidance for goals was presented. DSH was identified as a key area for action.</p> <p>b. Nationally published strategy (e-publication).</p>	Goals and plans to support suicide reduction in individuals who DSH.	Youth, adult, adults in later life.
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Canada & United States of America

The guidance presented in Table 3 is derived from clinical guidelines published by The U.S. Department of Health and Human Services. This resource presented guidance on the care of individuals with suicidal thoughts and behaviours, including DSH, citing work from the Registered Nurses' Association of Ontario (RNAO, 2009).

A total of 26 guidelines were presented for nurses providing care, evaluated across 6 levels of evidence graded by rigorousness of supporting evidence. Those relevant to DSH were (RNAO, 2009):

- 3.1 Establishing a therapeutic relationship.
- 3.2 Making efforts to reduce stigma, guilt, and shame associated with DSH.
- 3.3 Providing care to demonstrate cultural competence.
- 3.4 Gathering information (family, friends, previous service records) to support care.
- 3.5 Working collaboratively with the individual to understand their experience, areas of need and strength.
- 3.6 To maintain updated knowledge of current treatments.
- 3.7 To provide debriefing as part of a protocol with other clinical staff.
- 3.8 Minimizing individual's access to implements for DSH while in care.
- 3.9 Providing clinicians ready access to regular coaching and clinical supervision.
- 3.10 Having organizational support for professional development related to ongoing training to treat DSH.
- 3.11 Having organizational support for research related to DSH.
- 3.12 Having organizations implement best practice models within the service setting.

Table 3: Deliberate Self-Harm Treatment Guidelines in Canada via the United States of America

Authors / Developers	(a) Description of treatment guideline(s) (b) Modality	Focus	Age
U.S. Department of Health and Human Service (2009) ⁹	a. A set of 26 recommendations for nurses in various settings responding to suicidal behaviour, including DSH. b. US National Clearinghouse Guideline.	Guidance for nurses caring for individuals engaged in DSH and suicidal behaviour	adult

⁹ Although this guideline was found within the United States' Department of Health and Human Services internet resource, the bibliographic reference was for the Registered Nurses of Association of Ontario (RNAO: 2009).

Non-Suicidal Self-Injury: Description and Summary

*The United Kingdom*¹⁰

The guidance presented in Table 4 was published by The Royal College of Psychiatrists (2010), who developed a working group to enhance understanding of why individuals self-harm and kill themselves, and to examine evidence supporting response, treatment, research, and public policy (Royal College of Psychiatrists, 2010). Self-harm was observed to be increasing among young people despite the national decrease in suicide. The summary of recommendations presented here will be limited to those related to self-harm. Based on their collective expertise, consultation and research, recommendations were (Royal College of Psychiatrists, 2010):

- 4.1 Development of a cross-departmental initiative to raise awareness, support, and training of front-line staff in various settings (e.g. prisons) and disciplines and to support effective intervention and research regarding self-harm.
- 4.2 Developing a system of monitoring websites modeling self-harm should be included in the strategy, as should access to content and user-friendly electronic resources provided within the context of a national strategy.
- 4.3 Those responding to individuals presenting for care of self-harm should be able to distinguish between mental illness and situational distress, and how to refer to appropriate mental health services on those grounds.
- 4.4 Networks between volunteer, charity, and health provider's licensing and regulatory bodies should be developed to support each other's roles in reducing self-harm.
- 4.5 Mental health professionals and their regulatory bodies should collaborate to ensure that adequate and supportive information and resources are available for a diverse population of self-harming individuals.
- 4.6 National, medical, social, and charitable funding should prioritize supporting research regarding self-harm.
- 4.7 The Royal College of Psychiatrists should develop a core curriculum to share with other health care providers responding first to those who self-harm. Organizations should support staff to receive this training. For psychiatrists, examining self-harm from a biopsychosocial approach should be a mandatory prior to qualification for licensure. Exposure to self-harm should be part of training under the supervision of senior and experienced clinical supervisors available at front-line alongside qualifying doctors.
- 4.8 Improvement in organizations providing mental health services to ensure positive outcomes amongst those presenting for self-harm was recommended. This was to be achieved by adopting a reflective practice and having access to supportive and available colleagues.
- 4.9 Risk assessments should be evidence-based and part of the global biopsychosocial assessments. These assessments should be delivered by a practitioner trained according to NICE clinical guidelines (NICE, 2004).

¹⁰ Clinical guidelines retrieved for non-suicidal self-injury from Australia and New Zealand, and the United States were previously retrieved under searches for "deliberate self-harm."

4.10 Evidence-based psychological treatments should be available to those requiring it. Funding for research is required to improve the existing evidence supporting various psychological treatments.

4.11 Various models of service delivery for individuals who repeatedly self-harm should be developed, and self-harm services providing specialized care should have the effectiveness of their services regularly evaluated.

4.12 Specialty services for self-harming prisoners need to be developed which take into consideration caring for incarcerated individuals as well as those in the process of transfer. Training prisons staff to effectively respond to self-harm was recommended.

4.13 Charitable, volunteer, regulatory bodies, and mental health services were said to have a key role in collaboration to work in partnerships.

Table 4: Non suicidal Self Injury Clinical Guidelines in the United Kingdom

Authors / Developers	a. Description of treatment guideline(s) b. Modality	Scope	Age
Royal College of Psychiatrists, 2010	A working group's final report containing multiple recommendations to comprehensively understand self-harm, promote a public health agenda to treat self-harm, and to effectively treat individuals engaged in self-harm.	Clinical, research, public policy, and cross-sectoral recommendations to effectively reduce self-harm.	Lifespan

Borderline Personality Disorder: Description and Summary

*The United Kingdom*¹¹

The guidance presented in Table 5 was published by The National Institute for Health and Clinical Excellence. Clinical guideline 78 is dedicated to the treatment and management of Borderline Personality Disorder (BPD) (NICE, 2009b). The authors noted the limitation of the small number of randomized controlled trials providing efficacy data on psychological treatments for BPD, and inconsistent results within the existing studies. They added that although prescription recommendations were included, no specific medication had been expressly authorized for the treatment of BPD (NICE, 2009b). Their comprehensive guidance is summarized as follows (NICE, 2009b):

5.1 General Principles of working with the individuals diagnosed with BPD: This guidance emphasized the importance of removing barriers to treatment for those diagnosed with BPD. Independence and choice were to be emphasized in problem solving and crisis management, as was a trusting and collaborative therapeutic relationship. Families and “carers” were to be involved in assessment and care, whenever possible (NICE, 2009b).

Young people (under age 18) were to receive comprehensive services within appropriate child and youth mental health settings. Individuals from cultural and ethnic minority groups were to receive culturally appropriate care, including services in their language of choice via independent interpreters (NICE, 2009b).

This guidance included the recommendation that assessments be conferred for individuals with mild learning disabilities, and that standard treatment for BPD should be modified in consultation with learning disabilities specialists. Individuals with moderate to severe learning disabilities were not to be given a BPD diagnosis, but rather to receive assessment and treatment within learning disabilities services (NICE, 2009b).

In the context of assessment, the process, diagnosis, plans of care, and referrals should be discussed in non-technical language with the individual. Self-harm and suicide attempts should be assessed and treated based on formalized, evidence-based protocols (e.g., related NICE guidelines). Mental health professionals working across primary, secondary, and community-based specialized serves should be proficient in diagnosing BPD, competent in conducting risk assessments and generating treatment plans based on this guidance. Those working principally with individuals diagnosed with BPD should receive regular supervision.

¹¹ Comparatively few clinical guidelines were published for BPD. Clinical guidelines meeting inclusion criteria for this report were limited to a previously published guidelines for personality disorders and DSH, and the NICE (2009b) guideline on treating BPD.

5.2 BPD in primary care: This guidance encouraged referral to community-based specialized services for a diagnostic assessment if individuals demonstrated symptoms of BPD in primary care.

5.3 BPD Assessment in community-based specialized services: This guidance suggested that specialized settings outside of primary care should be responsible for ensuring that regular assessments occurred for individuals with BPD. Management of treatment was to be carried out within these services as well. Components of the BPD assessment were listed, as were the details of what to include in a plan of care for an individual diagnosed with BPD, and directions for sharing the plan of care with other service providers (NICE, 2009b).

This guidance also contained instructions for managing risk outside of primary care, and appropriate follow-up after crisis management. Clinician's burn-out was to be rated annually or more frequently for teams managing the care of multiple high-risk individuals (NICE, 2009b). Choosing psychological treatments for BPD was to occur in consultation with the individual. Providing written and multi-media resources on treatment options for the person to choose from was encouraged, as was a discussion about the effectiveness of the treatments offered (NICE, 2009b).

Recommendations were to offer treatments with an explicit theoretical model and associated standards of care for both the clinician and the therapist. Following the protocol accompanying the treatment model chosen, and observing the standard of care in this NICE guideline was encouraged (NICE, 2009b). Treatments less than 3 months in duration were discouraged. Women with BPD who also engaged in recurrent DSH were recommended to receive Dialectical Behavior Therapy (DBT). Outcomes for monitoring treatment efficacy were suggested (NICE, 2009b).

Parameters for pharmacotherapy were presented, including the management of insomnia. Polypharmacy was discouraged. Treatment management with respect to comorbidities alongside a BPD presentation were considered. It was recommended that Major Depressive Disorder, Post-Traumatic Stress Disorder, and Anxiety be treated within the context of a structured BPD program. BPD comorbid with severe eating disorders, Substance Dependence, or psychosis were to be referred to specialized services for those conditions initially. It was encouraged to follow the NICE clinical guidelines on comorbidity (NICE, 2009b).

5.4 BPD in inpatient services: This guidance recommended that inpatient hospitalization be considered only after exhaustively consulting other crisis resolution options outside of hospital admission. Criteria for admitting an individual with BPD for acute-stay hospitalization were outlined, as were criteria for children and youth. A review was to be ordered if the same individual with BPD was admitted twice or more within the same 6-month period (NICE, 2009b).

5.5 Organization planning for the implementation of BPD services: This guidance contained directions for developing multidisciplinary teams for the specialized treatment of BPD. Assessment and treatment management was to be tailored for complex individuals with high needs, as were protocols for information within an individual’s circle of care. Training on safe pharmacotherapy practices, and the management of multiple comorbidities was recommended (NICE, 2009b). Observing protocols for managing the transition of children and youth into adult services as they aged out of pediatric care was encouraged.

Multi-centre research initiatives on BPD were to be developed at the local and national level, including programming to develop anti-stigma campaigns for presentations to various social and community service settings. Individuals with BPD were to be involved in program development and professional training, and supported in the formation of peer-support groups (NICE, 2009b).

Table 5: Borderline Personality Disorder Clinical Guidelines in the United Kingdom

Authors / Developers	a. Description of treatment guideline(s) b. Modality	Scope	Age
NICE, (2009b)	a. National Institute for Health and Clinical Excellence (NICE) clinical guideline 78 (Borderline Personality Disorder: Treatment and Management). Multicomponent guidance was published within a larger framework that included key priorities for implementation, scope of guidance, implementation considerations, research recommendations, various versions and review dates of the guideline, the grading scheme used to evaluate the guideline, and author and reviewer appendices (NCCMH, 2009). b. NICE Guideline (e-publication).	Individuals diagnosed with BPD in primary, secondary and specialist community service settings within the National Health Service.	Adults and “young people.” ^{12 13}

¹² Defined in an accompanying manual (NICE 2009c) defining scope of this guideline as “People younger than 18 years with borderline symptoms, or putative borderline personality disorder” (p. 6).

¹³ In the introduction of clinical guideline 78 there is a provision that the care of individuals age 16 and younger should be informed by consent and treatment parameters for children. Individuals between the ages of 16-17 years old should receive treatment within specialized adolescent mental health services and reflect their parameters for consent and treatment (NICE 2009b).

Integration of Common Themes in Clinical Guidelines

Over the course of preparing this report, common themes expressed by various groups in their publication of clinical guidelines became evident. These unified recommendations are summarized as follows:

Treatment

1. An authentic, validating, and collaborative relationship must be quickly established by those responding, and supporting response, to self-harming individuals. This was to be facilitated by careful listening, non-reactive responding, and transparency in all aspects of providing care. No specific protocols to teach these clinical skills were mentioned.
2. Referral of children and youth to specialized child and youth services is required for the same spectrum of care offered to adults presenting for DSH and related concerns. Parameters for consent, mandatory care, and involvement of child protection will need to be implemented within protocols for children and youth, as will a youth-friendly culture of service provision. Family participation in treatment needs to be more fully developed, and is an area lacking evidence-based clinical guidance at present. Family and specialty services should also be part of caring for self-harming older adults.
3. Individual choice was a hallmark of good clinical practice. Whenever possible, choice of male or female clinician should be offered, as should choice of speaking in mother tongue, even if this requires the use of an interpreter. Choice of evidence-based and theory-driven psychological treatments was to be offered in a manner that did not require health literacy.
4. Risk assessments were to be informed by comprehensive clinical interviews, using checklists to supplement broader comprehensive clinical case formulation. Using checklist for determining risk indices in the absence of other input from clinical assessment was discouraged.
5. Clinical assessments were the hallmark of good care in first-line settings, determining the course of later treatment and referral. Lists of aspects to include in clinical assessments are published. In keeping with collaborative service provision, a recommendation was to share assessments with individuals upon whom they are based.
6. Treatment plans were to include referral for services to treat underlying mental health conditions, where these existed. Treatment plans were to articulate goals with respect to DSH that include (ideally) elimination or reduction of self-harm. Global functioning was to be addressed. Both short-term and longer-term goals were to be included in treatment plans, and these were to be revisited and updated over the course of therapy. Teaching

harm reduction strategies for “safer” self-harm was controversial, and not indicated within a best practice model.

7. No specific medications for DSH and related concerns have been identified, although the two primary pharmacological interventions for DSH and related concerns were anti-depressants and anti-psychotics. Safe prescription practices are available and should be observed, particularly in the management of insomnia. Polypharmacy is discouraged.
8. A clear protocol for referrals from primary care to specialized services is to be documented, with follow-up from the primary care setting to ensure that care has been successfully transferred. Eliciting a commitment from the individual to access care for which they have been referred would be helpful. A majority of individuals presenting for care of self-harm do not receive continuity of care. It is not unreasonable to query whether lack of follow-up and increase of completed suicide by individuals self-harming within the previous year are related. To offset this risk, dedication and follow-up on the part of both the clinician and the individual is required.
9. Various short-and-long term therapies were listed as providing preliminary efficacy in the treatment of DSH and related problems, with various levels of evidence supporting their implementation. Other researchers in our group evaluate evidence supporting psychological interventions.

Program Development

1. Service centres for DSH and related concerns should be available within every hospital, including children’s hospitals. Staff for this service should be available for consultation with other departments and health centres. Professional DSH consultation from staff providing these services should be available on a 24-hour basis.
2. Developing DSH services should be done in consultation with blueprints and templates for staffing and leadership, published by organizations who have implemented effective DSH services. For example, published guidelines exist that demonstrate how an inter-professional team providing DSH service can reduce waiting, assessment, and referral times, which in turn reduces the likelihood that individuals will leave prior to receiving a thorough assessment (The Royal College of Physicians and the Royal college of Psychiatrists, 2003).
3. Prisoner populations have been reported to have substantially higher base-rates of DSH than the general population. Vulnerability periods for DSH are immediately following arrest and incarceration. Intoxication, female sex, a history of mental illness and previous DSH are additional risk-factors. Clinicians working in forensic settings must work closely with health care groups to confer rapid referrals for emergency services when

needed, while balancing confidentiality within the prison system. Completed suicide was also high in prisoner populations.

4. Information for the layperson responding to DSH and related concerns was to be evidence-based and widely available. This was to be achieved by providing internet resources and pamphlets distributed in schools, as well as social and community services settings. Pro-bono public events could be regularly hosted by programs open to the community. Creating partnerships with voluntary sector organizations serving self-harming individuals would also be a key aspect of program development.

Research

1. Evaluation of programs, services, adverse events, and fidelity to projected timelines and therapy protocols was valued as highly as implementation of clinical guidelines. Involving individuals with lived experience from program planning, and client satisfaction ratings as an index of success was encouraged.
2. Qualitative and quantitative data collection based on non-homogeneous demographic samples representative of individuals who self-harm is required to determine the meaning, intent, and purpose of DSH and related concerns. This research must inform local programming and treatment.
3. Examination of DSH and related concerns amongst refugees and asylum seekers, survivors of child maltreatment and sexual assault in consultation with voluntary sector groups serving these populations.
4. Large-scale randomized controlled trials enabling adequate statistical power to test all outcomes associated with DSH and related concerns, including economic burden, quality of life, relationship formation and satisfaction, impact on education and employment.
5. Large-scale RCTs to determine therapeutic efficacy of various psychological treatments¹⁴. This research is required to truly support informed choice regarding which psychological treatments to offer individuals based on efficacy for various mental health concerns co-occurring with DSH. This aspect of research must also include trials investigating efficacy of interventions with a family component for children and youth, which is lacking from most treatment protocols at present. Interventions for older adults would also benefit from a family component, alongside appropriate trials to test treatment efficacy.

¹⁴ Dialectical Behavior Therapy (DBT) was noted to have promising preliminary data to support its use in women with BPD who engage in repeated DSH. No similar recommendations were made for men, despite the fact that subgroups of male youth and adult men are uniquely vulnerable to completed suicide.

6. Large-scale RCTs to determine efficacy of community-based intervention and prevention initiatives. This line of inquiry is lacking clinical guidelines at present but was identified as an area of need.

7. Population-based estimates of morbidity and mortality in relation to DSH and related concerns would generate national estimates of the burden to both individuals and society. This may be particularly helpful to facilitate movement towards development of national clinical guidelines in countries where none yet exist. National clinical guidelines implicitly and explicitly generate new standards of care and responsibilities to service providers, health administrators, researchers and policy makers.

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Appendix A

Public Information and Outreach: Deliberate self-harm (DSH) guidelines for the layperson

A small subset of clinical guidelines for DSH and related concerns met inclusion criteria, and were dedicated to treatment intended for a layperson responding to a crisis. These are included in Appendix A, given that public information and outreach of appropriate response to DSH and related concerns was recommended within many other clinical and best-practice guidelines.

Summary of Guidelines for the Layperson Responding to Self-Injury in Australia and New Zealand

Treatment guidelines summarized in Table 6.1 were retrieved from Australia and New Zealand. The first record was from an Aboriginal Mental Health and First Aid Training and Research Program, concerned with informing the public about effectively intervening in a culturally respectful manner with indigenous people engaged in deliberate self-injury (2008). Prior to assuming that intervention was needed, the authors encouraged querying whether injuries were part of cultural or spiritual practices. It was noted that some culturally normative grieving practices do involve small skin incisions (Aboriginal Mental Health and First Aid Training and Research Program, 2008). If spiritual and cultural practices are ruled out as a cause for deliberate self-injury, guidance was given on expressing concern in a non-judgmental manner. Coaching those engaged in deliberate self-injury involved encouragement to express distress non-physically (by speaking, drawing, or writing about emotional pain). Guidance also included parameters for bridging the self-injuring person to appropriate resources when indicated. Guidance for assessing emergencies, and responding effectively in an emergency was also presented (Aboriginal Mental Health and First Aid Training and Research Program, 2008)

Treatment guidelines summarized in Table 6.2 were published by the University of Melbourne-based Mental Health First Aid Training and Research Program (MHFA Training & Research Program, 2008a)¹⁵. These treatment guidelines were for members of the public supporting someone engaged in self-injury. The authors made a distinction that self-injuring individuals expressing suicidality should be professionally evaluated by a clinician. Recommendations were:

1. To respond non-judgmentally, avoiding extreme emotional response.
2. To determine mental state, calling an ambulance if the self-injuring person was disoriented, confused, or not fully conscious.
3. Evaluate severity of harm, calling an ambulance if the self-injuring person was rapidly losing blood, or had self-poisoned.
4. Encouraging self-harming individuals whose injuries were not life-threatening to seek mental health services. Recommendations also included coaching the individual to disclose self-harm urges to trusted others as a means of coping prior to engaging in the behaviour, in an effort to eliminate the behaviour going forward (MHFA Training and Research Program, 2008a).

¹⁵ These authors also published guidelines for “suicide thoughts and behaviours” dedicated to assessing and intervening in situations of self-injury where suicidal intent was present (MHFA Training & Research Program, 2008b). The guidelines were similar, with added recommendations to avoid promising to keep suicidal intent a secret as well ensuring that a person expressing suicidality is not left alone if acutely at-risk.

Table 6: Treatment Guidelines for the Layperson Responding to Self-Injury in Australia and New Zealand

Authors / Developers	a. Description of treatment guideline(s) b. Modality	Focus	Age
6 .1 Aboriginal Mental Health First Aid Training and Research Program (2008).	a. Guidelines developed in consultation with expert Aboriginal clinicians in Australia for responding in a manner that is culturally respectful. The guidelines are intended for a layperson intervening until a professional can provide care. b. Internet resource (e-Guideline).	Self-injury and related crises in Aboriginal or Torres Strait Islanders	Not specified
6 .2 Mental Health First Aid Training and Research Program (2008)	a. A set of recommendations for the layperson intervening on behalf of a non-suicidal individual engaging in self-harm. b. Internet resource (e-Guideline).	Self-injuring individual (non-suicidal)	Adolescent