

Self Harm
Guideline Consultation Comments Table
12th April – 7th June 2011

Order no.	Type	Stakeholder	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1		NICE	General	General		It is not clear how this and CG16 follow on and differ from each other in terms of providing patient care. This needs to be clear and all overlaps addressed so the relationship between the two can easily be understood within pathways. Many recommendations seem to duplicate those in CG16. At the moment this and CG16 seem disjointed. An example of this may be recommendation 1.9.1.13 in CG16- when does long term management begin? Why does the short term management guideline mention the provision of six sessions of developmental group psychotherapy?	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
2	SH	British Association for Counselling and Psychotherapy	Full	General	General	BACP thanks NICE for the opportunity to comment on this important draft guideline.	Thank you for your comments.
3	SH	RCGP	Full	General	General	A good review of the subject but I couldn't find any reference to the prison population which has a high risk of mental health problems and, in my experience as a Death in Custody Reviewer a high incidence of self-harm leading to suicide. Should this be a separate section rather than being included in the primary and secondary care without specific mention?	Thank you for your comments, this guideline has not reviewed the evidence for prison populations as this is unfortunately outside the scope of this guideline, however the recommendations may be relevant to those working within prison/forensic services.
4	SH	Department of Health	Full	General		Could you please consider clarifying at the start of the document (in a way it is addressed in the full guideline, but is rather buried) that this relates to recurrent self-harm, and not just the longer-term management of individual episodes of para-suicide. We feel that this is important, because the previous guideline on self-harm appeared to be concerned only with the first 48 hours. This guideline addresses a very different issue.	Thank you for your comment. This guideline relates to the longer term management of any type of self-harm, whether it be the first episode, or repeated episodes and regardless of intent. We have amended the second sentence of the Introduction to the NICE guideline and the Preface to the full guideline to read: <i>This guideline is concerned with the longer-term</i>

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							<i>psychological treatment and management of both single and recurrent episodes of self-harm.</i>
5	SH	NETSCC, HTA	Full	general	general	<p>2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).</p> <p>I was very impressed with the methodological quality of this guideline and have no comments.</p>	Thank you for your comments.
6	SH	NETSCC, HTA	Full	general	general	<p>2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.</p> <p>Again, I was very impressed with the methods of the economic evaluation. Economic evidence in the area of self-harm is rare and the authors have provided clear and appropriate reviews of the evidence available and a useful, if rather simplistic economic model. The findings of the model are exactly as I would expect; high levels of uncertainty and no way of coming to any meaningful conclusion as a result of the lack of generic measures of QoL. The research recommendations are more important in this field.</p>	Thank you for your comments.
7	SH	NETSCC, HTA	Full	general	general	<p>One thought – given the group included the (at the time) unpublished Green et al 2011 in the clinical review, I wonder why it wasn't mentioned in terms of economic evaluation since the paper includes both the clinical and economic evaluation results. The paper has now been published in the BMJ.</p>	Thank you for pointing out this study. The study has been reviewed and reported in the economic evidence section 7.1.9. The evidence from the study does not alter the available economic evidence on psychosocial intervention and therefore, does not affect the guideline recommendation significantly
8	SH	NETSCC, HTA	Full	General	general	<p>3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?</p> <p>The findings are justified and complete.</p>	Thank you for your comments.
9	SH	NETSCC, HTA	Full	general	general	<p>3.2 Are any important limitations of the evidence clearly described and discussed?</p> <p>The limitations of the data are clearly discussed.</p>	Thank you for your comments.
10	SH	NETSCC, HTA	Full	general	general	<p>4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the</p>	Thank you for your comments.

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						<p>recommendations have been reached from the evidence.</p> <p>Very well written, clear and well presented.</p>	
11	SH	NETSCC, HTA	Full	general	general	<p>4.2 Please comment on whether the research recommendations, if included, are clear and justified.</p> <p>Again, very clear and appropriate.</p>	Thank you for your comments.
12	SH	NETSCC, HTA	Full	General	General	<p>Section five – additional comments</p> <p>Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.</p>	
13	SH	NETSCC, HTA (Referee 2)	Full	general	general	<p>1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)</p> <p>Generally, the guideline appears to have addressed the scope</p>	Thank you for your comments.
14	SH	NETSCC, HTA (Referee 2)	Full	general	general	<p>2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).</p> <p>Given the limitations of much of the existing evidence, and subject to my comments below, the work seems to be valid</p>	Thank you for your comments.
15	SH	NETSCC, HTA (Referee 2)	Full	general	general	<p>Lines 3-4, the minus sign of the lower confidence limit has become separated from the numbers</p>	Thank you for your comment, unfortunately it is not possible to tell which page you are referring to and therefore we are unable to amend this. However, before publication the guideline will be thoroughly checked by the editors at NCCMH and any typos such as this will be amended.
16	SH	NETSCC, HTA (Referee 2)	Full	general	general	<p>3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?</p> <p>Given the limitations of the evidence in many areas, the recommendations appears appropriate</p>	Thank you for your comments.
17	SH	NETSCC, HTA	Full	general	general	<p>3.2 Are any important limitations of the evidence clearly described and discussed?</p>	Thank you for your comments. It is difficult to know which studies you are referring to, but we assume it

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		(Referee 2)				The studies used to support the recommendations are often of poor quality, or poorly reported, and often there is much heterogeneity between studies of the same interventions, suggesting variability of methods used or populations studied. These inadequacies are routinely reported in the review. More could perhaps be said in the recommendations for future research to encourage large multicentre trials of interventions for which there is some evidence of benefit to determine in which settings or under what conditions particular interventions might be most effective – to explore the reasons behind the high levels of heterogeneity, and to assess the extent to which these complex interventions can be effectively delivered in multiple settings.	is the ones reviewed in the Psychosocial Interventions chapter. These studies are bound to have much heterogeneity as the studies are looking at different types of therapies, with different practitioners, in different settings, with often the only similar factor of reducing self-harm. Therefore, we do not feel it necessary to amend the research recommendation as the heterogeneity is expected.
18	SH	NETSCC, HTA (Referee 2)	Full	general	general	4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence. Throughout the document there are many errors in grammar and punctuation, and tables often go from one page to the next, making the guideline difficult to read at times. There are several technical errors in the use of statistical language which I found frustrating.	Thank you for your comments, the guideline will be fully checked for errors in grammar and punctuation before publication.
19	SH	NETSCC, HTA (Referee 2)	Full	general	general	4.2 Please comment on whether the research recommendations, if included, are clear and justified.	
20	SH	NETSCC, HTA (Referee 2)	Full	general	general	The recommendations were generally well presented, and appeared to be justified given the evidence	Thank you for your comments.
21	SH	Royal College of Psychiatrists in Scotland	Full	general	general	Whilst most NICE guidelines relate to the treatment of specific conditions, this draft guideline relates to a specific behaviour which is typically a symptom of another disorder. Therefore, the management of the behaviour will usually depend on the underlying disorder. Attempting to provide general recommendations which would be applicable to everything from borderline personality disorder to bipolar depression to a drunken situational crisis is conceptually problematic.	Thank you for your comment, we agree that it is unlike some other guidelines which tend to focus on specific disorders, however the NICE topic selection board referred this guideline for development as the treatment of people who self-harm is challenging for many clinicians and it was felt the NHS could benefit from guidance in this area.
22	SH	Royal College of	Full	general	general	Unfortunately, despite the fact that psychiatric illness is strongly related to self-harm and suicidal behaviour –	Thank you for your comments, the GDG agree this is an important issue and have made a direct

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		Psychiatrists in Scotland				present in up to 90% of cases (Alberdi-Sdupe et al., 2011, Haw et al., 2001, Botega et al., 2010, Nock et al., 2008, Hayashi et al., 2010, Borges et al., 2010), NICE have made only cursory references to the potential importance of strong diagnostic assessment and management of underlying mental health conditions. Admittedly, they indicate the associations in the introductory paragraphs in the short guidance, but this doesn't appear to be translated into recommendations. To miss this is a significant omission and risks encouraging the focus of management onto a range of relatively unevidenced approaches rather than evidence-based treatments of common mental disorders.	recommendation regarding treating associated mental health conditions (see recommendation 1.5.1). This recommendation is also a key priority for implementation.																		
23	SH	Royal College of Psychiatrists in Scotland	Full	general	general	The terms children, young people and adolescents are used variable through the document with no definition.	Thank you, the guideline has been amended to ensure the terminology is consistent.																		
24	SH	Royal College of Psychiatrists in Scotland	Full	general	general	<p>With regards to the evidence summary for all studies, as shown below in Table 1, more than half of all studies could not be graded. Another 25% were graded 'Very Low' or 'Low' and only one-sixth (approximately) were rated 'Moderate'.</p> <p>Table 1. Evidence summary for all studies considered by NICE.</p> <table><tr><td></td><td>N</td><td>%</td></tr><tr><td>0 UNGRADED</td><td>85</td><td>56.7%</td></tr><tr><td>1 VERY LOW</td><td>4</td><td>2.7%</td></tr><tr><td>2 LOW</td><td>35</td><td>23.3%</td></tr><tr><td>3 MODERATE</td><td>26</td><td>17.3%</td></tr><tr><td>Total</td><td>150</td><td>100.0%</td></tr></table>		N	%	0 UNGRADED	85	56.7%	1 VERY LOW	4	2.7%	2 LOW	35	23.3%	3 MODERATE	26	17.3%	Total	150	100.0%	Thank you for your comment. According to NICE methodology, we only grade intervention trials (i.e. RCTs). For those included trials, we acknowledge that they are of relatively low quality.
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24	SH	Royal College of Psychiatrists in Scotland	Full	general	general	The Evidence summary for psychosocial interventions is shown below in Table 2. Again, the quality of evidence is poor, with less than one-fifth of studies being moderate.	Thank you for your comment. According to NICE methodology, we only grade intervention trials (i.e. RCTs). For those included trials, we acknowledge that they are of relatively low quality.																		

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						Table 2. Evidence summary for psychosocial interventions for self-harm. <table><tr><td></td><td>N</td><td>%</td></tr><tr><td>0 UNGRADED</td><td>66</td><td>50.4%</td></tr><tr><td>1 VERY LOW</td><td>4</td><td>3.1%</td></tr><tr><td>2 LOW</td><td>35</td><td>26.7%</td></tr><tr><td>3 MODERATE</td><td>26</td><td>19.8%</td></tr><tr><td>Total</td><td>131</td><td>100.0%</td></tr></table>		N	%	0 UNGRADED	66	50.4%	1 VERY LOW	4	3.1%	2 LOW	35	26.7%	3 MODERATE	26	19.8%	Total	131	100.0%	
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25	SH	Royal College of Psychiatrists in Scotland	Full	general	general	Less than one-third of questions rated ‘Critical’ or ‘Important’ had an evidence grading of ‘moderate’. The majority of questions pertinent to the guidelines had ‘low’ quality evidence to support them.	Thank you for your comment. According to NICE methodology, we only grade intervention trials (i.e. RCTs). For those included trials, we acknowledge that they are of relatively low quality.																		
26	SH	Royal College of Psychiatrists in Scotland	Full	general	general	Whilst 14/23 (60.9%) critical questions had ‘moderate’ evidence, only 3/30 (10%) of important questions had moderate quality evidence.	Thank you for your comment. According to NICE methodology, we only grade intervention trials (i.e. RCTs). For those included trials, we acknowledge that they are of relatively low quality.																		
27	SH	Royal College of Psychiatrists in Scotland	Full	general	general	The implication of points 7 and 8 is that almost all the recommendations are based on very low quality evidence. This is not really made apparent in the short guidelines, and the strength of evidence or strength of recommendation is not made apparent within the guidelines. Indeed, the short guidelines indicate that: “ <i>The following guidance is based on the best available evidence.</i> ” This may lead the reader to assume that the recommendations are grounded very much in a detailed evidence review of a robust evidence base, when they would appear to be a list of good-practice points emerging from the Expert Advisory Group. In fact, it is hard to find a single recommendation that is supported by a strong evidence base and it might be helpful to indicate that the “ <i>best available evidence</i> ” is remarkably poor.	Thank you for your comment. The guideline involved several very detailed literature reviews and it is therefore accurate to say that the recommendations are based on the best available evidence. The ‘Evidence to Recommendations’ sections in the main guideline are intended to give additional details of the rationale for recommendations. It is clear from reading the full guideline that the evidence base is thin and this is true for a number of areas in medicine, and particularly mental health. Nevertheless, and consistent with NICE methodology, where evidence is lacking we resort to consensus based recommendations based on the broad and substantial experience of the GDG.																		
28	SH	Royal College of Psychiatrists in Scotland	Full	general	general	Overall our Section believes that it would be important to:- a) Clearly define what is meant by terms used e.g. young people, adolescents, children. b) Include in the review evidence and guidance about self-harm throughout childhood and adolescent. c) Expand the Section on mental illness.	Thank you for your comments, please see the responses to your specific comments for answers to the points you have raised listed here.																		

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						<p>d) Expand the information on risk factors.</p> <p>e) Include Scottish legislation and legislation from other parts of the UK.</p> <p>f) Make links to existing policy and guidance e.g. SIGN, NICE and policy for mental health including children's mental health</p>	
29		RCGP	Full	General	General	<p>A good review of the subject but I couldn't find any reference to the prison population which has a high risk of mental health problems and, in my experience as a Death in Custody Reviewer a high incidence of self-harm leading to suicide. Should this be a separate section rather than being included in the primary and secondary care without specific mention?</p>	<p>Thank you for your comments, this guideline has not reviewed the evidence for prison populations as this is unfortunately outside the scope of this guideline, however the recommendations may be relevant to those working within prison/forensic services.</p>
30	SH	Royal College of Paediatrics and Child Health	Full	General	General	<p>We note that the population includes those from 8 years and up. The mixing of needs of children and adults throughout the draft guideline makes it difficult to tease out services for children and young people (under 18s) who are not seen by adult mental health services. In electronic versions of the document this could be achieved by a separate index listing (hyperlinking) issues relevant to services for under 18s.</p>	<p>Thank you for your comment. The GDG did discuss if there should be a separate section for children and young people, but decided that they should be included throughout the document. Each working group for the chapters included a children and young people specialist and the GDG consider these issues to be addressed throughout.</p> <p>A paragraph has been added to the full guideline in section 1.2.4 highlighting which sections relate to children and young people.</p>
31	SH	Royal College of Paediatrics and Child Health	Full	General	General	<p>In a paediatric setting it would be particularly difficult to get service users to come to staff educational meetings.</p>	<p>Thank you for your comment, we are unclear which section of the full guideline you are referring to, however we agree that this might be challenging to achieve in practice, but involving users in staff training has clear benefits. We have therefore retained the relevant sections.</p>
32	SH	Association of Child Psychotherapists	Full	General	General	<p>We welcome this thorough document. The inclusion of personal statements provides a grounding that underscores the distressing nature of the state of mind of those who self-harm and the complexity behind their suffering. A theme that arises is the importance of the therapeutic relationship - not so much the nature of the intervention, but the quality of the engagement with the practitioner who can offer respect, concern and allow the person to feel included in decision making.</p>	<p>Thank you for your comments, the GDG agree the therapeutic relationship is incredibly important for people who self-harm.</p>
33	SH	Wish	Full	General	General	<p>Self-injury by women in prison: The guidelines and evidence base have neglected the high rates of self-injury for women in prison. Women account for 52% of incidents of self-injury in prison in 2008 despite making up 5% of the total prison population (Ministry of Justice, 2009, Statistics</p>	<p>Thank you for your comments, this guideline has not reviewed the evidence for prison populations as this is unfortunately outside the scope of this guideline, however the recommendations may be relevant to those working within prison/forensic services.</p>

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						on Women and the Criminal Justice System). In reach mental health provision in prisons is varied and frequently of an inadequate standard. Women in prison who self-injure routinely face negative attitudes towards their behaviour and the belief it is 'attention-seeking'. Much more needs to be done to improve the quality of mental health provision in general and self-injury treatment in particular within prisons. The guidelines should make specific reference to the needs of this high-risk and frequently neglected group.	
34	SH	Royal College of Nursing	FULL	general	general	The form of separating information on young people in each section is good, it flows well.	Thank you.
35	SH	Royal College of Nursing	FULL	GENERAL	GENERAL	<p>When a young person has been assessed on a paediatric ward following an episode of self-harm – what timescale should the follow-up appointment be within? We know that discharge from a mental health ward requires a follow up within seven days.</p> <p>We know of services that have been providing follow-up to young people within two weeks for over ten years and this seems to work (obviously quicker as the risk/need is greater). Is there any evidence/good practice that recommends such timescales – what should services be working to?</p> <p>Can something be included about this please?</p> <p>We know that not all adults are offered up a follow-up appointment but we understand that young people should – but in what timescale?</p>	Thank you for your comment, however this issue is dealt with in short term management guideline (NICE CG16), and therefore not within the scope of this guideline.
36	SH	Royal College of Nursing	FULL	GENERAL	GENERAL	<p>The short term management of self-harm NICE guidelines defines young people as 8 to 16 years old. In this guideline young people are referred to as 8 to 17 years old, yet in practice, services are set up following RCP guidelines (1998), where young people are defined as under 16 years old – they are admitted on to a paediatric ward and seen by CAMHS and those 16 years old and over may not be admitted and so tend to be seen by Adult Mental Health Services.</p> <p>Having different age definitions is confusing and is not helpful to service providers and users (in this case, the</p>	Thank you for your comment. The scope of this guideline set the age range from 8 years old to 18 th birthday. This has been used consistently throughout the document and broadly reflects the current provision of Child and Adolescent Mental Health Services.

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						young people whom we provide services for).	
37	SH	Royal College of Nursing	FULL	GENERAL	GENERAL	There seems to be an omission of family therapy from the list of psychological therapies (all with little evidence) – it needs to be there with the others.	Thank you for your comment. Our review on psychological therapies was based on the search criteria of an existing Cochrane review. Family therapy would have been searched for, yet the review was limited by the thin evidence base.
38	SH	SANE	Full	General	General	<p>It is a shame that the review of qualitative work is buried in the section ‘Experience of Care’ – there seems to be a body of work available on the experience of self-harm itself that, properly analysed, could point towards new ways of managing self-harm. We cannot speak for the other studies reviewed, but we felt that the core message of our study (Horne & Csipke, 2009) was rather lost.</p> <p>It seems that only our descriptive findings were considered (that self-harm is used to regulate emotion; that the affective state preceding self-harm is one of isolation from others; and our findings related to the experience of pain), and only some of them. It is our analytic work, however, that has the most direct relevance for directing the development of new and existing interventions for self-harm.</p> <p>Our analysis sought to answer, not just the question “What are the functions of self-harm?” but also the question: “<i>How</i> does self-harm achieve its (contrary) functions?” Our model of the functions of self-harm shows how they can all be traced back to the effect of self-harm on embodied experience. We believe this finding is important, and points very clearly to certain kinds of intervention, which have not been emphasized in these guidelines.</p> <p>We understand that it may be contrary to NICE policy to make clinical recommendations based on theory (although we must remember that we are talking about <i>grounded</i> theory here, and one that is partially supported by evidence from RCTs – see our manuscript for discussion of DBT and its relation to our findings). However, there is in our view sufficient evidence here to recommend further research (see comment 5).</p>	<p>Thank you for your comments. This chapter deals with the experience of self-harm and does not evaluate interventions for managing self-harm. Interventions for self-harm are reviewed in Chapters 7 and 8. We agree that qualitative outcomes are important in assessing the experience of interventions and thus have incorporated this into the research recommendations in the intervention chapters.</p> <p>With regards to the findings reported, we did not extract all findings from each study but rather looked at common themes across studies and triangulated findings. The link between the findings reported in this study and interventions (DBT), was an interpretation of the authors based on theoretical mechanisms behind the reasons for self-harm and DBT, rather than empirical evidence. Typically, intervention evaluation is done via explicit testing of an intervention rather than a theoretical link. Given that this paper did not evaluate the effectiveness of DBT, it does not provide sufficient evidence to make a research recommendation.</p> <p>Most studies for DBT, which are reviewed in Borderline Personality Disorder guideline, and referred to recommendation 1.5.1, are for that personality disorder, even though their aim is to reduce self-harm. Please see the Borderline Personality Disorder (NICE CG78) guideline, for more a complete analysis of these studies.</p>
39	PR	Expert Reviewer (4)	Full	GENERAL	GENERAL	I THINK IT IS RATHER CONFUSING THAT THIS GUIDELINE IS ABOUT LONGER-TERM MANAGEMENT	Thank you for your comment. We acknowledge the overlap between the guidelines regarding

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		(Keith Hawton)		L	L	YET DEALS WITH PSYCHOSOCIAL ASSESSMENT WHICH IS ALSO IN 2004 GUIDELINE. IN SOME WAYS IS A PITY THAT IT WAS DECIDED TO DO A SEPARATE GUIDELINE RATHER THAN COMBINE THIS AND THE 2004 VERSION, ESPECIALLY AS ASSESSMENT AND INTERVENTIONS WERE IN THE 2004 GUIDELINE. ALSO IS 'LONGER-TERM' THE RIGHT WORD, SINCE MUCH OF THE FOCUS IS ON IN-HOSPITAL AND SHORT-TERM AFTERCARE?	assessment, but the GDG agreed that it was necessary to ensure that all individuals who self-harm are given a comprehensive assessment – whether that be in primary care or in specialist services. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
40	SH	RCPsych in Wales	Full	General	General	The full guideline is a very useful document covering a wide range of issues in detail. It is a useful summary of current knowledge and will be an important reference.	Thank you for your comments.
41	SH	RCPsych in Wales			General	The current guideline needs to clearly dovetail with the recommendations outlined in the previous guidelines concerning treatment of self-harm in the first 48 hours of an accident. There will be areas of overlap between the two documents but how they relate to one another is not always clear. This could be clarified by suggested care pathways amalgamating both guidelines.	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
42	SH	RCPsych in Wales	Full	General	General	The evidence concerning assessment of risk and need is presented in the guideline, and indicates that the specialist assessment will take place in CAMHS/CMHTs within a relatively short period after presentation. However, previous guidance on short-term management rightly highlights the need for specialist assessment, in most cases within 48 hours, often in A&E or medical wards (if admitted). The current guidelines need to reflect this.	Thank you for your comment. Although we agree that some assessment is likely to take place in A&E, the GDG highlighted the importance of a comprehensive assessment of risk and need to take place within specialist services. We do agree however, that this would be unhelpful if a full and comprehensive assessment had taken place in A&E and healthcare professionals should liaise with their colleagues to avoid unnecessary repetition (as stated in recommendation 1.1.25).
43	SH	RCPsych in Wales	Full	General	General	Negative attitudes towards self-harm can be associated with a lack of understanding of its complexity. Clinicians are therefore ill-prepared and feel powerless to help a person who is 'assumed' not to want help themselves. Common feelings can be described as "a combination of horrified, guilty, furious, betrayed, disgusted and sad" (Frances, 1987 In Favazza, 1998). Skills and attitudinal training is fundamentally important to engage 'hearts and minds' and to enable practitioners to develop and practice the skills needed to compassionately, safely and effectively engage	Thank you for your comments. The GDG agree that training for healthcare professionals is important in this area, and have made recommendations to reflect this.

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						with patients who self-harm.	
44	SH	RCPsych in Wales	Full	General	General	STORM now offer a module on self-harm as part of their portfolio of training. http://www.stormskillstraining.co.uk/	Thank you.
45	PR	Expert Reviewer (4) (Keith Hawton)	Full	General	66 etc.	29 onwards. Much of the focus of this and subsequent sections is on studies/patients with self-cutting or other self-injury. This makes it somewhat misleading, as approximately 75% of hospital SH presentations (the main focus of the guideline) are for self-poisoning. I think that this should be highlighted, and where appropriate the nature of the participants in terms of method of SH should be noted. In places, (e.g. p.71 line 14) seems to imply that self-harm=self-injury) 72 line 18 sudden switch to 'overdose' in section headed 'self-injury'.	Thank you for your comment. The guideline now clearly states that most of these studies deal with self-injury. It has also been clarified which studies examine the reasons behind self-poisoning. Moreover, the nature of the self-harm is clearly outlined in the study characteristics table in the appendices (appendix 15f). Finally, self-injury has been replaced with self-harm where appropriate.
46	SH	Derbyshire Healthcare NHS Foundation Trust		General	General	<ul style="list-style-type: none"> • Seeing self-harm as a symptom of other problems not the problem itself. <p>Although there is evidence within the documentation in regard to approaches that have been explored in relation to the management of self harm and for adults there appears a lack of clear evidence to support any one particular approach I wonder whether the guidelines may be more directly indicating that in the majority of presentations self harm is not necessarily the main problem, but the presenting situation or symptom that is indicative of other problems and difficulties that require to be addressed and as such self harm is either a coping strategy or a way of managing distress, despair or difficulties. From this therefore the importance could be seen that good clinical assessment in identifying the problems and difficulties is the most significant part of the clinical management and thus the approaches that are required to be taken should be those that are geared to be addressing the problems and difficulties that the person is facing, or at least providing mechanisms to try to equip the person to be able to contain, manage and support these issues.</p> <p>From my clinical experience it is very easy for professionals, particularly Mental Health professionals, to almost see self harm as the problem and try to produce actions and interventions to try to manage the behaviour and often to try to control the patients use of self harm whilst doing this often this will have the paradoxical effect</p>	<p>Thanks for these very helpful comments. We agree that self-harm is a behaviour which can have a variety of underlying causes and sections 2.15 and 2.17 in the Introduction to the main guideline were intended to convey this.</p> <p>In Chapter 6 we emphasise the need for a comprehensive assessment which will inform a management plan.</p> <p>Much of the evidence from trials is focussed on reducing self-harm, but we also discuss other aspects of management and other treatment goals in Chapter 7.</p>

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						that often increasing in that the self harm behaviour then becomes the focus and the attention to the main problems and difficulties becomes less prominent.	
47	SH	NETSCC, HTA		General	General	<p>1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)</p> <p>None</p>	Thank you.
48	SH	RCPsych in Wales		GENERAL	GENERAL	<p>The Guideline Development Group should be aware of imminent developments in Welsh mental health services. The Mental Health (Wales) Measure will lead to the new primary mental health services separate from primary care and from current community mental health teams and other specialist mental health services. While Welsh policy still supports community mental health teams as the core of the secondary services, it is not necessarily clear that all (or even the majority of) self harm would be managed in future by community mental health teams within secondary mental health services. There is a strong possibility that a significant proportion of patients will be redirected from community mental health teams/ secondary mental health teams to new services. Welsh primary mental health services could, and arguably should, develop expertise to manage much self harm.</p> <p>Part 3 of the Measure enables individuals who have been discharged from secondary mental health services (within three years) to refer themselves directly back to those services, bypassing their GP for a referral altogether.</p> <p>http://www.legislation.gov.uk/mwa/2010/7/contents/enacted</p>	Thank you for your comment. We understand that many NHS services are undergoing changes in structure and organisation. However, it is very difficult for the guideline to address future changes. In this guideline the GDG have aimed to make recommendations for the principles of care that should be adopted, regardless of setting.
49	SH	Royal College of Nursing	All	General	General	The Royal College of Nursing welcomes this guideline. It is timely.	Thank you.
50	PR	Expert Reviewer (4) (Keith Hawton)	Full		4	Inconsistent use of capitals	Thank you for pointing this out, it has been amended.
51		Expert Reviewer (4) (Keith)	Full	2	14	The definition of 'parasuicide' as per Kreitman is incorrect. He used it for all non-fatal acts of self-harm, irrespective of suicidal intent. See his book 'Parasuicide'	Thank you for your comments, the guideline has been amended.

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		Hawton)					
52	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	14	39 May be better to use Hawton et al (2002) BMJ reference here (is in refs)	Thank you for your comments, the guideline has been amended.
53	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	15	37 See Bergen et al ref for more up-to-date data on repetition – rate is higher than quoted.	Thank you for your comments, the guideline has been amended.
54	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	17	22 Would be helpful to tell reader what eight C's are.	Thank you for your comments, the guideline has been amended to reflect your suggestion.
55	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	18	20 But still need to make clear that patients reach criteria for PD (not just because have self-harmed).	Thank you, we agree this sentence could be misleading and have removed it.
56	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	19	<p>24-32 I think this section should be extended somewhat. I don't think the statement in line 26/27 is correct. We now have a lot of information about self-harm in adolescents. You might want to quote our study on rates of self-harm in adolescents x age. Hawton and Harriss (2008)The Changing Gender Ratio in Occurrence of Deliberate Self-Harm Across the Lifecycle. Crisis, 29, 4-10.</p> <p>25 Might be worth commenting on problems faced by younger and older adolescent self-harm patients (more younger patients with family problems, and more older adolescents with partner problems (see Hawton, K., Hall, S., Simkin, S., Bale, E., Bond, A., Codd, S., and Stewart, A. (2003) Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990-2000. Journal of Child Psychology & Psychiatry & Allied Disciplines, 44, 1191-1198</p> <p>27 The rate quoted is very misleading. We can supply rates for the Multicentre Study of Self-harm in England – they are in the 100's per 100,000.</p> <p>30 This was not primarily a F/U study – maybe omit 'follow-up'.</p>	Thank you, the references you have supplied have been included and the section expanded.
57	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	20	Older people There are some other useful papers on SH in older people e.g. Hawton and Harriss 2006 (in ref list); and Nav may be able to give details of a current paper from our multicentre study if provisional acceptance with BJPsych	Thank you for your comments, we gave referred to a large multi-centre study (Murphy <i>et al.</i> , in press) which confirms previous smaller studies that self-harm in older people is more likely to lead to suicide.

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						becomes full acceptance in time for finalisation of report.	
58	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	24	24 Suggest re-ordering this sentence to improve meaning.	Thank you for your comments, the guideline has been amended to reflect your suggestion.
59	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	25	26 This is a far lower figure that indicated by our multicentre study – see e.g. Hawton et al 2007 (in ref list).	Thank you for your comment, we have included reference to these higher extrapolated numbers to show that the NHS information centre data is a considerable underestimate.
60	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	30	3 ?sentence.	Thank you for your comment, this has been amended.
61	PR	Expert Reviewer (4) (Keith Hawton)	Full	2.1	37	30/31 Sentence does not make sense.	Thank you for your comment, this has been amended.
62	SH	Royal College of Psychiatrists in Scotland	Full	2.1.1	14	Within the introduction of Chapter 2 the focus is on the self-poisoning with medication or self-injury by cutting. There is no mention of e.g. mismanagement of diabetes which can cause problems for adolescents and is a form of self-harm.	Thank you for your comment, the mismanagement of other conditions is outside the scope of this guideline. This has been clarified in the introduction.
63	SH	Royal College of Paediatrics and Child Health	Full	2.1.1	14	We believe that Hawton et al's definition of self harm is incomplete. While the draft guideline discusses the varied and changing motivations people have for self harm, we think it is important the definition include the broad reason for self harm. Many people self harm for cultural reasons and for pleasure (e.g. those with multiple body piercings or tattoos). There is a body art society that includes behaviour such as self cutting as a art. We propose that deliberate self harm is therefore defined as "self poisoning or injury as a reaction to negative emotion or adverse life circumstances".	Thank you for your comment. The GDG did not think it appropriate to devise new meanings of self-harm, and decided to use already published and well known ones. However, we do agree that body piercing and tattoos are not addressed by this guideline and have amended the text to reflect this.
64	SH	RCPsych in Wales	Full	2.1.1	14	Consider highlighting the extreme importance of language when discussing self harm. There is still a significant amount of stigma regarding self harm. Stigma is a contributing factor to the secrecy regarding experiencing self harm and the difficulty accessing medical care. Even if the practitioner using a possibly offensive term has very compassionate views the distressed person may be offended by the injudicious use of some terms. This is extremely important and services need to assist in the reduction of the stigma and taboo surrounding self harm.	Thank you for your comment, this section does discuss terminology including avoiding the term 'deliberate' which may seem judgemental and has the danger of inferring motive. We believe this is sufficient.

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65	PR	Expert Reviewer (David Gunnell)	Full	2.1.4	15	Specify who comparison groups are here for some of the statements of lower / higher risk in relation to cutting	Thank you for your comments, the guideline has been amended to reflect your suggestion.
66	PR	Expert Reviewer (David Gunnell)	Full	2.1.4	16	Suggest make more of the Runeson paper – I think other papers may also show heightened risk by index method	Thank you for your comments, the guideline has been amended to reflect your suggestion.
67	SH	Royal Society of Medicine	Full	2.1.5	16	Line 24 – may be relevant to mention reference Taylor et al 1999 (cited later) at this point too	Thank you for your comment, but the GDG believes the references included are sufficient.
68	SH	Royal Society of Medicine	Full	2.1.5	16	Line 28 – may be relevant to mention study by Bruffaerts et al 2011 in B J Psych (currently online only) on reasons for people not seeking help after self harming	Thank you for your comment, the findings are for low income countries and related to health services in these settings and are therefore not relevant to this guideline.
69	SH	Royal College of Psychiatrists in Scotland	Full	2.1.5 , 2.1.6	16	Within these sections it is not made clear whether there is a difference or a similarity in motive between adults and adolescents Again there is no definition of adolescents.	Thank you for your comment, the definition of adolescents is now consistent throughout the document. It is not possible to describe whether motives are different as no direct comparisons using the same measures have been used. The narrative description given here is all that can be said on this topic.
70	PR	Expert Reviewer (David Gunnell)	Full	2.1.8		Include family history of self harm / suicide as a risk factor and perhaps also mention common precipitants (e.g. relationship breakdown).	Thank you for your comment. This has been added to the relevant section.
71	PR	Expert Reviewer (David Gunnell)	Full	2.1.8	17	Perhaps here or somewhere else describe age patterning of incidence (peak 15-19 in females / 20-24 in males. Etc.	Thank you for your comments, the guideline has been amended to reflect your suggestion.
72	SH	Royal College of Psychiatrists in Scotland	Full	2.1.9	19	Again young people are not defined. It is noted that self-harm /suicidal behaviour is rare in younger children. However, this does occur and is usually serious. It would be important to highlight issues related to this age group. Clinically it is noted that physical methods are more common and in the younger the child cognitive development can result in magical thinking. Autistic Spectrum Disorder is also a common co-morbidity in this group.	Thank you for your comment, the definition of young people is now consistent throughout the document. Unfortunately there is no data available to support this clinical observation.
73	SH	RCPsych in Wales	Full	2.1.9	19	Recent U.K. evidence suggests that childhood bullying and previous sexual abuse are associated with subsequent risk of attempted suicide in adult life (Bebbington P, Minot S, Cooper C, Meltzer H, Jenkins R, Brugha T, Dennis M. 2009 Suicide attempts, gender and sexual abuse: Data from the British psychiatric morbidity survey 2000. American Journal of Psychiatry, 166, 1135-	Thank you for your comments, the guideline has been amended to reflect your suggestion.

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						1140.) (Meltzer H, Vostanis P, Ford T, Bebbington P, Dennis M.S. 2011. Victims of bullying in childhood and suicide attempts in adulthood. European Psychiatry, DOI:10.1016/j.eurpsy.2010.11.006)	
74	SH	RCPsych in Wales	Full	2.1.9	19	The guideline needs to stress that the people of South-Asian origin living in the U.K. are a heterogeneous group with widely differing cultural and religious backgrounds.	Thank you for your comment, the GDG believe the section on South-Asian women is sufficient.
75	SH	Royal Society of Medicine	Full	2.1.9	20	Line 22 – subject of this sentence not clear. Could add further epidemiological information on LD: eg. COLLACOTT, R. A., COOPER, S. A., BRANFORD, D., et al (1998) Epidemiology of self-injurious behaviour in adults with learning disabilities. British Journal of Psychiatry, 173, 428 -432 (abstract below)	Thank you for your comments, this section of the guideline has been amended for clarification. This is a useful reference, however self-injurious behaviour in people with learning disabilities is not quite the focus of this guideline.
76	SH	RCPsych in Wales	Full	2.1.9	20	Lines 4-5: The study of Dennis and colleagues (2005) is misrepresented as it needs to be more specific. The second sentence of this paragraph should ideally read 'They found that two-thirds of older people that who were depressed and had self-harmed had significant suicide intent', rather than, 'They found that two-thirds of this group had significant suicide intent.'	Thank you, this has been amended for clarification.
77	SH	Royal College of Psychiatrists in Scotland	Full	2.1.10	20	It would be important to mention physical health treatments required by this group and links with Accident and Emergency/ Medical/ Surgical Services. Primary Care Services (and in particular General Practitioners) may be the first point of contact for these young people and it would be important to be clear about pathways of care.	Thank you for your comment, however physical health treatments fall outside the scope of this guideline and are addressed in the NICE guideline <i>CG16: Self-Harm: Short Term Management</i> .
78	SH	NHS Direct	Full	2.2.1	21	Care Pathways for individuals that self-harm needs to be explored. Individuals will disclose to other health professionals (e.g. NHS Direct). Regarding children and young people, they also come to the attention of other professionals and a significant number are on a waiting list for CAMHS. There needs to be a contact point for individuals on the waiting list.	Thank you for your comment, this chapter is purely descriptive and does not make recommendations. The evidence reviewed and subsequent recommendations can be found in chapters 4-9.
79	SH	Royal College of Psychiatrists in Scotland	Full	2.2.1	21	The Section on young people notes the role of schoolteachers and young people's health advisors. In Scotland the CAMHS Framework 2005 clearly outlines the role of Tier 1,2, 3 and 4 in CAMHS and the importance of mental health training for Tier 1 professionals who would include schoolteachers and young people's health advisors. Training is usually provided by Specialist CAMHS and it is very valuable in disseminating good practice to community workers involved with children on a day to day	Thank you for your comment, NICE guidelines are only applicable in England, Wales and Northern Ireland and therefore it would not be appropriate to refer to Scottish health systems.

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						basis. This training role is often not fully supported and recognised as the remit of Specialist CAMHS. When this is the case children and young people will present later to CAMH Services requiring more specialist intervention rather than having access to early prevention through trained Tier 1 professionals. In Scotland also the Choose Life Initiative has worked to develop training for community workers to deal with issues related to suicidal behaviour in the community.	
80	SH	Royal College of Nursing	FULL	2.2.1	21	It may be worth including a couple of references outside the usual 'hard' research that is included in the NICE guidelines. Refer to material available to help the healthcare professionals e.g. helping children and young people who self-harm McDougall et al (2010)	Thank you for your comment, this chapter is purely descriptive and does not make recommendations. The evidence reviewed and subsequent recommendations can be found in chapters 4-9.
81	SH	RCPsych in Wales	Full	2.2.1	21	Consider adding 'when presented with a patient who is displaying characteristics of depression or emotional distress it may prove valuable to routinely ask about thoughts and acts of self-harm.'	Thank you for your comment, this chapter is purely descriptive and does not make recommendations. The evidence reviewed and subsequent recommendations can be found in chapters 4-9.
82	SH	Royal Society of Medicine	Full	2.2.2	22	Line 34 – This would only apply to those who are established CMHT patients, and only then once the self harm presentation has been handled acutely by the A&E/CRT/HTT/Liaison team rather than CMHT. For non-CMHT patients the referral pathway may be more complicated and may involve the GP being sent an assessment by A&E or Liaison but them not being clear how to refer the patient on for secondary care. This was highlighted as a weakness of the Short-term guidelines, in terms of not making clearer the links between short-term management and those NICE guidelines advising on longer-term management (ie this current guideline and those advising on individual psychiatric diagnoses). This was discussed in: Pitman A. & Tyrer P. (2008) Implementing clinical guidelines for self harm – highlighting key issues arising from the NICE Guideline for Self-Harm. Psychology and Psychotherapy: Theory, Training and Practice (Special Issue: Implementing clinical guidelines in everyday practice) 8 (4): 377-397	Thank you for your comment. The section you are referring to is specifically addressing assessment in secondary care. The GDG agree that making links between the short and long term guidelines for self-harm is extremely important. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together and to resolve this issue. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
83	SH	Royal College of Paediatrics and Child Health	Full	2.2.2	22	The draft guideline refers to a rare need for admission to a psychiatric inpatient bed (for adults this quoted as 1.8 to 6% on page 198). There is no mention of delays in admission for under 18s (to tier 4 CAMHS). The numbers needing such admission are few but they are the most problematic cases. They can be housed on paediatric wards for many days before a tier 4 CAMHS bed is available. A paediatric	Thank you for your comments, the guideline has been amended to reflect your suggestion.

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						ward is a non-expert environment for such young people, and potentially unsafe for other patients if the young person has difficult behaviour. We think that the guideline should indicate the timescale for admission to a CAMHS (tier 4) bed, if required.	
84	SH	Royal College of Nursing	FULL	2.2.2	22	Under young people it says: 'Are likely to be admitted to a paediatric ward' –we consider that this line needs to be re-worded in stronger terms e.g. Should be admitted to a paediatric ward (same as Short Term page 66). It would be good to add in the evidence that supports this – Young people are less likely to repeat self-harm when admitted (Hawton and Fagg 1992).	Thank you for your comment, this chapter is purely descriptive and does not make recommendations. The evidence reviewed and subsequent recommendations can be found in chapters 4-9.
85	SH	NHS Direct	Full	2.2.2	22	Line 12 recommendations for referral on following assessment should also include referral to a mental health crisis resolution & home treatment team	Thank you for your comments, the guideline has been amended to reflect your suggestion.
86	SH	NHS Direct	Full	2.2.2	22	The support required by the family should not be overlooked. The care plan for children and young people should be family centred.	Thank you for your comments, the guideline has been amended to reflect your suggestion.
87	PR	Expert Reviewer(David Gunnell)	Full	2.2.2	22	I thought Liaison teams were responsible for assessment – need clarity here.	Thank you for your comment, this section is specifically focused on assessment in secondary care.
88	SH	Royal Society of Medicine	Full	2.2.3	23	For references to medications used in LD see for example those in : Martin, Peter, Guth, Christoph (2005) Unusual devastating self-injurious behaviour in a patient with a severe learning disability: treatment with citalopram Psychiatric Bulletin 29: 108-110	Thank you for your comments, this is a useful reference, however self-injurious behaviour in people with learning disabilities is not quite the focus of this guideline.
89	SH	Royal College of Psychiatrists in Scotland	Full	2.2.6	24	There is no reference to Scottish Legislation. We would suggest an inclusion of Mental Health Scotland Act and the Children's Act. It would be important to highlight in this area the issues of consent, capacity and confidentiality relating to children and young people e.g. a young person who has self-harmed following abuse by a primary carer. It would be important also to highlight the link with Child Protection.	Thank you for your comments, NICE guidelines are only applicable to England, Wales and Northern Ireland and therefore it would not be appropriate to include reference to Scottish legislation.
90	SH	Royal College of Psychiatrists in Scotland	Full	2.4	25	It would be important to highlight children and young people lost from school, educational issues, social isolation, bullying, crucial ages when examinations are being taken or transitions between different educational levels can be disadvantageous.	Thank you for your comment, this is not intended to be a comprehensive account of the problems of Looked After Children but only the specific issues relating to self harm in this group.
91	SH	Royal College of Nursing	FULL	2.4	25	We would suggest changing the wording of 'economic burden' – this seems to imply people who self-harm are a burden to society – perhaps use 'economic cost'.	Thank you for the suggestion. The wording has been changed to economic cost.

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92	SH	Royal Society of Medicine	Full	3.6	43	Line 7 Typo – “as key issue”	Thank you for pointing this out, it has been amended.
93	SH	Royal College of Nursing	FULL	4.1	49	Although the adult personal accounts are very good, there needs to be one or two accounts from young people as well - not all from adults.	We agree that it is important to incorporate the experience of young people who self-harm. We contacted a variety of organisations representing young people who self-harm, however we did not receive any accounts other than the accounts in the full guideline.
94	SH	NHS Direct	Full	4.2	50 - 64	Personal accounts of self harm & care / carer experience are really powerful & should be included in the final guideline.	Thank you for your comment
95	SH	Royal Society of Medicine	Full	4.2	49	For each Personal Account it would be helpful to have the respondent's gender (and age if possible) at the start of the account to help relate this to the epidemiology.	Thank you for your comment. Unfortunately, this is not possible as it would compromise the person's anonymity.
96	SH	Royal College of Paediatrics and Child Health	Full	4.2	49	We believe that the inclusion of personal accounts of those that self harm has no place in a guideline. The draft notes that these are not evidence-based but to illustrate the condition. What was the sample size and the size of population? How were these cases selected? In a 319 page document, the people who need to read these accounts will not see them. We think that this information should be disseminated but not through this guideline, and propose omitting it.	Thank you, the GDG believed that it was important to have some illustration of the experience of people who self-harm in the guideline.
97	PR	Expert Reviewer(David Gunnell)	Full	4.2	49ff	The qualitative accounts are fascinating, but I wonder if too high a proportion of these accounts relate to people who self-injure rather than those who take overdoses / people with higher intent.	We agree that it is important to incorporate the experience of people who take overdoses. We contacted a variety of organisations representing service users and carers; however we did not receive any accounts other than the accounts in the full guideline.
98	SH	Royal College of Psychiatrists in Scotland	Full	4.2.2	50	We note that this person started to self-harm at aged 10 years. It is not unusual for longer term self-harmers to commence self-harming at a young age and it would helpful to highlight as noted above the seriousness of self-harm in childhood. It is also notable that self-harm examples B and C similarly started in adolescence. It would be helpful to consider the role of early intervention in adolescence as a priority within service development. The personal account of the carer 4.3.2 also notes self-harm in her son as a child.	Thank you for your comment. As stated in the guideline, these personal accounts are not evidence-based and only serve to illustrate the condition. Therefore, they cannot be used as evidence for early intervention.
99	SH	Royal College of Nursing	FULL	4.3.2	62	Line 41 – spelling mistake - ‘Addiction’ ?	Thank you for bringing this to our attention. This error has been corrected.
100		NICE	Full	4.4.1	116	Training and supervision	Thank you for your comment. A statement has been

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				.12		Suggest adding a statement relating to the issue of discrimination and stigma and the need to avoid judgemental attitudes.	added to this effect.
101	SH	Royal Society of Medicine	Full	4.4.3	64	Line 27 – term “people with self harm” is not conventional and doesn’t make sense	Thank you for pointing this out, it was a typo and has been amended.
102	SH	SANE	Full	4.4.4	66	The reference to Horne & Csipke (2009) seems to imply that our study concerned people with learning disabilities or males. Whilst we had some males in our study, it was not about ‘male self-harm’ as such.	Thanks for bringing this to our attention. The text has been corrected.
103	SH	SANE	Full	4.4.4	69	The quote referenced to our paper (Horne & Csipke, 2009) does not appear in it.	Thanks for bringing this to our attention. The text has been corrected.
104	SH	Royal Society of Medicine	Full	4.4.4	73	Line 43 – typo – an extra s	Thanks for bringing this to our attention. The text has been corrected.
105	SH	Royal Society of Medicine	Full	4.4.5	73 onwards	This literature could be related to the recent international data on this comparing high income countries to middle and low income countries – see study by Bruffaerts et al 2011 in B J Psych (currently online only)	Thank you for your comment, this paper has been published online after our cut off date and therefore we are unable to include it. We have looked at it and are relieved to find it supports recommendation 4.4.5. Thank you for bringing it to our attention.
106	SH	Royal Society of Medicine	Full	4.4.6	83	Line 38 – typo – as	Thanks for bringing this to our attention. The text has been corrected.
107	SH	Royal Society of Medicine	Full	4.4.6	83	Line 42 – not clear why this sentence is in the first person	Thanks for bringing this to our attention. The text has been corrected.
108	SH	Royal Society of Medicine	Full	4.4.10	104	Line 9 -Typo – peoples who self harm	Thanks for bringing this to our attention. The text has been corrected.
109	SH	Royal College of Nursing	FULL	4.4.10	101 (LINE 32)	Redley (2010) examined clinicians’ understanding, We believe these clinicians were all doctors – so perhaps this should be clarified here – ‘doctors’ understanding...	Thank you for your comment. We commonly refer to doctors as clinicians in our guidelines and this is the accepted NICE terminology.
110	SH	Royal Society of Medicine	Full	4.4.11	112	Line 25 – for health and social care professionals who are not part of primary care or CMHTs (eg in services where self harm is rarer) it might be worth adding a line to explain how this works or how to find out more about the CPA, esp as it is a recommendation under 4.5	Thank you we have removed the reference to CPA following comments from other consultees.
111		NICE	Full	4.4.11	113	In social support section: “However, these voluntary support groups and websites can be destructive if not well moderated and managed.” This comment is not supported by the evidence summary 4.4.8 which does not mention this at all but does state that by reducing feelings of isolation support groups and websites can reduce the	Thank you for your comment. It has been made explicit in the text that this limitation of support groups is sourced from a personal account.

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						frequency of self harm. The only limitations of social support groups stated in section 4.4.8 are page 93 "...many participants felt that the depth of sharing could be compromised by the low frequency and time restraints of meetings, sometimes preventing deeper exploration of issues. 'Autonomy' emerged as important, primarily in the group being 'led and run by the participants themselves'" which contradicts the statement on page 113. The only evidence for this statement that support groups can be destructive comes from 4.2.2 Personal Account A who says "in my experience, support groups are unhelpful unless they are well moderated"- if this is where the view was sourced from then this needs to be made explicit and it should be explained that this is the view of one individual who attended a voluntary support group a number of years ago.	
112		NICE	Full	4.5.1	115	Based on the qualitative evidence presented in chapter 4 this is an important recommendation. It might be improved by using language that is clearly understood by professionals who don't have a specialist background. For example it is not clear what 'take account of the stigma and discrimination...' actually means. We suggest 'adopt a clear non-judgemental approach....,' might be better. Similarly the 4th bullet point in this recommendation refers to 'fostering people's autonomy' but it is not clear what this means over and above being involved in decision making about their care as recommended in the previous bullet point. Could this be expressed differently?	Thank you for your comment, we have partially amended the second bullet point of the recommendation in line with your suggestion. However, the GDG asserted that the forth bullet point would be fully understood by healthcare professionals as it will be included as part of their training.
113	SH	Royal College of Nursing	FULL	4.5.1 .1	115 (LIN E9/10)	CPA is instigated where there is complexity and high risk – not just about how many services are involved. Someone/a young person could have two services and be low risk and one service be high risk.	Thank you for your comment. On reflection the GDG felt it was unnecessary to specifically mention the CPA as the guideline covers the same aspects.
114	SH	NHS Direct	Full	4.5.1 .10	116	Full assessment of carers needs must be also offered	Thank you for your comment, this recommendation has been amended in line with your suggestion to read: <i>When families, carers or significant others are involved in supporting a person who self-harms:</i> <ul style="list-style-type: none"> • offer written and verbal information on self-harm and its management, including how families, carers and significant others⁵ can support the person • offer contact numbers and information about what to do and whom to contact in a crisis • offer information, including contact details, about

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						<p><i>family and carer support groups and voluntary organisations, and helping families, carers or significant others⁵ to access these</i></p> <ul style="list-style-type: none"> • <i>inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.</i>
115	SH	Royal College of Nursing	FULL	4.5.1 .11	116	<p>This sentence needs to be rephrased to include something about Risk for example Balance between developing autonomy and capacity of the young person with perceived risks, how these can be managed and the responsibilities and view of the parents/carers.</p> <p>Thank you for your comment, this has been amended to read: <i>CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with the perceived risks, and the responsibilities and views of parents or carers.</i></p>
116	PR	Expert Reviewer (3) (Richard Morriss)	Full	5	118-133	<p>There are some major barriers to research in training: There is no psychometrically derived measure of skills in a clinical setting with self-harm patients other than videotaping or audiotaping consultations but this is intrusive, difficult to perform in an adequate sample size and open to performance bias as you have noted. The SIRI is a psychometric measure and STORM has had no effect on its performance in two out of three evaluations. This may be because it is primarily a measure of person centred counselling in the context of self-harm and training is the assessment and management of suicide risk rather than person centred counselling. Our research group did explore with the Medical Research Council around 2002, the possibility of a large scale RCT of training on people at risk of suicide using suicide and serious self-harm as an outcome. Unfortunately statisticians concluded that a sample size of around 15 million people was required and even then contamination between areas randomised to training and non-training was a major methodological problem. Therefore the proposed RCT was abandoned. Suicide training is very emotive. In Appleby et al 2000 and Gask et al 2006, we explored the possibility of performing a RCT of training staff to manage people at risk of suicide but found that it was not acceptable to NHS Trusts who insisted that the training must be provided to their staff in the study or the study did not go ahead – hence the before and after</p> <p>Thank you for your comments. The GDG agree that trials would be challenging and may require specific measures of skill acquisition to be developed, but the research recommendations also suggested that other, more patient centred outcomes be included.</p> <p>Contamination is an issue even with cluster designs. Powering a study on suicide and serious self-harm would obviously require a huge sample, however powering on the basis of some of the other staff and patient outcomes suggested, or repetition of self-harm (regardless of seriousness) might be more feasible.</p> <p>The GDG agree suicide is an emotive issue. The GDG were suggesting not that healthcare professionals have been given no training – they will have some suicide training as part of their general professional training – but that they are given no additional specialist training. The research recommendation has been amended to reflect this.</p> <p>Involving service users in the design of interventions is important, especially in this area and have recommended that they are involved in research recommendation 5.5.1.2.</p>

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						design. There are recent developments in RCT design such as stepped wedge that could get over this but there are still formidable problems in measurement of outcome unless self-harm itself in a high risk group could be used. It is a notable weakness that persons who self-harm have not been consulted about the development of the intervention except in a consultative capacity to check the items were acceptable and understandable. They have not tended to be involved in the design or delivery of training nor its evaluation.	
117	SH	Royal Society of Medicine	Full	5.1	118	Instead of “training in self harm” – “training in the management of self harm”	Thank you for pointing this out, it has been amended.
118	PR	Expert Reviewer (4) (Keith Hawton)	Full	5.1	118	20 Much longer history of this development. Began in mid-1970s – see, for e.g. Hawton, K., Gath, D. and Smith, E. (1979) Management of attempted suicide in Oxford. <i>British Medical Journal</i> , 2 , 1040-1042	Thank you for bringing this to our attention. This reference has now been added to the introduction of the training chapter.
119	SH	Royal College of Nursing	FULL	5.1	118 – LINE 15	Could ‘analogous’ be replaced with ‘similar’ – most people may not know what analogous means.	Thank you for your comment, this has been amended.
120	PR	Expert Reviewer (3) (Richard Morriss)	Full	5.1.2	119-120	<p>Thank you for asking me to comment on the draft full guideline on training. I agree the quality of the intervention studies is quite poor and there are no randomised controlled trials that I know of. There are some other before and after training studies of people at risk of suicide that were not reviewed, including a health economics study; if they are not included it would be worth stating why:</p> <ul style="list-style-type: none"> • Appleby L et al Psychol Med 2000; 30: 805-812 – assesses skills, attitudes and confidence plus health economics assessment of an intervention targeted at GPs, emergency staff and mental health professionals in one health area. • Morriss R et al Psychol Med 2005; 35: 957-960 – examines effects on suicide rates of above. • Gask L et al 2008 BMC Health Serv Res 2008; 8: 246. Large sample of before and after evaluations of attitudes and confidence. • Ranberg IL, Wasserman D. Nord J Psychiatry 2004; 58: 389-394. <p>The first three plus Gask et al 2006 and Morriss 1999 (that</p>	Thank you for bringing these papers to our attention. We have now included all of them with the exception of Ramberg (2004) in the training section. This was excluded as it was carried out in a non-UK setting. The limitations that you have mentioned have also been added to the evidence summary.

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						you have included) are all evaluations of STORM training. Together they may indicate that STORM improves attitude, confidence and clinical communication in the short-term. In addition to the problems that you have already stated, longer –term follow-up in all these studies has a high attrition rate that might also be differential in nature (ascertainment bias) and assessments are usually performed in volunteer samples of staff who may be quite different in terms of skills, attitudes and knowledge etc compared to other staff who will not volunteer (another form of selection bias).	
121	SH	NETSCC, HTA (Referee 2)	Full	5.2.1	120-121	2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise. A lot of results are given in the text within the first paragraph so it is difficult to digest – could this information be presented in table. There are similar instances throughout the document, where several results from single studies could be tabulated rather than listed in the text.	Thank you for your comments, the GDG feel these are sufficiently presented.
122	SH	Royal Society of Medicine	Full	5.2.1	121	Line 30 – typo - trianing	Thank you for pointing this out, it has been amended.
123	SH	NETSCC, HTA (Referee 2)	Full	5.2.1	123	Another general comment that arises throughout the document. The reporting of p-values does not follow a consistent format, for example, on this page, we have $p<0.0001$, $p=0.001$, $p<0.001$ and $p<0.05$. It may be that this is how the p-values were reported in the original papers, in which case there is not much that can be done (except, perhaps, giving a footnote to this effect), but where possible, a consistent format should be employed.	Thank you for your comment. The p-values were reported as they were presented in the paper.
124	SH	NETSCC, HTA (Referee 2)	Full	5.2.1	123	Another general presentational point. The numbers of decimal points used in presenting results should be consistent, if possible (I first spotted in on page 123, but it happens before and after this) – the first two mean (SD) figures are given as 6.55 (1.4) and 6.7 (1.41). [the worst example I found was on page 161, line 22, where the lower confidence limit for an odds ratio was given as “1”, not “1.00”]	Thank you for your comment. The figures are reported as they are displayed in the papers.
125	SH	RCPsych in Wales	Full	5.3	128	Consider adding that unpublished work identified an association between GPs and other primary care practitioners attending the Connecting with People suicide and self harm awareness element of the RCGP accredited Primary Mental Health Care Accredited module and an	Thank you for your comment, as the work is unpublished it is unlikely it would have been retrieved in our searches as these focus on published literature. Moreover, as you describe it this doesn't appear to be a research study or publication but

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						increase in coding of self harm post training. (data available upon request)	instead a policy and/or training document. In any event thank you for drawing our attention to it but wouldn't be able to include it.
126	SH	RCPsych in Wales	Full	5.3	129	NICE Guidelines suggest that all patients following self harm have psychosocial assessment by A&E professionals. (Horrocks et al 2003 reported 58% of A&E cases met this) 2009 audit of a North Wales A&E cases (n=64): <ul style="list-style-type: none"> • 94% assessed for immediate risk; • 89% identified previous mental illness; • 81% Mental State Examination 	Thank you but this is within the scope of the previous guideline (NICE CG16), and therefore can not be included in this guideline.
127	SH	Royal College of Nursing	FULL	5.4	131 – LINE 7/8	How do we assess the effect of training of healthcare professionals? It would be helpful to make the link with service user feedback forms – ask every young person to complete the form after every self-harm assessment. Did they feel listened to, understood, etc After training feedback from service users should be positive if not this can be picked up with staff - more training/mentoring offered.	Thank you for your comments, we do address training in chapter 5 and refer to the issues you raise in the NICE guideline, recommendations 1.1.9-1.1.11.
128		NICE	Full	5.4	129-130	The evidence for training presented in section 5 is not strong and you acknowledge this in the evidence to recommendations section. Some of the material presented from chapter 4 about service user experience could usefully be referred to in the evidence to recs section of chapter 5 to make the case for training stronger.	Thank you for your comment. This has now been noted in the evidence to recommendations section in chapter 5.
129	SH	RCPsych in Wales	Full	5.4	130	Consider the inclusion of the following papers regarding professionals attitude to risk assessments: <ul style="list-style-type: none"> • Cole-King A Lepping, P Suicide mitigation: time for a more realistic approach. 2010. BJGP 3-4 • Cole-King A Lepping P (2010) Personal view: Will the new Government change our approach to risk? <i>British Medical Journal</i>, July. 341: c3890. • Cole-King A Green G, Peake-Jones G, Gask L (2010) The Assessment and Management of Patients with Suicidal Thoughts in Primary Care: An introduction to the concept and practicalities of suicide mitigation. <i>InnovAiT</i> Vol 4, Num 5, 288-295 • Cole-King A Green G, Wadman S, Peake-Jones G, Gask L (2010) Therapeutic assessment of patients following self harm in primary care. <i>InnovAiT</i> Vol 4, Num 5, p278-287 	Thank you for sending us these references. We have considered them carefully and the new models of assessment and management that they propose. However, the papers do not contain the level of evidence that would warrant us recommending use of these models over others.

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130	PR	Expert Reviewer (4) (Keith Hawton)	Full	5.4	131	32/33 Except that just using information (e.g. posters) for training is probably unhelpful.	Thank you for your comment. We have now added this to the evidence to recommendations.
131		NICE	Full	5.4.1	130	Can the evidence to recommendations include a consideration of the balance between benefits and costs and whether the recommendations have any resource impact?	Thank you for your comments. Unfortunately, there was no available economic evidence.
132	PR	Expert Reviewer (3) (Richard Morriss)	Full	5.5	131-132	I am happy with your clinical recommendations. STORM might be a starting point for training in assessment and management coupled with a session involving people who self-harm.	Thank you for your comments.
133	SH	NHS Direct	Full	5.5	131	Recommendations for training should be expanded to include minimum standards for training i.e. Assessment skills & tools such as risk assessment; enhanced communication skills such as empathy & demonstration of compassion; management of therapeutic relationships; knowledge & use of local & national services & how to signpost / refer to them.	Thank you for your comment, unfortunately there is a lack of an evidence base on which to recommend minimum standards for training. However the whole guideline gives an indication of which areas the GDG felt are important.
134		NICE	Full	5.5.1 .1	131	Please specify the priority professionals who would need this training. The phrase ‘..working with people who self harm..’ could be broadly interpreted but the evidence isn’t strong enough to support a blanket recommendation.	Thank you for your comments. Once a person has self-harmed the likelihood they will die by suicide is increased 100 fold. Self-harm is also associated with considerable morbidity – approximately 90% of people who self-harm will have a mental health condition. This suggests that anyone who works in mental health should be trained. We have restricted this, nevertheless to people who work directly with them.
135	PR	Expert Reviewer (3) (Richard Morriss)	Full	5.6	132-133	In the research recommendation, consideration should be given to the development of a psychometrically tested measure of clinical skills in suicide assessment and management.	Thank you for your comment. Unfortunately this would be too detailed for our recommendations and beyond the remit to prescribe this.
136	SH	NETSCC, HTA (Referee 2)	Full	5.6.1 .1	132	typo in reporting p-value on line 3	Thanks for bringing this to our attention. This has now been corrected.
137	PR	Expert Reviewer (David Gunnell)	Full	6.0		The literature review of risk factors for repeat self-harm and suicide is extensive – I am not familiar enough with papers in this field to identify if any key omissions. The section would be greatly helped by an overall summary table perhaps commenting on the strength of association and prevalence of each particular risk / protective factor, focusing on the most recent cohorts and European settings.	Thank you for your comment. We will add a summary table.

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138	SH	NETSCC, HTA (Referee 2)	Full	6.2.4	139	There are 3 footnotes, all with the same text	Thank you for your comment; unfortunately we are unsure what you are referring to as there are no footnotes either on page 139 or in section 6.2.4.
139	SH	NETSCC, HTA (Referee 2)	Full	6.2.4	140	In the second paragraph, the unadjusted odds ratio is given as 2.98 (0.9, 9.58) [note the lower confidence limit should be given to two decimal places], and the adjusted odds ratio as 2.19 (1.25, 3.81). It is noted that the adjusted OR is lower than the unadjusted value, but for me the striking feature of the adjusted OR is that it is much more precise, and is quite clearly significant, whereas the unadjusted OR was not.	Thank you for your comment. We acknowledged the difference observed. We double checked the data and it was correct.
140	SH	Royal Society of Medicine	Full	6.2.4	140	Line 9 - associated confounds – confounders? Also appears throughout section.	Thank you for your comment, this has been amended.
141	SH	NETSCC, HTA (Referee 2)	Full	6.2.4	141	In the second paragraph, figures are given for repetition rates, but not over what timescale – it is surely important to report this when discussing repetition rates	Thank you for your comment. These figures could be found in Appendix 15b.
142	SH	NETSCC, HTA (Referee 2)	Full	6.2.4	141	The first paragraph under “Alcohol misuse ...” reports effect measures from WANG2006 and KAPUR2006, without explaining on what scales these are measured	Thank you for your comment. The studies did not report the measuring scales. But KAPUR2006 defined it as “harmful use or >7 units daily”.
143	SH	NETSCC, HTA (Referee 2)	Full	6.2.4	141	Under “Schizophrenia related symptoms ...”, line 2, the term “unadjusted hazards” should read “unadjusted hazard ratio”; also on the last line, the “CI” is missing.	Thank you for your comment, this has been amended.
144	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.4	142	18 Should be BILLE-BRAHE, here and below (page 144 x2).	Thank you for your comment. The relevant references and appendices have been amended.
145	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.4	144	Harriss, L., Hawton, K., Zahl, D. (2005) Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. British Journal of Psychiatry, 186, 60-66 provides information on suicidal intent and repetition of SH in large UK sample.	Thank you for your suggestion. This study has been added to the relevant section.
146	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.5	146	4 If you want more UK evidence data also available in Hawton, K. and Fagg, J. (1988) Suicide and other causes of death following attempted suicide. British Journal of Psychiatry, 152, 359-366.	Thank you for your suggestion. This study has been added to the relevant section.
147	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.5	148	1 See comment 17 above. Paper provides data on suicide following SH.	Thank you for your suggestion. This study has been added to the relevant section.
148	PR	Expert	Full	6.2.5	149	3 Data also in: Hawton, K., Zahl, D., Weatherall, R.(2003)	Thank you for your suggestion. This study has been

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		Reviewer (4) (Keith Hawton)				Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. British Journal of Psychiatry, 182, 537-542	added to the relevant section.
149	SH	NETSCC, HTA (Referee 2)	Full	6.2.5	150	First noted at this point, but throughout the document, effects of risk factors are reported as odds ratios, but without reference to what time frame is being referred to – e.g. the odds ratio between groups for an outcome over 6 months is generally not the same as the odds ratio for the same outcome over 12 months	Thank you for your comment, the time frame has been added and the data summarized into a table.
150	SH	NETSCC, HTA (Referee 2)	Full	6.2.5	150	In the first two lines of the first paragraph, “hazards ratio” should read “hazard ratio”; on the penultimate line, “hazards” should read “hazard ratio” – the document needs a thorough proof-reading for similar minor errors	Thank you for pointing this out, it has been amended and the document will be proof-read by the editors at NCCMH before publication.
151	SH	NETSCC, HTA (Referee 2)	Full	6.2.5	152	The first sentence under “Narrative review” reports an odds ratio and CI, without stating the timescale	Thank you for your comment. The timescale of all studies have been included in Appendix 15b, and will not be reported individually due to the limitations in space.
152	SH	NETSCC, HTA (Referee 2)	Full	6.2.5	153	Lines 12-15: It states that the follow-up period varied from 4 to 20 years. This is a strange way to phrase it, given that there are only two studies. Note that the timescales are very different, so is it sensible to pool the odds ratios from these two studies in the next paragraph? Note also that lines 25-26 state that BECK1989 reported odds ratios that could not be pooled with other studies, which is contradicted by the previous paragraph.	Thank you for your comment. We acknowledge this is a limitation to the analysis. We double checked the sentence referring to BECK1989 and it did not contradict with the previous paragraph.
153	SH	NETSCC, HTA (Referee 2)	Full	6.2.5	154	Line 18: how does the value of the hazard ratio “result in” high heterogeneity?	Thank you for your comment, this has been amended.
154	SH	NETSCC, HTA (Referee 2)	Full	6.2.6	155	Lines 9-10: If findings were not adjusted, how can psychiatric history be said to be an independent risk factor?	Thank you for your comment, this has been amended.
155	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.6	155	24 See also: Haw C, Hawton K. (2010) Living alone and deliberate self-harm: a case-control study of characteristics and risk factors. Social Psychiatry and Psychiatric Epidemiology, DOI 10.1007/s00127-010-0278-z.	Thank you for your suggestion, but this study did not meet our criteria for inclusion as it was not a prospective cohort study.
156	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.6	156	21 Data also in: Hawton, K., Zahl, D., Weatherall, R.(2003) Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. British Journal of Psychiatry, 182, 537-542.	Thank you for your comment. This has been added to the narrative review.
157	SH	NETSCC,	Full	6.2.7	156	Lines 6-11: If this finding was corrected in an erratum, why	Thank you for your comment, this has been

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		HTA (Referee 2)				is it reported as being significant?	amended.
158	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.9	160	9 Might be better to stick with studies of hospital samples?	Thank you for your comment. The text has been amended to include 2 extra odds ratios, 1 of which is calculated from hospital clinical samples, the other calculated from community samples.
159	SH	NETSCC, HTA (Referee 2)	Full	6.2.9	162	Note that if an odds ratio or hazard ratio is reported with a p-value, then it is possible to derive the confidence interval. Also, if results are reported in subgroups only, it is still possible to include them in a meta-analysis – this will effectively combine the results from the subgroups. If preferred, results from the subgroups can first be combined to give a pooled estimate from that study, and then incorporated into a meta analysis with other studies.	Thank you for your comment. We cannot respond to your comment as we are unable to locate the reference to your comment.
160	SH	NETSCC, HTA (Referee 2)	Full	6.2.9	164	Line 12 the sentence reads as if something is missing – adjusted for what?	Thank you for your comment. We cannot respond to your comment as we are unable to locate the reference to your comment.
161	SH	NETSCC, HTA (Referee 2)	Full	6.2.1 0	165	Line 3 the word “strong” shouldn’t be there – there was no evidence	Thank you for your comment, this has been amended.
162	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 3	166	Not sure that this section is helpful as not all patients in studies had self-harmed. See p 168.	Thank you for your comment. We have made it clear that this section is a review of risk factors by psychiatric sub-groups, and not all patients have self-harmed.
163	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 3	168	Alcohol, 16 Haw – now all are SH patients	Thank you for your comment. This has been included in the narrative review of "Alcohol abuse as a risk factor for completed suicide"
164	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 3	168	Alcohol, 16 Preuss – now minority	Thank you for your comment. We have made it clear that this section is a review of risk factors by psychiatric sub-groups, and not all patients have self-harmed.
165	SH	Royal Society of Medicine	Full	6.2.1 5	170	Need to make the point that the high prevalence of psychiatric disorder relates to this population of those who present to hospital – ie excludes those who present in other settings, and those who do not present.	Thank you for your comment. We have clarified the setting.
166	SH	Royal Society of Medicine	Full	6.2.1 6	170	Line 41 – need to be clear about which are protective factors against repeat SH and which are against suicide as it appears the latter is not discussed	Thank you for your comment. It is difficult to separate these risk factors as they often overlap with each other. The outcomes (whether fatal or non-fatal) of these studies are described and reported in each study.
167	SH	NETSCC, HTA	Full	6.2.1 6	171	Line 6: the phrase “only two or fewer studies” seems strange	Thank you for your comment. We will amend the sentence.

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		(Referee 2)					
168	SH	NETSCC, HTA (Referee 2)	Full	6.2.1 6	171	I noticed particularly when reading this section that for many studies, no indication is given about the sample size.	Thank you for your comment. These figures could be found in Appendix 15b.
169	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 6	172	6 O'Connor Highlight that is a community study.	Thank you for your comment. This has been highlighted in the review.
170	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 6	172	15 Grammar	Thank you for pointing this out, it has been amended.
171	SH	Royal Society of Medicine	Full	6.2.1 8	174	Line 2 – grammar - in the children and adolescence population	Thank you for pointing this out, it has been amended.
172	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 8	174	5 Grammar	Thank you for pointing this out, it has been amended.
173	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.2.1 8	174	37 Grammar	Thank you for pointing this out, it has been amended.
174	SH	RCPsych in Wales	Full	6.3.1 – 6.3.8	178 - 192	The guideline highlights the difficulties of relying on risk assessment instruments. This correlates with the findings of RCPsych report suggesting that if risk assessment tools are used these are only an adjunct to a skilled clinical assessment. Royal College of Psychiatrists (2010) Self-harm, suicide and risk: helping people who self-harm. College Report CR158. p. 78-80 http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf	Thank you for your comments, the GDG agree risk assessment tools should only be used as an aid to structure a skilled clinical assessment.
175	SH	Royal College of Paediatrics and Child Health	Full	6.3.2	178	This section on risk assessment scales misses the Pierce score, one of the earliest and one with supporting research. Anecdotally, a modified version of this has been used in paediatrics for years. As with all of these tools, it is very sensitive but poorly specific. It picks up a large mass of children at moderate/high risk, but more usefully defines a small category of children at particularly low risk, who may be managed as out- patients rather than via hospital admission.	Thank you for your comment, the studies reviewing the Pierce score did not meet our inclusion criteria.
176	PR	Expert	Full	6.3.2	178	26 See also: Bergen, H., Hawton, K., Waters, K., Cooper,	Thank you, the guideline has been amended to

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		Reviewer (4) (Keith Hawton)				J., Kapur, N. (2010) Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. Journal of Affective Disorders, 127, 257-265	reflect your suggestion.
177	SH	Royal College of Nursing	FULL	6.3.3	180 TAB LE 19	Could an extra column be added indicating age range/suitability of use of the different scales (this has relevance to working with children and young people).	We considered this comment carefully. This table was intended to summarise only the scales that had been used and the studies in which they had been tested. Further details of the populations in each of the studies are included in the text.
178	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.3.4	180	Table 19 ?include Hawton and Fagg 1995 here – is included on page 186.	Thank you, the guideline has been amended to reflect your suggestion.
179	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.3.5	183	8 Spelling.	Thank you for pointing this out, it has been amended.
180	PR	Expert Reviewer(David Gunnell)	Full	6.3.6	184	Suggest give likelihood ratios here as well as sensitivity / PPV etc.	We considered this comment carefully but decided to exclude likelihood ratios for the following reasons: <ul style="list-style-type: none"> - inclusion of the LRs would require substantial additional explanation and further interpretation of the findings, - the LRs can be calculated from the figures already presented in the full guideline by the interested reader. - Inclusion of LRs would not substantially alter our findings or recommendations.
181	SH	NETSCC, HTA (Referee 2)	Full	6.3.6	185	For SANTOS2009, it is said that confounding variables were not adjusted for. However, if matching had been used, and the data analysed appropriately, then adjustment is not necessarily appropriate	Thank you for your comment.
182	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.3.7	187	42 May be misleading to include GALFAVY as is study of depressed patients, not SH?	Thank you for your comment. We agree that this may be misleading and have added a sentence at the end of this paragraph to highlight this limitation. “ When interpreting these results, it is important to note that this is not a study of a pure self-harm population but a study of depressed people, some of whom have a history of self-harm.” This study was included because it meets the inclusion criteria and does report that 54% of the sample have a history of self-

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							harm.
183	SH	NETSCC, HTA (Referee 2)	Full	6.3.7	188	The last sentence of the first paragraph and the first sentence of the second paragraph seem to say the same thing	Thank you for your comment. We cannot respond to this comment as the page number given seems to be incorrect. We have checked the paragraphs in this section and cannot see any changes that need to be made,
184	SH	NETSCC, HTA (Referee 2)	Full	6.3.7	188	If BHS >5 (or >=5 ?) has a sensitivity of 0% and specificity of 100%, does this mean that no one had a BHS score above the threshold? i.e. everyone was negative by this criterion? In that case, I make the NPV to be 252/304 or 82.9%, but it is rather pointless to report diagnostic stats for a test that is never satisfied.	Thank you for your comment. The NPV was calculated as being 82.89473% however we have used one decimal place and did not round the number therefore reported an NPV of 82.8%
185	SH	NETSCC, HTA (Referee 2)	Full	6.3.7	188	The HDRS with a cut-off of 2 is reported to have a sensitivity of 4% and specificity of 94%, PPV 12% and NPV 82.5%. This implies that the HDRS is worse than not testing – the probability a suicide attempt given a positive test (PPV) is actually less than the overall probability of a suicide attempt in the whole population (a similar argument can be made around the NPV value)	Thank you for your comment. We agree that the PPV for HDRS is worse than the overall probability of suicide attempt in the whole population, which implies that, as a scale, the HDRS is worse than not giving an assessment.
186	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.3.7	188	19 Corcoran 1997 not in refs.	Thank you for your comment. The reference has been added.
187	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.4.1	192	24 Suggest add Attitudes to help/care.	Thank you for your comment. This has been added.
188	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.4.1	192	Also add Establishment of problem list with patient	Thank you for your comment. This has been added.
189	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.4.1	192	Should include exposure to suicide/SH by others – in family, environment, media (NB internet).	Thank you for your comment. This has been added.
190	SH	NETSCC, HTA (Referee 2)	Full	6.5.1	194	Lines 16-17 report a PPV of 38% and a NPV of 62.9% - this implies that those with a negative test had a probability of repeated suicide attempt of 37.1%, very similar to those with a positive test, suggesting little discriminatory ability	Thank you for your comment. We agree that the results show little discriminatory ability for this scale.
191	PR	Expert Reviewer (4) (Keith	Full	6.5.1	199	5-8 Suggest re-word as suggests that there really were differences.	Thank you for your comment. This has been re-worded.

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		Hawton)					
192		NICE	Full	6.6.2	199-204	This section on current practice reads like a series of recommendations for practice. It needs to be rewritten so that it is descriptive of current practice rather than proscriptive.	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
193	SH	Royal Society of Medicine	Full	6.6.2	200	Line 36 – this reads as what “should” happen, yet is headed Current Practice. This is confusing given that section 6.7 advises on what should happen on the basis of the evidence. There seems to be unnecessary repetition in these consecutive sections.	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
195	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.6.2	201	28-31 Unclear meaning.	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
196	SH	Royal Society of Medicine	Full	6.6.2	203	Line 46 – in order to reinforce the link between this guideline and those NICE guidelines for each psychiatric disorder might be worth listing those existing guidelines at this point, and including weblinks for ease of reference	Thank you for your comment, the NICE guidelines are listed in the references and are also listed at the end of the NICE guideline with the relevant web links.
197	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.6.2	203	33 Add Access to means	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
198	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.6.2	204	1-8 Useful to have checklist of potential problem areas to go through following the patient’s account to see if anything missed Also need to add Physical health issues.	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
199	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.6.2	204	33 Also add whether usual coping ability undermined (e.g. due to depression).	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
200	SH	Royal Society of Medicine	Full	6.6.2	205	Lines 3 to 5 are an important place at which to make the above point, and makes no reference to longer term management at all. In fact the sense of this sentence is not clear: which/where are these longer interventions?	Thank you for your comment. On reflection the GDG felt this section was superfluous as the recommendations outline what should be involved in an assessment. It has therefore been deleted.
201		NICE	Full	6.7	204-205	Many recommendations appear to be derived from the qualitative evidence presented in chapter 4 about service users’ experience of care. This needs to be made explicit and detailed in section 6.7.	Thank you, 6.7 refers to the evidence to recommendations section of the guideline for the chapter on risk, not to Chapter 4.
202	SH	Derbyshire Healthcare NHS Foundation	Full	6.8 and General	general	Repeaters and CPA I believe that one of the major challenges for both Mental Health Services as well as Primary Care and Acute	Thank you for your comment. The GDG did not identify people who repeatedly self-harm as a sub-group as there is a danger of these individuals then being stigmatised or treated differently. It is the

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		Trust				<p>Hospitals, particularly the Emergency Department is those who self harm on a regular basis and present some challenges to the services on how best to manage. Without doubt consistency and continuity is very important and good communications between all agencies is paramount. On the reading of these guidelines I am not clear that this sub group have received a high degree of attention and although the principle should apply across the whole population who self harm I think there is merit in exploring whether some additional emphasis and additional recommendations should be made on managing those who may start to attend more frequently. As a crude parameter we could look at four or more attendances to E.D within a six month period or more than six attendances within a year. Whilst the guidelines do describe the importance of the CPA process for those that are open to Mental Health Services I wonder whether a recommendation could come forward to actually encourage that any person who falls into the more frequent attendee at say an Emergency Department, that whether or not they are under CPA that a review meeting is held and the encouragement at that meeting is for all parties who may encounter or have contact with that person to be invited to attend to contribute their awareness, knowledge and information but also to help form part of a broader care team for that person. Thus it would be important under these circumstances to invite representatives from the Emergency Department, from the Ambulance Service, from the Police if they have been involved as well as encouraging the GP, or other primary or social care contacts that the person may have as well as inviting anyone from any helplines or support services that person may currently use or may be thought to have benefit in using in the future. From this approach a much broader “care programme approach” could be seen to be occurring providing the opportunity for consistency, continuity as well as validating the person who is presenting in that they would see that all were trying to work with them in order to help address the issues.</p> <p>Below are extracts from the document that partially relate to</p>	<p>opinion of the GDG that each episode of self-harm should be treated seriously and in its own right, whilst also taking into account “methods and patterns of current and past self-harm” (see recommendation 1.3.6).</p>
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						<p>the above.</p> <p>“6.8.1.26 Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.</p> <p>One study (HAW2007) reported female frequent repeaters were at increased risk of completed suicides as opposed to less frequent repeaters and non-repeaters.</p> <p>It is also good practice for health and social care professionals to use the Care Programme Approach (CPA) whenever more than one service is involved to ensure continuity of care.</p> <p>use the Care Programme Approach (CPA) whenever more than one service is involved.</p> <p>6.8.1.5 If a person who self-harms is receiving treatment or care in primary care as well as secondary care, primary and secondary health and social care professionals should ensure they work cooperatively, routinely sharing up-to-date care and risk management plans. In these circumstances, primary health and social care professionals should attend CPA meetings.”</p>	
203	SH	Derbyshire Healthcare NHS Foundation Trust	Full	6.8 and General	General	<ul style="list-style-type: none"> • Tools and screening <p>In regard to the use of tools and screening tools whilst I applaud the efforts that have gone into to actually establish the recommendations that have been made I wonder whether currently they are a little bit too strong in almost dissuading clinicians from using the tools that are potentially available. I wonder whether although it is within the document but stronger emphasis could be given that the tools are very useful as memory joggers or pointers and for ensuring that the assessment has looked into the variety of factors that need to be brought into the final assessment and formulation. I think the current way of writing it may lead clinicians to not use tools at all which I think would be a step backwards, although I do appreciate that the use of</p>	<p>Thank you for your comment. The GDG have recommended that risk assessment tools are not used to predict future episodes of self-harm. This however does not mean that risk assessment should not be carried out to focus on what help the service user may need. We have suggested in recommendation 1.3.13 that risk assessment tools may be used to help structure a risk assessment. The guideline has been amended to clarify the difference between risk assessment tools and risk assessment.</p>

						<p>the tools have been somewhat arbitrary applied across Trust's and more as a blanked risk prevention type strategy without full awareness of their effectiveness.</p> <p>From the document 6.8.1.17 Do not use risk assessment tools and scales to predict future suicide 1 or repetition of self-harm. 2 6.8.1.18 Do not use risk assessment tools and scales to determine who should 3 and should not be offered treatment or who should be discharged. 4 6.8.1.19 Risk assessment tools may be considered to help structure risk 5 assessments as long as they include the areas identified in 6 recommendation 6.8.1.12.</p>	
204	PR	Expert Reviewer (4) (Keith Hawton)	Full	6.8.1	210	<p>21 Need to define longer-term treatment and distinguish this from short-term intervention e.g. brief CBT/problem solving.</p> <p>23-25 is unclear in this respect</p> <p>ALSO suggested role of CMHT services undermines currently established general hospital self-harm services, and these provide a better model that having different CMHT's having to go to hospital.</p>	<p>Thank you. We have defined longer term treatment as anything beyond the first 48 hours (see section 1) but have rephrased this for clarity.</p> <p>We were using CMHTs to refer to specialist mental health services in a generic sense. It was not the GDG's intention to exclude liaison and general hospital mental health services, many of whom provide an excellent service for individuals following self-harm. This recommendation has been reworded for clarity: <i>Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3), and the longer-term treatment and management of self-harm. In children and young people this responsibility should be taken by tier 2 and 3 CAMHS services.</i></p>
205	SH	Royal College of Paediatrics and Child Health	Full	6.8.1 .2	207	<p>The draft rightly highlights the need for planned transfer of children from CAMHS to adult services. However, it neglects the huge hole in mental health services for the 16-18 years population. Anecdotally, young people of 16 years cannot be admitted to a children's hospital and have to attend an adult hospital even though they are still under the care of CAMHS.</p>	<p>Thank you for your comment, however this issue is dealt with in short term management guideline (NICE CG16), and therefore not within the scope of this guideline.</p>
206	SH	Royal College of Nursing	FULL	6.8.1 .15	209	<p>We agree with proposals to remove/safe storage of medicines but suggest that this should say 'consider removal of other means of harm – harm minimisation approach indicates for some people 'removal of' means increases the risks.</p>	<p>Thank you for your comment, as this refers to children and young people the GDG did not feel it appropriate to amend the recommendation.</p>

207	SH	Royal College of Paediatrics and Child Health	Full	6.8.1 .17	210	The draft discusses risk assessment towards developing a risk assessment plan. Beck's or Pierce score may be useful in determining risk and informing a risk management strategy for a service user.	Thank you for your comment, the studies reviewing the Pierce score did not meet our inclusion criteria. The Beck score was included in the systematic review.
208		NICE	Full	6.8.1 .18	209	This recommendation states: 'Do not use risk assessment tools and scales to predict future suicide or repetition of self harm'. This appears to contradict the recommendation in the guideline on the short term management of self harm which states: If a standardised risk assessment scale is used to assess risk, this should be used only to aid in the identification of people at high risk of repetition of self harm or suicide. Can you explain this?	Thank you for your comments. In this guideline a systematic review was conducted to examine the effectiveness of specific assessment tools. None were found to be effective at predicting self-harm and therefore the GDG have recommended they are not used for this purpose. The analysis of risk in this guideline supersedes the previous analysis, and therefore the guideline on short term management will be changed.
209	SH	Royal College of Nursing	FULL	6.8.1 .24	211	Many teams providing self-harm services are not or no longer multi-disciplinary e.g. consultant nurse led or nurse only teams. Referral to another discipline e.g. psychiatrist would only be done as needed not as part of standard care – so care plans would not be multi-disciplinary.	Thank you for your comment. It was the view of the GDG that multi-disciplinary teams more closely capture current and good practice.
210	SH	Royal College of Nursing	FULL	6.9	212	Is it recommended that young people are included in this study/research? They need to be.	Thank you for your comment, the research recommendation has been amended to reflect your suggestion.
211	SH	The British Psychological Society	Full	7 and 4	213 – 249 and 49 - 114	It would be useful to see the research findings from both of these sections (7 and 4) amalgamated and used to inform psychological treatment; both psycho-educational treatment and psychotherapy.	Thank you for your comment. We acknowledge the findings from the experience of service users can be used to inform interventions. This has been reflected in our research recommendations.
212	PR	Expert Reviewer(David Gunnell)	Full	7.1.1	214	Several recent RCTs have been published including Iranian postcards study; Hassanian-Moghaddam et alBJPsych 2011. I have not critiqued this section of the review as I imagine it is taken largely from the ongoing Cochrane review and you will be receiving comments from Keith Hawton on this.	Thank you for drawing attention to this. It is a remarkably positive and study, however as it is conducted in Iran it will have standard care in Iran as a comparator. We therefore omitted this from the analysis in the guideline. You may be interested to know that we have looked at the effect of including this study along with other postcard interventions in a meta-analysis separate to the guideline: the result is still not statistically significant.
213	SH	NETSCC, HTA	Full	7.1.2	219-220	Lines 40-41 seem to be saying that 74% is greater than 79%	Thank you for your comment. We cannot respond to your comment as we are unable to locate the

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		(Referee 2)					reference to your comment.
214	PR	Expert Reviewer(David Gunnell)	Full	7.1.2	224-225	Note a longer term (12 month) follow-up of the Evans et al paper has been published: Evans J et al. Br J Psych 2005;187:186-7	Thank you for your comment. The results reported include the data at 12 months follow up. We will add the missing reference to the reference list.
215	PR	Expert Reviewer (4) (Keith Hawton)	Full	7.1.2	218	Need to indicate here how quality of studies assessed – should not expect reader to have to find in Appendix.	Thank you for your comment, unfortunately we are unable to change this as it is NICE style to have the quality checklists in the appendices.
216	PR	Expert Reviewer(David Gunnell)	Full	7.1.2	218	I'm aware aspects of the Cochrane systematic review are currently being worked on, it will be critical to liaise with the review lead on ensuring congruence between the published Cochrane review and NICE guideline findings.	Thank you for your comment. The review lead (Professor Keith Hawton) is one of our expert reviewers and he has been invited to comment on our review.
217	SH	NETSCC, HTA (Referee 2)	Full	7.1.2	220	The SMD on page 219, line 31, of -0.54 is described as “small to moderate”, whereas on page 220, line 4, a SMD of -0.43 is described as “moderate” – this is not consistent	Thank you for your comment. We will amend the sentence.
218	SH	NETSCC, HTA (Referee 2)	Full	7.1.2	225	Lines 32-33: I do not agree with this conclusion. The short term RR was 1.28 and significant, longer term it was 1.32 but not significant (wider CI). Short term there was no heterogeneity, i.e. both studies must have had RRs of about 1.28. Longer term there was a lot of heterogeneity (between the two studies), i.e. one study must have had a larger RR, and one study a smaller RR. This suggests that it may be possible to maintain the beneficial effect, but it would be necessary to identify (and verify) the differences between the two studies that contributed to the difference in longer term benefit.	Thank you for your comment. We cannot respond to your comment as we are unable to locate the reference to your comment.
219	SH	Royal College of Paediatrics and Child Health Royal College of Paediatrics and Child Health	Full	7.1.5	240-242	One of the few treatments for which there <i>is</i> sufficient good evidence is Dialectical Behaviour Therapy. On page 241, the authors write: “Finally, participants were mostly women, thus limiting the applicability of the findings.” This seems a bit churlish and dismissive, given that the majority of recurrent self-harmers, especially those with Borderline Personality Disorder, are female! The other objections to this body of research also seem rather nit-picking and dismissive, given that the evidence quoted consists of no fewer than nine studies which cumulatively establish strong evidence for this particular treatment modality.	Thank you for your comment. DBT is not mentioned in the guideline as the populations in the DBT trials are all people with personality disorders. These trials therefore are reviewed in the NICE guideline CG78 Borderline Personality Disorder.
220	SH	Royal College of Nursing	FULL	7.1.7	244	Under <i>Recruitment Setting</i> the word ‘deliberate’ needs to be removed.	Thank you for pointing this out, it has been amended.
221	SH	Royal College of Nursing	FULL	7.1.7	244	There is currently a large investment, £4.5 million in an RCT – SHIFT (Self-Harm Family Therapy) whilst this will not be completed until 2014; it needs to be	Thank you for your suggestion, unfortunately we are unable to refer to this study as it will not be finalised until 3 years after the guideline is published.

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						mentioned/referenced so people are aware that it is happening.	
222		NICE	Full	7.1.9	general	Given the quality of the data and the complexity of the treatment area the approaches appear overall to be of good quality and are clearly laid out.	Thank you.
223		NICE	Full	7.1.9	249	On the review of the paper by Byford and colleagues (2003) I found a few of the details difficult to follow. A table summarising the results would have been easier to interpret.	Thank you for your comment. A detailed table with results of all the health economic papers reviewed including Byford and colleagues (2003) can be found in Appendix 14.
224		NICE	Full	7.1.9	250	For Byford and colleagues (2003) can the probability of MACT being cost effective at £20,000 and £30,000 per QALY willingness to pay be quoted?	Thank you for your comment. The probability of MACT being cost-effective at £20,000 and £30,000 was not stated in the original study by Byford and colleagues (2003). However, the probability of MACT being the cost-effective option was given to range from 44% to 88% and at willingness to pay (WTP) level of £66,000 or less, MACT has a higher probability of being cost-effective. As it will be difficult to extrapolate the exact cost-effectiveness probability of MACT at £20,000 and £30,000 from the study, the approximate range of probability at £20,000 and £30,000 is between 65% and 60% respectively.
225		NICE	Full	7.1.9	250	The issue about whether QALYs are a suitable health outcome for self harm is an important one. However is this the result of the short time horizon in the model that meant the long term benefits of reducing self harm were not captured?	Thank you for your comments. This section of the guideline has been reviewed to reflect the possible resource impact of the psychosocial intervention at longer term. The initial estimate was based on a 6-month time horizon. At a longer time horizon of 12 months and more, the psychosocial intervention is shown to be potentially more cost-effective. However, given the uncertainties in the clinical evidence and variations in the modalities of service delivery, the evidence to recommendation has been expanded to reflect these variations including scenarios with significant resource impact.
226		NICE	Full	7.1.9	251	In the introduction a explanation for not using QALYs would be good since it is not clear what the exact rationale was. This should be made explicit as it varies from the NICE reference case. Plus an explanation over why the utility values from the published were not utilised at all in the analysis, even if it is limited to a sensitivity analysis.	Thank you for your comment. The text has been amended in the introduction to economic modelling to expand the explanation for why QALYs were not used as the final outcome measure.
227	PR	Expert Reviewer(David Gunnell)	Full	7.1.9	255	Economic model, table 31 - the assumption of an RR for risk of repeat self harm (presume this is 12 months risk) of 0.33 seems high – 0.20 might be more realistic. – suggest conduct some sensitivity analyses around this assumption – esp if some of these repeat episodes do not present to	Thank you for pointing this out. We agreed that some of the repeat episodes do not present to services and therefore, the annual self-harm repetition risk of 0.33 derived from the pooled data of the meta-analysis studies could be high. However, the literature shows

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						services.	that the annual risk of self-harm repetition varies from 15% to 33% (Owens et al., 2002; Zahl & Hawton, 2004; Lilley et al., 2008b) with 33% estimate by Lilley and colleagues (2008b) being more reflective of risk of repetition taken into account the individual episodes. We assumed that sensitivity analysis using 24% (average of 15% and 33%) may be more reasonable and the result using this estimate has been included in the health economic section (section 7.1.9).
228	SH	NETSCC, HTA (Referee 2)	Full	7.1.9	258	Line 25: To state that no conclusions can be drawn “as it is a single study” is not accurate. The wording used on p226, line 4: “due to the small evidence base” is much better	Thank you, the guideline has been amended to reflect your suggestion.
229		NICE	Full	7.1.10	259	Can the evidence to recommendations be expanded to include the discussion over how the results were actually interpreted? So did the GDG conclude that given the cost per reduction in self harm events was approximately £3000 and that the long term health benefits of this reduction were likely to be significant that Psychological support was likely to be cost effective?	Thank you for your comments. This section of the guideline has been reviewed to reflect the possible resource impact of the psychosocial intervention at longer term. The initial estimate was based on a 6-month time horizon. At a longer time horizon of 12 months and more, the psychosocial intervention is shown to be potentially more cost-effective. However, given the uncertainties in the clinical evidence and variations in the modalities of service delivery, the evidence to recommendation has been expanded to reflect these variations including scenarios with significant resource impact.
230	SH	The British Psychological Society	Full Full Full Full	7.1.10 and 4.2 to end of section 4 and 4.2 to end of section 4	260 49 - 114 49 - 114 260	<p>The review of the psychological and psychosocial interventions reported here has recommended further research which fits into a quantitative research paradigm, and in the main resembles the randomised controlled trial model for pharmaceuticals and physical interventions. Yet, the quantitative research papers analysed are predominately reported as being unsatisfactory with little or no homogeneity and it appears that their results are therefore not generalisable.</p> <p>However, the qualitative research projects analysed in section 4 of this document give an excellent steer as to where these interventions should lie.</p> <p>This client group, as described in section 4, has diagnoses that are both complex and multiple, frequently with a maladaptive childhood and other traumatic events described as playing a large part in causation i.e. having experienced multiple types and events of abuse or trauma.</p>	Thank you for your comments. The two types of research complement each other, and whilst qualitative research supplies rich information, quantitative tests are needed to measure the effects of it. The GDG agree that it is important to have substantive qualitative elements to any quantitative research, and have recommended so in the current recommendations.

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				on 4 and 7.1.1 0		<p>Cont'd/</p> <p>With such a complex group of clients, perhaps what is needed is a new approach with the use of qualitative research methods. These methods focus on understanding both the problem and solutions from the clients' world view, rather than from a view that tends to lead to client work being 'done to' clients as opposed to the work being 'done with' them.</p> <p>It is therefore suggested that, in addition to new quantitative research projects, a quantitative research trial of long-term psychotherapy is commissioned. We recommend that such a trial focuses on relational therapeutic work, for instance the Person Centred Approach or Cognitive Relational Therapy, as the damage that self-harming clients have experienced, and which underlies their self-harming behaviour, often originates within unsatisfactory relationships.</p> <p>Additionally, we recommend that the research trial is carried out using the most experienced therapists, with a high level of training (Masters or Doctoral level) and the underlying causes addressed, rather than focussing solely on symptom reduction. This may seem counter intuitive for cost effectiveness; such highly qualified people appear at first sight to be expensive. However, this approach is anecdotally reported to be promising, and if this is the case, it will actually be much more cost-effective, not just in financial terms, but in terms of enhanced quality of life, as the ultimate aim of treatment is recovery and a cessation of the need for services.</p>	
231	SH	The British Psychological Society	Full	7.1.1 0 and 4.2 to end of section 4	260 and 82 – 102	<p>As this is a consultation on long-term management, and as the clients in section 4 have highlighted that it is long term relationships with staff having the appropriate values and skills to work with them, and who work with them over a long term, that help to make a difference to clinical outcomes and their lives, the Society queries why the guidance has only suggested a very short-term psychotherapy/psychological research project for this client group (6 sessions).</p>	<p>Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore the recommendation has been amended to include the full range of sessions suggested by the studies reviewed, that is 3-12. The recommendation has also been amended to suggest interventions are tailored to individual need:</p> <p><i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural,</i></p>

							psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.
232		NICE	Full	7.1.1 0 7.2.1 .1	261	Could the rationale for recommending 6 therapy sessions be clarified? You have suggested that it relates to the average number of sessions used in the reported studies, which is not a very strong case. Is this recommendation also supported by current practice for brief interventions	Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore the recommendation has been amended to include the full range of sessions suggested by the studies reviewed, that is 3-12.
233	PR	Expert Reviewer(David Gunnell)	Full (and NICE)	7.2	261	The recommendation to provide 6 sessions of psychological intervention to people who self-harm is based on quite mixed trial evidence, from studies carried out at times when community aftercare services may have been more limited than nowadays. Eligibility criteria for some trials were quite restrictive. Clearly, as recommended in a later section, there is a need for a large definitive trial in this area. Such a trial should take account of the heterogeneity of underlying conditions leading in self-harm. Furthermore, can the NICE guidelines be more specific about which patients 6 sessions of therapy may be most applicable to?	<p>Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore the recommendation has been amended to include the full range of sessions suggested by the studies reviewed, that is 3-12. The recommendation has also been amended to suggest interventions are tailored to individual need:</p> <p><i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i></p>
234	SH	British Association for Counselling and Psychotherapy	Full	7.2.1 .1 and 7.2.1 .2	261	<p>BACP notes the recommendations for psychosocial interventions in 7.2.1.1 and 7.2.1.2 and would strongly argue for the inclusion of humanistic counselling into this list, with an acknowledgement that self-harm can also be reduced by providing a space for individuals to focus on the cause, rather than the symptom.</p> <p>In the experience of our members, humanistic approaches work very effectively in supporting people with self-harm, across the board (in HE settings, the voluntary sector and in secondary psychiatric services and crisis support).</p> <p>BACP has concerns about the efficacy of targeting simply</p>	Thank you for your comment, we are unable to recommend humanistic therapy as our review found no data for its efficacy.

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						<p>the behaviour <i>without</i> connecting as a priority with the person/distress behind the behaviour. The danger is that by focusing on stopping self-harm (which is a laudable aim), the distress is acted out in different ways (including another form of self-harm). For example, a person who self-injures and focuses on that specific behaviour will in all likelihood, if the 'cause' is not addressed, move to a more self-harming behaviour, such as sexual risk-taking or eating disorders, moving from 'direct' self-harm to 'indirect' self-harm.</p> <p>The recommendations might have validity for people who attend counselling with the specific intention of wanting to stop self-harm. However our experience is that people generally tend not to approach services with a 'goal' of self-harm reduction, but instead to feel better, during which process the self-harm will reduce anyway.</p>	<p>This is a result of the evidence we have, which is derived from a meta-analysis of trials of psychological treatments that specifically aim to decrease self-harm. We do also refer to other guidelines to treat the underlying associated mental health condition (recommendation 1.5.1).</p>
235	SH	SANE	Full	7.3	261	<p>Following our research into the mechanisms by which self-cutting appears to have its effect, we would like to see a recommendation for research into embodiment-focused therapies, both to develop and pilot new therapies and to further develop and evaluate existing ones, such as mindfulness-based therapies.</p>	<p>Thank you for your comment. In order to prioritise research recommendations it was necessary to restrict them to interventions for which there was some existing RCT research evidence and the potential for widespread implementation in the health service. But we agree other approaches such as mindfulness might be helpful.</p>
236		NICE	Full	7.4.4	265	<p>Line 17: "...a solicitor from the York and Selby Primary Care Trust" Remove from the York and Selby Primary Care Trust. The solicitor in this paper works for Hempsons, the firm used for legal advice by York and Selby PCT.</p>	<p>Thank you, the guideline has been amended to reflect your suggestion.</p>
237		NICE	Full	7.5.1 .1	266	<p>Harm reduction</p> <p>Given the limits of the evidence we suggest qualifying the first bullet point by adding 'If stopping self-harm is unrealistic..'</p> <p>Rec 1.4.6 states '..there is no safe way to self poison'</p> <p>Should this be referred to in the section on harm reduction?</p> <p>Are there any other cases when harm reduction should not be considered? If so do these need to be stated explicitly?</p>	<p>Thank you for your comment. We have redrafted the recommendation:</p> <p><i>If stopping self-harm is unrealistic in the short term:</i></p> <ul style="list-style-type: none"> • <i>consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible</i> • <i>consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others⁵ where this has been agreed with the service user, and the wider multidisciplinary team</i> • <i>advise the service user that there is no safe way to self-poison.</i>

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							We have not found any evidence of cases when harm reduction should not be considered – it is down to clinical judgement.
238	PR	Expert Reviewer (4) (Keith Hawton)	Full	7.5.1 .2	267	NB Is very difficult in inpatient setting, where the goal for most of the patients will be no self-harm. This potential conflict should be discussed.	Thank you for your comment. We agree that this is a very complex area and have discussed this conflict in the full guideline (see section 7.4). Unfortunately due to a lack of evidence we were unable to make any recommendations for inpatient settings.
239	SH	Royal College of Psychiatrists in Scotland	Full	8.2.1	268	There are some questionable approaches to evidence appraisal in the long guidelines (page 268). It is stated that, “...the GDG [Guideline Development Group] decided to exclude 2 studies (MONTGOMERY1983 and VERKES1998) because they looked at people who had a diagnosis of personality disorder. Pharmacological treatment options in the treatment of personality disorder are partly covered in the NICE Borderline Personality Disorder guideline (NICE, 2009e).” We struggle to understand why the presence of an underlying psychiatric diagnosis in some of the studies should result in their exclusion. Other studies were considered despite the subjects having depression (which also has an accompanying NICE guideline). Similarly, studies where the diagnosis was not reported were included. This is difficult to understand. Given the high prevalence of self-harm in borderline PD, any evidence for this important patient group should at least be considered and such idiosyncrasy in appraising the evidence is difficult to justify.	<p>Thanks you for your comment. The GDG did not consider the psychological treatment trials for Borderline Personality Disorder in detail because these had been reviewed by the recent NICE BPD guideline. However, they are mentioned in section 7.1.5. and we have included a brief narrative discussion of these two studies in the full guideline.</p> <p>If a study is designed to treat Borderline Personality Disorder or Depression this is dealt with in the appropriate guideline. For people with BPD the psychological or drug treatment is exhaustively reviewed in that guideline. Studies of self-harm which aim to reduce self-harm or associated problems, but have no diagnostic inclusion/exclusion criteria have been reviewed here in this guideline.</p>
240	SH	Royal College of Psychiatrists in Scotland	Full	8.2.1	268	One of the excluded studies (Montgomery et al., 1983) is stated to have been excluded (in Appendix 15D) because: “ <i>Borderline Personality Disorder population. Self-harm outcome does not seem to be the primary outcome.</i> ” However, the study was a “a six month double-blind trial of the efficacy of an antidepressant [Mianserin 30mg] in reducing suicidal behaviour” (Montgomery et al., 1983). Perhaps self-harm (and suicidal behaviour) was a primary outcome? Does the GDG want to reconsider?	Thank you for your comment. As stated, this study was excluded because 79% of the population had a diagnosis of BPD, and 32% of them had a diagnosis of histrionic personality disorder.
241	SH	Royal College of	Full	8.2.1	268	The other excluded study (Verkes et al., 1998) was a trial of paroxetine and contrary to the suggestion in appendix 15D that “ <i>Self-harm outcome does not seem to be the primary</i>	Thank you for your comment. As stated, this study was excluded because 92% of the population had a diagnosis of BPD,

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		Psychiatrists in Scotland				<i>outcome</i> ”, “ <i>Recurrence of suicidal behaviour</i> ” was assessed at regular outcomes in the study and was analysed as a primary study outcome. Again, does there need to be a reconsideration of some of the excluded studies – and perhaps some of the included studies?	
242	SH	Royal College of Psychiatrists in Scotland	Full	8.2.1	268	The justification for exclusion of these studies appears to be difficult to reconcile with the actual study design and the apparent need to explore treatment options for self-harm in particular patient populations. Perhaps this reflects the apparent confusion about self-harm being a treatable entity independently of underlying disorders and/ or precipitating factors.	<p>Thank you for your comment. The GDG did not consider the psychological treatment trials for Borderline Personality Disorder in detail because these had been reviewed by the recent NICE BPD guideline. However, they are mentioned in section 7.1.5 and we have included a brief narrative discussion of these two studies in the full guideline.</p> <p>If a study is designed to treat Borderline Personality Disorder or Depression this is dealt with in the appropriate guideline. For people with BPD the psychological or drug treatment is exhaustively reviewed in that guideline. Studies of self-harm which aim to reduce self-harm or associated problems, but have no diagnostic inclusion/exclusion criteria have been reviewed here in this guideline.</p>
243	SH	NETSCC, HTA (Referee 2)	Full	8.2.2	269	Table 33: should the limits in the rightmost column of the rows labeled “Cost of self-harm” and “Baseline risk (0.33)” be swapped? i.e. lower value, higher value?	Thank you for your comment. We cannot respond to your comment as we are unable to locate the reference to your comment.
244	SH	Royal College of Psychiatrists in Scotland	Full	8.2.3	270	The Montgomery (1979) study of flupentixol versus placebo study is discussed in the long guidelines (page 270) but is largely dismissed, despite statistically significant differences being found between intervention and placebo in a randomised, double-blind with low risks of bias. Although the trial is relatively small, it seems to have escaped the reviewers’ attention that this is stronger evidence than most of the other interventions being endorsed elsewhere. Of course, a recommendation needs to balance the evidence with the risks and benefits of such an intervention, but the primary reasons for dismissing this study seem to be based on an apparent evidentiary basis. Again, there is an inconsistent approach to how the evidence review influences the guideline recommendations.	Thank you for your comment. As stated in the chapter, Montgomery(1979) was a small trial with only 37 participants. Therefore, the quality of the outcome from this single trial had been downgraded following a consistent approach (trials with less than 300 participants). Thus, no recommendations could be made based on a single trial.
245	SH	NETSCC, HTA (Referee 2)	Full	8.2.4	272	Line 13 refers to 6 months of treatment. The preceding table reports 6 weeks of treatment	Thank you for your comment, this has been amended.

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246	PR	Expert Reviewer (4) (Keith Hawton)	Full	8.2.4	272	8 ? ‘attempts’	Thank you for your comment; this has been clarified in the text.
247	SH	NHS Direct	Full	9	277	Reinforce the recommendations for training as stated above. This will support training for staff when making the decision to breach confidentiality and seek care for the individual, as remote assessments can be very challenging.	Thank you for your comment, unfortunately there is a lack of an evidence base on which to recommend minimum standards for training. However the whole guideline gives an indication of which areas the GDG felt are important.
248	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	277	Line 38: On caption title Delete from “Five” onwards and substitute: The Mental Capacity Act establishes five principles	Thank you, the guideline has been amended to reflect your suggestion.
249	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 2: Delete “A” and substitute: To enable a person to make a decision about receiving medical treatment, that	Thank you, the guideline has been amended to reflect your suggestion.
250	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 5: after “question,” insert: the objectives of the treatment, the consequences of being treated,	Thank you, the guideline has been amended to reflect your suggestion.
251	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 6: Delete “Assessment and”. Delete “an”. Change “attempts” . Delete “repeatedly”	Thank you, the guideline has been amended to reflect your suggestion.
252	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 7: After “obtain” insert “the patient’s” .	Thank you, the guideline has been amended to reflect your suggestion.
253	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 13: Delete contents of Box 3 and substitute: Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain? Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act. Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? For a person to lack capacity to make a decision, the Act	Thank you, the guideline has been amended to reflect your suggestion.

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						says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.	
254	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Delete lines 15 to 17 and insert: A person will be deemed to be unable to make a particular decision if they cannot perform the tasks set out in Text Box 4.	Thank you, the guideline has been amended to reflect your suggestion.
255	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	278	Line 19: Delete Box 4 and insert: Text Box 4: assessing a person's capacity to make a decision A person is unable to make a decision if they cannot 1. understand information about the decision to be made (the Act calls this 'relevant information') 2. retain that information in their mind 3. use or weigh that information as part of the decision-making process, or 4. communicate their decision (by talking, using sign language or any other means).	Thank you, the guideline has been amended to reflect your suggestion.
256	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	279	Line 7 Delete "formal"	Thank you, the guideline has been amended to reflect your suggestion.
257	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	279	Line 8 at the end insert: whose role is to advise the decision maker	Thank you, the guideline has been amended to reflect your suggestion.
258	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.1	279	Line 15: Delete "limit" and substitute " impair ".	Thank you, the guideline has been amended to reflect your suggestion.
259	PR	Expert Reviewer (5)	Full	9.2.1	279	Line 19: Delete "full capacity returns" and insert " regains capacity ".	Thank you, the guideline has been amended to reflect your suggestion.

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		(Richard Jones)				Delete line 21, 22 and 23 up to “countries”.	
260	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.2	280	Lines 8 and 9: Delete from “The Mental” to “states that”.	Thank you, the guideline has been amended to reflect your suggestion.
261	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.2	280	Line 10: Delete “ meet more stringent requirements” and insert: satisfy the requirement of the Mental Capacity Act Box 5: Delete the passage in brackets.	Thank you, the guideline has been amended to reflect your suggestion.
262	PR	Expert Reviewer (2) (Jim Bolton)	Full	9.2.4	280-281	An extremely helpful summary of the issues pertaining to the assessment of capacity to refuse treatment. I strongly recommend that this is included in the final version. Could the NICE include reference to this section of the full, so readers know where to seek more information?	Thank you for your comments.
263	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.4	281	Line 12: Delete “the code of practice for”.	Thank you, the guideline has been amended to reflect your suggestion.
264	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.4	281	Line 22: After “administered” insert “ in the absence of consent ”	Thank you, the guideline has been amended to reflect your suggestion.
265	PR	Expert Reviewer (5) (Richard Jones)	Full	9.2.4	281	Line 23: After “2007b” insert: Therefore treating the physical consequences of the patient’s suicidal behaviour is authorised under the Mental Health Act if that behaviour has been caused by the patient’s mental disorder. Apart from advance decision to refuse ECT, an advance decision to refuse treatment is not valid if the treatment is being provided under Part 4 of the Mental Health Act.	Thank you, the guideline has been amended to reflect your suggestion.
266	SH	Royal Society of Medicine	Full	9.4	282	Line 14 – before talking about public interest would be helpful to have some comment on sharing information with other members of the care team and how this is managed if the patient refuses consent yet such communication would be in their interest. Without such comment it is hard to know how to follow recommendation 9.6.1.2 in such circumstances.	Thank you, but we feel that we have covered the limits of confidentiality adequately in this document. We have nevertheless modified recommendation 1.1.1 to read: <i>Health and social care professionals working with people who self-harm should:</i> <ul style="list-style-type: none">• <i>aim to develop a trusting, supportive and engaging relationship with them</i>• <i>be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach</i>

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							<ul style="list-style-type: none"> • ensure that people are fully involved in decision-making about their treatment and care • aim to foster people's autonomy and independence wherever possible • maintain continuity of therapeutic relationships wherever possible • ensure that information about episodes of self-harm are sensitively communicated to other team members.
267	SH	Royal College of Paediatrics and Child Health	Full	9.5	283	There is reference throughout the document to safeguarding children, mostly around a young person who discloses potential abuse. We think the GDG could consider including advice in regards to an adult who discloses past abuse (i.e. when they were a child). For example, should this disclosure be investigated under safeguarding procedures in case the abuser has ongoing contact with (other) children?	Thank you for your comment. We considered it carefully. Adults may disclose childhood abuse in a variety of settings both mental health and non-mental health. In fact, data from self-harm monitoring systems suggests that reports of such abuse specifically following self-harm are actually quite rare. Given that the issue of past child abuse is an issue for many mental health service users (not just those who self-harm) we have not included guidance on this general point.
268	SH	SANE	Full	Appendix 15	Appendix 15	Horne & Csipke (2009) last column displays the title of the paper again instead of limitations.	Thank you for bringing this to our attention. The limitations have been added.
269	PR	Expert Reviewer (4) (Keith Hawton)	Full	10	300	41-43 Repeats previous reference.	Thank you for pointing this out, it has been amended.
270	SH	RCPsych in Wales	Appendix	General	General	Consider the inclusion of the table of risk factors published in the InnovAiT article as a useful 'aide memoir' within the appendix. <i>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) Therapeutic assessment of patients following self harm in primary care. InnovAiT Vol 4, Num 5, p280-281)</i>	Thank you for your comment, this article addresses implementation and therefore does not meet out inclusion criteria for the guideline.
271	SH	PAPYRUS	Appendix 15a	general	general	Within the outline of risk assessments, the validity or potential usefulness of the tool by the information provided is unclear. One receives information on the demographics of who was included in the study of the instrument and in what setting. There is no easily identifiable way to assess whether the tools would be appropriate to use and in what manner based on data provided.	Thank you for your comment, a full description of each scale reviewed is available in section 6.3 of the full guideline.
272	SH	NETSCC, HTA (Referee 2)	App 16			Many of the forest plots presented in Appendix 16 include single studies which seems quite redundant	Thank you for your comment. It is our protocol to include forest plots for single studies.

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273		NICE	NICE	General		As my comments were addressed before consultation, I only have a few remaining comments to make.	Thank you for your comments.
274	SH	Royal College of Paediatrics and Child Health	NICE	General	General	Including references to other guidelines in the NICE is unhelpful. Someone reading this short version will want to see information presented quickly in the one document.	Thank you for your comments, unfortunately it would be unfeasible to print all recommendations from other guidelines that may be relevant to someone who self-harms in the NICE guideline.
275	SH	Association of Child Psychotherapists	NICE	General	General	The guidance is written principally about adults; the situation and needs of children is mentioned only occasionally. In our view, the guidance needs to cover the whole population who self harm or are at risk of doing so; a significant number of these are children and adult self-harming behaviour is likely to have begun in childhood. The guidance should cover the whole age range, with all that this implies.	Thank you for your comment. The GDG did discuss if there should be a separate section for children and young people, but decided that they should be included throughout the document. Each working group for the chapters included a children and young people specialist and the GDG consider these issues to be addressed throughout.
278	SH	Association of Child Psychotherapists	NICE	General	General	In order to understand the origins and meaning of the self-harm, a detailed three-generation family history and genogram should be taken.	Thank you for your comment, taking a family history is a routine part of any psychiatric/mental health assessment and is not specific to self-harm.
279	SH	Association of Child Psychotherapists	NICE	General	General	An incongruent presentation, such as inappropriate affect, may lead the assessor to conclude that there is a lower level of risk when it is often an indicator of greater disturbance and higher risk.	Thank you for your comment, we agree that overt signs are not always the best indicators of intent. This is discussed in the introduction to the guideline as well as elsewhere (see section 6.6.2).
280	SH	Association of Child Psychotherapists	NICE	General	General	Multi-agency thinking about the self-harming individual may offer interventions which will be more readily taken up than those offered by mental health services. A flexible network may also be able to respond appropriately and quickly to changes in the situation and the level of risk.	Thank you for your comment, we agree that involvement of other organisations and sectors can be helpful in individual cases but this is beyond the scope of the current guideline, which is focussed on interventions provided by the health and social care sector.
281	SH	Association of Child Psychotherapists	NICE	General	General	People who have difficulties in maintaining relationships, who are significantly represented among those who self-harm, may respond better to the offer of flexible, one-at-a-time appointments than to an intervention which is seen as a longer-term commitment. This is particularly true of adolescents.	Thank you for your comment. On reflection, the GDG agree that there should be more flexibility in the recommendations, and the guideline has been amended to reflect this: <i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the</i>

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							therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.
282	SH	PAPYRUS	NICE	General	general	PAPYRUS welcomes the guidelines as a tool to be used especially as it is condensed into user friendly formats that will be accessible for not just health professionals but for carers and service users themselves.	Thank you for your comments.
283	SH	Wish	NICE	General	General	The term ‘self-harm’: Wish believes that the term self-injury is preferable to self-harm for two reasons. Firstly, it is less pejorative, in keeping with the guidelines focus on changing attitudes and reducing dismissive or ill-informed approaches. Secondly, the term more clearly excludes that which is outside the scope of the guidelines (eating disorders, excessive drinking of alcohol and risky sexual behaviour) while it more explicitly includes the practices under discussion (cutting, swallowing etc).	Thank you for your comment, the GDG decided to use the term ‘self-harm’ as it is wider known, and ‘self-injury’ can often only be associated with people who cut themselves, rather than other forms of self-harm such as poisoning, burning etc.
284	SH	Wish	NICE	General	General	Gender and self-injury: From Wish’s experience women’s practice of self-injury has gender-specific factors. The guidelines recognise to a certain extent the links between experiencing abuse or domestic violence and practicing self-injury (section 1.1.21). However, there needs to be greater recognition of self-injury as a gendered practice, frequently associated with the experience of harm at the hands of others, particularly family members and intimate partners. People should be able to choose the gender of the health professional they see, especially where they have experienced gender-based violence.	<p>Thank you for your comment. In light of yours and others’ comments, and the views of the GDG, we have decided to refer to ‘people’ rather than ‘women’ in this recommendation. About a quarter of domestic violence is against men and although, therefore three quarters is against women, it would be biased to only refer to women.</p> <p>Whilst we agree in principle that it would, in some cases, be beneficial for service users to be able to choose the gender of the healthcare professional treating them, the GDG decided this would be impractical and could raise further clinical problems making it unfeasible to recommend. However, the NICE guideline does state in the ‘Person Centred Care’ section that: <i>Treatment and care should take into account service users’ needs and preferences.</i></p>
285		Stonewall	NICE	General	General	Stonewall is a national organisation that campaigned for the 3.6 million lesbian, gay and bisexual people across Britain since 1989.	Thank you for your comments.
286		Stonewall	NICE	General	General	In 2008, Stonewall published its ground-breaking research into the health needs of lesbian and bisexual women, <i>Prescription for Change</i> . Surveying 6,178 women across a range of health, well-being and service experience areas.	Thank you for your comments.
287			NICE	General	General	<i>Prescription for Change</i> highlighted gross health inequalities for lesbian and bisexual women in mental	Thank you for your comments, the GDG recognises that sexual orientation can be a risk factor for self-

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		Stonewall				<p>health, service experience and health advice.</p> <p><i>Prescription for Change</i> found high rates of self-harm and suicidal thoughts in young lesbian and bisexual women. In the past year 1 in 5 lesbian and bisexual women said they had deliberately harmed themselves, compared to 0.4% of the general female population.</p> <p><i>Prescription for Change</i> found 50% of lesbian and bisexual women under the age of twenty self-harmed, compared to 15% of women generally, in the same age group.</p> <p>Of those who had self-harmed in the previous year, 75% deliberately cut themselves and 1 in 5 stated they had swallowed pills or objects.</p> <p><u>Count Me In Too</u> (2008) a survey into the mental health needs of lesbian, gay and bisexual and trans people conducted by the University of Brighton found 8.95 of the 819 respondents reported self-harming in the past five years.</p> <p>The <u>Department of Health</u> (2007) briefing into the mental health of lesbian, gay and bisexual people states that LGB people are more likely to be at risk of deliberate self-harm.</p>	harm in section 2.1.8.
288		Stonewall	NICE	General	General	<p><i>Prescription for Change</i> also found that 50% of respondents reported negative experiences of health care in the previous year, despite it being unlawful to discriminate on the grounds of sexual orientation. In addition, 50% of respondents were not open about their sexuality to their GP and, 9 in 10 felt that their partner was unwelcome during a consultation.</p> <p>King et al.(2003) found a third of gay men and up to two-fifths of lesbian women recounted negative or mixed reactions from mental health professionals when being open about their sexuality</p>	Thank you for your comments, the GDG recognises that sexual orientation can be a risk factor for self-harm in section 2.1.8.
289	SH	RCPsych in Wales	NICE	General	General	The short guideline contains limited comment on the motives and significance of self harm which is very usefully covered in 2.1.5 of the full guideline. The motive for self harm is an important aspect of the overall risk assessment and should influence any further referrals and interventions.	Thank you for your comment. The motive for self-harm should be explored as part of a full needs and risk assessment, as outlined in recommendations 1.3.2 and 1.3.6.
290		Healthcare Inspectorate Wales	NICE	General	General	Healthcare Inspectorate Wales (HIW) welcomes the draft guidelines, which addresses a number of areas of concern such as communication, risk assessment and safeguarding,	Thank you for your comments.

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						<p>that we have raised in recent reports. These include:</p> <ul style="list-style-type: none"> ▪ Mental Health Act Monitoring report for 2009 – 10 ▪ Deprivation of Liberty Safeguards monitoring report for 2009 – 10 ▪ Safeguarding and Protecting Vulnerable Adults in Wales: A review of the arrangements in place across the Welsh National Health Service (2010) ▪ Safeguarding and Protecting Children in Wales: A review of the arrangements in place across the Welsh National Health Service (2009) ▪ Services for children and young people with emotional and mental health needs (2009) ▪ Reviews of Homicides where Perpetrator was a Mental Health Service User <p>These reports are available on HIW's website http://www.hiw.org.uk/home.cfm?orgid=477</p>	
291		Healthcare Inspectorate Wales	NICE	General	General	<p>NICE might also wish to consider other documents produced in Wales, in particular the Welsh Assembly Government's National Action Plan to Reduce Suicide and Self-Harm in Wales http://wales.gov.uk/topics/health/improvement/index/talk/?lang=en</p>	Thank you for your comments, this guideline is evidence based and therefore can not consider policy documents when making recommendations.
292	PR	Expert Reviewer (David Gunnell)	NICE	General	General	<p>General: throughout documents I found the distinction between the scope of "short term management" (Guideline 16) and this guideline on "longer term management" unclear. Some issues covered in the guideline e.g. guidance concerning use of risk assessment tools seem to be more appropriate to immediate care / assessment of risk. In some ways having two separate guidelines on the same issue may be quite confusing unless they are issues/re-issued together with careful attention to ensure one does not contradict the other.</p>	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
293	PR	Expert Reviewer (2) (Jim Bolton)	NICE	General	General	<p>Could the document clarify how it fits with the short-term (first 48 hours) guideline, particularly in terms of what should be done when and by whom? For example, there is a lot about risk assessment; is this referring to the assessment of risks beyond the first 48 hours, or the time that the risks are assessed (i.e. after at least 48 hours have elapsed)?</p>	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
294	SH	Royal	NICE	Gen	Gen	<p>There is very little reference to harm minimisation</p>	Thank you for your comment. We agree that this is

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		College of Nursing		eral	eral	throughout the document. Only a very brief reference is made at 1.4.11. Please see article by Benbow M and Deacon M (2011). Helping people who self-harm to care for their wounds. Mental Health Practice. Volume 14, Number 6. There has to be more advice within the document about providing care when a patient is likely to or known to continue to self-harm, as in "safe self-harm" advice and care planning, actions to be taken when a patient self-harms within an in-patient area .. rather than solely aiming to stop it from happening. This is essential to prevent the sometimes dangerous practice of secretive self-harm.	an important issue in the treatment and management of self-harm. However, the GDG were unable to find any evidence to support a recommendation for specific techniques for harm reduction. This is discussed in section 7.4 of the full guideline.
295	PR	Expert Reviewer (2) (Jim Bolton)	NICE & Fulls	General	General	The recommendation that information about self harm is given to service users families and carers is mentioned in several places. Are there any current recommended resources e.g. the RCPsych Help is at Hand Leaflet? If so, could these be given as part of a list of resources?	Thank you for your comment. Unfortunately it was unfeasible for the GDG to review the suitability/effectiveness of all information available on self-harm and therefore are unable to make a specific recommendation on which materials to use. However, in the 'Understanding NICE guideline' document developed for service users and carers a list of some materials will be provided and will also be considered by the implementation group.
296	SH	Department of Health	NICE /Full	General		It is stated at the outset that the guideline is not concerned with the physical management of self-harm, but then goes on to describe recommendations for acute hospital staff to ensure that adult medical and paediatric services are properly aligned (please see pages 5-6 of the shorter version). In our view, this appears to be anomalous.	Thank you for your comment. Whilst the guideline does make some recommendations for healthcare professionals to work closely together to ensure the best care for service users, this guideline does not make specific recommendations for treating the physical effects of self-harm. However, the guideline on the short-term management of self-harm does make recommendations on physical care and NICE are developing a pathway to inform clinicians how the two guidelines will fit together.
297	SH	Department of Health	NICE /Full	General		On page 7 of the shorter version, there is a recommendation to <i>"use the Care Programme Approach (CPA) whenever more than one service is involved"</i> . We consider this to be sensible, but feel also that it should be made clear that it should apply when treatment and care will continue (in other words, for more than a specified period – in our view, there may be little point if it is only for a matter of days).	Thank you for your comment. On reflection the GDG felt it was unnecessary to specifically mention the CPA as the guideline covers the same aspects, and as you suggest could be misinterpreted as to when it should, or should not be used.
298		Stonewall	General	General	General	Stonewall welcome the opportunity to respond to this consultation and are happy to work with the National Institute of Clinical Excellence on further work in developing	Thank you for your comments.

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						this guidance.	
299	SH	National Self Harm Network	NICE	Introduction	3	'Self harm is associated with a wide range of psychiatric problems': Self harm is not necessarily a symptom of mental illness; it is also a coping mechanism adopted to deal with extreme stressors in life.	<p>Thank you for your comment. We agree that self-harm is a complex behaviour which can have a variety of underlying functions, including (but not restricted to) coping. Sections 2.15 and 2.17 in the Introduction to the full guideline were intended to convey this.</p> <p>In Chapter 6 the need for a comprehensive assessment, which will inform a management plan has been emphasised. Much of the evidence found from randomized trials is focussed on reducing self-harm, but we also discuss other aspects of management and wider treatment goals in Chapter 7.</p>
300	SH	RCPsych in Wales	NICE	Introduction (1 st para)	3	This paragraph is confusing; the third sentence is presumably drafted in error as it seems to confuse this guideline with the one on short term management. The third sentence of the third paragraph in the introduction does not read clearly. Presumably the words "and increases" should read "which increase".	<p>Thank you for your comment. We have redrafted the opening paragraph of the introduction to address your concerns.</p> <p>In the third paragraph we mean that self-harm increases the likelihood a person will die by suicide – we have reordered the sentence to avoid confusion.</p>
301	SH	RCPsych in Wales	NICE	Introduction (3 rd para)	3	<p><i>'Self-harm is associated with a wide range of psychiatric problems'</i>. Self harm is also very much associated with emotional distress and psychosocial problems in addition to a 'psychiatric problem'. Self-harm is a manifestation of emotional distress; an indication that something is wrong rather than a primary disorder.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) Therapeutic assessment of patients following self harm in primary care. InnovAiT Vol 4, Num 5, p278 -287)</p>	Thank you. The guideline does not suggest that self-harm is a disorder unto itself.
302	SH	RCPsych in Wales	NICE	Introduction (3 rd para)	3	The third sentence of this paragraph does not read clearly. Presumably the words "and increases" should read "which increase".	Thank you for your comment. We mean that self-harm increases the likelihood a person will die by suicide – we have reordered the sentence to avoid confusion.
303	SH	Association of Child Psychotherapists	NICE	General	3	It is unclear whether this sentence – 'It is concerned with the longer-term psychological treatment and management of self-harm, and does not include recommendations for the physical treatment of self-harm' refers to the NICE clinical guideline 16 or to the current guideline. Should the sentence be reworded to begin: 'This guideline is concerned ...'?	Thank you for your comment. We have redrafted the opening paragraph of the introduction to address your concerns.
304	SH	RCPsych in	NICE	Intro	3	There are two important points to highlight:	Thank you for your comments, some amendments

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		Wales		ducti on (3 rd para)		<ul style="list-style-type: none"> The incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is among the highest in Europe with rates of around 400 per 100,000 of population (Horrocks and House, 2002). Although self-harm is associated with a 100 fold increase in completed suicide rate, usually the motivation to self-harm is generally to sustain life as it may be the only mechanism that some people have to cope with their unbearable distress or 'starve off' their suicidal thoughts 	have been made to the introduction which the GDG feel highlights the importance of this guideline.
305		NICE	Introd uctio n	Intro ducti on	3	The introduction needs to explicitly state that CG16 (published 2004) remains valid and reflects current best practice in the short term management of self-harm. I don't think this is clear as it is currently written.	Thank you for your comment –we have redrafted the opening paragraph to improve clarity.
306	PR	Expert Reviewer (David Gunnell)	NICE		3	para 3 – perhaps given an estimate of annual incidence (all ages – approx 0.5%)	Thank you for your comment, this has been amended.
307	PR	Expert Reviewer (David Gunnell)	NICE		3	End of para 3 – the 100 fold increase in risk is, I think, only in relation to the 12 month period after an episode of SH. Lifetime increase in risk amongst people who self-harm is considerably less than this.	Thank you for your comment, this has been amended.
308	SH	Nottingham hire NHS Trust	NICE	Intro ducti on	3	Ambiguous sentence in paragraph two: '...irrespective of motivation' because this would imply anything from accidents to suicidal intent	Thank you for your comment; however we do not think it is ambiguous; we make it clear later in the paragraph that there are exceptions, including accidents.
309	SH	Royal College of Nursing	NICE	INTR ODU CTIO N	4	The short term management of self-harm NICE guidelines defines young people as 8 to 16 years old. In this guideline young people are referred to as 8 to 17 years old, yet in practice, services are set up following RCP guidelines (1998), where young people are defined as under 16 years old – they are admitted on to a paediatric ward and seen by CAMHS and those 16 years old and over may not be admitted and so tend to be seen by Adult Mental Health Services. Having different age definitions is confusing and is not helpful to service providers and users (in this case, the young people whom we provide services for).	Thank you, as recognised in your comment the age range for 'children and young people' often changes in different guidelines/policy. The scope of this guideline set the age range from 8years old to 18 th birthday and this has been used consistently throughout this guideline.
310		Healthcare Inspectorate Wales	NICE	Pers on centr	Page 5	HIW agree that that transition between services for young people needs to be managed appropriately, however we would point out that the document <i>Transition: getting it right</i>	Thank you for your comment. The text you refer to is supplied as part of the NICE template and we are therefore unable to amend it. We will however, raise

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				ed care		<i>for young people:</i> referred to was published by the Department of Health and thus applies to England, but not necessarily to Wales.	your concerns with NICE.
311	SH	RCPsych in Wales	NICE	Pers on-centred care	5	<i>'Good communication between health and social care professionals and service users is essential.'</i> We suggest the sentence should end with "...the foundation of which is a compassionate, non – judgemental and validating response."	Thank you for your comment but the section on 'Person centred care' is standard NICE text and therefore cannot be changed.
312	SH	RCPsych in Wales	NICE	Pers on-centred care	5	Every contact with an individual who self-harms is a chance to address the unbearable emotional distress that (s)he are feeling. If addressing self-harming behaviours is seen solely as the preserve of specialist mental health services, opportunities for intervention will be missed.	Thank you for your comment. We were using CMHTs to refer to specialist mental health services in a generic sense. It was not the GDG's intention to exclude liaison and general hospital mental health services, many of whom provide an excellent service for individuals following self-harm. This recommendation has been reworded for clarity: <i>Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3), and the longer-term treatment and management of self-harm. In children and young people this responsibility should be taken by tier 2 and 3 CAMHS services.</i>
313	SH	Royal College of Nursing	NICE	KEY PRIORITIES	7- 10	This section appears to just repeat what was said on pages 11+, whilst it may be good to have the title and the headings highlighted, it does not seem to add value to repeat all the words on the following pages.	Thank you for your comments, this section repeats the following recommendations as it lists the 'Key Priorities for Implementation'. These are the recommendations the GDG deemed to be most important for healthcare professionals.
314	SH	Association of Child Psychotherapists	NICE	General	7 & 11	'Health and social care professionals working with people who self-harm should: aim to develop a trusting, supportive and engaging relationship with them.' It seems that the formation of such a relationship is key to successful implementation of guidelines. What if the professional involved with the person who self-harms feels unable to do this? In our view this section should include a recommendation to refer on to a service that can assess/address this.	Thank you for your comment. The GDG did not consider lack of engagement as a sufficient reason for referral to CMHT/CAMHS as often difficulty in engaging a service user is as a result of other risk factors. The guideline recommends that all healthcare professionals work hard to establish such a relationship.
315	SH	Association of Child Psychotherapists	NICE	Key Priorities	8	Risk assessment: add emotional abuse to the list of factors contributing to risk.	Thank you for comment. We have amended this recommendation to be more inclusive. It now reads: <i>When assessing the risks of repetition of self-harm or risks of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:</i> <ul style="list-style-type: none"> • methods and frequency of current and past self-harm

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							<ul style="list-style-type: none"> • <i>current and past suicidal intent</i> • <i>depressive symptoms and their relationship to self-harm</i> • <i>any psychiatric illness and its relationship to self-harm</i> • <i>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</i> • <i>specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm</i> • <i>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</i> • <i>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</i> • <i>immediate and longer-term risks.</i>
316	SH	National Self Harm Network	NICE	Key priorities for implementation – Care plans	8	Reduce the incidence of self harm	Thank you for your comment, this is included in recommendation 1.4.2.
317	SH	Nottinghamshire NHS Trust	NICE	Risk assessment	8	Need to clarify ‘do not use risk assessment tools to predict future suicide’ – surely these tools have a place in raising risk awareness, which by default is a means of prediction? Perhaps needs to state that risk assessments should not be relied on or used as stand-alone measures?	Thank you for your comment, the GDG agree that risk assessment tools can be helpful in structuring assessments and have recommended this in 1.3.13.
318	PR	Expert Reviewer (David Gunnell)	NICE		8 (see also page 19)	Line 4: suggest separate “methods” from “patterns” (separate points) as assessment of method is quite distinct and appears to be a key (often overlooked) risk factor for later suicide if a high lethality method is used in the index episode of SH (see Runenson B et al BMJ 2010 . I’m not clear what is meant by “patterns”	Thank you for your comment, the recommendation has been amended for clarity and now refers to ‘frequency’ of self-harm.
319	SH	Association	NICE	Gen	9	Interventions for self-harm: self-harm is an expression of	Thank you for your comment. We agree that self-

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		of Child Psychotherapists		eral		and a way to manage extreme emotional distress. It is not a symptom to be treated in isolation from other aspects of the individuals' life. Interventions designed to reduce self-harm should focus on the meaning of the actions and consider what alternative the individual has to express their difficulties. There are risks associated with removing self-harming behaviour, in terms of indirect forms of self-harm such as eating disorders and/or drug use (Royal College of Psychiatrists' report, 2010).	harm is a complex behaviour which can have a variety of underlying functions, including (but not restricted to) coping. Sections 2.15 and 2.17 in the Introduction to the full guideline were intended to convey this. In Chapter 6 the need for a comprehensive assessment, which will inform a management plan has been emphasised. Much of the evidence found from randomized trials is focussed on reducing self-harm, but we also discuss other aspects of management and wider treatment goals in Chapter 7.
320	SH	Nottinghamshire NHS Trust	NICE	Key priorities	9-10	Not clear what tier of service should be accessed for therapy, or why six sessions are offered. Six sessions with a psychologist, or with a CPN, or with an IAPT worker? Not clear what 'significant experience' means.	Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore the recommendation has been amended to include the full range of sessions suggested by the studies reviewed, that is 3-12. We agree that the recommendation was not clear and have amended it to read: <i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i>
321	SH	Nottinghamshire NHS Trust	NICE	1 Guidance 1.1	11	No guidance on what to do if trusting, supportive relationship cannot be established. Who is left with responsibility for the patient?	Thank you for your comment. This is a difficult problem throughout mental health. It is the responsibility of all healthcare professionals to work hard to engage service users in this way. The responsibility remains with the healthcare professional.
322	SH	Royal College of Psychiatrists in Scotland	NICE	1.1	11	These are all non-specific aspirations rather than distinct recommendations. Such 'principles' will be very hard to measure, demonstrate, or translate into changes in care delivery. It's difficult to see how these general principles are specific to self-harm and they are probably equally applicable to any medical treatment.	Thank you. To some extent this is true – they are about person centred care specifically with people who self-harm and are derived from our review of service user experience.

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323	SH	Royal College of Psychiatrists in Scotland	NICE	1.1	11	There are recommendations that “Health and social care professionals who work with people who self-harm (including children and young people) should be trained in the assessment, treatment and management of self-harm.” However, it is far from clear what ‘treatment’ options professionals should be trained in, since the recommended treatments are supported by minimal evidence. PCTs and other organisations might find it difficult to determine the training needs of their staff in such situations.	Thank you for your comments, the GDG agree that training is necessary but the evidence base to comment definitively on the content of training or to recommend one type of training over another is unfortunately lacking. When we refer to professionals being trained in treatment and management we do not mean that they should necessarily be in a position to provide therapies themselves, especially given the rather limited evidence base. The evidence for the effectiveness of interventions is discussed in detail in chapters 7 and 8.
324		Healthcare Inspectorate Wales	NICE	1.1.1		<p>HIW would like to point out that in Wales, guidance states that the Care Programme Approach is applied to any adult referred to or receiving care or treatment from secondary mental health services, including 16-18 year olds where they are in contact with adult services.</p> <p>In addition the implementation of the Mental Health Measure (Wales) in 2011-12 will introduce statutory care plans for children, young people and adults receiving secondary mental health services in Wales.</p> <p>See <i>Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance (2010)</i> http://wales.gov.uk/topics/health/publications/health/guidance/cpa/?lang=en</p> <p>HIW suggests the bullet point covering CPA be amended to reflect that there are policy and process differences between England and Wales.</p>	Thank you for your comment. On reflection the GDG felt it was unnecessary to specifically mention the CPA as the guideline covers the same aspects.
325	SH	RCPsych in Wales	NICE	1.1.1	11	<p>Non-disclosure of self-harm</p> <p>Shame and fear of discovery mean that people often keep self-harm a secret. Unless medical treatment is required, self-harm is not usually reported. The reasons why people do not seek help following self-harm are not known but it is assumed that stigma is an important factor. Some may not disclose their self-harming behaviours because the issue is not directly addressed. Therefore, when presented with a patient who is displaying characteristics of depression or emotional distress it may prove valuable to routinely ask about thoughts and acts of self-harm.</p>	Thank you for your comment. This guideline can only focus on the longer term treatment and management of self-harm and therefore the GDG are unable to make recommendations for people presenting with other mental health problems.

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326	SH	Wish	NICE	1.1.1	11	Care planning emphasis: Wish welcomes the emphasis on Care Plans rather than risks assessments as the driving force behind care and treatment.	Thank you for comments, the GDG agree that assessments should not focus only on risk.
327	SH	Wish	NICE	1.1.1	11	Stigma: Wish welcomes the recognition of the negative impact of discriminatory and dismissive attitudes towards people who self-injure. The elimination of such negative attitudes and stigmatisation will be essential if trusted relationships can be built between service-users and those developing care plans.	Thank you for your comments, the GDG agree that such negative attitudes can have an adverse impact on the service user and highlight the importance for a good therapeutic relationship.
328		Stonewall	NICE	1.1.1	11	Stonewall agree that health and social care professionals must develop supportive relationships with patients and, take into account stigma and discrimination usually associated with self-harm. However, <i>Prescription for Change</i> found that lesbian and bisexual women report negative experiences of healthcare, therefore, guidance should focus on treating patients with dignity and respect alongside supportive relationships.	Thank you for these comments, this recommendation has been amended to better reflect this: <i>Health and social care professionals working with people who self-harm should:</i> <ul style="list-style-type: none"> • aim to develop a trusting, supportive and engaging relationship with them • be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach • ensure that people are fully involved in decision-making about their treatment and care • aim to foster people's autonomy and independence wherever possible • maintain continuity of therapeutic relationships wherever possible • ensure that information about episodes of self-harm are sensitively communicated to other team members.
329	PR	Expert Reviewer (David Gunnell)	NICE	1.1.1	11	Include here that staff should "communicate information about episodes of self-harm with other team members."	Thank you for your comments, we have amended the recommendation in line with your suggestion: <i>Health and social care professionals working with people who self-harm should:</i> <ul style="list-style-type: none"> • aim to develop a trusting, supportive and engaging relationship with them • be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach • ensure that people are fully involved in decision-making about their treatment and care • aim to foster people's autonomy and independence wherever possible • maintain continuity of therapeutic relationships wherever possible

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							<ul style="list-style-type: none"> • ensure that information about episodes of self-harm are sensitively communicated to other team members.
330	PR	Expert Reviewer (David Gunnell)	NICE	1.1.1	11	In this section, or elsewhere, suggest that follow-up should occur soon after the index episode as risk is greatest in the early days / weeks after the index episode.	Thank you for your comment, this is focusing on the short term management of self-harm and therefore is outside the scope of this guideline.
331	PR	Expert Reviewer (2) (Jim Bolton)	NICE	1.1.1	11	“take account of the stigma and discrimination usually associated with self-harm...” Can this be expanded upon to indicate in what way this should be taken into account? It is important to highlight the stigma, but this principle is a little vague in what is intended.	<p>Thanks for these comments, this recommendation has been amended for clarification: <i>Health and social care professionals working with people who self-harm should:</i></p> <ul style="list-style-type: none"> • aim to develop a trusting, supportive and engaging relationship with them • be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach • ensure that people are fully involved in decision-making about their treatment and care • aim to foster people’s autonomy and independence wherever possible • maintain continuity of therapeutic relationships wherever possible • ensure that information about episodes of self-harm are sensitively communicated to other team members.
332	SH	Royal College of Nursing	NICE	1.1.1	11	CPA is instigated where there is complexity and high risk – not just about how many services are involved. Someone/young person could have two services and below risk and one service and be high risk.	Thank you for your comment. On reflection the GDG felt it was unnecessary to specifically mention the CPA as the guideline covers the same aspects.
333		NICE	NICE	1.1.2	11	This recommendation asks that healthcare professionals be familiar with websites offering information and support without mentioning the fact that websites should be from a trusted (NHS evidence accredited) source. There may be many websites out there which offer incorrect or conflicting advice to that within this guideline.	Thank you for your comment. Unfortunately it was unfeasible for the GDG to review the suitability/effectiveness of all information available on self-harm and therefore are unable to make a specific recommendation on which materials to use. However, in the ‘Understanding NICE guideline’ document developed for service users and carers a list of some materials will be provided and will also be considered by the implementation group.
334	PR	Expert Reviewer (2) (Jim Bolton)	NICE	1.1.2	11	“familiar with national and local resources...” Could the guideline include sources of information or current recommended websites?	Thank you for your comment. Unfortunately it was unfeasible for the GDG to review the suitability/effectiveness of all information available on self-harm and therefore are unable to make a specific

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							recommendation on which materials to use. However, in the 'Understanding NICE guideline' document developed for service users and carers a list of some materials will be provided and will also be considered by the implementation group.
335		Healthcare Inspectorate Wales	NICE	1.1.2 – 1.1.8		HIW welcomes the inclusion of a section on capacity and consent, as we have reported on several occasions that knowledge and application of legislation is not strong, nor is there necessarily a recognition of a person's rights. HIW suggests the inclusion of a reminder that health and social care professionals have a duty under their professional codes to ensure they have authority to administer care and treatment to an individual within the appropriate legal framework.	Thank you for your comment, the NICE guideline deals with this in the section on consent and confidentiality at length (1.1.12-1.1.18). We cannot refer to healthcare professional codes as we would need to refer to all relevant professional codes which would be unmanageable in this document.
336		Healthcare Inspectorate Wales	NICE	1.1.3		HIW welcomes the statement regarding providing a full range of treatments for children and young people within CAMHS services. Our report of 2009 identified a wide variation of services available within CAMHS, with the age of transition not being uniform. Services in Wales have a target of providing CAMHS to all under 18 by March 2012.	Thank you for your comments.
337	SH	Association of Child Psychotherapists	NICE	1.1.4	12	Access to services: should include ensuring that children in prison and other residential settings also have access to comprehensive services.	Thank you for your comments, this guideline has not reviewed the evidence for prison populations as this is unfortunately outside the scope of this guideline, however the recommendations may be relevant to those working within prison/forensic services.
338	SH	Association of Child Psychotherapists	NICE	1.1.5	12	Include services for the hearing-impaired.	Thank you for your comment, services for the hearing-impaired would be covered by ' <i>in an accessible format</i> ' included in the recommendation.
339		Healthcare Inspectorate Wales	NICE	1.1.7		HIW would like to point out that in Wales, guidance states that the Care Programme Approach is applied to any adult referred to or receiving care or treatment from secondary mental health services, including 16-18 year olds where they are in contact with adult services. In addition the implementation of the Mental Health Measure (Wales) in 2011-12 will introduce statutory care plans for children, young people and adults receiving secondary mental health services in Wales. See <i>Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance (2010)</i> http://wales.gov.uk/topics/health/publications/health/guidance/cpa/?lang=en HIW suggests the bullet point covering CPA be amended to	Thank you for your comment. On reflection the GDG felt it was unnecessary to specifically mention the CPA as the guideline covers the same aspects, and care should be delivered following these principles.

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						reflect that there are policy and process differences between England and Wales	
340		Stonewall	NICE	1.1.9	13	Training for health and social care professionals should include dimensions on the reasons for self-harming, which may differ across groups and, must recognise health inequalities that exist across these groups. <i>Prescription for Change</i> found higher reported rates of deliberate self-harm for young lesbian and bisexual women than women in general, training needs to reflect this difference to ensure health and social care professionals are aware of the relationship between self-harm and sexual orientation.	Thank you for your comment, unfortunately there is a lack of an evidence base on which to recommend minimum standards or requirements for training. However the whole guideline gives an indication of which areas the GDG felt are important.
341	SH	University of Manchester	NICE	1.1.9	13	There should be a specific training and clinical decision pathway for YP under 18 Evidence shows particular characteristics and response to intervention in this group In particular the presence of personality disorder and differential response to intervention needs to be taken into account (Green et al 2011)	Thank you for your comment. NICE is currently developing a self-harm pathway covering both short and long term management. The current plan is for management of young people to be incorporated into this pathway, rather than for a separate pathway to be developed for this group.
342	SH	RCPsych in Wales	NICE	1.1.9	13	Training should also be targeted to increase empathy, compassion and understanding in addition to knowledge and competencies. Training should include an element designed to specifically tackle myths and stigma in addition to identifying and minimising barriers to delivering compassionate responses to people who self –harm.	Thank you for your comment, unfortunately there is a lack of an evidence base on which to recommend minimum standards for training. However the whole guideline gives an indication of which areas the GDG felt are important.
343	SH	Royal College of Nursing	NICE	1.1.10	P13 + P26	How do we assess the effect of training on healthcare professionals? It would be helpful to make the link with service user feedback forms – i.e. ask every young person to complete the form after every self-harm assessment. Did they feel listened to, understood, etc – after training feedback from service users should be positive if not this can be picked up with staff - more training/mentoring offered.	Thank you for your comment. We have updated the recommendation which now reads: <i>Health and social care professionals who provide training about self-harm should:</i> <ul style="list-style-type: none"> • involve people who self-harm in the planning and delivery of training • ensure that training specifically aims to improve the quality and experience of care for people who self-harm • assess the effectiveness of training using service user feedback as an outcome measure.
344	SH	Association of Child Psychotherapists	NICE	1.1.11	13	We welcome and fully endorse this statement: ‘Routine access to senior colleagues for supervision, consultation and support should be provided for health and social care professionals who work with people who self-harm. Consideration should be given of the emotional impact of self-harm on the professional and their capacity to practice	Thank you for your comments.

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						competently and empathically.’	
345		NICE	NICE	1.1.1 2		Could this recommendation be moved to the section on training so that it doesn’t get missed by healthcare professionals who may be organising training for their staff?	The GDG feels this recommendation is better placed in the section on consent and capacity.
346		NICE	NICE	1.1.1 3		If the above recommendation is moved, I suggest starting recommendation 1.1.13 with ‘Health and social care professionals who work with people who self-harm should...’	The GDG feels this recommendation is better placed in the section on consent and capacity.
347		NICE	NICE	1.1.1 8		Could this recommendation be moved to the section on training, so that it doesn’t get missed by healthcare professionals who may be organising training for their staff?	The GDG feels this recommendation is better placed in the section on consent and capacity.
348		Healthcare Inspectorate Wales	NICE	1.1.2 0		HIW would like to make NICE aware that the Common Assessment Framework has not been adopted in Wales.	Thank you for your comment, we have added a footnote to reflect this.
349		Healthcare Inspectorate Wales	NICE	1.1.2 2		It would be helpful if the guidance clarifies the steps to take if a person who self harms does not have the capacity to agree for their family, carers or significant others to be involved in their care. We have come across examples where an inability to consent is taken as consent not having been given, thus excluding carers from involvement when this may be in the patient’s best interests.	Thank you for your comment. This is a complex issue which is outside the scope of this guideline.
350		Stonewall	NICE	1.1.2 2	15	Stonewall welcome the commitment to the inclusion of families, carers and significant others in a person’s care. However, <i>Prescription for Change</i> found that 9 in 10 lesbian and bisexual women felt their partner was unwelcome during a consultation. To advance equality of opportunity, as set out in the Equality Act (2010) and Public Sector Equality Duty, Stonewall would like to see the guidance reflect and specify same-sex partners. Too often, doctors assume a same-sex partner is a sibling or a parent or other, NICE guidance should take the opportunity to reinforce healthcare workers responsibilities and duties under equality legislation.	Thank you for your comment, the guideline states ‘ <i>Significant other</i> ’ refers not just to a partner but also to friends and any person the service user considers to be important to them. The GDG felt this sufficiently covers same-sex partners.
351	SH	Association of Child Psychotherapists	NICE	1.1.2 2	9 (line 4) and 15	The inclusion of family/friends in the treatment plan may perpetuate harmful dynamics, which contribute to the drive to self-harm. The difficulties, which are expressed in self-harm, are likely to have their origins in family relationships and to be reprised in later relationships. The assessment should take this into account and look for evidence that family/friends etc are acting in the best interests of the suicidal or self-harming individual.	Thank you for your comment. We agree that the family/social relationships are very important to take into account when assessing people who self-harm. This is taken into account in the ‘assessment of need’ recommendation 1.3.2. and in ‘assessment of risk’ recommendation 1.3.6.
352		NICE	NICE	1.1.2 3		First bullet: This is the only recommendation that specifies ‘written and verbal’ information, rather than simply	Thank you for your comment; we have added ‘written and verbal’ to recommendations 1.1.14 and 1.4.6, but

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						'information'. Is there a particular reason why this bullet is different to the other bullets in this recommendation and to other recommendations?	we do not feel it is necessary to repeat 'written and verbal' in the bullets of 1.1.23.
353	PR	Expert Reviewer (David Gunnell)	NICE	1.1.23	16	Can a weblink be provided to exemplars of written information sources / helpful websites/ organisations?	Thank you for your comment. Unfortunately it was unfeasible for the GDG to review the suitability/effectiveness of all information available on self-harm and therefore are unable to make a specific recommendation on which materials to use. However, in the 'Understanding NICE guideline' document developed for service users and carers a list of some materials will be provided and will also be considered by the implementation group.
354	SH	Royal College of Nursing	NICE	1.1.24	16	This sentence needs to be re-phrased to include something about risk e.g. balance between developing autonomy and capacity of young person with perceived risks, how can these be managed and responsibilities and views of the parents/carers.	Thank you for your comment, we have amended this recommendation to read: <i>CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with the perceived risks, and the responsibilities and views of parents or carers.</i>
355	SH	Association of Child Psychotherapists	NICE	1.1.25	16	We welcome and fully endorse this statement: 'Anticipate that the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm...'	Thank you for your comment.
356		Healthcare Inspectorate Wales	NICE	1.1.25		NICE may wish to consider referring to the right for rapid reassessment for former users of secondary mental health services being introduced under the Mental Health Measure (Wales).	Thank you for your comment. We understand that many NHS services are undergoing changes in structure and organisation. However, it is very difficult for the guideline to address future changes. In this guideline the GDG have aimed to make recommendations for the principles of care that should be adopted, regardless of setting.
357		Stonewall	NICE	1.1.25	16	Stonewall support outlines in the guidance to recognise the ending of treatment can increase the risk of self-harm. <i>Prescription for Change</i> highlighted the negative experiences lesbian and bisexual women have had when accessing healthcare, which can lead to people dropping out of the system altogether. When a person has been self-harming and is provided with care, the practitioners of that care must ensure they treat each individual with dignity and respect. Stonewall know that homophobic comments are rife in the NHS and can lead to people not accessing care services again in the future, increasing costs in the long-term.	Thank you for your comment, we agree that appropriately managing transitions and endings is extremely important for all service users.

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358		Healthcare Inspectorate Wales	NICE	1.1.2 7		HIW suggests referring to mental health services rather than trusts, as such services are provided by Health Boards not Trusts in Wales	Thank you for your comment, this has been amended in line with your suggestion.
359	PR	Expert Reviewer (David Gunnell)	NICE	1.2	17	Somewhere in this section should you recommend that GPs take care with all prescribing to people who have previously self-harmed, particularly in relation to prescribing of potentially toxic medicines e.g. tricyclic antidepressants, opiates.	Thank you for your comment, this is recommended in the NICE guideline – see 1.5.2.
360	SH	Royal College of Psychiatrists in Scotland	NICE	1.2.1	17	There are multiple instances of apparent contradiction when discussing risk assessment and the use of risk assessment tools. For example, Section 1.2.1 mentions “a risk of repetition” but Section 1.3.11 states: “Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.” In order to determine referral to community mental health teams, the guidelines highlight the importance of assessing future risk, but at the same time it cautions against using risk assessment tools. It is therefore unclear how such risks are to be determined in primary care, particularly from a clinical governance perspective.	Thank you for your comment. The GDG have recommended that risk assessment tools are not used to predict future episodes of self-harm. This however does not mean that risk assessment should not be carried out to focus on what help the service user may need.
361	SH	Association of Child Psychotherapists	NICE	1.2.1	17	Given that a vital factor is for the practitioner to engage with the person who self-harms, it may be important to make referral to a local community mental health team/ CAMHS a priority when the primary care practitioner finds she/he is unable to engage with the person who self-harms. Might the difficulty in engaging in itself be an index of risk?	Thank you for your comment. The GDG did not consider lack of engagement as a sufficient reason for referral to CMHT/CAMHS as often difficulty in engaging a service user is as a result of other risk factors.
362	PR	Expert Reviewer (David Gunnell)	NICE	1.2.1	17	This paragraph appears to be more relevant to “short term management”	Thank you for your comment, whilst the GDG agree this refers to acute management, crises and episodes or repeat self-harm may also occur in the context of longer term management. We have therefore retained this recommendation.
363	SH	RCPsych in Wales	NICE	1.2.1 -3	17	The sense of the full guidance is that management of self harm is complex but a function of the whole health system, yet the tone of the short guideline suggests that the locus for assessment and treatment should fall on specialist services. Primary care is specifically covered in the short guideline by only three points [1.2.1. - 1.2.3] covering less than a page. However,	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.

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						<p>the short guideline acknowledges that a significant amount of self harm presents to, and can and should be identified in primary care, and further implies that not all such self harm should be referred to specialist/secondary care: page 17</p> <p>1.2.1 – “If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them...” This is inconsistent with 1.4.1 quoted above.</p> <p>This section of the short guideline also offers guidance for referral to more specialist services. This could also include 1) the presence of significant suicidal thinking or intent, 2) risk of severe physical harm and 3) the presence of severe mental disorder.</p> <p>The full guideline clearly envisages a range of appropriate interventions for self harm, and acknowledges that some cases can and should be managed in primary care; many of the interventions implied in 1.5.1 of the guideline can be provided in primary care. This is not carried through to the short guideline, which appears to offer more restrictive guidance.</p> <p>It would be helpful if these scattered references could be collated under 1.2.</p>	
364		NICE	NICE	1.3		Could the heading ‘Assessment of need’ be changed to ‘Assessment of needs’ to match the NICE recommendations?	Thank you for your comment; we have changed the heading as you have suggested.
365		NICE	NICE	1.3		Consider making the heading ‘Risk assessment tools and scales’ a subheading of the section on risk assessment.	Thank you for your comment; we have changed the heading as you have suggested.
366	PR	Expert Reviewer(David Gunnell)	NICE	1.3	18	This section appears to be more relevant to “short term management”	Thank you for your comment. We acknowledge the overlap between the guidelines regarding assessment, but the GDG agreed that it was necessary to ensure that all individuals who self-harm are given a comprehensive assessment – whether that be in primary care or specialist services. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the existing guideline to resolve any inconsistencies.
367		NICE	NICE	1.3.1		Should this recommendation include cross-references to the recommendations on assessment of needs, as well as those on risk assessment?	Thank you for your comment; we have added cross-references as you have suggested.
368	SH	Royal College of	NICE	1.3.2	18	Section 1.3.2 indicates that: “Assessment of needs should include: mental and physical health”. This woolly reference	Thank you for your comment. We agree this recommendation is not clear enough and have

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		Psychiatrists in Scotland				to 'mental health' misses the opportunity to reinforce the need for any kind of diagnostic assessment in community mental health teams.	<p>amended it to read: <i>Assessment of needs should include:</i></p> <ul style="list-style-type: none"> • <i>skills, strengths and assets</i> • <i>coping strategies</i> • <i>mental health problems or disorders</i> • <i>physical health problems or disorders</i> • <i>social circumstances and problems</i> • <i>psychosocial and occupational functioning, and vulnerabilities</i> • <i>recent and current life difficulties, including personal and financial problems</i> • <i>the need for psychological intervention, social care and support, occupational rehabilitation, and drug treatment for any associated conditions</i> • <i>the needs of any dependent children.</i> <p>The GDG did not feel it necessary to specifically recommend diagnostic assessment.</p>
369	SH	Association of Child Psychotherapists	NICE	1.3.2	18	Assessment of needs should include: social circumstances and problems, with particular reference to the emotional support from current relationships. Assessment of needs should also include the needs of carers.	Thank you for your comment, the GDG feel this recommendation is sufficient as it is in regards to social circumstances and relationships. The GDG did agree that a carer's assessment should be included and recommendation 1.1.23 has been amended to include your helpful suggestion.
370		Healthcare Inspectorate Wales	NICE	1.3.2		HIW suggests that the needs of any vulnerable adults who depend on rely on the person who self harms should be assessed, as well as those of dependent children.	Thank you for your suggestion, the GDG felt this was sufficiently covered in recommendation 1.1.21.
371		Healthcare Inspectorate Wales	NICE	1.3.2 – 1.3.5 (Assessment of need)		HIW suggests this section could helpfully make reference to undertaking carers assessments for relevant family, carers or significant others involved in supporting the person who self harms, as our experience is that their needs are often not considered.	Thank you for your comment, recommendation 1.1.23 has been amended to ensure carers are informed of their right to an assessment and given information on how to access one.
372		Healthcare Inspectorate Wales	NICE	1.3.3		HIW suggests a clearer reference to any caring responsibilities the older person may have	Thank you for your comment, the guideline has been amended to reflect your suggestion: <i>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 who self-harm (see recommendations 1.3.1 and 1.3.2). In addition:</i>

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							<ul style="list-style-type: none"> • <i>pay particular attention to the potential presence of depression, cognitive impairment and physical ill health</i> • <i>include a full assessment of the person's social and home situation, including any possible role as a carer, and</i> • <i>take into account the higher risks of suicide following self-harm in older people.</i>
373	SH	Association of Child Psychotherapists	NICE	1.3.4	19	In our view, children who self-harm may be communicating a state of distress and frustration connected to current neglect or abuse. This should form a working hypothesis in the assessment of need/risk.	Thank you for your comment. Whilst we recognise the connection between abuse and self-harm in children, there is no evidence of the definite correlation and therefore we are unable to recommend this. The recommendation does state that child protection issues should be considered.
374	SH	Association of Child Psychotherapists	NICE	1.3.4 and 1.4.2	19 & 21	In order to make a comprehensive assessment of needs and to construct long-term plans, an extended assessment needs to be made, including a comprehensive family and individual history which will identify the origins and development of the self-harming thinking and behaviour.	Thank you for your comment, we agree and have outlined that a full and comprehensive assessment be conducted not just of risk (recommendation 1.3.6), but also of need (recommendation 1.3.2).
275	SH	Association of Child Psychotherapists	NICE	General	General	The guidance is written principally about adults; the situation and needs of children is mentioned only occasionally. In our view, the guidance needs to cover the whole population who self harm or are at risk of doing so; a significant number of these are children and adult self-harming behaviour is likely to have begun in childhood. The guidance should cover the whole age range, with all that this implies.	Thank you for your comment. The GDG did discuss if there should be a separate section for children and young people, but decided that they should be included throughout the document. Each working group for the chapters included a children and young people specialist and the GDG consider these issues to be addressed throughout.
376	SH	Association of Child Psychotherapists	NICE	1.3.5	19	Add 'irrespective of the degree of self-harm'.	Thank you we struggled to understand where you wanted this put and what point you were making. We think that the recommendation would not benefit from adding a comment about the degree of self-harm. Currently the recommendation would apply to any degree of severity of self-harm.
377	SH	RCPsych in Wales	NICE	1.3.6	8	Assessment of self-harm should explore the events leading up to the self-injury in depth. This includes exploring the current situation, recent events and current problems; exploring the patient's emotional and psychological state both leading up to the event and afterwards; exploring how the individual has self-harmed; and determining whether there is an immediate risk of self-harming again. To help GPs assessing patients who have self-harmed, Wadman	Thank you for your comment. This information is covered in the chapter on psychosocial assessment in the full guideline (Chapter 6). The GDG found no evidence for specifically recommending the 'SOS' model.

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						<p>and Cole-King propose the new mnemonic ‘SOS’:</p> <p>Severity: How severe is the situation? Is medical treatment required? Can wounds be managed in-house? Does the patient need to be referred to A&E? (Recommended for all cases of overdose). How severe was the emotional distress when the patient self-harmed? How severe is it now? How severe is any mental illness? How severe are the patient’s psychosocial problems/life events and has anything changed?</p> <p>Outcome: What was the intended outcome of the self harm? Was there a death wish? Did the individual secure the means specifically for the self harm? What was the extent of planning and preparation? Were there any attempts not to be discovered? What was the individual thinking at the moment of self harm? Were any boundaries in place to ensure safety or possibility of rescue? e.g. someone close by, informed someone, did not use all available means, depth of cut, number of cuts etc. Does the individual regret self-harming?</p> <p>Support systems: Explore the patient’s network of supportive family/friends. Beware of social isolation (perceived or real), relationship instability or recent loss e.g. via bereavement. Are there adequate and appropriate support systems in place?</p> <p>It may be useful to consider this process in relation to both self harm and suicide risk as many people may engage in self harm in addition to having suicidal thoughts (Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care. InnovAiT Vol 4, Num 5, p278 -287</i>)</p> <p>Additionally the risk assessment process should be transparent and understood by the patient.</p>	
378		NICE	NICE	1.3.6	19	Is the use of the word ‘antecedents’ in bullet point 7 necessary? This is not a widely understood word and should maybe be replaced with previous circumstances/occurrences/events.	Thank you, we have changed ‘antecedents’ to ‘factors preceding episodes of self-harm’.
379	SH	National Self Harm Network	NICE	1.3.6	19	“When assessing the risks of repetition of self-harm or of <i>attempted</i> suicide”	Thank you for your comment. We mean the risk of suicide rather than repetition of attempted suicide. We have reworded the recommendation to avoid this ambiguity.

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380	PR	Expert Reviewer (2) (Jim Bolton)	NICE	1.3.6	19	“the differentiation between long-term and more immediate risks.” Could this be more didactic in terms of the risks that should be assessed? This may be clear to more experienced health professionals, but would help others in the service planning and development of educational materials. Currently this seems a little vague as a recommendation for a Nice guideline.	Thank you for comment. We have amended this recommendation to be more inclusive. It now reads: <i>When assessing the risks of repetition of self-harm or risks of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:</i> <ul style="list-style-type: none"> • <i>methods and frequency of current and past self-harm</i> • <i>current and past suicidal intent</i> • <i>depressive symptoms and their relationship to self-harm</i> • <i>any psychiatric illness and its relationship to self-harm</i> • <i>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</i> • <i>specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm</i> • <i>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</i> • <i>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</i> • <i>immediate and longer-term risks.</i>
381	PR	Expert Reviewer (David Gunnell)	NICE	1.3.8 , 1.3.9	20	Both these sections refer to initial management	Thank you for your comment, whilst the GDG agree this refers to acute management, crises and episodes or repeat self-harm may also occur in the context of longer term management. We have therefore retained this recommendation.
382	SH	Association of Child Psychotherapists	NICE	1.3.9	20	As in the case of with older people where all acts of self-harm are taken as evidence of suicidal intent until proven otherwise, any act of self-harm in children might be considered as evidence of neglect/abuse until proven otherwise - particularly in the case of looked after children.	Thank you for your comment. Whilst we recognise the connection between abuse and self-harm in children, there is no evidence of the definite correlation and therefore we are unable to recommend this.
383		Healthcare Inspectorate Wales	NICE	1.3.9		HIW suggests that this section regarding removal of medications and access to other means of self harm is equally applicable to any person who self harms,	Thank you for your comment. The guideline does recommend ‘safe prescribing’ for people who self-harm (see recommendation 1.5.2). The GDG

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						<p>particularly vulnerable adults.</p> <p>In addition, HIW suggests NICE refers to managing access to the means of self harm within inpatient or institutional settings, as we come across practices and environments of care of concern to us during visits where risk management processes do not appear to be sufficiently robust to manage them appropriately.</p>	<p>discussed this issue and agreed that it is not possible to manage the risk of self-harm by just managing the environment – this has to be done on a case by case basis.</p> <p>Managing self-harm within inpatient settings is challenging and the full guideline has been amended (see section 7.4.5) to reflect this. It was beyond the scope of the guideline to make recommendations regarding ligature points and other environmental risks.</p>
384	SH	National Self Harm Network	NICE	1.3.9	20	<p>We would not suggest to carers, friends and family to remove the tools used to self harm as this is often construed as a lack of trust in the person. Whilst we can understand that it is often done instinctively, a lot of our members have reported finding another, often less safe, tool to replace what has been taken from them. However, this could be advised by a healthcare professional who has thoroughly assessed the individual prior to making this suggestion.</p>	<p>Thank you for your comment, as this refers to children and young people the GDG did not feel it appropriate to amend the recommendation.</p>
385	SH	Royal College of Nursing	NICE	1.3.9	20	<p>We agree with proposals to remove/safe storage of medicines but suggest that this should say ‘consider removal of other means of harm – harm minimisation approach indicates for some people removal of means increases the risks.</p>	<p>Thank you for your comment, as this refers to children and young people the GDG did not feel it appropriate to amend the recommendation.</p>
386	SH	Royal College of Psychiatrists in Scotland	NICE	1.3.10	20	<p>The suggestion that: “1.3.10 <i>Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise</i>” is somewhat ‘fuzzy’. First, it is difficult to prove a negative, but may imply that the very presence of older age is a more significant risk factor than a detailed understanding of the episode of self-harm. Conversely, one could suggest that the absence of such a recommendation for younger people implies that self-harm in younger people should not be taken as evidence of suicidal intent unless proven otherwise. This is where a ‘strength of evidence’ rating and clearer wording would be helpful.</p>	<p>Thank you for your comment. It is clear that suicide presents as a risk for all people who self-harm. However, the evidence for the risks being higher in older people is significant. A prospective cohort study (included in our review – see section 6.2.12) showed that older adults were associated with greater suicidal intent. Moreover, another retrospective study (Dennis 2007) showed similar findings. Also, a recent large multi-centred study in the UK (Murphy <i>et al.</i>, in press) confirms this.</p>
387	SH	National Self Harm Network	NICE	1.3.10	20	<p>We do not agree that all acts of self harm should be taken as evidence of suicidal intent; a large evidence base suggests that this is not the case. Self harm and suicidal intent may be connected in some cases, however it is not something that should be assumed as self harm is primarily a coping mechanism.</p>	<p>Thank you for your comment. The GDG found evidence for the risks of suicide being higher in older people who self-harm significant. A prospective cohort study (included in our review – see section 6.2.12) showed that older adults were associated with greater suicidal intent. Moreover, another</p>

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							retrospective study (Dennis 2007) showed similar findings. Also, a recent large multi-centred study in the UK (Murphy <i>et al.</i> , in press) confirms this.
388	SH	RCPsych in Wales	NICE	1.3.10	20	<i>'Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.'</i> Consider adding the ratio of self harm to completed suicide to highlight this issue.	Thank you for your suggestion, the full guideline has been amended to include this, see section 6.2.12.
389	SH	Nottinghamshire NHS Trust	NICE	1.3.10	20	Why is this only considered in older people – surely the risk of suicidal intent should be considered in all cases of self-harm? And if you take this stance, how does this affect the treatment plan?	Thank you for your comment. It is clear that suicide presents as a risk for all people who self-harm. However, the evidence for the risks being higher in older people is significant. A prospective cohort study (included in our review – see section 6.2.12) showed that older adults were associated with greater suicidal intent. Moreover, another retrospective study (Dennis 2007) showed similar findings. Also, a recent large multi-centred study in the UK (Murphy <i>et al.</i> , in press) confirms this.
390	PR	Expert Reviewer (David Gunnell)	NICE	1.3.11	8	The recommendation not to use risk assessment tools is strong and such tools are in widespread use. Are there any circumstances when they may be useful e.g. an aide memoire to new staff performing assessments? Prioritising for admission patients who cannot be assessed within 24 hours?	Thank you for your comment. The GDG have recommended that risk assessment tools are not used to predict future episodes of self-harm. This however does not mean that risk assessment should not be carried out to focus on what help the service user may need. We have suggested in recommendation 1.3.13 that risk assessment tools may be used to help structure a risk assessment. The guideline has been amended to clarify the difference between risk assessment tools and risk assessment.
391	SH	Calderstones Partnership NHS Foundation Trust	NICE	1.3.11 1.3.6	8 19	Do not use risk assessment tools and scales to predict future risk...yet risk assessment is stressed throughout the document. Section 1.3.6 seems to be a structure for risk assessment...this would be quite confusing for clinicians and structured assessment is part of NHS culture and embedded in practice...this would be very difficult to reconcile.	Thank you for your comment. The GDG have recommended that risk assessment tools are not used to predict future episodes of self-harm. This however does not mean that risk assessment should not be carried out to focus on what help the service user may need. The guideline has been amended to clarify the difference between risk assessment tools and risk assessment.
392	SH	Royal College of Psychiatrists in Scotland	NICE	1.3.11	20	The comments on 'Risk assessment tools and scales' leave a puzzling gap in guidance on how professionals should make such judgements. If structured approaches to risk assessment are to be avoided, what do NICE suggest is a	Thank you for your comment. The GDG have recommended that risk assessment tools are not used to predict future episodes of self-harm. This however does not mean that risk assessment should

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						better guide to risk assessment? The longer guidance (p. 179) rightly says that they don't necessarily affect outcome and that predicting rare events is notoriously difficult. However, the evidence base for most of the other recommendations about forging relationships and provision of care are equally unsupported by a robust evidence base ¹ . It could be argued that such scales may provide a framework (or an <i>aide memoire</i>) for some health professionals to assess suicidal behaviour in a structured way – to some extent this has been acknowledged in recommendation 1.3.13. Indeed, this is probably the current thinking about risk assessment in mental health: the tools aren't robust predictors, but they help structured risk management. Perhaps the wording needs to acknowledge that using them as a sole, or primary, indicator of risk should not replace competent clinical risk assessment.	not be carried out to focus on what help the service user may need. The guideline has been amended to clarify the difference between risk assessment tools and risk assessment.
393	PR	Expert Reviewer (David Gunnell)	NICE	1.3.1 1	20	Perhaps rephrase: "do not use risk assessment tools and scales <i>alone</i> to determine...."	The guideline has been amended to clarify the difference between risk assessment tools and risk assessment.
394	SH	Royal College of Psychiatrists in Scotland	NICE	1.3.1 3	20	Recommendation 1.3.13 suggests: "Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in recommendation 1.3.6." Unfortunately, the areas in area 1.3.6 do not seem to be based in evidence; i.e. their value hasn't been demonstrated in any kind of trial. Consequently, the weakness in the evidence base for the predictive validity of risk assessment tools is being used to guide practice which is based on an equally poor evidence base. This is a problem.	Thank you for your comment. When developing clinical guidelines any new approach, such as recommending a specific risk assessment tool, must be measured for effectiveness against treatment as usual. The review conducted found that no specific tool was more effective than treatment as usual. Recommendation 1.3.6 was formed from GDG consensus of what treatment as usual should be.
395	PR	Expert Reviewer (David Gunnell)	NICE	1.4	21ff	This section refers to "longer term treatment and management" – but this is the focus of the whole guideline?	Thank you for your comment, but we considered that it was worth emphasising that this was for longer-term treatment
396	SH	Royal College of Psychiatrists	NICE	1.4.1	21	Recommendation 1.4.1 (page 21) suggests that, " <i>Community mental health services, and tier 2 and 3 CAMHS, should be responsible for the routine assessment</i>	Thank you. We have defined longer term treatment as anything beyond the first 48 hours but have rephrased this for clarity.

¹ For example, the recommendations on Needs Assessment, despite their face validity rely on a narrative review of two studies (page 193, long guidelines). This is a very low grade of evidence.

		in Scotland				(see section 1.3), and the longer-term treatment and management of self-harm.” Is this the case regardless of whether the individual has a diagnosed and/ or treatable mental disorder? If so, then the remit of CMHTs would appear to be managing a particular behaviour (which has a remarkably weak evidence base for intervention), rather than treating mental illness (which has a much more robust evidence base). We think that when the role of services is defined by whether or not people exhibit a particular behaviour, the risks of patients ‘falling through the gaps’ and lack of clarity around the remit of services are both increased. We are pretty sure that cardiologists would not appreciate being responsible for all ‘chest pain’ occurring in hospitals and the community, regardless of cause. But this is what is being suggested here. Whilst it is reasonable to suggest that CMHTs have a role in the assessment of self-harm, asserting that they should be responsible for the long-term treatment (for which there is a minimal evidence base) and management, irrespective of diagnosis, is controversial and difficult to justify.	We were using CMHTs to refer to specialist mental health services in a generic sense. It was not the GDG’s intention to exclude liaison and general hospital mental health services, many of whom provide an excellent service for individuals following self-harm. This is a very good analogy. We are suggesting that, just as with chest pain, self-harm should be managed by general mental health services in the community, not by cardiologists (or psychiatric specialists). We have now recommended that both CMHTs and liaison should be involved as cardiologists would want to help general physicians with chest pain. This recommendation has been reworded for clarity: <i>Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3), and the longer-term treatment and management of self-harm. In children and young people this responsibility should be taken by tier 2 and 3 CAMHS services.</i>
397	SH	RCPsych in Wales	NICE (and FULL)	1.4.1	21	<p>There appears to be inconsistency between the short guideline [page 21] and the full guideline [page 22] in covering assessment and interventions.</p> <ul style="list-style-type: none"> • Full guideline 2.2.2 (Assessment) states that “Subsequent to assessment, the assessing clinician may recommend <i>no follow-up, follow-up in primary care, referral to a Community Mental Health Team, referral for psychological treatment or a recommendation for inpatient admission</i>”; the outcomes in italics do not reflect “community mental health services” – a flexible set of outcomes. It also states that “Assessment for adults most commonly occurs in the context of the community mental health team”, again allowing flexibility to address need. • The short guideline 1.4.1 (Provision of care) suggests that “Community mental health services...should be responsible for the routine assessment...and the longer-term treatment and management of self-harm” – a more restrictive pathway. It is not clear why all self harm should be assessed and managed by specialist 	<p>Thank you for your comment. This recommendation has been amended to reflect yours, and other stakeholders’ comments:</p> <p><i>Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3), and the longer-term treatment and management of self-harm. In children and young people this responsibility should be taken by tier 2 and 3 CAMHS services.</i></p>

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						services.	
398	PR	Expert Reviewer (David Gunnell)	NICE	1.4.1	21	I thought Liaison services were responsible for routine assessment of self-harm?	<p>Thank you. We have defined longer term treatment as anything beyond the first 48 hours (see section 1) but have rephrased this for clarity.</p> <p>We were using CMHTs to refer to specialist mental health services in a generic sense. It was not the GDG's intention to exclude liaison and general hospital mental health services, many of whom provide an excellent service for individuals following self-harm. This recommendation has been reworded for clarity.</p> <p><i>Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3), and the longer-term treatment and management of self-harm. In children and young people this responsibility should be taken by tier 2 and 3 CAMHS services.</i></p>
399		Healthcare Inspectorate Wales	NICE	1.4.2 – 1.4.5 (care plans and risk management plans)		The Mental Health Measure (Wales) will introduce statutory care plans for children, young people and adults receiving secondary mental health services in Wales in 2011-12. It would be helpful for the guidance to make reference to the requirements these will place on services in Wales.	<p>Thank you for your comment. We understand that many NHS services are undergoing changes in structure and organisation. However, it is very difficult for the guideline to address future changes. In this guideline the GDG have aimed to make recommendations for the principles of care that should be adopted.</p>
400	SH	RCPsych in Wales	NICE	1.4.2	8	Add in: to aim to mitigate against escalation in self harm if the person engaging in self-harm is unable to reduce their self harm.	<p>Thank you for your suggested addition. We have amended the recommendation to read:</p> <p><i>Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:</i></p> <ul style="list-style-type: none"> • prevent escalation • reduce harm arising from self-harm, decrease or stop self-harm • decrease or stop other risk-related behaviour • improve social or occupational functioning • improve quality of life • improve any associated mental health conditions.

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							<i>Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.</i>
401	SH	Association of Child Psychotherapists	NICE	1.4.2	21	Add 'understand the issues that lead to self-harm' and 'work to develop a life worth living'. 'Realistic and optimistic long-term goals' should include the consideration of what changes need to take place for the individual to have 'a life worth living.'	<p>Thank you for your comment. This information is covered in chapter on psychosocial assessment in the full guideline (Chapter 6). The recommendation has also been amended recommendation 1.3.2 to better reflect this:</p> <p><i>Assessment of needs should include:</i></p> <ul style="list-style-type: none"> • <i>skills, strengths and assets</i> • <i>coping strategies</i> • <i>mental health problems or disorders</i> • <i>physical health problems or disorders</i> • <i>social circumstances and problems</i> • <i>psychosocial and occupational functioning, and vulnerabilities</i> • <i>recent and current life difficulties, including personal and financial problems</i> • <i>the need for psychological intervention, social care and support, occupational rehabilitation, and drug treatment for any associated conditions</i> • <i>the needs of any dependent children.</i>
402	SH	Wish	NICE	1.4.2	21	Care Plan outcomes: The outcomes to be considered when creating care plans currently do not include harm minimisation. Although they include stopping or reducing self-harm this is not enough to encourage harm minimisation as a part of care plans. In Wish's experience of working with women who self-injure, harm minimisation is a key outcome for many women and is very beneficial. It is important as a goal in itself but also as a stepping stone towards desistance.	Thank you for your comment. The recommendation does mention 'decrease or stop self-harm' which the GDG believe adequately covers this point. The GDG agreed that whilst harm reduction can be used as a method to work towards stopping self-harm, it should not be an outcome in itself. Recommendation 1.4.9 directly address harm reduction.
403	SH	RCPsych in Wales	NICE	1.4.3	9	<p>Consider the addition of the terms in red:</p> <p>'Care plans should be multidisciplinary and co- developed collaboratively with the person who self-harms and their family, carers or significant others (if appropriate). They should be bio-psychosocial and person centred.</p> <p>Consider the inclusion of the table taken from the Innovaite paper regarding bio-psychosocial ways to mitigate the immediate risk and longer term risk of self harm.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care</i>. InnovAiT Vol 4, Num 5, p284)</p>	Thank you for your comment. The GDG considered these suggestions, but on reflection decided the recommendation is adequate as it stands. At the beginning of the NICE guideline, it states that all treatment and care should be person centred.

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404	SH	Association of Child Psychotherapists	NICE	1.4.3	21	Care plans should: identify realistic and optimistic long-term goals, including education, employment and occupation.	Thank you, the guideline has been amended to reflect your suggestion.
405	SH	RCPsych in Wales	NICE	1.4.3	22	We recommend adding to the final bullet point: "be shared with the person's GP [1] and with other relevant agencies and significant others, [2] with the patient's consent".	Thank you for your comment. The GDG considered these suggestions, but on reflection decided the recommendation is adequate as it stands.
406	PR	Expert Reviewer (David Gunnell)	NICE	1.4.3 / 1.4.4	9	Suggest add: Care plans / risk management plans and information about an episode of self-harm should be rapidly shared with all relevant staff – i.e. reliable communication between liaison team / care co-ordinator / inpatient unit / CMHT / primary care. From participation in suicide audits I'm aware such information is not always shared, but is key to formulation of risk management plans / immediate patient management	Thank you for your comment. After consideration, the GDG agreed that although in many incidences speedy information sharing is appropriate it is, nevertheless a matter for clinical judgement as for some people it will not be necessary. Therefore, we will not be amending the recommendation.
407	PR	Expert Reviewer (2) (Jim Bolton)	NICE	1.4.4	22	If the guideline is intended to include risk assessment made at the time of first presentation, but pertaining to the longer term, could there be more explicit reference as to how this guideline might fit with initial assessment, especially in A&E?	Thank you for your comment. To accompany this guideline NICE are developing a pathway to inform clinicians how the two guidelines will fit together. Amendments will also be made to the Short Term Management guideline to resolve any inconsistencies.
408	SH	Calderstones Partnership NHS Foundation Trust	NICE	1.4.8 1.1.6	9/10 of 37 12	DBT is not mentioned as an intervention despite some evidence of effectiveness. Also for people with a learning disability 6 sessions is not seen as a realistic time frame for psychological intervention, taking into account cognitive difficulties. Therefore section 1.1.6 although the spirit of accessing the same services as the general population is important, the difficulties of engaging people with learning disabilities in therapeutic intervention needs to be highlighted as the time frame would probably differ greatly.	<p>Thank you for your comment. DBT is not mentioned in the guideline as the populations in the DBT trials are all people with personality disorders. Please see section 7.1.5 of the full guideline for our full rationale.</p> <p>On reflection, the GDG agree that 6 sessions may not be flexible enough for all service users, including people with learning disabilities, and have therefore amended the recommendation to read: <i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i></p>

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409	SH	Royal College of Psychiatrists in Scotland	NICE	1.4.8	23	We can't help but suggest that recommendation 1.4.8 (<i>"Consider offering six sessions of a psychological intervention specifically structured for people who self-harm with the specific aim of reducing self-harm"</i>) should be accompanied by a comment about the low quality evidence to support such a recommendation. Indeed, the long guidelines point out that, <i>"Given the variation in modality and duration of psychological therapies, components of standard care, and prevalence of psychiatric disorders in these studies, the results should be interpreted with caution."</i> (page 218) The evidence review went on to comment that when it came to effects of psychological therapy on repetition up to six months, <i>"...the outcome was of low quality."</i> (page 218) Effects of psychological interventions on repetition between 6 and 12 months were not statistically significant; and again, when it came to repetition beyond 12 months <i>"...the outcome was of low quality"</i> .	Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore have amended the recommendation to include the full range of sessions suggested by the studies reviewed, that is 3-12.
410	SH	Royal College of Psychiatrists in Scotland	NICE	1.4.8	23	The recommendation of 6 sessions comes from the fact that <i>"The number of sessions in studies varied with an average of 6 sessions."</i> (page 260) However, outcomes are likely to vary by diagnosis, severity, complexity, and co-morbidity and to simply average out the number of sessions and make this a recommendation seems, quite frankly, absurd. Although the poor evidence is acknowledged in the long guidelines (page 260): <i>"...there is considerable uncertainty and heterogeneity with respect to the population, treatment length and treatment modality and settings, which lowers the quality of the evidence"</i> , the recommendation for six sessions appears in the document that most people will read without any caveats about the quality of evidence.	Thank you for your comment. On reflection, the GDG agree that 6 sessions may not be flexible enough for all service users, including people with learning disabilities, and have therefore amended the recommendation to read: <i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i>

411	SH	Royal College of Paediatrics and Child Health	NICE and Full	1.4.8 7	23 217-250	<p>“Consider offering six sessions of a psychological intervention specifically structured for people who self-harm with the specific aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should have significant experience of working with people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.”</p> <p>This summary paragraph seems at first sight rather lacking in helpful advice. We understood why when reading the evidence summarised in the full. There seems to be very little in the way of a coherent conclusion to be gained from most of this research, which consists mainly of negative results. Could the GDG find a way of rephrasing this paragraph that would be more useful to practising clinicians?</p> <p>The first sentence in particular could do with some improvement. What is the research basis for the recommendation of six sessions? In clinical practice, the number of sessions is determined by a number of factors, including the severity of the client’s presenting symptoms and their degree of engagement. In the client group consisting of those who have contact with CAMHS following an overdose, the number of post-overdose sessions varies tremendously, and it would defy common sense to aim for a universal target of six sessions (outside of a research trial).</p> <p>The word ‘specific’ is used twice. What is the difference between an intervention that is specifically structured for people who self-harm and one that is non-specifically structured? Does this indicate that therapists should not be targeting the comorbid symptoms at all? If so, this is contradicted elsewhere in the guideline. What is the difference between having a specific aim to reduce the self-harm and having a non-specific aim? Perhaps targeting symptoms other than self-harm may be more successful than targeting the self-harm symptom? This has been proven for bulimia nervosa, for which a therapy that eschews focus on eating and food, such as Interpersonal Therapy, can be just as successful as a therapy focusing on food and eating behaviour such as CBT.</p>	<p>Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore have amended the recommendation to include the full range of sessions suggested by the studies reviewed, that is 3-12. The recommendation has been amended to read:</p> <p><i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i></p>
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						The third sentence does not extend much beyond what would probably be obvious to most practicing clinicians and is therefore also not as helpful as it might be.	
412	SH	Association of Child Psychotherapists	NICE	1.4.8	23	In relation to the statement: 'Consider offering six sessions of a psychological intervention specifically structured for people who self-harm with the specific aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements', the inclusion of further sessions of psychological intervention or follow-up might be helpful, particularly in relation to children and young people.	Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore have amended the recommendation to include the full range of sessions suggested by the studies reviewed, that is 3-12.
413	SH	Association of Child Psychotherapists	NICE	1.4.8	23	'Therapists should have significant experience of working with people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.' It is important here to clarify what constitutes 'significant experience' and to stress the importance of supervision for the many workers who may not have 'significant experience' with people who self-harm.	<p>Thank you for your comment. We agree that the recommendation was not clear and have amended it to read:</p> <p><i>Consider offering a range from 3 to 12 sessions of a psychological intervention tailored to individual need, which is specifically structured for people who self-harm with the aim of reducing self-harm. The intervention may include cognitive-behavioural, psychodynamic or problem-solving elements. Therapists should be trained and supervised in the therapy they are offering for people who self-harm, and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</i></p> <p>The GDG agree that supervision is important and recommend healthcare professionals are given adequate support in recommendation 1.1.11 of the NICE guideline and in Chapter 5 of the full guideline.</p>

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414	SH	Wish	NICE	1.4.8	23	Offering psychological intervention: Whilst offering six sessions may be helpful to many people who self-injure it may be appropriate to offer longer programmes for those who need to discuss longstanding mental harm and experience of abuse. There should be greater flexibility as to the length of the psychological intervention and type of counselling models available.	Thank you for your comment. On reflection, the GDG agree that an average should not be taken, and therefore have amended the recommendation to include the full range of sessions suggested by the studies reviewed, that is 3-12.
415	SH	Royal College of Psychiatrists in Scotland	NICE	1.4.9	23	The guidelines suggest that “ <i>Assessment of needs should include...the need for psychological or pharmacological intervention...</i> ” (Page 7) but Section 1.4.9 (page 23) makes it clear: “ <i>Do not offer drugs as a specific intervention to reduce self-harm.</i> ” These recommendations are potentially contradictory and it’s not clear if NICE are endorsing drug treatment or not. We would suggest that some coherence should be sought in how the recommendations are worded.	Thank you for your comment, although pharmacological treatment for underlying/associated conditions may be appropriate, there is no evidence for efficacy of pharmacological interventions in preventing self-harm (see Chapter 9 of the full guideline). This has now been clarified in the recommendation to read: “ <i>the need for psychological intervention, social care and support, occupational rehabilitation, and drug treatment for any associated conditions</i> ”
416	SH	National Self Harm Network	NICE	1.4.10	23	Please include a note to say that harm minimisation advice is not suitable to all individuals who self harm.	Thank you for your comment. The GDG agree that this approach may not be appropriate for all people who self-harm, and for that reason the recommendation states that this approach could be ‘considered’.
417	SH	Calderstones Partnership NHS Foundation Trust	NICE	1.4.10	23	Consider strategies for harm reduction: a definition and guidance on what constitutes harm reduction would be helpful including clinicians responsibilities in this area particularly for inpatients.	Thank you for your comment. The NICE guideline is essentially a list of the recommendations developed and fully discussed in the full guideline. Please see section 7.4 for a more in-depth discussion of the issues surrounding harm reduction.
418	SH	Wish	NICE	1.4.10-11	23-4	Harm-minimisation approaches: Whilst the guidelines draw attention to harm-minimisation approaches (sections 1.4.10 and 1.4.11), Wish recommends fuller reference to the range issues that this approach addresses and its potential to benefit those who do not want to stop their self-injury. The guidelines could include greater explanation of the content of the harm-minimisation approach including education around safer cutting, the use of sterile blades and self-wound care. It could also be linked to outcomes (see point 3).	Thank you for your comment. The NICE guideline is essentially a list of the recommendations developed and fully discussed in the full guideline. Please see section 7.4 for a more in-depth discussion of the issues surrounding harm reduction.
419	SH	Royal College of Nursing	NICE	1.4.11	24	Many teams providing self-harm services are not or are no longer multi-disciplinary e.g. consultant nurse led or nurse only teams. Referral to another discipline e.g. psychiatrist would only be done as needed not as part of standard care – so care plans would not be multi-disciplinary.	Thank you for your comment. It was the view of the GDG that multi-disciplinary teams more closely capture current and good practice.

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420		NICE	NICE	1.5.1		For clarity can the opening sentence of this recommendation be reworded. For example:	This comment appears to be incomplete and we are therefore unable to respond to it.
421	SH	RCPsych in Wales	NICE	4.1	25	<p>Effectiveness of training</p> <p>Please find below two unpublished audits conducted as part of a Quality Improvement initiative in North Wales related to training and improvements in supervision and documentation:</p> <ol style="list-style-type: none"> 1. Re-audit of junior doctors' assessments following Connecting with People training, enhanced documentation and supervision showed major improvements in care. <p>Documentation rates increased as follows:</p> <ul style="list-style-type: none"> • Current suicidal thoughts: 67% to 100% • Method: 40% to 93% • Circumstances: 43% to 93% • Subjective intent: 43% to 80% • Drugs and alcohol during self harm: 30% to 73% • Use of Pierce suicide intent scale: 33% to 63% • Current alcohol/drug use: 47% to 87% • Social history: 77% to 90% • Summary/Opinion of Risk/Clinical Impression: 37% to 66% <p>(All highly significant improvements: 'p' values <0.0002)</p>	Thanks for your comment, these audit results are very interesting. Unfortunately, we do not include unpublished audits to examine effectiveness as they do not meet our inclusion criteria.
422	SH	PAPYRUS	NICE	4.2	General	PAPYRUS agrees with the need to assess the usefulness of risk assessment tools on the outcome of treatment with clients.	Thank you for your comments.
423	SH	RCPsych in Wales	NICE	4.5	29	<p>Observational study exploring different harm-reduction approaches</p> <p>Hawton et al (1999) in their Cochrane review of psychosocial and pharmacological treatments for self harm, highlighted that despite much research the optimum treatment for self harm remain elusive. We suggest that this may be due to the approach of 'managing self-harm'; focusing on the self-harm itself rather than on the needs of the individual. Furthermore, any treatment strategy relies heavily on an empathic therapeutic relationship and the ability of the practitioner to demonstrate a validating and compassionate approach and this cannot be prescribed.</p>	Thank you for your comment, We have already emphasized the importance of engagement in Chapter 4 (Experience of care) and Chapter 6 (Psychosocial assessment). Moreover, this article addresses implementation and therefore does not meet our inclusion criteria for the guideline.

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						<p>Consider highlighting the importance of therapeutic engagement and a person centred approach rather than 'treating the self harm'.</p> <p>(Ref: Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L (2011) <i>Therapeutic assessment of patients following self harm in primary care.</i> InnovAiT Vol 4, Num 5, p280-281)</p>	
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These stakeholder organisations were approached but did not respond

Alder Hey Children's NHS Foundation Trust

Association for Clinical Biochemistry

Association for Cognitive Analytic (ACAT) Therapy

Association For Family Therapy and Systemic Practice in the UK (AFT)

Association for the advancement of meridian energy techniques (AAMET)

Association of Dance Movement Psychotherapy UK

Association of Higher Education Programmes on Substance Misuse

Association of Psychoanalytic Psychotherapy in the NHS

Autism West Midlands

Berkshire Healthcare NHS Foundation Trust

Birmingham and Solihull Mental Health Foundation Trust

Blackburn with Darwen Teaching Care Trust Plus

BMJ

Bournemouth University

Bright

Bristol Crisis Service for Women

British Association for Behavioural & Cognitive Psychotherapies (BABCP)

British Association of Art Therapists

British Association of Drama Therapists

British Association of Psychodrama and Sociodrama (BPA)

British Medical Association (BMA)

British National Formulary (BNF)

British Psychodrama Association

British Psychological Society, The

Business Boosters Network CIC

Care Quality Commission (CQC)

Centre for Mental Health Research

Cerebra

CIS'ters

Citizens Commission on Human Rights

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Cleft Lip and Palate Association
Cochrane Depression, Anxiety & Neurosis Group
College of Emergency Medicine
College of Mental Health Pharmacy
College of Occupational Therapists
Connecting for Health
County Durham PCT
Criminal Justice Womens Strategy Unit

Critical Psychiatry Network

Department for Communities and Local Government
Department for Education
Department of Health Advisory Committee on Antimicrobial Resistance
and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland
(DHSSPSNI)
Depression Alliance
Durham University
Faculty of Public Health
George Eilat Hospital Trust
Gloucestershire LINK
Government Office Yorkshire and the Humber
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Hafal

Hampshire Partnership NHS Foundation Trust

Harm-ed
Harmless
Healthcare Improvement Scotland
Healthcare Quality Improvement Partnership
Hertfordshire Partnership NHS Trust
Humber NHS Foundation Trust
Institute of Liver Studies
Intapsych Ltd
Janssen
Kent & Medway NHS and Social Care Partnership Trust
King's Health Partners
Lambeth Community Health
Lancashire Care NHS Foundation Trust

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Leeds Irish Health and Homes
 Leeds Partnerships NHS Foundation Trust
 Leeds PCT
 Liverpool Community Health
 Liverpool PCT Provider Services
 Luton & Dunstable Hospital NHS Foundation Trust
 Manchester Community Health
 MBB Connections Healthcare
 MDF The Bipolar Organisation
 Medicines and Healthcare Products Regulatory Agency (MHRA)
 Mencap
 Mental Health Nurses Association
 Mental Health Providers Forum
 MIND
 Ministry of Defence (MoD)
 Mother and Child Foundation
 Mothersvoice
 National advisory council for children's mental health

 National Association for Children of Alcoholics

 National CAMHS Support Service

 National Mental Health Development Unit (NMH DU) Equality programme

 National Offender Management Service

 National Patient Safety Agency (NPSA)
 National Poisons Information Service (NPIS) Edinburgh
 National Treatment Agency for Substance Misuse
 NEt (North East Together)
 NeuroDiversity International(NDI)/NeuroDiversity Self-Advocacy
 Network(NESAN)
 NHS Bath and North East Somerset
 NHS Bradford & Airedale

 NHS Clinical Knowledge Summaries Service (SCHIN)

 NHS Knowsley
 NHS Milton Keynes
 NHS Milton Keynes
 NHS North of Tyne
 NHS North West
 NHS Plus

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NHS Sefton
NHS Sheffield
NHS Western Cheshire
No Secrets
North East Council on Addictions
Northamptonshire Healthcare NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Nottinghamshire Acute Trust
Offender Health - Department of Health
Oxford Health NHS Foundation Trust
Panacea Healthcare
Paracetamol Information Centre

Partnerships in Care

Patients Council
Poole and Bournemouth PCT
Positively Pregnant
Pottergate Centre for Dissociation & Trauma
Primary Care Mental Health Forum, RCGP
Public Health Wales

Rethink
Retreat, The
Rotherham NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners Wales
Royal College of Obstetricians and Gynaecologists

Royal College of Paediatrics and Child Health

Royal College of Pathologists

Royal College of Physicians London

Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England

Royal Pharmaceutical Society of Great Britain

Samaritans
Sandwell PCT

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Scottish Intercollegiate Guidelines Network (SIGN)
Sensory Integration Network
Sheffield Health and Social Care Foundation Trust
Sheffield PCT
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence (SCIE)
Society for Acute Medicine
Solent Healthcare
South Asian Health Foundation
South Essex Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South West Autistic Rights Movement
South West London and St Georges Mental Health NHS Trust

South West Yorkshire Partnership NHS Foundation Trust

St Andrew's Healthcare
St Mungos
Sussex Partnership NHS Foundation Trust
Swansea University
Tavistock & Portman NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust
The Survivors Trust
Tuke Centre, The
Turning Point
United Kingdom Council for Psychotherapy
University of Edinburgh
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)

West Hertfordshire PCT & East and North Hertfordshire PCT

West London Mental Health NHS Trust
Western Cheshire Primary Care Trust
Worcestershire PCT
Wound Care Alliance UK

York Teaching Hospital NHS Foundation Trust

Young Minds
Youth Access
YouthNet

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