Self-harm in over 8s: management and prevention of recurrence

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Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Derbyshire Healthcare NHS Foundation Trust	General	General	**Constitution of the NICE committee** Constitution of the NICE committee for this sensitive subject area, appears light in its representation of those with lived experience alongside those groups and organisations that represent them. There is substantial professional group representation but limited lived experience. The committee should also reflect on whether there is sufficient research expert input – to ensure that a wide breadth of research evidence is considered.	Thank you for your comment, the constituency for this guideline includes 3 lay members, in line with NICE processes, to ensure a good representation from those with lived experience. The constituency has recently been revised to additionally include a 'Community support or third sector worker, or service manager' which will also bring a greater service user perspective.
Derbyshire Healthcare NHS Foundation Trust	General	General	**Safety Plans** "Safety plans" and "Staying safe from suicide plans" are being widely recommended and used within the UK (community and healthcare settings) and so reference to these needs to be included in the guidance. – Including a statement around the fact that there is currently limited available evidence for their effectiveness. *Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., ... & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. JAMA psychiatry, 75(9), 894-900.* *O'Connor, R. C., Lundy, J. M., Stewart, C., Smillie, S., McClelland, H., Syrett, S., ... & Brown, G. K. (2019). SAFETEL randomised controlled feasibility trial of a safety planning intervention with follow-up telephone contact to reduce suicidal behaviour: study protocol. BMJ open, 9(2), e025591.*	Thank you for your comment. Safety plans will be reviewed as part of the evidence for interventions. The scope has been amended to add safety plans as an example of interventions to be reviewed.
Derbyshire Healthcare NHS Foundation Trust	General	General	**Overnight Hospital Admission** Within the original SH NICE guidance, there was reference to admission to hospital overnight, which traditionally, but not exclusively, were more often used for younger people.	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission.

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			However, the benefits of (particularly late at night) being able to sleep off the effects of the overdose, the influence of alcohol and also allowing the distress to subside either prior to a full assessment, or to keep the person safe until assessment in the morning. This also ensures the person is not being discharged in the middle of the night, and straight back to the environment that may have played a part in the initial presentation. Also contact with those who can corroborate the account and potentially be of support is less easy in the middle of the night. So is there evidence to support this type of approach and should it be considered in the care pathway?	
Derbyshire Healthcare NHS Foundation Trust	General	General	**Assertive Case Management and Follow Up** Although not a therapeutic intervention, there have been studies exploring assertive case management/follow up practices following initial psychosocial assessment for self-harm within a general hospital setting. These management approaches were to maintain contact/engagement, encourage concordance with care plan and provide a "safety net" – ensuring that the person can contact a clinician familiar with their situation up to 6 months after self-harm if they are struggling. Consideration should be given to exploring this further. *Kroll, D. S. (2018). Supporting Suicidal Patients After Discharge from the Emergency Department. Journal of Clinical Outcomes Management, 25(7), 304-310.*	Thank you for your comment, any relevant evidence for effective models of care will be addressed under review question 2.3 'what are the most effective models of care for people who have self-harmed?'

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			Kawanishi, C., Aruga, T., Ishizuka, N., Yonemoto, N., Otsuka, K., Kamijo, Y., ... & Hitomi, Y. (2014). Assertive case management versus enhanced usual care for people with mental health problems who had attempted suicide and were admitted to hospital emergency departments in Japan (ACTION-J): a multicentre, randomised controlled trial. The Lancet Psychiatry, 1(3), 193-201. *Furuno, T., Nakagawa, M., Hino, K., Yamada, T., Kawashima, Y., Matsuoka, Y., & Hirayasu, Y. (2018). Effectiveness of assertive case management on repeat self-harm in patients admitted for suicide attempt: findings from ACTION-J study. Journal of affective disorders, 225, 460-465.* *Morthorst, B., Krogh, J., Erlangsen, A., Alberdi, F., & Nordentoft, M. (2012). Effect of assertive outreach after suicide attempt in the AID (assertive intervention for deliberate self harm) trial: randomised controlled trial. Bmj, 345, e4972.*	
Derbyshire Healthcare NHS Foundation Trust	004 & 008	019, 012, 013	**Psychosocial vs. Biopsychosocial** The term "Psychosocial assessment" is used throughout the document. "Bio-Psycho-social" may be more accurate to ensure equal consideration to any physical health needs of the individual at assessment e.g. terminal illness diagnosis or chronic pain which may have been a precipitating factor to self-harm. **"Older people who are experiencing chronic health conditions, particularly tinnitus, malignancies, diabetes and chronic pain may**	Thank you for your comment, the terminology in the scope has been amended to be 'biopsychosocial' as you suggest.

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			be at risk of self-harm. Targeted screening may assist in identifying older people at risk of self-harm."Mitchell et al., (2017) *Mitchell, R., Draper, B., Harvey, L., Brodaty, H., & Close, J. (2017). The association of physical illness and self-harm resulting in hospitalisation among older people in a population-based study. Aging & mental health, 21(3), 279-288.* **"Physical pain is a consistent risk factor for suicidal thoughts and behaviors."Calati et al., 2015** *Calati, R., Bakhiyi, C. L., Artero, S., Ilgen, M., & Courtet, P. (2015). The impact of physical pain on suicidal thoughts and behaviors: meta-analyses. Journal of psychiatric research, 71, 16-32.*	
Derbyshire Healthcare NHS Foundation Trust	005	006	**Proposed exclusion of guidance around practical/physical care response**. The plan to not refer to practical responses to self-harm within this guidance needs to be reconsidered. Whilst it is acknowledged that other NICE guidance may cover areas such as wound care, treatment of overdose, etc., the current self-harm guidelines highlight the importance of things like ensuring people are treated with respect and dignity, the use of pain management, etc., and this must be retained. Sadly, people who attend healthcare settings for physical treatment of self-harm still report encountering a lack of understanding and compassion during their physical care. Consequently the need to state that this is the expected standard whilst delivering physical care for self-harm is still necessary.	Thank you for your comment. As you suggest the physical management of wounds, poisoning etc. is covered by other guidance and therefore the decision was taken to exclude it from this scope. However, the guideline will still look at the care and respect that should be given to people when receiving care after an incident of self-harm. These issues will be addressed in review questions 1.1 and 1.2 about information and support, and 8.1-8.4 about skills and supervision. Review question 2.1 has also been amended to: 'What are the principles

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			The guidance needs to consider how stigma, distress and despair can affect the care provider and the service user. **"a significant minority held negative attitudes, stating that they found it difficult to be compassionate (10%; n = 6) and believing that patients usually self-harm to get attention (9%; n = 5). One-fifth (n = 12) agreed that, on a departmental level, conservative management (as opposed to surgery) was offered more frequently for self-harm injuries compared with accidental injuries, contrary to national guidance." Heyward- Chaplin et al., (2018)** *Heyward-Chaplin, J., Shepherd, L., Arya, R., & O'Boyle, C. P. (2018). Audit of healthcare professionals' attitudes towards patients who self-harm and adherence to national guidance in a UK burns and plastic surgery department. Scars, burns & healing, 4, 2059513118764100.* **"Self-harm educational content for ED staff should include areas of knowledge building including explanations and causes of self-harm; range, forms, and functions of self-harm; staff responses to self-harm; assessment, management, and interventions; professional practice issues." Rayner et al., (2019)** *Rayner, G., Blackburn, J., Edward, K. L., Stephenson, J., & Ousey, K. (2019). Emergency department nurse's attitudes towards patients who self-harm: A meta-analysis. International journal of mental health nursing, 28(1), 40-53.*	underpinning safe, **equitable** and effective care for people who have self-harmed?' to clarify that the guideline will focus on how to ensure services give equal care to those who have self-harmed.
Derbyshire Healthcare NHS	009	024 - 029	**Inclusion of Training and Type of Training**	Thank you for your comment. The guideline will look at how care should

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Foundation Trust			The importance of training around awareness and responses needs to be included, along with guidance around who should receive such training. Currently there is reference to skills within the assessment section. However we would suggest training needs to be broader than this. Attitudes, beliefs, stigma and prejudice needs addressing – it is OK to deliver assessment skills training, but if an assessment is not delivered in a compassionate, informed and understanding way, it is unlikely to be effective. **"There were 5 major themes identified—causes of self-harm are multifactorial; beliefs about self-harm can change over time; <u>emergency departments should only focus on the physical</u>; self-harm occurs on a spectrum; and the system has failed. The results suggest participants <u>felt ill-prepared and lacking in appropriate training to help patients that self-harm</u>…" Koning et al., (2017)** *Koning, K. L., McNaught, A., & Tuffin, K. (2018). Emergency department staff beliefs about self-harm: a thematic framework analysis. Community mental health journal, 54(6), 814-822.* **"Self-harm educational content for ED staff should include areas of knowledge building including explanations and causes of self-harm; range, forms, and functions of self-harm; <u>staff responses to self-harm</u>; assessment, management, and interventions; <u>professional practice issues</u>." Rayner et al., (2019)** *Rayner, G., Blackburn, J., Edward, K. L., Stephenson, J., & Ousey, K. (2019). Emergency department nurse's attitudes towards patients who*	be delivered after an incident of self-harm. These issues will be addressed in review questions 1.1 and 1.2 about information and support, and 8.1-8.4 about skills and supervision. Review question 2.1 has also been amended to: 'What are the principles underpinning safe, equitable and effective care for people who have self-harmed?' to clarify that the guideline will focus on how to ensure services give equal care to those who have self-harmed.

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			self-harm: A meta-analysis. International journal of mental health nursing, 28(1), 40-53. **"a significant minority held negative attitudes, stating that they found it difficult to be compassionate (10%; n = 6) and believing that patients usually self-harm to get attention (9%; n = 5). One-fifth (n = 12) agreed that, on a departmental level, conservative management (as opposed to surgery) was offered more frequently for self-harm injuries compared with accidental injuries, contrary to national guidance." Heyward- Chaplin et al., (2018)** *Heyward-Chaplin, J., Shepherd, L., Arya, R., & O'Boyle, C. P. (2018). Audit of healthcare professionals' attitudes towards patients who self-harm and adherence to national guidance in a UK burns and plastic surgery department. Scars, burns & healing, 4, 2059513118764100.*	
Derbyshire Healthcare NHS Foundation Trust	009	011, 012, 013	**Recognising and addressing precipitating non-health needs** There is currently a large proportion of content planned around assessment and much less on interventions/responses. Whilst it may be important to highlight evidence based *health*/*clinical* interventions, it should also be noted that the provision of guidance, support and approaches to address the range of needs known to be common contributory factors to self-harm is important e.g. social, relationship, financial, educational and employment problems. Interventions to address such aspects are vital as this may lead to a reduction in vulnerability to self-harm. Primary Care, Liaison Psychiatry services and Emergency Departments are an ideal setting for such advice and guidance to be delivered.	Thank you for your comment, the question is broad and overarching to capture any relevant interventions that may look to address some of the issues you raise. Whilst we agree that these factors can have an impact on self-harm, this is a clinical guideline and we are unable to address those that are public health issues.

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			"The most frequently reported problems at first episode of self-harm within the study period were relationship difficulties (especially with partners). Mental health issues and problems with alcohol were also very common (especially in those aged 35–54 years, and those who repeated self-harm). Those who repeated self-harm were more likely to report problems with housing, mental health and dealing with the consequences of abuse. Townsend et al., 2016 *Townsend, E., Ness, J., Waters, K., Kapur, N., Turnbull, P., Cooper, J., ... & Hawton, K. (2016). Self-harm and life problems: findings from the Multicentre Study of Self-harm in England. Social psychiatry and psychiatric epidemiology, 51(2), 183-192.* **Increased rates of self-harm were found in areas where there were greater rises in rates of unemployment. Work, financial and housing problems increased in people who self-harmed. Changes in welfare benefits may have contributed. Hawton et al., 2016** *Hawton, K., Bergen, H., Geulayov, G., Waters, K., Ness, J., Cooper, J., & Kapur, N. (2016). Impact of the recent recession on self-harm: longitudinal ecological and patient-level investigation from the Multicentre Study of Self-harm in England. Journal of affective disorders, 191, 132-138.*	
Derbyshire Healthcare NHS Foundation Trust	008, 009	012 - 034	**Proposed Separate Discussion of Risk Assessment from Psychosocial Assessment** It is currently proposed that the guidance will discuss risk assessment as a separate issue from psychosocial assessment. We recommend	Thank you for your comment. The assessment of risk can take place at the same time as the psychosocial assessment. This question is

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		001 & 002 003 - 006	discussing "risk assessment" as part of the psychosocial assessment process. Risk is effectively assessed through a psychosocial assessment – the consideration of a range of factors and what they mean to that individual. It is more difficult to make the case that risk should be assessed through clinical formulation, as opposed to a formal risk assessment process or scales intending to predict or categorise individuals, if you are talking about it as distinct from the process whereby you reach a clinical formulation i.e. psychosocial assessment. **"Comprehensive psychosocial assessments of the risks and needs that are specific to the individual should be central to the management of people who have self-harmed." Chan et al., (2016)** *Chan, M. K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., ... & Kendall, T. (2016). Predicting suicide following self-harm: systematic review of risk factors and risk scales. The British Journal of Psychiatry, 209(4), 277-283.* **"Clinician classification was too inaccurate to be clinically useful. After-care should therefore be allocated on the basis of a needs rather than risk assessment." Woodford et al., (2019)** *Woodford, R., Spittal, M. J., Milner, A., McGill, K., Kapur, N., Pirkis, J., ... & Carter, G. (2019). Accuracy of clinician predictions of future self-harm: a systematic review and meta-analysis of predictive studies. Suicide and Life-Threatening Behavior, 49(1), 23-40.*	separated out from the psychosocial assessment section as the evidence, and the way to search for the evidence, may differ. However, it is not necessarily how the recommendations will be presented.
Edge Hill University	General	General	The draft scope includes those who self-harm from the age of 8. It is unclear why this is. The services for those over the age of 16 differ from	Thank you for your comment. The previous 2 guidelines that are being

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			those for children under the age of 16 and reasons for self-harm may also differ?	updated by this guideline specified 'self-harm in those over 8'. In response to feedback from stakeholders this guideline however, will not make that distinction and does not exclude any age group.
Edge Hill University	005	005	Why is this guidance not covering the management of repetitive self-injurious behaviours? Seldomly the act of self-injury happens once or twice.	Thank you for your comment, the guideline will cover acts of repeated self-harm. It will not however cover repetitive stereotypical self-injurious behaviour, for example head-banging in people with a significant learning disability. This has been clarified in the scope.
Edge Hill University	008	023	We feel that it is important to consider the impact of targets, particularly in ED upon the impact of conducting a full psychosocial assessment and the management of the distressed patient	Thank you for your comment. We note this comment and will consider it when we comment on current practice in the introductory sections, appraise studies and make recommendations.
Edge Hill University	009	003	For risk assessment does this includes using risk manual as a tool to assess? E.g. Short-Term Assessment of Risk and Treatability (START) tool?	Thank you for your comment, the guideline will consider both clinical assessments of risk and risk assessment tools.
Edge Hill University	009	020 - 023	Would it be better to consider the effectiveness of these strategies for children, teenagers and adults, as strategies may differ depending upon age group?	Thank you for this comment. As it is written, "people" covers children, teenagers and adults, but when the guideline committee develops the review protocols, considers the

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				evidence and agrees the recommendations, these subpopulations will be a key part of the decisions and the guideline committee will certainly consider whether strategies differ between them.
Edge Hill University	010	General	For Main outcomes section – should there be consideration on the impact of specific interventions to which appropriate client groups when examining and assessing evidence?	Thank you for this comment. The list of outcomes are examples of outcomes the guideline is likely to look at, but the specific outcomes that will be considered for each of the review questions will be limited to a maximum of seven per review question, and these will be chosen and defined by the guideline committee when the protocols for the different review questions are agreed. They are likely to differ between the different questions depending on the focus of the review questions in order to capture the most relevant outcomes for each question.
Ministry of Justice	General	General	Someone from the prisons sector is a full member of the committee (rather than just co-opted).	Thank you for your comment, we had to make a pragmatic decision about how to balance the constituency of the group, as this guideline covers children, young people and adults a

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				large number of experts are required. Therefore, it was decided that this should be a co-opted position.
Ministry of Justice	002	029	The criminal justice system should be a stated, full and explicit target area for the guidelines. Self-harm incidents continue to rise in prisons; self-harm incidents reached a record high of 60,594 incidents in the 12 months to June 2019, up 22% from the previous 12 months. The number of individuals self-harming increased by 5% in the 12 months to June 2019, to 12,740, and the number of self-harm incidents per individual increased by 17% from 4.1 to 4.8. There is clearly a particular problem with self-harm in prisons, which needs addressing directly.	Thank you for your comment, the scope has been amended to explicitly state that the guideline is relevant for those in the criminal justice system. In addition, the NICE guideline on Mental health in the criminal justice system (NG 66) makes recommendations for the assessment of risk of self-harm of those in contact with the CJS, and make links to the existing self-harm guidelines.
Ministry of Justice	003	015	People in custody, and people recently released from custody should also be considered in the discussions recommended by the equality impact assessment. The support structures particular to these establishments need to be considered, for example that prison officers may be key support providers, and guidance needs to be appropriate and relevant for them.	Thank you for your comments. The equalities impact assessment has been amended to consider access to services for prisoners.
Ministry of Justice	007	027	For people in custody, key sources of support will be prison staff/officers. For this are, we would suggest that the guidance considers their information and support needs, in addition to those of the individual and their families.	Thank you for your comment, review questions 8.3 and 8.4 address the skills and supervision (which would include information and support) requirements for staff working in settings that are not specialist mental health services, which would include

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				those working in the criminal justice system.
Ministry of Justice	008	027	Bullet point 3.8 considers how self-harm is managed/treated in criminal justice settings. This also needs to consider referrals to outside hospital for those prisoners who are seriously unwell, and might need treatment in a secure mental health facility.	Thank you for your comment, this would be an issue for any prisoner with any serious physical or mental health issue, and therefore not specific to self-harm. These issues are addressed in the NICE guideline on Mental health of adults in contact with the criminal justice system (NG66).
Ministry of Justice	009	016	It may be worth also considering safer prescribing in the context of prisons, for example as per the NICE Physical Health of People in Prison guidance (https://www.nice.org.uk/guidance/ng57/chapter/Recommendations)	Thank you for your comment, as the criminal justice system is one of the settings for this guideline, safer prescribing in prisons will be considered.
Ministry of Justice	009	024	When considering 'What skills are required for staff in specialist/non-specialist settings who assess and treat people who have self-harmed?' it is worth considering that in prisons, officers are often the principal of support, rather than GPs/healthcare. Guidance needs to be appropriate and relevant for prison staff, who are responsible for identifying and supporting people who are self-harming, or who are at risk of self-harm.	Thank you for your comment, these review questions are not restricted to healthcare, but rather any settings that are not specialist mental health services, which would include those working in the criminal justice system.
Neonatal and Paediatric Pharmacists Group	004	023 - 027	The majority of pharmacological interventions for this indication will not be licensed for use in children and young people. Please review the evidence for off-label use of medicines in this population which will not be covered in Summary of Product Characteristics.	Thank you for your comment, evidence for all medications will be looked for even if they are off-label.

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NHS England and NHS Improvement	002	014-016	Data covering GP attendance presumably also applies to first episode of self-harm. Possibly useful to confirm whether these attendances are within scope or not	Thank you for your comment, the guideline will look at all incidences of self-harm.
Nottinghamshire Healthcare NHS Foundation Trust	002	013	Is there new evidence about pharmacology for self-harm as NICE used to have a 'do not do' – re prescribing for self-harm – caution that this doesn't open door for prescribing inappropriately.	Thank you for your comment. We will review any new literature in the course of the guideline and will revisit previous recommendations as appropriate.
Nottinghamshire Healthcare NHS Foundation Trust	002	028	Plus a guidance document (achieving better access to 24/7 urgent and emergency mental health care (2016) that lists criteria for a 'divergence' from self-harm NICE guidelines – it is not helpful having different guidelines advocating different things.	Thank you for your comment, we are unable to comment on documents developed locally. Services should aim to follow NICE guidelines where appropriate.
Nottinghamshire Healthcare NHS Foundation Trust	003	003	Comma needed after services	Thank you, this has been amended.
Nottinghamshire Healthcare NHS Foundation Trust	003	003 and 005	Commissioners stated twice	Thank you, this has been amended.
Nottinghamshire Healthcare NHS Foundation Trust	004	019	How psychosocial assessment is defined? And whether this would be considered a therapeutic assessment and again, if so how this would be defined?	Thank you for your comment, review question 3.1 has been revised to focus on the effective components of a biopsychosocial assessment which should inform how this is defined.

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Nottinghamshire Healthcare NHS Foundation Trust	004	019	For young people being medically and physically fit prior to assessment, e.g. having overnight stay where needed, not vomiting, sleep deprived etc, is essential – please can this be clarified under section of psychosocial assessment – when this should take place.	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission. It is anticipated that the review questions in section 3.5 relating to how an assessment should be undertaken will review any evidence available for the appropriate point in the pathway when these assessments should take place.
Nottinghamshire Healthcare NHS Foundation Trust	005	002	Insert/list personality disorder after mental health problems	Thank you for your comment, there are many mental health disorders that could be listed here, we have not specified any as it encompasses them all.
Nottinghamshire Healthcare NHS Foundation Trust	005	005	It would be helpful to give a definition of repetitive stereotypical self-injurious behaviour so people understand what is excluded.	Thank you for your comment, the scope has been amended to include an example for clarity.
Nottinghamshire Healthcare NHS Foundation Trust	005	010	It would it be helpful to signpost/refer to where this information is available/cross reference as done with other examples above	Thank you for your comment. We could not identify any obvious NICE guidance on the treatment of cuts or burns, however the treatment of cuts and burns will be same regardless of how they occurred and therefore this guideline will not make

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				recommendations on how to treat them.
Nottinghamshire Healthcare NHS Foundation Trust	007	022	Insert section on stigma and possible discrimination facing people who self-harm and their families	Thank you for your comment, it is anticipated that review questions 1.1 and 1.2 relating to the information and support needed by people who have self-harmed, and their families will address the impact of stigma. Review questions 8.1-4 should also tackle this issue by looking at the skills and supervision needed by staff working with those that have self-harmed. Additionally, the NICE guideline on Preventing suicide in community and custodial settings (NG105) makes recommendations to address changing public attitudes to reduce stigma that can be associated with self-harm and suicide.
Nottinghamshire Healthcare NHS Foundation Trust	007 and 008	023 and 029	Will the increased risk of suicide in people with ASC (Autistic Spectrum Condition) be discussed/ addressed?	Thank you for your comment, the equalities impact assessment for this guideline includes people with neurodevelopmental disorders, and therefore specific issues relating to people with ASC will be considered.
Nottinghamshire Healthcare NHS	008	005	I think there needs to be something specific about overnight admission for young people under	Thank you for your comment, an additional question has been added to

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Foundation Trust				the scope to review the benefits and harms of overnight hospital admission.
Nottinghamshire Healthcare NHS Foundation Trust	008	031	What is the evidence for this – overnight admission for young people? In my 20 years experience of assessing young people on paediatric wards I think this practice has saved lives by taking it seriously, giving time/space for reflection, thorough assessment and therapeutic engagement etc – this is now being 'overruled' I think for financial reasons in achieving better access to 24/7 urgent and emergency mental health care (2016) We need to know the evidence – what is best for young people and their families.	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission.
Nottinghamshire Healthcare NHS Foundation Trust	009	003	Include needs – risk and needs assessment – self-harm is often about unmet needs.	Thank you for your comment, the assessment of needs would be included under the biopsychosocial assessment.
Nottinghamshire Healthcare NHS Foundation Trust	009	009	Include evidence e.g. is 7 or 14 day follow-up recommended following general hospital assessment. Also delays due to waiting lists e.g. referral for community CAMHS and managing multiple changes in professionals seen.	Thank you for your comment, review question 2.3 will look at which models of care are most effective for people who have self-harmed.
Nottinghamshire Healthcare NHS Foundation Trust	009	032	An additional category - What skills are required for staff in non-specialist settings who e.g. school staff who are in contact with (they often don't assess and treat – don't use this language) people who have self-harmed.	Thank you for your comment, this will be covered by revised review question 3.2 looking at how assessments should be undertaken in non-specialist settings, such as schools, colleges and universities.

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Nottinghamshire Healthcare NHS Foundation Trust	009	033	An additional section on what are the attitudes and values expected from everyone supporting people who self-harm – caring, compassionate, non-judgemental etc	Thank you for your comment, this will be included under the skills needed to treat people who have self-harmed.
Nottinghamshire Healthcare NHS Foundation Trust	010	010	Under psychological functioning – specifically self-esteem	Thank you for your comment, there can be many factors under psychological functioning such as hopelessness or problem solving, in addition to self-esteem. Psychological functioning will cover all these factors and therefore the text has not been amended.
Pennine Care NHS Foundation Trust	General	General	Section 3.3: We would suggest that the scope covers psychosocial formulation and risk formulation, in addition to psychosocial assessment and risk assessment	Thank you for your comment, the scope has been amended to include formulation in review question 4.1. Review question 3.1 has been amended to focus on the effective components of a bio-psychosocial assessment and will therefore consider if formulation should be included.
Pennine Care NHS Foundation Trust	General	General	Section 3.3: We would suggest the scope on skills and supervision should incorporate what clinical supervision and debriefing is needed for staff	Thank you for your comment, as you suggest it is anticipated that such considerations will be addressed by review questions 8.1-8.4.
Public Health England	General	General	PHE recommends including reference to being age sensitive in providing care and considering the evidence for building self-care capability and resilience.	Thank you for your comment, it is expected that such considerations will be addressed by the review questions

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				on information and support (1.1 and 1.2).
Public Health England	001	022	National prevalence survey of the mental health of children and young people in England https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 reported that 7.3% 11 to 16 year old girls and 3.6% 11 to 16 year old boys reported self harm or suicide attempt at some point. The figures for 17-19 year olds are 21.5% girls and 9.7% boys respectively.	Thank you for your comment, the text has been amended in line with your suggestion.
Public Health England	002	007	Add in 'at home' to the list of locations where self-harm can present.	Thank you for your comment, the text has been amended in line with your suggestion.
Public Health England	002	009	Useful to check whether child and adolescent mental health services (CAMHS) teams hold relevant evidence on management.	Thank you for your comment, we will review any relevant published evidence on management.
Public Health England	003	001	Make clearer that the guideline is also appropriate for nursing and residential care providers, and other organisations providing supported accommodation to children and adults.	Thank you for your comment, this has been clarified by adding 'residential care' to this section.
Public Health England	003	003	It would be useful to include reference to Senior Leadership Teams in education settings as a relevant audience for this guideline as they would play a key role in signposting awareness of the guideline to relevant staff including teachers and pastoral leads.	Thank you for your comment, senior leadership teams have been added to this section.
Public Health England	003	028	Although the title references the scope of the guideline being 'over 8s' it would be helpful to insert a form of wording to clarify the age range to which it applies – for example across the whole life course.	Thank you for your comment. The previous 2 guidelines that are being updated by this guideline specified 'self-harm in those over 8'. In response to feedback from

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				stakeholders this guideline however, will not make that distinction and does not exclude any age group.
Public Health England	004	009	Suggest use term 'education settings' on the basis that schools, further education sector, higher education institutes sector would all be in scope if the guideline applies to all ages over 8.	Thank you, this has been amended.
Public Health England	008	012	In addition to knowing whether a psychosocial assessment helps inform the nature of support provided for people who have self-harmed (3.1) and the type of assessment that supports improved outcomes, a question could be added about whether it matters who makes the psycho social assessment in terms of outcomes and for this to replace 3.2-3.11. Evidence shows that in relation to treating childhood anxiety brief, evidence-based guided parent-led interventions can be effective[i], be more cost-effective than an alternative brief psychological intervention[ii,iii]. The current list does not refer to parents/carers or communities (except community mental health services line 34). Qualitative feedback from children and young people highlights that relationships with peers, family or trusted adults including for example in youth and community settings, play an important role in supporting mental health outcomes. http://www.youngpeopleshealth.org.uk/wp-content/uploads/2019/10/Findings-and-recommendations-on-wellbeing-FINAL.pdf [i] Thirlwall, Kerstin, et al. "Treatment of child anxiety disorders via guided parent-delivered cognitive-behavioural therapy: randomised controlled trial." The British Journal of Psychiatry 203.6 (2013): 436-444	Thank you for your comment, the scope has been amended to include a review question looking at effective ways of involving families and carers.

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			[ii] Creswell, C., Hentges, F., Parkinson, M., Sheffield, P., Willetts, L., & Cooper, P. (2010). Feasibility of guided cognitive behaviour therapy (CBT) self-help for childhood anxiety disorders in primary care. *Mental health in family medicine*, 7(1), 49 [iii] Creswell, C., Violato, M., Fairbanks, H., White, E., Parkinson, M., Abitabile, G., ... & Cooper, P. J. (2017). Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: a randomised controlled trial. *The Lancet Psychiatry*	
Public Health England	008	012	PHE suggests it be clearer that the guideline will consider in which contexts, demographics and types of presentations that psychosocial assessments work most effectively.	Thank you for your comment, as outlined in the equality impact assessment form the guideline will specifically look for evidence for people within black and Asian and minority ethnic groups, older or younger people, looked after children, those with neurodevelopmental disorders such as Autism and LGBTQ+ people who have self-harmed.
Public Health England	009	009	It would be helpful to be able to understand the components of effective support that can be facilitated through self-care, that which can be facilitated through care provided by family/ peers/ community, and that which requires therapeutic/ specialist expertise.	Thank you for your comment, all types of psychosocial interventions will be looked for under review question 5.2, including self-care, self-help or interventions facilitated by family/peers/ community. Specifying

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				specific interventions at this stage could lead to important treatments being missed, and therefore the question is broad and overarching.
Public Health England	009	024	Should providers of care and housing (e.g. sheltered homes) be included in the list	Thank you for your comment, these review questions are not restricted to healthcare, but rather any settings that are not specialist mental health services, which would include those working in sheltered homes etc.
Public Health England	010	001	PHE suggests morbidity also be included as an outcome	Thank you for your comment, this has been added to the outcomes.
Public Health England	010	002	It is unclear whether the list of outcomes are those being defined by professional assessment. Self-reported wellbeing measurement data could additionally be used as an outcome measure providing an indication of the effect of self-harm and the quality of interventions/support (https://www.bmj.com/content/354/bmj.i4969).	Thank you for this comment. The list of outcomes are examples of outcomes the guideline is likely to look at, but the specific outcomes that will be considered for each of the review questions will be limited to a maximum of seven per review question, and these will be chosen and defined by the guideline committee when the protocols for the different review questions are agreed. They are likely to differ between the different questions depending on the focus of the review questions in order to capture the most relevant outcomes for each question.

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Royal College of General Practitioners	004	002	Can the committee ensure • The transition between child and adult services is included within this section. There is a significant issue at this period of change in service provider *Community* services including school nurses (not usually based in schools) are considered which are not primary care or school based.	Thank you for your comment, as noted in the scope review questions 2.1, 2.2 and 2.3 will include transitions between services.
Royal College of General Practitioners	004	011	Can the committee consider adding voluntary organisations who provide childcare and aftercare activities which are not always places of education	Thank you, this has been amended.
Royal College of General Practitioners	004	021	Can the committee take into consideration the significant underfunding of mental health services for young people when making recommendations on management of self harm. The current waiting time for child and adolescent mental health services is often months long with no other NHS services available. Families, carers and health professionals are left with nowhere to refer these young people to other than privately paid counselling which is not viable for most.	Thank you for your comment, unfortunately NICE clinical guidelines are unable to make recommendations about funding. However, the aim of the recommendations is to ensure services are properly commissioned and funded to deliver them.
Royal College of General Practitioners	004	021	Can the committee consider social prescribing and social support interventions for the index patient and their carers/ families in addition to psychosocial interventions	Thank you for your comment, any available evidence relating to social prescribing or social support interventions will be identified under review question 5.2 relating to the effectiveness of psychological and psychosocial interventions.
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes the opportunity to review and comment on the draft scoping document for self-harm in over 8s: management and prevention of reoccurrence.	Thank you for your comments.

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			The draft scope seems comprehensive.	
Royal College of Nursing	General	General	We note the importance of this clinical topic in view of the increasing prevalence of children and young people's mental health issue. We also note the commentary from the Healthcare Safety Investigation Branch about two separate guidelines on the short-term and long-term management of self-harm potentially leading to confusion,	Thank you for your comments, it the aim of this guideline to address this potential confusion by updating the two existing guidelines into one.
Royal College of Occupational Therapists	002	003 - 005	It is important that the guideline recognises that people who self-harm are at a greater risk of suicide.	Thank you for your comment.
Royal College of Occupational Therapists	004	013	There should be a mention of occupational performance / functioning in relation to management (though the preferred term to management would be intervention or treatment). Management implies being done to, i.e. an order or instruction, which is not person-centred or collaborative.	Thank you for your comment, the question relating to psychosocial interventions is broad and overarching to capture any relevant interventions. The scope has been amended to 'treatment and care' rather than management. In addition, the outcomes have been amended to include occupational functioning.
Royal College of Occupational Therapists	007	013 - 023	Continual assessment of risk would ensure that the length of time a person remains in hospital is congruent with their health and recovery. This in turn would improve cost efficiency.	Thank you for your comment, review question 4.1 will look at which models of risk assessment are the most effective.
Royal College of Occupational Therapists	007	027 - 029	The guideline should address the impact of stigma on the person who self-harms.	Thank you for your comment, it is anticipated that review questions 1.1 and 1.2 relating to the information and support needed by people who have

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				self-harmed, and their families will address the impact of stigma. Review questions 8.1-4 should also tackle this issue by looking at the skills and supervision needed by staff working with those that have self-harmed. Additionally, the NICE guideline on Preventing suicide in community and custodial settings (NG105) makes recommendations to address changing public attitudes to reduce stigma that can be associated with self-harm and suicide.
Royal College of Occupational Therapists	007 - 008	027 - 029 001 - 002	The guideline should also address the impact of stigma on those providing care and support for people who self-harm.	Thank you for your comment, the review questions relating to the skills and supervision for staff (8.1 - 8.4) will review any evidence for strategies to reduce the impact of stigma on staff.
Royal College of Occupational Therapists	008	001 - 034	The issue of a parent self-harming needs to be addressed in terms of safeguarding of dependents, assessment and training for those undertaking assessment and to consider needs of unborn child and dependents. This should include any carer self-harming that has dependents to consider, particularly if they are a lone carer, safeguarding approaches will be paramount within provision of care.	Thank you for your comment, review question 2.2 has been amended to read: 'What is the most effective approach to obtain consent, ensure confidentiality and promote safeguarding when people have self-harmed?' This will capture how to ensure safeguarding for those who have self-harmed, and their

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				dependants following an incident of self-harm.
Royal College of Occupational Therapists	009	004 - 006 019 - 023	There is talk of different physical environments but little of the effect of these environments on self-harm, i.e. where people are unable to cut so instead ligature – how do we measure the 'success' of this intervention?	Thank you for your comment. We will be examining the effect of all interventions on self-harm – including detrimental effects where recorded. Also, review question 2.1 will look at how to deliver safe care for people who have self-harmed.
Royal College of Occupational Therapists	009	011	Either add the term 'occupational' to list of interventions or include an additional question: *What occupational interventions are effective for people who self-harm?*	Thank you for your comment, all types of psychosocial interventions will be looked for under review question 5.2, including occupational interventions. Specifying specific interventions at this stage could lead to important treatments being missed, and therefore the question is broad and overarching. **In addition, the outcomes have been amended to include occupational functioning.**
Royal College of Occupational Therapists	009	019 - 023	When interventions appear to have a detrimental effect upon a person, consideration should be given as to whether this continues to be a therapeutic risk.	Thank you for your comment, we will consider the benefits, or harms of all interventions, using a variety of outcomes listed in the scope.

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Royal College of Occupational Therapists	009	019 - 023	What are the pros and cons of self-harm minimisation strategies? For example, as a consequence of preventing a particular self-harm behaviour, this may lead to the person finding alternative methods of self-harm.	Thank you for your comment, we will consider the benefits, or harms of all interventions, using a variety of outcomes listed in the scope.
Royal College of Occupational Therapists	009	019 - 023	When delivered under compulsion, therapies that focus on self-harm need to evidence their effectiveness.	Thank you for your comment, we will consider the benefits, or harms of all interventions, using a variety of outcomes listed in the scope.
Royal College of Occupational Therapists	009	024 - 032	Supervision should consider the impact on staff of working with people who self-harm.	Thank you for your comment, we will look for all evidence relating to the supervision needs of staff.
Royal College of Paediatrics and Child Health	General		The reviewer was happy with the draft scope.	Thank you for your comments.
Royal College of Paediatrics and Child Health	General		The reviewer stated that the scope seems very comprehensive.	Thank you for your comments.
Royal College of Paediatrics and Child Health	General		The reviewer noted that it is very helpful to have a guideline that encompasses the full scope of self-harm including children with learning difficulties, self-injurious behaviour etc.	Thank you for your comments.

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Royal College of Paediatrics and Child Health	Section 3		A specific question on whether admission is required for assessment acutely would be very helpful. As currently default under 16 years is admission, and this can often be unhelpful for children and young people who present recurrently, or for those with cutting rather than overdose.	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission.
Royal College of Paediatrics and Child Health	Sections 3 and 4		With reference to inpatient admission of all self-harm in CAYP for assessment1 , such admissions are now soaring. The reviewer suggested that it would be timely to include in this review, whether not all forms of self-harm require inpatient admission for risk assessment 2, as compared with effective psycho social and risk assessment at presentation, and subsequent outpatient CAMHS review. References *1 RCPsych report CR192, managing self-harm in young people* *2 Lancet Psychiatry Volume 6 (4) P327-337, April 01, 2019* *Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study. Mars, Heron et al*	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission.
Royal College of Psychiatrists	General	General	The scope should include public health interventions for self-harm. There is a related guideline, “Preventing suicide in community and custodial settings (NG105)” but it is not specific to self-harm and it misses some of the key recent developments in the field of self-harm, especially in young people.	Thank you for your comment, this is a clinical guideline and therefore it is beyond the scope to include public health interventions.
Royal College of Psychiatrists	General	General	The scope should include the role of media, including social media, in self-harm.	Thank you for your comment, the role of social media in self-harm will be addressed under review question 1.1 ‘What are the information and support needs of people who have self-harmed’.

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Royal College of Psychiatrists	General	General	We understand why medical management is not included within the scope of the guidelines, however, it is crucial not to miss the role of acute services in self-harm, especially the need for an overnight admission for young people who present to A&E with self-harm.	Thank you for your comment, an additional question has been added to the scope to review the benefits and harms of overnight hospital admission.
Royal College of Psychiatrists	005	005	"The management of repetitive stereotypical self-injurious behaviour" is not included within the scope of the guidelines. This behaviour requires a better definition. If what is meant here is self-harm in young people with neurodevelopmental disorders, then a comment is required of where this behaviour is going to be addressed.	Thank you for your comment, the scope has been amended to include an example for clarity.
University of Exeter	general	general	Although the scope page 3 lines 27-29 states that "Groups that will be covered - All people who have self-harmed, including those with a mental health problem, neurodevelopmental disorder or a learning disability", there is very little reference to the custodial population throughout the scope. Prisoners are a particularly vulnerable and high risk group with well reported health inequalities. For example, the most recent 'Safety in Custody Statistics for England and Wales' published on the 31st October 2019 reported that, "Self-harm incidents reached a record high of 60,594 incidents in the 12 months to June 2019, up 22% from the previous 12 months (a rate of 732 per 1,000 prisoners). In the most recent quarter, self-harm incidents increased by 13% to a record high of 16,342 incidents. The number of individuals self-harming increased by 5% in the 12 months to June 2019, to 12,740, and the number of self-harm incidents per individual increased by 17% from 4.1 to 4.8".	Thank you for your comment, the scope has been amended so that it is clear that it is relevant for those working in the criminal justice system. The CJS is also listed under 'settings that will be covered' and the equalities impact assessment has been amended to add access issues for those in contact with the CJS. In addition, the NICE guideline on Mental health in the criminal justice system (NG 66) makes recommendations for the assessment of risk of self-harm of those in contact with the CJS, and make links to the existing self-harm guidelines.

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			The most recent government statistics for 'Self-harm by young people in custody' published on 27th June 2019 reports that white young people in custody are a particularly vulnerable and high risk group. In 2017-2018: • the rate of self-harm by White young people in custody was just over 5 times that of young people from all other ethnic groups combined • for every 100 White young people, there were 19.8 incidents of self-harm each month • there were 3.4 incidents of self-harm per 100 young people from all other ethnic groups combined At a more general level, the 'Youth Justice Statistics, England and Wales, April 2017 to March 2018' (children aged 10-17 in the system) reports that: "The number of self harm incidents has seen the greatest increase compared to other behaviour management measures in the latest year, increasing by 40% to nearly 1,800 incidents This is the highest number of self harm incidents seen in the last five years. There was an increase of nearly 200 injuries that required medical treatment because of self harm (to 535) and the average number of self harm incidents per child and young person involved increased in the latest year after being largely stable for the previous three years……The rate of self harm incidents per 100 children and young people in custody has been increasing over the last five years. In the latest year, there were 12.5 self harm incidents per 100 children and young people in custody, up from 9.0 in the previous year and over double the rate five years ago". These figures suggest that prisoners (at all ages and at all stages of custody) should accordingly be represented in the "equality	

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			considerations" of the scope (page 3 lines 15-24) and within the scope generally (for example, how should assessment for people who have self-harmed be 1 undertaken in child/adult custodial settings?), especially as no explanation is provided within equality impact assessment as to why this group is excluded from the scope (page 3 line 19).	