Self harm: assessment, management and preventing recurrence

Consultation on draft guideline - Stakeholder comments table
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Academic Unit of Health Economics, University of Leeds	Committee member list	General	General	COMMITTEE MEMBERSHIP: We suggest including a health economist on the committee to support the scrutiny of economic evaluation evidence.	Thank you for your comment. The committee comprised a multidisciplinary team of a range of healthcare professionals (such as psychiatrists, psychologists, mental health nurses, paediatricians, specialists in emergency medicine, GPs and social workers) and lay members with experience in self-harm. It is not routine practice to include people with technical expertise in NICE guideline committees, nor was it considered essential to include a health economist in the committee, as the committee was supported (but also provided advice, where relevant) in all stages of reviewing economic evidence, developing the economic model and interpreting economic findings. The health economics team that contributed to the development of the guideline helped the committee interpret existing economic evidence, encouraging them to consider its plausibility, applicability and limitations. The economic models were developed by the health economics team in collaboration with a committee sub-group who advised on the model structure, including the epidemiology and treatment patterns of self-harm in the UK, and model assumptions, in areas where evidence was lacking. Results were discussed with the committee to confirm plausibility. Regarding further scrutiny of the economic models, all inputs and model formulae

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					were systematically checked. The models were tested for logical consistency by setting input parameters to null and extreme values and examining whether results changed in the expected direction. The economic models were checked for their validity and accuracy by a health economist that was external to the guideline development team.
Academic Unit of Health Economics, University of Leeds	Evidence review J	General	General	SELF-HARM MEASURES: Multiple different ways of measuring self-harm are identified (e.g. self-report, collateral report, clinical records, or research monitoring systems). But the degree to which the choice of measure could impact the effectiveness and cost-effectiveness of interventions is not explored. Since it is plausible that self-reported cases of self harm are less severe than clinically identified episodes, for instance, it would be very useful to include a sensitivity analysis which disaggregates self-reported and clinically reported self-harm outcomes.	Thank you for your comment. The guideline utilised published Cochrane reviews in order to estimate the clinical effectiveness of interventions and to inform the guideline economic modelling. The Cochrane reviews, according to the published report, "included both self-reported and hospital records of SH, where available. Preference was given to clinical records over self-report where a trial reported both measures". The meta-analysis of CBT vs TAU in the Cochrane review that informed the economic analysis (Witt et al., Analysis 1.2, Repetition of SH at six months) included 12 RCTs and had low heterogeneity (I squared only 2% when the outcome was expressed as an odds ratio and 26% when the outcomes was expressed as a risk ratio [RR], which was utilised in the economic analysis, as shown in Evidence review J). The RR (95%CI) of the meta-analysis of the 12 studies, which was reported in the Cochrane

					review, was: 0.66 (0.53, 0.82). The following analyses were not part of the Cochrane review and were undertaken exclusively in response to your concern: The RR (95%CI) of the meta-analysis when only 6 RCTs which reported self-reported information (Brown 2005; Davidson 2014; Husain 2014; Tapolaa 2010; Wei 2013; Weinberg 2006) were included was slightly lower with somewhat higher confidence intervals: 0.61 (0.39, 0.95). The RR (95%CI) of the meta-analysis when only 4 RCTs which reported self-reported information supplemented by clinical, hospital, and/or medical records (Evans 1999b; Guthrie 2001; Lin 2020; Tyrer 2003) were included, was very similar to the base-case analysis: 0.64 (0.44, 0.95). Only two RCTs reported outcomes based on clinical, hospital, and/or medical records (Owens 2020; Salkovskis 1990). The RR obtained from these two studies was 0.41 (0.09, 1.95), which was based on N=82 and was characterised by very wide 95%CI. When these 2 RCTs were excluded from the analysis, the RR (95%CI) of the remaining 10 RCTs was 0.67 (0.53, 0.84), practically identical to that of the base-case analysis. The estimated RRs based on either self-reported

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					data or self-reported data supplemented by medical records or a combination of the two are very similar to the one estimated in the base-case analysis, and thus their use is not expected to change the cost-effectiveness results. The RR estimated from the 2 RCTs that reported clinician-rated data is characterised by a limited evidence base and high uncertainty, and therefore it was not considered robust to use in the economic analysis. Regarding the baseline risk of repeating self-harm, this was taken from Lilley et al. According to this study "to identify episodes of self-harm and collect the data, research staff scrutinised assessment forms completed by general hospital and psychiatric staff, emergency department records, psychiatric referrals, medical records and other sources." No self-reported versus clinician-rated episodes were reported in the study, so no sub-group analysis (by method of reporting) was possible to undertake in the economic analysis. Regarding the DBT-A economic analysis, the ICER was so much higher than the NICE cost-effectiveness threshold, that no plausible change in the RR would result in the intervention becoming cost-effective.
Academic Unit of	Evidence review J	General	General	HETEROGENEITY:	Thank you for your comment. The guideline utilised published Cochrane reviews in order to estimate

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Health Economics, University of Leeds				Populations who self-harm are likely to be heterogenous, particularly in terms of mental health diagnosis, and history (frequency/severity/method) of self-harm. The economic model does not explore heterogeneity. Since the cost-effectiveness results are shown to be sensitive to relatively small changes in intervention costs (e.g. number of CBT sessions delivered), it is also possible that cost-effectiveness results would differ across different populations. In addition, we note that no sensitivity analysis is provided by population starting age.	the clinical effectiveness of interventions and to inform the guideline economic modelling. No subgroup analyses were undertaken by the authors of the Cochrane review according to patient characteristics, but it is noted that the heterogeneity in the meta-analyses utilised in the economic analysis was rather small. For CBT-informed psychological therapy in adults, I squared was only 2% when the outcome was expressed as an odds ratio and 26% when the outcome was expressed as a risk ratio, which was utilised in the economic analysis. For DBT-A in children and young people, I squared for sub-group analysis was 21.1% when the outcome was expressed as an odds ratio and 31.9% when the outcome was expressed as a risk ratio. Regarding the DBT-A economic analysis, the ICER was so much higher than the NICE cost-effectiveness threshold, that no plausible change in the RR would result in the intervention being cost-effective. The information reported in the individual RCTs, which was subsequently reported in the Cochrane review, did not allow any meaningful subgrouping of populations in terms of mental health diagnosis, and history (frequency/severity/method) of self-harm to be undertaken (as these data were not always reported in RCTs), but since heterogeneity was not found to be significant, this lack of

					information and the inability to explore the impact of potential differences in the study populations on economic results was not a major concern. Sensitivity analyses assumed changes in costs associated with self-harm, as populations who self-harm may incur higher or lower costs depending on their diagnosis and history. These analyses have been taken into account by the committee. Regarding the starting age, it is noted that this affected only mortality and no other outcomes in the analysis. The Cochrane review reports that of the 64 included trials that reported information on age, the weighted mean age of participants at trial entry was 31.8 years (SD: 11.7 years). According to this evidence, self-harm appears to affect mostly younger populations, which was confirmed by the committee's expert advice. The economic model utilised a starting age of 29 years, based on a large cohort study of an adult population self-harming in the UK. Since the time horizon was 5 years and mortality in the general population of this age very low, a relatively small change in the starting age was not expected to affect the cost-effectiveness of CBT. In any case, deterministic analysis conducted in response to your comment showed the following results, for different starting ages (SA): ICER FOR SA of 19 years: £8,439/QALY. ICER for SA of 29 years [base-case analysis]: £8,393/QALY

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					ICER for SA of 39 years: £8,256/QALY Therefore, plausible changes in the starting age of the cohort appear to have a negligible effect on the results of the guideline economic analysis.
Academic Unit of Health Economics, University of Leeds	Evidence review J	61-62	15	IMPACT OF SELF-HARM MEASURE ON HEALTHCARE COSTS: We anticipate that the choice of self-harm measure (i.e. inclusion of self-report, collateral report, clinical records, or research monitoring systems) would affect healthcare costs. Clinically identified self-harm episodes, for example, will likely incur much higher hospital costs than self-reported cases of self-harm. The hospital costs reported in the study by Sinclair (2011) are derived from both clinically- and self-reported cases of self-harm. However, it is unclear whether the proportion of cases identified through self-report/clinical report in the Sinclair (2011) study is comparable with the proportions identified through self-report/clinical report in the effectiveness evidence (i.e. Figure 3 page 62). If these proportions are substantially different	Thank you for your comment. As you acknowledge, the Sinclair study reported costs derived from both clinically- and self-reported cases of self-harm so that it was not possible to distinguish between the two. The effectiveness evidence, as indicated in a response to a related comment of yours, is derived mostly from self-reported cases of self-harm. The clinical-reported data on self-harm are limited and characterised by uncertainty, and therefore would not be informative to use alone. In any case, a sensitivity analysis has already been undertaken in which healthcare costs were varied by ±50% to explore the impact of costs associated with self-harm on the guideline economic results, as reported in Appendix I of Evidence review J.

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				then the estimated self-harm costs might be highly inaccurate. It would be particularly informative to conduct sensitivity analyses in the economic model using effectiveness estimates and healthcare costs for a population where self-harm is identified through clinical report only.	
Academic Unit of Health Economics, University of Leeds	Evidence review J	15	45	ADDITIONAL EVIDENCE: In our own review of decision analytic models of self-harm, we identified an economic evaluation study by Kinchin et al. (2020) that has not been included in the NICE systematic literature review. Please check/confirm if the study by Kinchin et al. (2020) should be included. Kinchin, I., Russell, A.M., Petrie, D., Mifsud, A., Manning, L. and Doran, C.M., 2020. Program evaluation and decision analytic modelling of universal suicide prevention training (safeTALK) in secondary schools. Applied health	Thank you for your comment. The study did not meet inclusion criteria as the study population was beyond the guideline scope. The guideline focused on people who have already self-harmed (including prevention of recurrence of self-harming episodes) while this study assesses an intervention targeted at the general population to prevent suicide. The study was excluded at title/abstract screening and therefore does not appear in the excluded studies list. NICE has published separate guidance on preventing suicide in the community and custodial settings, found here: https://www.nice.org.uk/guidance/ng105

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				economics and health policy, 18(2), pp.311-324.	
Academic Unit of Health Economics, University of Leeds	Evidence review J	59	42 - 44	TIME HORIZON: The justification for the 5-year time horizon is not sufficient. Whilst there is limited evidence on longer term costs and benefits, it is plausible that the intervention benefits would extend beyond 5 years. This should be explored in a sensitivity analysis with a longer time horizon.	Thank you for your comment. There is no evidence on the efficacy of the interventions beyond 5 years. The Cochrane review that informed the economic analysis considered outcomes of up to 2 years' follow-up. Moreover, the baseline risks of self-harm were taken from a study with a maximum follow-up of 18 months (Lilley et al). The committee advised that it was reasonable to estimate costs and benefits for a period of up to 5 years, but using a longer time horizon would require a significant extrapolation of shorter-term data on the course of self-harm. In any case, by utilising the available data, the ICER does practically remain unchanged from 2 years onwards, as shown by the results of the deterministic analysis: time horizon 6 months: £47,740/QALY time horizon 1 year: £12,199/QALY time horizon 2 years: £8,638/QALY time horizon 3 years: £8,467/QALY time horizon 4 years: £8,427/QALY time horizon 5 years: £8,393/QALY Therefore, and after using those data that have currently informed the economic model (since no alternative, longer term data are available), the cost-effectiveness of CBT-informed psychological

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					intervention is not expected to change considerably in the longer term.
Academic Unit of Health Economics, University of Leeds	Evidence review J	60	General	INCLUSION OF MENTAL HEALTH BENEFITS: Psychological interventions such as CBT can provide mental health benefits (e.g. see NICE CG90 [depression], CG185 [bipolar disorder], CG113 [anxiety and panic disorders]). The economic analysis does not include mental health benefits directly, either as part of intervention effectiveness or in the decision analytic model structure. This might mean that the model underestimates the cost-effectiveness of interventions. For example, in addition to reduced likelihood of self-harm, overall HRQoL may be improved. Even if the improvement is modest, a small improvement over a sufficient time period may represent a substantial QALY gain above and beyond that avoided by self-harm incidents. Furthermore, it is possible, for example, that the mental health benefits of CBT persist throughout the 5-year time horizon and that mental	Thank you for your comment. It is noted that the economic analysis of CBT-informed psychological intervention utilised two sets of utility values: a. Utility value of the general population of appropriate age for the non-repeating self-harming state (no RSH) and the utility value of adolescents who self-harmed for the RSH state in the base-case analysis. b. Utility value of 'mental/behavioural problems' or 'history of mental disorder' for the no RSH state and the utility value of suicide attempt for the RSH state in sensitivity analysis. The former set assumes that the non-RSH state has the utility value of the general population, implying that the intervention has had a positive impact on other mental health problems. Estimating additional improvements in HRQoL would double-count the benefits of the intervention regarding the improvement in mental health outcomes. The latter set attaches the utility value of mental/behavioural problem or history of mental disorder to the non-RSH state. This is a utility value non-specific to the non-RSH condition and may

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				health outcomes may impact on future likelihood of self-harm. So, we suggest that the impact of excluding mental health outcomes from the model should be discussed. Even though CBT is already identified as cost-effective there may be important implications for committee recommendations if changes to the economic model altered the base case ICER in relation to the CE threshold.	also include improvement in other mental health problems (since it also reflects the value of 'history' of a mental disorder). Therefore, also in this case, estimating additional improvements in HRQoL might again double-count the benefits of the intervention regarding the improvement in mental health outcomes. Self-harm is strongly associated with mental health problems, and related utility values reflect the overall HRQoL of people experiencing/living with self-harm and other mental health problems (or improvements in both self-harming behaviour and mental health problems), as it is not possible to isolate and report separately HRQoL relating to self-harm and HRQoL relating to another mental-health problem. Therefore, the utility values used in the model reflect HRQoL related to self-harm that incorporates mental health problems or related improvements. Evidence review J (Appendix I, discussion) has now been updated to include discussion of this issue.
Academic Unit of Health Economics,	Evidence review J	63	2 -32	DECREASING RATES OF SELF HARM AFTER 24 MONTHS: We note that the Kaplan Meier curves in Lilley (2008) indicate that self-harm	Thank you for your comment. In the Lilley study patients were subject to variable lengths of follow-up, from 1 day to 18 months. Thus the study does not present data after 24 months. According to the data presented in the Kaplan Meier curve that used

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University of Leeds				rates decline over time since last episode and are as low as <10% after 24-months since the last self-harm episode. However, as currently structured, the model does not currently capture this lower rate (<10%) since assumptions about the rate of repeat self-harm are based on the higher rates reported by Lilley (2008) at 6 and 12-months. Consequently, we are concerned that the baseline rate of repeat self-harm is likely to be (increasingly) overstated as the model progresses across the time horizon. Ideally time dependencies and the impact on cost-effectiveness should be explored. We note with interest that a sensitivity analysis is provided around baseline risk, where reductions in risk of repeat self-harm increase the ICER. The impact may be further amplified for longer time horizons (as suggested in comment 6).	recurrent event analysis, the risk of repeating self-harm at 0-6 months was 0.288; at 6-12 months it was 0.074; and at 12-18 months it was 0.058. The risk indeed decreased significantly in the second 6-month period of the study, as you suggest, but data between 6-12 and 12-18 months were not materially different. The economic model used a 6-month cycle. As reported in Evidence review J, Appendix I, the risk at 0-6 months was used to estimate the 6-month risk of remaining in the RSH state (that is, the 6-month risk of RSH in people who had self-harmed within the last 6 months); the risk at 6-12 months of the study was used to estimate the 6-month risk of moving to the RSH state from the non-RSH state (that is, the 6-month risk of RSH in people who had not self-harmed in the last 6 months). The model does take into account the fact that self-harm rates decline over time since last episode, and has indeed captured the <10% risk for people who have not self-harmed for at least 6 months. This risk becomes even lower if people have not self-harmed for longer periods of time (i.e. from 0.074 for people who have not self-harmed in the last 6 months, it goes down to 0.058 if people have not self-harmed in the last 12 months). However, this difference in the risk for people who have not

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					self-harmed for at least 6 months versus at least 12 months was considered to be too small to have an impact on the model results, and therefore it was decided to use the higher figure of 0.074 for people who have not self-harmed in the last 6 months as a conservative higher estimate. This detail has now been added to the model write up. To include the lower risk of 0.058 would require adding tunnel states with time dependencies, increasing the complexity of the model for a very small benefit. It is noted that when the transition probability of 0.074 for people who have not self-harmed in the last 6 months (non-RSH to RSH transition) was replaced by the lower risk of 0.058 (which is an underestimate as this value is relevant only to a smaller proportion of people in the non-SH state), the deterministic ICER changed from £8,393/QALY to £7,N878/QALY, suggesting a small and inconsequential impact on the results.
Academic Unit of Health Economics, University of Leeds	Evidence review J	064 & 083	9	UTILITY SCORES: We consider the baseline utility value (0.94) for the no repeat self-harm state to be unrealistically high. This value corresponds to general population utility values (Kind, 1999) rather than a population who have presented at hospital for self-harm with mental health comorbidities. We would favour	Thank you for your comment. It is noted that the utilities used for the no-repeat self-harm (no RSH) health state [which was based on Kind 1999] and the repeat self-harm (RSH) health state [which was based on Tubeuf 2019] are fully consistent with those used by McDaid et al., European Psychiatry, 65(1), e16, 1-8. As discussed in Evidence review J (economic appendix I, 'Utility input parameters'), the

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				using the lower utility values estimated by Cottrell (2018) for the base case. The committee rejected these values on the basis that Cottrell (2018) reported only small differences in utility values between the repeat self-harm and no repeat self-harm states. We do not think this is sufficient justification to support their decision. We note that a sensitivity analysis showed that use of Cottrell's utility values increased the ICER from £9,000 to £16,000 per QALY. We also note that in combination with changes to other parameters (e.g. increasing the number of CBT sessions), the ICER could exceed £30,000 per QALY, indicating that the choice of base case utility values could have important implications for decision making.	committee considered the utility values corresponding to the two states that were eventually used in the base-case analysis, and expressed the view that both values were overestimates but the difference in utility values between the two health states of RSH and non-RSH (0.25) was probably reflective of changes in HRQoL between these two states, thus confirming the face validity of the differential utility data used in the model. It is noted that these data are consistent with NICE criteria for the estimation of utility values (i.e. both utility values were derived from EQ-5D ratings). In a sensitivity analysis, the CBT model utilised alternative data that had been used by an economic analysis by Quinlivan et al. (and not data reported in Cottrell et al.). The utility value for the RSH state did not meet NICE criteria. Moreover, the committee considered the difference in this set of utility values (0.13) to be very narrow and unlikely to be reflective of the true difference between the utility in the non-RSH and RSH health states (which, as you have noted in another comment, includes additional mental health benefits); hence, these data were only tested in sensitivity analysis. Nevertheless, a series of 2-way sensitivity analyses

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				If the current base case utility values are retained, we suggest presenting results of multi-way sensitivity analyses for example altering CBT session number and utility values simultaneously.	were conducted and have now been added in Appendix I: a. use of Quinlivan et al. utility data combined with 8 sessions of CBT-informed psychological intervention. The ICER became £27,557/QALY. b. use of Quinlivan et al. utility data combined with 10 sessions of CBT-informed psychological intervention. The ICER became £46,203/QALY. c. use of Quinlivan et al. utility data combined with a 50% reduction in the base-case extra cost associated with self-harm. The ICER became £32,498/QALY. The committee has now considered these additional analyses, but expressed the view that all 3 analyses and in particular b. and c. reflect relatively extreme scenarios, where a narrow range of utility values is combined with either a large number of psychological therapy sessions or with a cost that is likely lower that the usual cost associated with self-harm. Therefore, these scenarios did not alter recommendations. This discussion has now been added in the economic appendix. For DBT-A, use of either set of alternative utility data in the analysis resulted in the intervention not being cost-effective, therefore no 2-way sensitivity analysis was meaningful.

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Association of Paediatric Emergency Medicine (APEM)	Guideline	16	20	1.6.2 For consistency, we would recommend the use of the term "physical health" rather than "medical health"	Thank you for your comment. This change has been made.
Association of Paediatric Emergency Medicine (APEM)	Guideline	18	29	1.6.10 As per comment 1. Use of the term "medical treatment" suggests treatment for mental health problems is not the same as that for physical health.	Thank you for your comment. This has been changed to physical treatment.
Association of Paediatric Emergency Medicine (APEM)	Guideline	19	1	1.6.10 We were wondering if there could be some clarification of what constitutes immediate risk of further self-harm or suicide. Is this in the next hours or days or weeks? Will there be guidance offered for Emergency Department staff on this aspect of the assessment, particularly if we are no longer recommending assessment tools?	Thank you for your comment. This would be a matter for clinical judgement and cannot be specified in a guideline.
Association of Paediatric Emergency Medicine (APEM)	Guideline	19	12	1.6.11 Again use of the term "medical care"	Thank you for your comment. This has been changed to physical healthcare.
Association of Paediatric Emergency	Guideline	19	13	1.6.12 This recommendation may be challenging to achieve based on current issues with funding and staffing	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current

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Medicine (APEM)				of CAMHS services. If access to CAMHS services as per recommendation 1.6.21 is not achieved in the same timescale as this recommendation, we feel that if a child or young people presents after hours when access to CAMHS services is currently difficult, they might not want to wait until the morning and adherence to the recommendation may create more distress.	funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards.
Association of Paediatric Emergency Medicine (APEM)	Guideline	19	16	1.6.14 We would recommend adding "or with a responsible adult who can supervise the child or young person"	Thank you for your comment. This recommendation is about where the person is waiting not who they are waiting with and so this change has not been made.
Association of Paediatric Emergency Medicine (APEM)	Guideline	19	23	1.6.15 Again use of the term "medical care"	Thank you for your comment. This has been changed to physical care.
Association of Paediatric Emergency Medicine (APEM)	Guideline	19	25	1.6.15 Access to both systems may be limited due to CAMHS and ED services using different computer systems and databases, particularly if they are operating from different trusts, even if collocated.	Thank you for your comment. Addressing this issue will be a matter for local implementation.

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Association of Paediatric Emergency Medicine (APEM)	Guideline	20	4	1.6.16 We wondered if there might be clarification or guidance as to what procedures are expected. Would they be different to standard 'left without being seen' or 'left against medical advice' procedures?	Thank you for your comment. These procedures would be as you referenced.
Association of Paediatric Emergency Medicine (APEM)	Guideline	21	1	1.6.21 Can this be on call child psychiatry services? This recommendation is likely to have a cost implication as well as being challenging to staff.	Thank you for your comment. The evidence did not support naming a specific service. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Potential resource implications of the guideline were considered by NICE when preparing the guideline's Resource impact summary report.
Association of Paediatric Emergency Medicine (APEM)	Guideline	24	8	1.8.2 We would welcome some clarification on what constitutes 'a ward that can meet the needs of young people'. This may have implications for staffing, as most paediatric services only go up to < 16 years.	Thank you for your comment. Different areas will have different settings for teenagers and young adults so the recommendation has been written with this in mind. It is therefore not possible to be more prescriptive. The committee want to ensure that teenagers and young adults are not admitted to adult wards that are not appropriate to their needs (for example geriatric wards)
Association of Paediatric Emergency	Guideline	30	1	1.11.4 As previously stated in comment 8, this may be challenging if CAMHS services are operating from different trusts to primary and	Thank you for your comment. Addressing this issue will be a matter for local implementation.

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Medicine (APEM)				secondary care, even if collocated, and using different computer systems or databases that do not communicate with each other.	
Association of Paediatric Emergency Medicine (APEM)	Guideline	32	2	1.13.2 We would welcome a national training course that could be delivered to address the training requirements as per the recommendation.	Thank you for your comment. It is not within the remit of NICE guidelines to develop training courses. Provision of the training recommended in the guideline will be a matter for local implementation.
Avon and Wiltshire Mental Health Partnership NHS Trust	Guideline	11	General	There is very little on positive risk taking. Should this be more comprehensively considered and further guidance provided on best practice in this area.	Thank you for your comment. Therapeutic risk taking is covered in recommendation 1.11.14
Avon and Wiltshire Mental Health Partnership NHS Trust	Guideline	13	28	This could be a little more specific. There is evidence which explores this area in detail: Social Media Use and Deliberate Self-Harm Among Youth: A Systematized Narrative Review Candice Biernesser, PhD,a,b Craig J.R. Sewall, MSW,c David Brent, MD,a Todd Bear, PhD,b Christina Mair, PhD,b and Jeanette Trauth, PhDb	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive. Please note that the review cited would not have been included in any systematic review because it does not meet the inclusion criteria as set out in the

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				This review highlighted four possible risk factors of DSH associated with young people's use of social media: heavy use, problematic use, experiences of cybervictimization, and exposure to DSH content within online spaces. Additionally, the review highlighted two possible protective factors of DSH among youth: social support and social connectedness. Interestingly the guidelines state that CYP admitted to a paediatric ward following an episode of self-harm should have access to CAMHS 24 hours a day, suggesting the 24/7 CIOT service will be used overnight for assessments. Initial aftercare to be offered within 48 hours of the psychosocial assessment. CYP with significant emotional dysregulation or frequent episodes of self-harm should be offered DBT-A.	protocols, for example because it does not include studies in which the participants are people who have self-harmed. It is out of the scope of the guideline to consider the effect of social media on all children and young people.
Avon and Wiltshire Mental Health	Guideline	32	General	Should there be more focus here on relationship building across emergency departments and mental health services. There is a comprehensive	Thank you for your comment. The recommendations made about training were based on the evidence of the skills that both specialist and non-specialist staff need. The guideline did not look

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Partnership NHS Trust				section on Primary care but should this be enhanced with further guidance about joint training and localised pathway awareness.	at the most effective methods for delivering this training and so is not able to make recommendations in this area.
BASW Cymru	Guideline	General	General	As this guidance will cover the 4 countries that make up the UK then consideration needs to be given to reflect that legislation and guidance may be different. While you always refer to that which is relevant in England it may be worth including a comment about this and that there could well be different policies and legislation which are relevant to the other 3 countries.	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
BASW Cymru	Guideline	8	10-12	I am concerned about the phrase "at all times". Does this mean a 24 hour availability to this support, as this is unlikely to happen.	Thank you for your comment. The committee agreed that it was important that all staff working with people who self harm have access to specialist advice and legal advice if there are issues relating to capacity and consent. They considered that systems should already be in place to get specialist advice at all times. The wording of the recommendation has been amended to clarify that access to legal advice would be 'as needed' rather than 'at all times'. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that

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					should be expected, and to encourage commissioners to fund services to meet these standards.
BASW Cymru	Guideline	8	16 – 19	It may be considered later on, but if the individual is not able to give consent to involve their family or carers, then a best interest decision must be made and documented and shared with all relevant people.	Thank you for your comment. Section 1.4 sets out recommendations for how to appropriately involve families. In addition, the guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on the person's rights in relation to confidentiality and involving families and carers.
BASW Cymru	Guideline	9	8 -9	The term "if appropriate" needs a great deal of thought and discussion and explanation as the individual may be at greater risk if this discussion takes place with others present – unless it becomes clear who the alleged abuser is. This conversation always needs to happen when the individual is alone.	Thank you for your comment. The committee acknowledges that this is a difficult area to navigate for many areas of healthcare, and not just self-harm. That is why they have used the term 'if appropriate'.
BASW Cymru	Guideline	11	13 – 14	Again this would be with their consent	Thank you for your comment. No treatment of any kind should be conducted without consent, and therefore the committee did not feel it necessary to include your suggestion here.
BASW Cymru	Guideline	11	4 – 8	Excellent idea – but this discussion needs to see an outcome of how the individual can express their distress to	Thank you for your comment. The recommendation suggests that families and carers are supported to do exactly as you suggest.

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				others. So, prior agreement of what this should be. It could be as simple as an agreed word or picture.	
BASW Cymru	Guideline	12	17 – 18	This may not always be possible, so should take this into account in this sentence.	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.
BASW Cymru	Guideline	13	1	1.5.10 Would it be helpful to consider the use of such tools as ecomaps or genograms as visual assessment tools?	Thank you for your comment. The committee agreed that assessment and care should be based on the individual's needs and vulnerabilities, not risk. The committee did not find any evidence to recommend the use of any risk tools.
BASW Cymru	Guideline	15	18	Shouldn't there be an explanation as to why these tools shouldn't be used? Have you considered which are the appropriate tools to use in assessing risk?	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction or risk of harm anyway. Instead, the committee outlined a number of principles and

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					considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this. Details of these deliberations are already included in the rationale and impact section of the guideline and Evidence review G.
BASW Cymru	Guideline	15	5 – 6	Consider the way that the care plan is written, e.g. it may need to be in a pictorial way, or a different language etc.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
BASW Cymru	Guideline	19	16 - 21	Provision in emergency departments for these may be outside of the control of staff	Thank you for your comment. The committee appreciates that for some services it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.

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BASW Cymru	Guideline	21	7 -10	Aren't you stating the obvious here? This is (or should be!) the approach all social care staff take and is clear within professional codes of conduct.	Thank you for your comment. In the committee's experience, whilst this should be standard practice it often doesn't happen and so a recommendation was made.
BASW Cymru	Guideline	21	11 – 13	Any social care assessment will take place as and when it is needed. There may be instances where it has been agreed not to undertake a social care assessment until other assessments or plans are in place. What is needed is close liaison and communication around the timeliness of any social care assessment.	Thank you for your comment. The committee agree that close liaison and communication about timeliness of social care assessments is key. However this is not specific to self-harm and so it has not been included in the recommendation.
BASW Cymru	Guideline	33 – 34	19	Section on Supervision. Could this be extended to reflect on the need for both formal and informal supervision. The informal supervision could be reflecting immediately with a supervisor when an incident of self harm has occurred – a bit like a de-brief. The formal one then would focus on the aspects that you have identified.	Thank you for your comment. Informal support is already covered by recommendation 1.15.2.
Battle Scars	Guideline	15	7	"If a person presents with frequent episodes of s/h or if treatment has not been effective" Treatment of the s/h injury? This needs clarifying. Also, what defines the effectiveness of this treatment?	Thank you for your comment. The committee think it is clear that the recommendation is referring to treatment of the self-harming behaviour. It is not possible to be define what constitutes effectiveness of treatment as this will be different for different people.

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Battle Scars	Guideline	16	8	"treatment with respect, dignity and kindness" Compassion would be a more appropriate word instead of kindness. Could an addition be made here? "Ensure their body language is non-judgemental". A person can be kind and professional but their body language can give a completely different message.	Thank you for your comment. Kindness has been replaced by compassion as suggested. The training recommendations in section 1.14 highlight that staff should be educated on the need to avoid judgemental attitudes. This should address the issue of body language.
Battle Scars	Guideline	22	7 & 13	"Educational setting staff are supposed to have guidance about how to identify s/h behaviours and what to do if they suspect s/h". Most staff in such setting we've spoken to don't know how to identify and are unsure about what to do if they suspect s/h. Maybe here they could be encouraged to develop a clear s/h policy? Every organisation needs one and not a few lines in a safeguarding policy. (We offer support to write such a policy)	Thank you for your comment. Recommendation 1.8.3 is about educational settings developing policies and procedures to help staff support students who self-harm. This should ensure that staff do know what to do in future. The wording has been amended to make this clearer.
Battle Scars	Guideline	26	2	"Treatment for s/h" Best that was "treatment following s/h". S/h is not a condition or an illness!	Thank you for your comment. This change has been made.
Battle Scars	Guideline	26	5	CBT structured for adults who s/h isn't offered to people with autism as it's ineffective. Does that mean that nothing is offered to them? A distinction could be useful here or	Thank you for your comment. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be

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				people could think that CBT is a viable therapy for them only to be disappointed later when they get turned down for it. An initial offer that is then withdrawn could make the person feel there is no help for them and make things worse.	considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. Recommendation 1.11.2 signposts to the two existing NICE guidelines on autism spectrum disorder in adults and under 19s for further information.
Battle Scars	Guideline	28	6	Why "self-cut"? What about hitting, burning, scratching where harm minimisation can have a role to play? Maybe use the term "external self-harm" to separate it from overdosing and self-poisoning.	Thank you for your comment. The wording has been changed to self-harm.
Battle Scars	Guideline	28	9	"in the spirit of hope and the expectation of recovery" Just an observation but isn't this sentence too "flowery" for this document? Especially when everybody views recovery differently.	Thank you for your comment. The committee's experience was that people can be 'given up on' and not given any hope of recovery and reducing self-harm if they are using harm minimisation techniques. The committee wanted to ensure this is not seen as the end of the person's treatment journey with no hope for them.
Battle Scars	Guideline	30	7	"Assess the safety of the environment, balancing the need for restrictions against respect for autonomy, and remove items that may be used to self harm"	Thank you for your comment. The recommendation has been amended to incorporate involving the person in the decision about removing items. Use of the least restrictive measures has also been added.

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				Removing items is such bad advice! It only makes people more desperate to find other ways. Maybe this would be better phrased emphasising that tablets or bleach for example, need to be removed but sharps are a different thing. Encourage the person who self-harms to surrender them, give them to someone to safekeep, maybe even returned when asked for to allow for controlled self-harm, but mostly, to have a discussion about sharps and safe self-harm. Further control should not be taken away from people.	
Battle Scars	Guideline	36	1-3	Harm minimisation should be clearly stated as a last resort. We strongly object to ice cubes and red pen techniques being listed as "alternatives". They are not alternatives to self-harm; they are self-harm or reminders of. That should be made clear in the document. It's also dangerous that examples of such harm minimisation methods are given with a high risk they will be the only ones remembered, while no examples of healthy distractions or alternatives are provided. By all means, use the	Thank you for your comment. The examples that were initially given in the definition have been removed to clarify these are not specifically being recommended. Instead, the committee agreed to amend the definition to focus on avoiding, delaying or reducing self-harm, to centre the definition of harm minimisation around the aims of the approach rather than giving examples. However, given there is no consensus definition of harm minimisation, no existing quantitative evidence, and no body of work around defining harm minimisation, the committee agreed it would be premature and inappropriate to be more definitive in the terms section without any evidence.

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				suggestions on our website (https://www.battle-scars-self-harm.org.uk/ideas-to-avoid-delay-reduce.html) or similar, but give a range of ideas to provide a starting point. This whole section can be misleading especially considering it was included without evidence. In various places suggestions of ways to manage are given with no examples which is not helpful to those who have to deal with the person who self-harms.	
Berkshire Healthcare NHS Foundation Trust	Evidence review A	45	22	The group felt it was appropriate to encourage self-help and disagree that this would discourage help seeking. It may also limit the range of support options that different people find helpful	Thank you for your comment. Recommendation 1.1.1 now includes information on self-care and the Committee's Discussion of the Evidence section has been amended accordingly.
Berkshire Healthcare NHS Foundation Trust	Evidence review C	9	40	We agree with the principles around information sharing but feel it will be helpful to not only make a recommendation but also include links on where to obtain more information given the complexity and challenges associated with this in practice especially linked to capacity – some	Thank you for your comment. Links have been included in the guideline document, which is where the recommendations are located

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				acknowledgement of the principles set out in evidence review A.	
Berkshire Healthcare NHS Foundation Trust	Evidence review G	13	51	We agree that risk stratification is unhelpful in determining risk of repeat self harm. We feel a number of important issues need to be acknowledge and addressed Limited resources and how these can be allocated – need for honesty around this We agree re improved risk formulation – linking to guidance is required Alternatives to risk stratification ?	Thank you for your comment. Training on risk formulation has been recommended for specialist staff in recommendation 1.14.3, and a definition for risk formulation has been given in the Terms section. However the guideline is not intended to be a manual. The committee discussed the fact that health and social care staff may be concerned about how to assess without the use of risk stratification, but agreed that it is unlikely to give an accurate answer regarding prediction or risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
Berkshire Healthcare NHS Foundation Trust	Evidence review G	14	10	The narrative states using risk stratification ratings would be likely to result in unnecessary treatment costs for many patients who self-harmed. Thus, the committee agreed that there was unlikely to be a significant resource impact from the recommendations made. Important to also consider risk stratification and in	Thank you for your comment. There should be no significant resource impact from removing risk stratification because access to services should already be determined by patient needs, not arbitrary risk thresholds. Risk tools and stratification do not accurately predict future risk of self-harm, so denying access to treatment on the basis of a low risk rating would only artificially lower costs in the short term and could result in higher costs overall if

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				particular low risk often means people do not meet service thresholds. Higher costs will be incurred initially when this threshold is removed. Guidance will also be required regarding how to use formulation effectively	the person repeatedly self-harms as a result of not being provided necessary treatment at the appropriate time. This section has been amended to clarify these issues.
Berkshire Healthcare NHS Foundation Trust	Evidence review H	8	9	Need to also consider the new PSIRF	Thank you for your comment. Discussion of the PSIRF would not be appropriate in the cited text. However, reference to the PSIRF has been made in recommendation 1.9.5.
Berkshire Healthcare NHS Foundation Trust	Evidence review L	9	16	The group all felt this section was confusing in terms of a clear message about harm minimisation strategies and service user views might be helpfully considered.	Thank you for your comment. Service users are included in the composition of the committee and their views were used to inform the recommendations in light of the lack of evidence. The harm minimisation recommendations have been amended to be clearer and the Committee's Discussion of the Evidence section has also been edited to reflect these changes.
Berkshire Healthcare NHS Foundation Trust	Evidence review M	9	28	Explicitly Include safety planning as part of the process	Thank you for your comment. Safety planning has been recommended in recs 1.11.7-1.11.8. For more information about the committee's consideration of safety planning as part of a care pathway please refer to the Committee's Discussion of the Evidence section in Evidence Review J.

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Berkshire Healthcare NHS Foundation Trust	Evidence review Q	18	49	Could restorative clinical supervision be considered in light of the roll out on the PNA in nursing	Thank you for your comment. The committee agreed that restorative clinical supervision was not a clearly defined and well established term and so have not specified this in the recommendation or referenced in the Committee's Discussion of the Evidence.
British Association of Behavioural and Cognitive Psychotherapies	General	General	General	This response has been prepared by BABCP – the British Association of Behavioural and Cognitive Psychotherapies. BABCP is the lead organisation for CBT in the UK and Ireland. BABCP promotes, improves, and upholds standards of CBT practice, supervision, and training. BABCP accredits CBT training programmes in the UK and Ireland and publishes Minimum Training Standards (i.e. a national curriculum) for training CBT therapists. BABCP is a multi-disciplinary professional organisation operating a highly respected voluntary register for accredited cognitive behavioural psychotherapists. We also operate a voluntary register for Psychological Well-being Practitioners (PWPs) and	Thank you for your comments.

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				other low intensity clinicians including Educational Mental Health Practitioners (EMHPs). Members of BABCP work clinically with children, young people, and adults in a range of NHS and community settings.	
British Association of Behavioural and Cognitive Psychotherapies	General	General	General	As this guideline covers adults, young people and children we feel that other professionals should be added to the 'Who is it for' list Our members who work in schools and colleges frequently are asked to support school staff to whom children or young people disclose self-harm or suicidal thoughts and there is a clear need for advice in this area. BABCP suggests that school staff, sports coaches, and other adults who have regular contact with children and young people should be added to the 'Who is it for?' list.	Thank you for your comment. Text has been added to clarify that the guideline is also relevant to those in educational settings.
British Association of Behavioural	guideline	16-21		**1.6** **Assessment and care by health and social care professionals:**	Thank you for your comment.

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and Cognitive Psychotherapies				BABCP very much welcome the tone of the committee's recommendations and their awareness of the need to treat the person with respect, kindness and to maximise their dignity.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	26-27	General	1.10 Interventions for self-harm: BABCP welcome the inclusion of CBT based psychological interventions for adults who self-harm and DBT- for children and adolescents who self-harm. BABCP also welcome the recommendation that interventions are delivered collaboratively and in partnership.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	26-27	General	1.10 BABCP suggest that the committee consider recommending interventions to support family members or parents/carers. BABCP are aware that the evidence base on effectiveness of family intervention or support is weak but note that there is plentiful evidence that family members, parents/carers report unmet needs.	Thank you for your comment. Recommendations were made about the provision of support for family members and carers based on qualitative evidence - please see Evidence Review B and recommendations 1.1.2 - 1.1.3. A review of the evidence on formal psychosocial interventions for/ assessment of family members and carers of people who have self-harmed was not prioritised for this guideline and so the committee are not able to make recommendations regarding this topic.

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				For example, De Miranda Trinco, M. E., Santos, J. C., & Barbosa, A. (2017). Experiences and needs of parents of adolescentes with self-harm behaviors during hospitalization. *Revista de Enfermagem Referência, 4*(13), 115-124. doi:10.12707/RIV17008 Fu, X., Yang, J., Liao, X., Lin, J., Peng, Y., Shen, Y., Ou, J., Li, Y., & Chen, R. (2020). Parents' Attitudes Toward and Experience of Non-Suicidal Self-Injury in Adolescents: A Qualitative Study. *Frontiers in psychiatry, 11*, 651. doi:10.3389/fpsyt.2020.00651 Hughes, N. D., Locock, L., Simkin, S., Stewart, A., Ferrey, A. E., Gunnell, D., Kapur, N., & Hawton, K. (2017). Making Sense of an Unknown Terrain: How Parents Understand Self-	

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				Harm in Young People. *Qualitative Health Research, 27*(2), 215-225. doi:10.1177/1049732315603032 Krysinska, K., Curtis, S., Lamblin, M., Stefanac, N., Gibson, K., Byrne, S., Thorn, P., Rice, S. M., McRoberts, A., Ferrey, A., Perry, Y., Lin, A., Hetrick, S., Hawton, K., & Robinson, J. (2020). Parents' Experience and Psychoeducation Needs When Supporting a Young Person Who Self-Harms. *International journal of environmental research and public health, 17*(10). doi:10.3390/ijerph17103662 McDonald, G., O'Brien, L., & Jackson, D. (2007). Guilt and shame: experiences of parents of self-harming adolescents. *Journal of Child Health Care, 11*(4), 298-310.	

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				doi:10.1177/1367493507082759 Russell, S. N. (2018). *Experiences of parents of self-harming adolescent children.* (79), ProQuest Information & Learning, Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,sso&db=psyh&AN=2018-00726-231&site=ehost-live&authtype=sso&custid=s9872838 Available from EBSCOhost psyh database. Tuls, K. S. (2011). *Parent response to adolescent self-injurious behavior: A collective case study.* (72), ProQuest Information & Learning, Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,sso&db=psyh&AN=2011-99240-120&site=ehost-live&authtype=sso&custid=s98	

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				72838 Available from EBSCOhost psyh database. There is also quantitative evidence about the characterstics of parents of young people who self-harm, and on the impact on their well-being. For example, Morgan, S., Rickard, E., Noone, M., Boylan, C., Carthy, A., Crowley, S., Butler, J., Guerin, S., & Fitzpatrick, C. (2013). Parents of young people with self-harm or suicidal behaviour who seek help - a psychosocial profile. *Child and Adolescent Psychiatry and Mental Health,* *7*(1), 13. doi:10.1186/1753-2000-7-13 Tubeuf, S., Saloniki, E.-C., & Cottrell, D. (2019). Parental Health Spillover in Cost-Effectiveness Analysis: Evidence from Self-Harming Adolescents in England. *PharmacoEconomics*	

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				, 37(4), 513-530. doi:10.1007/s40273-018-0722-6 Whitlock, J., Lloyd-Richardson, E., Fisseha, F., & Bates, T. (2018). Parental Secondary Stress: The Often Hidden Consequences of Nonsuicidal Self-Injury in Youth. *Journal of clinical psychology, 74*(1), 178-196. doi:10.1002/jclp.22488 BABCP suggest that the committee consider adding a recommendation about how services should assess and support family members, parents/carer based on their own experience and the 'grey' literature from agencies that support families (e.g. Young Minds, Charlie Waller Trust).	
British Association of Behavioural and Cognitive	guideline	1.13	32-33	Given the lack of awareness and confidence in this area, BABCP are extremely pleased to see that the committee recommends training for all staff who work with people of any age who self harm.	Thank you for your comment.

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Psychotherapies				BABCP agrees with the contents of training outlined by the committee and particularly endorses: • involving people who self-harm and their families • exploring staff attitudes, values, beliefs and biases • education about stigma and discrimination • communicating compassionately • cultural competence • risk assessment	
British Association of Behavioural and Cognitive Psychotherapies	guideline	1.14	33-34	Supervision: BABCP agrees that staff who work with people who self-harm require ongoing, high-quality supervision. BABCP also agrees that the aspects of supervision identified by the committee should be included in supervision.	Thank you for your comment.
British Association of Behavioural and Cognitive	guideline	2	10-11	1.5.7 BABCP agree that the assessment should be carried out in a private area where the conversation cannot be overheard but also recognises that this	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage

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Psychotherapies				recommendation may often not be feasible in busy clinical areas.	commissioners to fund services to meet these standards.
British Association of Behavioural and Cognitive Psychotherapies	guideline	5	3-4	BABCP welcome the committee's recommendation to share information with family members or carers (where appropriate).	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	5	19-21	BABCP also welcome the recommendation that professionals should support family members of the person who has self-harmed.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	6	18-25	1.1.3 BABCP welcome the specificity of this advice and the inclusion of sensitivity, empathy, support, respect, hope, and other important attributes during this very distressing time.	Thank you for your comments.
British Association	guideline	7		1.2	Thank you for your comments.

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of Behavioural and Cognitive Psychotherapies				BABCP agree with the committee about the necessity for health and social care professionals to be familiar with and to act in accordance with the relevant Acts. BABCP agree also that this is a complex area of work and appreciate the recommendation to seek further guidance about consent and to direct people to mental capacity advocates.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	7	1-5	1.1.4 BABCP welcome the consideration given to people who experience discrimination and/or to those with protected characteristics.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	8	10-22	1.2.3 1.2.4 1.2.5 1.2.6 BABCP agree that these recommendations are important. BABCP suggest that an additional recommendation is made that addresses the psychological impact of	Thank you for your comment. This issue is addressed by recommendations 1.15.1 and 1.15.2.

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				this work on staff and recommending that this issue is addressed routinely in regular, scheduled supervision and that workplaces provide support and counselling for staff who work with people who self-harm or have suicidal thoughts or behaviours.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	9		1.3 Safeguarding: BABCP is very pleased to see that there is specific guidance about the need for safeguarding training for all health care professionals who have contact with people who self-harm. BABCP suggest that this section could be extended by adding a recommendation that health and social care professionals (and other workers e.g. teachers) should receive training in safeguarding, including assessment, documenting, and liaising with appropriate local services.	Thank you for your comment. This recommendation has been made relevant to all staff.
British Association of Behavioural	guideline	9		1.4 BABCP welcome the principle that family members and/or carers should be involved where possible.	Thank you for your comment. Whilst the committee acknowledges that this can be a difficult issue, it is not one that is wholly specific to self-harm. The guideline has been amended to make reference to

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and Cognitive Psychotherapies				BABCP also suggest that where a child or young person self-harms or discloses suicidal thoughts or behaviours to a professional that parents/carers should usually be involved, and that the committee consider strengthening this recommendation for children and young people. BABCP agrees that the autonomy of the child/young person is a very important consideration but considers that where there is a threat to their life that this may be out weighted. BABCP also considers that additional guidelines could be provided to help professionals make a judgement about when sharing information **should** not occur. BABCP suggests that where a professional judges that it is not appropriate to involve a parent or carer of a child our young person under 16 that the professional seeks a second opinion from a senior colleague on the decision.	the NICE guidance on 'Babies, children and young people's experience of care' which makes extensive recommendations about how to address the issues of consent, privacy and confidentiality of children and young people, and the appropriate way to involve their parents or carers.

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				Further, BABCP suggest that if a professional has not involved the parent/carers of a child or young person in decisions about their care that the professional considers how the child/young person can be kept safe and that this is an explicit part of the safety plan.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	9	18-22	1.3.2 BABCP very much welcomes the explicit reference to 'education' in this paragraph and suggests that 'education' is referenced throughout the guidelines. Many children and young people disclose self-harm and suicidal thoughts to staff at schools and colleges, and other professionals working with children and young people (e.g. sports coaches, music teachers, police, prison staff) etc have limited understanding of how to respond and support the child/young person. This causes them distress and means that children and young people may not be supported or may receive unhelpful responses.	Thank you for your comment. Staff in educational settings have already been included in the recommendations, where relevant.

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British Association of Behavioural and Cognitive Psychotherapies	guideline	11 12	22-23 24-25 3-4	1.5.2/1.5.4 BABCP are pleased that the committee recommends that psychosocial assessment should not wait until after medical treatment or be delayed by measures of alcohol levels.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	11		1.5.1 BABCP welcome the recommendation that an assessment should be carried out by a mental health professional 'at the earliest opportunity possible'. BABCP further welcomes the tone of this recommendation, particularly the need to develop a 'collaborative' relationship, a 'shared understanding' and the focus on the person getting the 'care they need'	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	12	17-18	1.5.8 BABCP very much welcome the focus on meeting the preferences of the person who has self-harmed but recognises that the recommendation to have a healthcare professional of the same sex carry out the assessment is unlikely to be feasible in many	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.

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				services, including A&E or primary care.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	12	19-29	1.5.9 BABCP appreciate the committee's focus on the meaning of self-harm to the person and on their obvious commitment to recognising the need for understanding, empathy, and compassion.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	13	3-13	1.5.10 BABCP would like to draw attention to the specific vulnerability of people who identify as LGBT+, who have high rates of self- harm. Some indicative references are, *Hatchel, T., Polanin, J. R., & Espelage, D. L. (2021). Suicidal thoughts and behaviors among LGBTQ youth: Meta-analyses and a systematic review. Archives of suicide research, 25(1), 1-37.* *Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender*	Thank you for your comment. Recommendation 1.14.2 already states that staff should receive training which should cover "being culturally competent through respecting and appreciating the cultural contexts of people's lives". The committee agreed this includes LGBTQ+ identities, as outlined in the Committee's Discussion of the Evidence section in Evidence Review P. Although the studies referenced could not be included in any systematic review conducted because they do not meet inclusion criteria, the committee agreed that LGBTQ+ people are likely to face additional discrimination, which informed recommendation 1.1.4 and a number of assessment recommendations (sections 1.7 and 1.8) which state people should be treated with respect and dignity, and that the underlying reasons for self-harm should be explored.

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				youth. American journal of preventive medicine, 42(3), 221-228. *Sheehy, K., Noureen, A., Khaliq, A., Dhingra, K., Husain, N., Pontin, E. E., ... & Taylor, P. J. (2019). An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. Clinical psychology review, 73, 101779.* BABCP suggest that the committee consider recommending that staff who assess people who self-harm are skilled in working with people with a range of sexual and gender identities and can provide a sensitive assessment, that includes consideration of the unique stressors that they may be managing.	
British Association of Behavioural and Cognitive	guideline	13	3-13	1.5.10 BABCP welcome the acknowledgement that cultural factors should be considered in a psychosocial assessment. We are	Thank you for your comment. The committee agreed that other areas were higher priorities for further research.

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Psychotherapies				aware that there may be differences between religious groups e.g. Gearing, R. E., & Alonzo, D. (2018). Religion and suicide: New findings. *Journal of Religion and Health*, *57*(6), 2478-2499. BABCP considers that this area of research is under-developed and suggests that the committee might want to add a research recommendation related to cultural and ethnic risk and protective factors.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	14	8-11	1.5.11 BABCP warmly welcome additional recommendations in relation to children and young people who have self-harmed. BABCP suggest that this recommendation is also relevant to children and young people who may not have self-harmed but who have disclosed suicidal ideas and plans.	Thank you for your comment. Making recommendations for people who have not yet self-harmed is outside the scope of the guideline.
British Association of Behavioural and Cognitive	guideline	14	12-22	1.5.12 BABCP also welcome the inclusion of a specific recommendation focusing on the needs of older people and the potential risk of other factors, including cognitive difficulties, isolation, and	Thank you for your comments.

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Psychotherapies				increased risk that older people present.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	14	23-26	1.5.13 We are pleased to see this acknowledgement that a full psychosocial assessment may not be feasible and welcome the identification of priorities for clinicians.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	14	27-29	1.5.14 Thank you for including the recommendation that a risk formulation should be part of every psychosocial assessment. BABCP are aware that the term '*formulation'* may have different definitions for professionals who have trained in different disciplines (e.g. psychiatry, nursing, clinical psychology). Therefore, and to avoid ambiguity, BABCP suggest that the committee consider expanding the definition provided on page 35 so that the contents of a risk formulation are	Thank you for your comment. Training on risk formulation has been recommended for specialist staff in recommendation 1.14.3. However the guideline is not intended to be a manual and so explicit instructions on how to do risk formulation have not been added.

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				explicit, and professionals are aware of what should routinely be included.	
British Association of Behavioural and Cognitive Psychotherapies	guideline	7 & 8	22-23 1-9	1.2.2 BABCP very much welcome the specific attention about children and young people. We would also add that children and young people often disclose self-harm and/or suicidal thoughts to school staff and that this guidance should explicitly address this group of staff. BABCP agree that assessing capacity is crucial in making decisions about how to support and care for children and young people who self-harm. BABCP suggest that the committee add the recommendation that all health and social care staff working in general services e.g. A&E, primary care, or in services that work with children and young people, should be required to have training in assessing capacity and in the relevant legislative frameworks.	Thank you for your comment. This recommendation intends that all healthcare professionals and social care practitioners should have an understanding of the overarching principles of these pieces of legislation, appropriate to their role and position in the organisation, and how to apply them (not in-depth knowledge of the duties and powers contained in the legislation). While some education staff might have some working knowledge of the relevant legislative frameworks, the committee would not expect all education staff to have this knowledge or undertake capacity assessments. Instead they would expect them to seek further advice as needed and recommended in 1.2.3.

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				BABCP further suggest that this additional recommendation is extended to include school staff	
British Association of Behavioural and Cognitive Psychotherapies	guideline	15	1-4	1.5.15 BABCP appreciate the committee's recommendation that the care plan should be developed with the person who self-harms and (if appropriate) their family. BABCP agrees that collaborative care is an essential part of the package of care that people who self-harm are likely to need	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	15	5-6	1.5.16 BABCP also agree that people who self-harm should always be given a copy of the collaborative care plan that they agree with a mental health professional.	Thank you for your comments.
British Association of Behavioural and Cognitive Psychotherapies	guideline	15	7-17	1.5.17 BABCP agree that for people who self-harm frequently that a multi-disciplinary review is indicated.	Thank you for your comments.

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British Association of Behavioural and Cognitive Psychotherapies	guideline	15		1.5.18 1.5.19 1.5.20 1.5.21 BABCP agree that methods of predicting future suicide or self-harm are not supported by the evidence and that they should not be used to make decisions about treatment or to estimate future risk.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	17	4-7	1.6.4 BABCP strongly agrees with the committee's clear statement about NOT using aversive treatment, punishment, or other negative consequences as an intervention for frequent self-harm. This is a very important recommendation that BABCP hopes will be widely publicised.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	19	13-15	1.6.12 BABCP strongly agrees with this recommendation but is aware that it will present difficulties in some services where mental health professionals are under-resourced in ED departments.	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels in some settings. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Potential resource implications of the guideline were

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					considered by NICE when preparing the guideline's Resource impact summary report. However, as specified in the rationale and impact section of the guideline, this recommendation should not have a cost or resource impact because this should already be standard practice.
British Association of Behavioural and Cognitive Psychotherapies	guideline	19	16-18	1.6.13 BABCP agree with this recommendation – we also suggest that this area should be suitable and equipped for assessments with children and adolescents and should include space for family members or carers.	Thank you for your comment. The evidence did not support including this level of specificity in the recommendation so no changes have been made
British Association of Behavioural and Cognitive Psychotherapies	guideline	20	18-20	1.6.19 BABCP welcomes this recommendation	Thank you for your comment.
British Association of Behavioural and Cognitive	guideline	20	21-23	1.6.20 BABCP welcomes this recommendation – we are aware that this may present challenges to hospitals where mental health professionals are not well resources and hope that this recommendation will	Thank you for your comment. A recommendation has been made in section 1.14 about the training needed for staff who observe people who have self-harmed. The committee agreed any training needs were justified because clinical observation is an intervention (see the definition in the Terms used section) and therefore should not be carried

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Psychotherapies				encourage all hospital trusts to provide adequate staffing and support for mental health care. BABCP recognise that many adolescents are admitted to adult wards following an episode of self-harm. BABCP suggest that this recommendation is extended to ensure that adolescents should always be assessed by a child and adolescent mental health specialist even if they are admitted to an adult ward.	out by untrained staff. Recommendation 1.5.11 covers the need for psychosocial assessment for children and young people who have self-harmed to be undertaken by a mental health professional experienced in assessing children and young people who self-harm.
British Association of Behavioural and Cognitive Psychotherapies	guideline	21		**1.7** **Assessment and care by non-health and social care professionals** BABCP warmly welcome this section of the guidance and are aware that many of our members are approached by school staff to whom children and young people disclose self-harm.	Thank you for your comment.
British Association of Behavioural and Cognitive	guideline	22	19	1.7.3 BABCP agree that all schools should have a designated lead in this area and suggest that this should be the designated mental health lead that all schools are expected to have in place by 2025.	Thank you for your comment. The committee decided not to specify who the designated lead should be to allow flexibility during implementation.

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Psychotherapies				This reflects joint policy by DoH and DfE and there is extensive funded training and support for the school staff who take these roles. The committee may wish to link this recommendation to the following information https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf https://www.gov.uk/guidance/senior-mental-health-lead-training	
British Association of Behavioural and Cognitive Psychotherapies	guideline	23	14-16	1.7.7 BABCP are delighted that the committee considered the role of the criminal justice system and specifically recognised that people who are involved in the justice system or are detained for other reasons are at increased risk of self-harm. BABCP suggests that staff in these facilities are very likely to need specific training in mental health and self-harm	Thank you for your comment. This training is already recommended in 1.14.2.

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				and thus that the committee might suggest making this a recommendation	
British Association of Behavioural and Cognitive Psychotherapies	guideline	24	8-9	1.8.2 BABCP agrees that where young people are admitted to a general hospital, they should be admitted to a ward that can meet the needs of young people. BABCP are aware that many young people under 16 are admitted to adult wards and therefore suggests that specifying 16–17-year-olds may be too narrow. BABCP suggests that this recommendation may benefit from rewording, for example 'If a child or young person (i.e. under 18 years) is admitted to a general hospital, ensure it is to a ward that can meet their needs."	Thank you for your comment. The intention of this recommendation was to reduce the practice that committee members felt was prevalent - which was older adolescents being admitted to adult wards.
British Association of Behavioural and Cognitive	guideline	25	12-14	1.9.2 BABCP welcomes the specificity of the recommendation that aftercare is provided within 48 hours of the psychosocial assessment.	Thank you for your comment. The committee acknowledged that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.

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Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	guideline	13 & 14		1.5.10 BABCP welcomes this comprehensive recommendation for assessing people who present with self-harm or suicidal ideas or behaviours. BABCP recognises the logistical challenges that this complex and extensive assessment may present to clinicians, especially when they are working in busy clinical environments and patients are distressed. Given this challenge, BABCP suggests that the committee consider highlighting aspects of the assessment that may be more 'essential' if a comprehensive assessment cannot be conducted.	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
British Association of Behavioural and Cognitive Psychotherapies	guideline	27 28	16-30 1-4	1.10.9 BABCP agree that clinicians should also be aware of the NICE guidelines for commonly co-morbid conditions	Thank you for your comment.

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British Association of Behavioural and Cognitive Psychotherapies	guideline	31	18-23	1.12.5 BABCP warmly welcome this recommendation that healthcare professionals routinely enquire about self-harm at regular consultations and medication reviews. BABCP is aware that many healthcare professionals are worried that talking about self-harm or suicide with patients will 'put the idea into their heads' and that therefore patients are not offered opportunities to disclose these thoughts.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	37	4-6	BABCP is extremely pleased to see the research recommendation related to models of care for children and young people and agrees that this is a priority area.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	37	8-9	BABCP welcome the recommendation for research in non-specialist settings – given the important role of schools and colleges for young people we suggest that the recommendation specifically refers to educational settings so that this area is not neglected.	Thank you for your comment. Schools, colleges and universities are included in the list of non-specialist settings in Appendix L of Evidence review E.

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British Association of Behavioural and Cognitive Psychotherapies	guideline	37	11-12	BABCP welcome the recommendation for research on the effectiveness of routine or automatic admission for young people or adults who have self-harmed.	Thank you for your comment.
British Association of Behavioural and Cognitive Psychotherapies	guideline	38	2-3	BABCP welcome the recommendation for research on the effectiveness of psychological interventions in general and agree that digital interventions require evaluation. Inclusion of children and young people is implied in the text; BABCP suggest that the committee consider expanding the recommendation to highlight specific populations or settings that might be of highest priority.	Thank you for your comment. This level of details is included in Appendix L or Evidence review J.
British Association of Behavioural and Cognitive Psychotherapies	guideline	19 & 20	22-30 1-3	1.6.15 BABCP agrees in the strongest possible terms that these governance arrangements are essential to ensure safe practice with adults, children and adolescents who self-harm.	Thank you for your comment.

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British Association of Behavioural and Cognitive Psychotherapies	guideline	20 & 21	28-29 1-5	1.6.21 BABCP agree that it is important that children and young people who have been admitted to a paediatric ward after an episode of self-harm should be assessed by a child and adolescent mental health specialist. BABCP also agree with the recommendation that mental health teams and paediatric teams review children and young people every day and continue to hold multi-disciplinary meetings beyond the date of discharge. BABCP further suggest that where a young person is admitted to an adult ward rather than a paediatric ward that they should also be assessed by a child and adolescent specialist.	Thank you for your comment. Recommendation 1.5.11 covers the need for psychosocial assessment for children and young people who have self-harmed to be undertaken by a mental health professional experienced in assessing children and young people who self-harm.
Compass	Guideline	5	3	Recommendation 1.1.1 Not all services are commissioned to provide 'wraparound' care for family members of the client.	Thank you for your comment. This recommendation is asking health and social care staff to simply provide information to families and carers.
Compass	Guideline	8	10	Recommendation 1.2.3 Not all services will have staff available to support pupils who self-harms such as schools and tier 1 and 2 services	Thank you for your comment. The committee agreed that it was important that all staff working with people who self harm have access to specialist advice and legal advice if there are issues relating to capacity and consent. They

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				'all the times'. It is important to ensure that this distinction between these services and tier 3 and above services-	considered that systems should already be in place to get specialist advice at all times. The wording of the recommendation has been amended to clarify that access to legal advice would be 'as needed' rather than 'at all times'
Compass	Guideline	11	13	Recommendation 1.5.1 How realistic is it to achieve this intervention, there is not current capacity to deliver this in a timely manner. Perhaps a timescale should be included if it is going to be meaningful.	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. The committee acknowledged that practice is variable in this area but the evidence did not support recommending a specific timescale. However they agreed that it should be carried out as soon as possible.
Compass	Guideline	12	8	Recommendation 1.5.6 Should be also include review and amend accordingly. Sometimes the care plan may no longer be fit for purpose.	Thank you for your comment. Reviewing the care plan has been added to recommendation 1.5.15.
Compass	Guideline	12	19	Recommendation 1.5.9 This may not always be possible to achieve due to SEN clients and the YP willing to engage and disclose at the time- needs rewording.	Thank you for your comment. The committee acknowledge that it may not always be possible to achieve this recommendation but agreed it was still important to try to explore the functions of self-harm for the person. Therefore the recommendation has not been reworded.

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Compass	Guideline	15	6	Recommendation 1.5.16 Health professionals- do we mean GP as well? Often this information is not share which leads to less joined up working.	Thank you for your comment. This refers to all healthcare professionals involved in their care, which could include GPs.
Compass	Guideline	15	19	Recommendation 1.5.18 This is a move away from most professional learning- risk assessment and history as a predictor of future risks. If this needs to be implemented, then future training needs to reflects these changes- what evidence these changes also help to support practitioner's learning.	Thank you for your comment. Making changes to training to align with the recommendations in the guideline will be a matter for local implementation.
Compass	Guideline	23	12	Recommendation 1.7.7 It would be cross referencing guidance on Safer Custody guidance published by the MoJ to the HM Prison and Probation Service through PSI (Prison Service Instructions) and PSO (Prison Service Orders) to create synergy.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice systems. Text has been added to the guideline to clarify that, because of the need to take other national guidance into account, the recommendations may need to be tailored for certain criminal justice system settings during implementation.
Compass	Guideline	28	7	Recommendation 1.10.10	Thank you for your comment. The wording has been changed to self-harm.

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				'cutting' was the only self-harm reference here-are there other guidance for other forms of self harm?	
Department of Health – Northern Ireland	Guideline	5	3	1.1.1 - Should consent be considered at this point where it is suggested sharing care plans, etc other than the term 'as appropriate'	Thank you for your comment. Recommendation 1.1.1 is about sharing information, not care plans. Recommendations in section 1.2 cover consent.
Department of Health – Northern Ireland	Guideline	5	18	The inclusion of psychoeducation and its potential benefits would be useful	Thank you for your comment. Psychoeducation is a specific intervention whereby education is usually delivered through dialogue with a specialist, including teaching components about emotions and psychological responses tailored to individual needs. It would not usually be provided to people as part of a standard provision of information, and there was insufficient evidence to recommend it as an intervention.
Department of Health – Northern Ireland	Guideline	6	12	The inclusion of psychoeducation and its potential benefits would be useful	Thank you for your comment. Psychoeducation is a specific intervention whereby education is usually delivered through dialogue with a specialist, including teaching components about emotions and psychological responses tailored to individual needs. It would not usually be provided to people as part of a standard provision of information, and there was insufficient evidence to recommend it as an intervention.
Department of Health –	Guideline	7	1	A comprehensive biopsychosocial assessment should be standard practice across all settings	Thank you for your comment. The guideline sets out the same expectation by making

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Northern Ireland					recommendations that everyone should have an assessment after an episode of self-harm.
Department of Health – Northern Ireland	Guideline	7	9	Would recommend including The Mental Capacity Act (NI) 2016	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Department of Health – Northern Ireland	Guideline	8	1	Would recommend including the children (Northern Ireland) Order, 1995	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Department of Health – Northern Ireland	Guideline	8	10	It would be useful to clarify the level of staff referred to here. For example it could it refer to teachers / third sector organisations necessarily	Thank you for your comment. This recommendation relates to all staff working with people who have self-harmed, where there are issues about capacity and consent. Text has been added to the guideline to clarify that the recommendations apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group.
Department of Health – Northern Ireland	Guideline	8	22	Where practicable the individual should be aware of the breach prior to it occurring with staff taking the least forceful action in line with safety	Thank you for your comment. The recommendation has been amended to include informing the person about the confidentiality breach where possible but it has not been specified that this should be done

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					prior to the breach because this is not possible in all circumstances.
Department of Health – Northern Ireland	Guideline	9	6	Would recommend including NI relevant policy: The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 and Adult safeguarding operational procedures 2016	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Department of Health – Northern Ireland	Guideline	10	3	Would recommend providing access to wellbeing and support organisations so that carers may access support while caring for their family member	Thank you for your comment. This is already covered in recommendation 1.1.2.
Department of Health – Northern Ireland	Guideline	10	9	Would recommend Include Gillick competence	Thank you for your comment. A cross reference to section 1.2 has been added, which makes recommendations about confidentiality and consent, including Gillick competence.
Department of Health – Northern Ireland	Guideline	11	13	Would recommend further guidance on a timeframe e.g. if a person presents to ED with self-harm they should have an assessment either at the time of presentation or within X days.	Thank you for your comment. The committee acknowledged that practice is variable in this area but the evidence did not support recommending a specific timescale. However they agreed that it should be carried out as soon as possible.
Department of Health – Northern Ireland	Guideline	11	19	Would recommend guidance for mental health professionals when triaging referrals i.e. who should access specialist MH services and who can be diverted to third sector organisations would be useful	Thank you for your comment. The guideline states that everyone who has self-harmed should be given an assessment by a mental health specialist. Actions to be taken after the assessment are covered by other sections of the guideline.

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Department of Health – Northern Ireland	Guideline	12	3	1.5.4 This could potentially put some individuals at risk that may appear to be able to engage in the process of assessment and care planning.	Thank you for your comment. Recommendations 1.5.3 and 1.5.5 cover this scenario and further information about when to provide an assessment is provided in the rationale and impact text. As such we have not made any changes based on your comment.
Department of Health – Northern Ireland	Guideline	12	9	Would recommend a review and update of the care plan to be conducted in conjunction with the psychosocial assessment were appropriate	Thank you for your comment. Reviewing the care plan has been added to recommendation 1.5.15.
Department of Health – Northern Ireland	Guideline	12	10	1.5.7 This is frequently not achievable in EDs.	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards.
Department of Health – Northern Ireland	Guideline	12	12	1.5.8 Providing the option to have a healthcare professional of the same sex is difficult given staff ratios between male and females, shift patterns, out of hours assessments, etc. Options for a chaperone could be listed if preferred by an appropriate person.	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.

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Department of Health – Northern Ireland	Guideline	13	14	It would be useful to consider capability, impulsivity, intentions, access to means, feelings of entrapment and burdensomeness	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Department of Health – Northern Ireland	Guideline	13	25	Would recommend including misuse of prescribed medication and over the counter medication	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Department of Health – Northern Ireland	Guideline	14	7	Would recommend the Inclusion of personal strengths and resilience	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential

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					considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Department of Health – Northern Ireland	Guideline	14	23	1.5.13 How does this apply to individuals who present to EDs that refuse to engage with MH practitioners?	Thank you for your comment. No treatment of any kind should be conducted without consent. If the person does not want to engage with the mental health practitioner it is their choice.
Department of Health – Northern Ireland	Guideline	14	26	It may be useful to refer to how follow-up should take place i.e. ED staff to ensure X/Y/Z happens eg communication with GP / mental health service provider if known to MH services.	Thank you for your comment. Follow-up is covered in section 1.10.
Department of Health – Northern Ireland	Guideline	14	27	Is it possible for this to include utilising the pashani risk formulation in line with towards zero suicide developments	Thank you for your comment. The committee agreed that assessment and care should be based on the individual's needs and vulnerabilities, not risk. The committee did not find any evidence to recommend the use of any risk tools.
Department of Health – Northern Ireland	Guideline	15	1	1.5.15 Should this include a safety plan?	Thank you for your comment. Recommendations on safety plans are made in section 1.11 and have not been repeated here.
Department of Health – Northern Ireland	Guideline	15	7	1.5.17 Is there guidance on the term 'frequent', how many times in what period of time? This is open to individual perspective and interpretation.	Thank you for your comment. The committee considered if it was possible to define the frequency of episodes here but came to the conclusion that it would be too restrictive to define x number of episodes in x months as 'frequent' and that if they did so it could lead to stratifications of risk which the guideline recommends against.

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Department of Health – Northern Ireland	Guideline	15	18	Could this point be rephrased as the list below is all do not do x/y/z . It may be helpful to state what should be used to guide these decisions re offering further care or discharging from ED. Clarification would be helpful in relation to; Is it effectively saying ALL patients who present to ED with self-harm should be referred for MH assessment and that the detailed psychosocial assessment will guide further treatment options? If so it would be helpful if the recommendations stated that explicitly.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this. Recommendation 1.7.13 already states that people attending ED after an episode of self-harm should be referred for a psychosocial assessment. Recommendation 1.5.15 already states that the information derived from the psychosocial assessment should be used to develop a care plan.
Department of Health –	Guideline	16	8	Would recommend adding compassion	Thank you for your comment. This has been amended.

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Northern Ireland					
Department of Health – Northern Ireland	Guideline	17	10	NI could utilise the multi-disciplinary teams attached to primary care, however there is an issue with equity of access given that only 27% of GP practices have a mental health practitioner attached to the surgery.	Thank you for your comment. The committee appreciates that for some services it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant activity is being planned.
Department of Health – Northern Ireland	Guideline	17	27	It would be useful to include what sort of support non- NHS sector organisations could offer. From a public health / early intervention perspective it maybe worth including more guidance here so that cases are not 'held' in primary care until they deteriorate /escalate so that they can reach thresholds for specialist services. E.g. is there a role of problem solving therapy/ CBT that many counselling organisations could offer. If CBT based approaches are effective within specialist services this might suggest CBT approaches in primary care or other sectors may be useful?	Thank you for your comment. The wording of this recommendation has been amended to clarify it relates to the person having 'information about available social care, voluntary and non-NHS sector support and self-help resources'. It is not possible to make recommendations on what support non-NHS sector organisations could offer based on the available evidence. The guideline makes recommendations that risk assessment should not be used to determine access to treatment. This should alleviate some of the issues around needing to meet thresholds to access services.

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				Would be helpful to outline what sort of skills or qualifications these organisations should hold.	
Department of Health – Northern Ireland	Guideline	18	22	May be worth highlighting that transporting to ED should not be the default position as ED can be a distressing environment and lead to escalation of the distress.	Thank you for your comment. This recommendation is about looking for alternatives to sending someone to ED, which implies that this should not be the default position. However it is not possible to state this more explicitly because there may be circumstances where ED attendance is needed.
Department of Health – Northern Ireland	Guideline	19	5	There is a likelihood of individual leaving before seen by ED staff	Thank you for your comment. The committee hope that if the recommendations are implemented and people are given the assessment and care they need by the appropriate specialists as soon as possible it will encourage them to stay.
Department of Health – Northern Ireland	Guideline	19	15	It would be useful to specify whether this relates to all SH attendances or whether those who are already under the care of mental health services and may have an upcoming meeting with their team / key worker within days can wait to see their own team if the ED clinician feels that they are safe to do so.	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one.
Department of Health – Northern Ireland	Guideline	20	18	Would recommend potential re-word to : All people who are admitted to hospital due to self-harm should be seen by	Thank you for your comment. The committee did not think rewording the recommendation was necessary as its meaning is currently clear.

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				....as soon as possible and before discharge.	
Department of Health – Northern Ireland	Guideline	21	1	Would recommend adding compassion.	Thank you for your comment. Treating people with compassion is already covered by other recommendations and so has not been repeated here.
Department of Health – Northern Ireland	Guideline	22	9	Would recommend inclusion of LIFELINE in NI	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Department of Health – Northern Ireland	Guideline	23	16	Would recommend stating that people in CJ should have at least equitable access to psychosocial interventions as people in community. The needs of this population are higher so there is a case for more support to address needs but should be at least comparable access.	Thank you for your comment. The recommendations in section 1.5 apply to people who have self-harmed in all settings, including the CJS. In section 1.5 it is recommended that all people who self-harm should receive a psychosocial assessment.
Department of Health – Northern Ireland	Guideline	25	4	Would recommend Include signposting for family and carers where appropriate	Thank you for your comment. Provision of information and support to family members and carers, including signposting, is covered by recommendation 1.1.2. Recommendation 1.10.1 covers sharing of the care plan with family members and carers.
Department of Health –	Guideline	25	12	The meaning of this is not clear. Is it stating that all people should have	Thank you for your comment. The committee acknowledge that this recommendation may be

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Northern Ireland				follow up within 48hrs and that follow up should be with either the GP, MH team or the team who carried out the assessment? Note some people who present to ED will have no follow up with MH services arranged if assessed as low risk. Is this stating that the GP should see all those cases within 48h? Or is it stating that the assessing team should do a follow up within 48h for all cases that they assess? 1.9.2 Is initial aftercare down to each teams' interpretation? Does aftercare require consent?	difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.
Department of Health – Northern Ireland	Guideline	26	5	It would be helpful to refer to the type of skills / qualifications that are required to be able to provide this? Can it be provided in primary care? Can it be provided by third sector? Is the same sort of approach useful for young people who do not meet the threshold for DBTA? In N Ireland there is the Self Harem Intervention Programme (SHIP) where CBT/ problem solving / integrative counselling approaches are used for both adults and young people.	Thank you for your comment. A recommendation has been added to section 1.11 to clarify that interventions can be provided by an appropriately trained and supervised person (recommendation 1.11.5). The recommendations in section 1.6 clarify that risk stratification should not be used to establish thresholds determining whether people are offered treatment.

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Department of Health – Northern Ireland	Guideline	26	13	It would be helpful to have clarification in relation to young people. What about young people who have first or second episode of SH but wouldn't necessarily meet the threshold for DBTA as set out within this document? Where can they access support for early intervention rather than just wait until the situation escalates further surely? Public Health preventative approach is important not just focus on this with most severe needs. Acknowledge and appreciate that the evidence base if very limited.	Thank you for your comment. The committee acknowledge that the evidence base is very limited in this area and therefore have made a research recommendation. With respect to where young people might access support, the committee would envisage that this would happen within existing primary care, mental health and third sector services. In the absence of strong evidence for specific interventions, the committee would expect professionals to follow the principles outlined in the guideline.
Department of Health – Northern Ireland	Guideline	32	4	Would recommend including: Supportive structures should be put in place to care for those who are involved in the delivery.	Thank you for your comment. This has already been recommended in 1.15.2 and so has not been repeated in this section which is about staff training.
Department of Health – Northern Ireland	Guideline	32	12	Would recommend considering changing 'staff who work with' to All health professionals should be offered self-harm awareness training	Thank you for your comment. This recommendation is intended to apply to non-healthcare professionals too and so we have not made this change.
Derbyshire Healthcare NHS Foundation Trust	Guideline	General	General	With increasing demand on mental health services, such as liaison teams (and a drive to "train up" non mental health specialists within ED settings to undertake psychosocial assessments), there is a risk that motivation of self-harm (suicidal intent) and /or method	Thank you for your comment. The guideline already recommends that everyone should receive an assessment. As such we have not made your suggested change.

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				of self-harm are used to "prioritise" who should receive psychosocial assessments, and/or other care from mental health specialists, or at all. It would be extremely beneficial for the guidance to include a statement highlighting that neither motivation, nor method of self-harm should be used as a criteria for assessment or treatment by a mental health specialist. There is reference to this within the definition of self-harm ("context") within the guidance, but it is important to have this highlighted within the hospital assessment sections. Page 11, Section 1.5.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	5	General	Increased prominence of providing information and support – particularly to carers, friends and relatives. This is an important part of self-harm support and prevention work. On the issue of the involvement of others, perhaps more direct reference could be made to the consensus statement to help highlight the importance of proactively seeking and supporting the views, involvement and opinions of others.	Thank you for your comment. A link to the consensus statement has been added to recommendation 1.2.1.

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Derbyshire Healthcare NHS Foundation Trust	Guideline	13	14-15	There is a considerable body of evidence and understanding of many of the ongoing problems, difficulties and final precipitants related to self-harm presentations. Many of these do not fall directly under the mental illness or mental health umbrella but often relate to social, relationship, work, studies, financial etc., related issues. Whilst it is understandable that current mental illness and mental health problems may increase the vulnerability to self-harm of someone experiencing these, it is often other life problems and difficulties that the person is facing that have a strong connection with the self-harm episode and immediate risk. Whilst the current guidelines are good at highlighting and supporting the delivery of evidence based mental health interventions, it must be noted that the same evidence base also demonstrates that not everyone will be helped by such interventions. There is currently advice within the	Thank you for your comment. The committee agreed they could not provide a list of examples for the way in which a safety plan might result in care and referral to other services because this will be highly individual for each person. The committee agreed that instead, the recommendations should convey the principle that safety plans should address the needs of the person, which could be in the areas highlighted in your comment.

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				guidelines in relation to problem solving and strengths-based approaches. But we do not see are any direct guidance regarding the exchange of information, support, guidance and potential monitoring in relation to life problems and difficulties that the person reported to be related to their self-harm episode. Reference is made to changeable and current factors, as well as recent and current life difficulties needing to be understood. However, we see that these are not expanded on particularly well in regard to what support/guidance interventions could help to address or mitigate these. A simplistic example would be: If relationship issues are a key factor, explore techniques to improve relationships e.g. couple's counselling, marital guidance, RELATE. If financial difficulties, explore debt management approaches, referrals to agencies that deal exclusively with this area.	

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				If there are problems regarding work or studies – explore what help and support could be given by the person's employer, academic institution, peer/self-help group. There is a potential danger in the guideline focusing too much on interventions related to mental health services, and that we miss the important role that both the individual concerned, as well as their friends, family work colleagues and local communities can play, in helping to support and normalise factors which we see so often see precipitate self-harm.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	14	12	Is there empirical evidence to support that it needs to be a specialist in older adult mental health and self-harm who should conduct a psychosocial assessment for those who are aged 65years and over who have self-harmed? Whilst it makes sense that this should be the preference to ensure the patient receives care from the most	Thank you for your comment. Assessment by a mental health professional experienced in assessing older people who self-harm was recommended based on the experience of the committee, for the reasons you have cited. Recommendation 1.5.1 is that the assessment should happen at the earliest opportunity. The committee would still expect this to happen for older adults.

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				appropriately trained and experienced professional, the availability of a professional specialising in older adult care, should not cause any delay in a person receiving a psychosocial assessment when other mental health specialists are available.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	14	27	It is highly beneficial to highlight the importance of risk formulation as part of the psychosocial assessment and to move away from the more traditional view of "a risk assessment". A Psychosocial assessment can be seen as exploring and understanding the person's story, with clinical formulation helping to pull the various threads together as to what is important for that individual (in the context of known risk factors – for the individual and from research on population factors).	Thank you for your comment.
Derbyshire Healthcare NHS Foundation Trust	Guideline	18	3 - 5	We are concerned that there is not a stronger message about the need within 48 hours of a self-harm episode for a hospital attendance - to ensure any immediate threats to physical health resulting from the self-harm act are treated. This concern comes from our many years of experience working within an emergency department	Thank you for your comment. The committee have discussed this but disagreed with the premise that every time someone self-harms they need to be taken to hospital – there will be instances when this is not necessary. There was also qualitative evidence that blanket decisions to take people to hospital, regardless of the severity of the self-harm, can cause distress which can lead to further self-harm.

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				setting and learning from serious untoward incidents related to both deaths and near misses following self-harm episodes. Once in hospital there is then also the opportunity for a full biopsychosocial assessment from a specialist mental health professional (e.g. Liaison teams). Whilst we appreciate the initiatives around appropriate diversion from the emergency department, we are concerned that we must not miss the important message that all self-harm acts should be taken seriously and are reviewed and treated as appropriate regarding their medical seriousness. Examples from clinical practice: It is not uncommon for people presenting with self-cutting to later be found to have taken a potentially fatal overdose. It is also not uncommon for what a person has said they have taken in overdose, to later be found to be different in terms of type and quantity – this sometimes only becoming	The recommendations made do not place the onus on the patient to decide whether to attend the ED, they apply when the person who has self-harmed does not need urgent physical care. Being able to independently assess the severity of the situation and discern whether someone urgently needs to go to the ED would be part of standard training for ambulance staff and paramedics and is not an issue that is specific to self-harm. A new recommendation has been made which states that when deciding if the person should see another service ambulance staff and paramedics should assess immediate safety concerns.

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				apparent following blood tests. Many factors can account for these difficulties including distress, being in crisis, effects of alcohol or other substances, the person feeling reluctant or embarrassed to share what they have done, or the person perhaps wanting to minimise the situation. Locally we have guided our clinical staff to consider that any overdose discovered or revealed within a 48 hour time window should normally be directed to A&E usually by 999 call. Historically there have been tragic consequences when Emergency Department attendance has been delayed following the onus being given to the patient to decide whether to attend and they have not done so. Whilst it is understood that the present NICE guideline directs readers to other guidelines related to immediate first aid for self poisoning etc., we would like to see the important message related to the risks following self-harm if	

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				appropriate medical screening and access to emergency medical support where needed is not sort.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	21	15	We are concerned that there is not a stronger message about the need within 48 hours of a self-harm episode for a hospital attendance - to ensure any immediate threats to physical health resulting from the self-harm act are treated. This concern comes from our many years of experience working within an emergency department setting and learning from serious untoward incidents related to both deaths and near misses following self-harm episodes. Once in hospital there is then also the opportunity for a full biopsychosocial assessment from a specialist mental health professional (e.g. Liaison teams). Whilst we appreciate the initiatives around appropriate diversion from the emergency department, we are concerned that we must not miss the important message that all self-harm acts should be taken seriously and are reviewed and treated as appropriate regarding their medical seriousness.	Thank you for your comment. The committee have discussed this but disagreed with the premise that every time someone self-harms they need to be taken to hospital – there will be instances when this is not necessary. There was also qualitative evidence that blanket decisions to take people to hospital, regardless of the severity of the self-harm, can cause distress which can lead to further self-harm. The recommendations for non-healthcare professionals already state that immediate physical health needs should be addressed, for example by calling 999. An additional recommendation has been added that the severity of the injury and how urgently medical treatment is needed should be assessed.

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				Examples from clinical practice: It is not uncommon for people presenting with self-cutting to later be found to have taken a potentially fatal overdose. It is also not uncommon for what a person has said they have taken in overdose, to later be found to be different in terms of type and quantity – this sometimes only becoming apparent following blood tests. Many factors can account for these difficulties including distress, being in crisis, effects of alcohol or other substances, the person feeling reluctant or embarrassed to share what they have done, or the person perhaps wanting to minimise the situation. Locally we have guided our clinical staff to consider that any overdose discovered or revealed within a 48 hour time window should normally be directed to A&E usually by 999 call. Historically there have been tragic consequences when Emergency Department attendance has been delayed following the onus being given	

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				to the patient to decide whether to attend and they have not done so. Whilst it is understood that the present NICE guideline directs readers to other guidelines related to immediate first aid for self poisoning etc., we would like to see the important message related to the risks following self-harm if appropriate medical screening and access to emergency medical support where needed is not sort.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	22	2 -4	We are concerned that there is not a stronger message about the need within 48 hours of a self-harm episode for a hospital attendance - to ensure any immediate threats to physical health resulting from the self-harm act are treated. This concern comes from our many years of experience working within an emergency department setting and learning from serious untoward incidents related to both deaths and near misses following self-harm episodes. Once in hospital there is then also the opportunity for a full biopsychosocial assessment from a specialist mental health professional (e.g. Liaison teams).	Thank you for your comment. The committee have discussed this but disagreed with the premise that every time someone self-harms they need to be taken to hospital – there will be instances when this is not necessary. There was also qualitative evidence that blanket decisions to take people to hospital, regardless of the severity of the self-harm, can cause distress which can lead to further self-harm. The recommendations for non-healthcare professionals already state that immediate physical health needs should be addressed, for example by calling 999. An additional recommendation has been added that the severity of the injury and how urgently medical treatment is needed should be assessed.

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				Whilst we appreciate the initiatives around appropriate diversion from the emergency department, we are concerned that we must not miss the important message that all self-harm acts should be taken seriously and are reviewed and treated as appropriate regarding their medical seriousness. Examples from clinical practice: It is not uncommon for people presenting with self-cutting to later be found to have taken a potentially fatal overdose. It is also not uncommon for what a person has said they have taken in overdose, to later be found to be different in terms of type and quantity – this sometimes only becoming apparent following blood tests. Many factors can account for these difficulties including distress, being in crisis, effects of alcohol or other substances, the person feeling reluctant or embarrassed to share what they have done, or the person perhaps wanting to minimise the situation.	

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				Locally we have guided our clinical staff to consider that any overdose discovered or revealed within a 48 hour time window should normally be directed to A&E usually by 999 call. Historically there have been tragic consequences when Emergency Department attendance has been delayed following the onus being given to the patient to decide whether to attend and they have not done so. Whilst it is understood that the present NICE guideline directs readers to other guidelines related to immediate first aid for self poisoning etc., we would like to see the important message related to the risks following self-harm if appropriate medical screening and access to emergency medical support where needed is not sort.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	25	12	Whilst we see that there are many benefits from "Within 48 hours of the psychosocial assessment after an episode of self-harm, provide initial aftercare from the mental health team, GP or team who carried out the psychosocial	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.

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				assessment" Firstly this will have resource implications and secondly it is possible that the person may not want initial aftercare to be provided by the team who carried out the initial assessment. However overall we do support this recommendation as a very positive way forward.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	26	14-15	There is a considerable body of evidence and understanding of many of the ongoing problems, difficulties and final precipitants related to self-harm presentations. Many of these do not fall directly under the mental illness or mental health umbrella but often relate to social, relationship, work, studies, financial etc., related issues. Whilst it is understandable that current mental illness and mental health problems may increase the vulnerability to self-harm of someone experiencing these, it is often other life problems and difficulties that the person is facing that have a strong connection with the self-harm episode and immediate risk.	Thank you for your comment. The committee have tried to acknowledge as far as possible, the complexity and multiple aetiology of self-harm and the wide variety of possible approaches that may be helpful. The guideline has not discussed every possible intervention. Instead it makes a strong recommendation that professionals and practitioners should focus on service users needs and intervene accordingly.

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				Whilst the current guidelines are good at highlighting and supporting the delivery of evidence based mental health interventions, it must be noted that the same evidence base also demonstrates that not everyone will be helped by such interventions. There is currently advice within the guidelines in relation to problem solving and strengths-based approaches. But we do not see are any direct guidance regarding the exchange of information, support, guidance and potential monitoring in relation to life problems and difficulties that the person reported to be related to their self-harm episode. Reference is made to changeable and current factors, as well as recent and current life difficulties needing to be understood. However, we see that these are not expanded on particularly well in regard to what support/guidance interventions could help to address or mitigate these. A simplistic example would be:	

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				If relationship issues are a key factor, explore techniques to improve relationships e.g. couple's counselling, marital guidance, RELATE. If financial difficulties, explore debt management approaches, referrals to agencies that deal exclusively with this area. If there are problems regarding work or studies – explore what help and support could be given by the person's employer, academic institution, peer/self-help group. There is a potential danger in the guideline focusing too much on interventions related to mental health services, and that we miss the important role that both the individual concerned, as well as their friends, family work colleagues and local communities can play, in helping to support and normalise factors which we see so often see precipitate self-harm.	
Derbyshire Healthcare	Guideline	27	7	There is a considerable body of evidence and understanding of many	Thank you for your comment. The committee have tried to acknowledge as far as possible, the

Stakeholder	Document	Page No	Line No	Comments	Developer's response
NHS Foundation Trust				of the ongoing problems, difficulties and final precipitants related to self-harm presentations. Many of these do not fall directly under the mental illness or mental health umbrella but often relate to social, relationship, work, studies, financial etc., related issues. Whilst it is understandable that current mental illness and mental health problems may increase the vulnerability to self-harm of someone experiencing these, it is often other life problems and difficulties that the person is facing that have a strong connection with the self-harm episode and immediate risk. Whilst the current guidelines are good at highlighting and supporting the delivery of evidence based mental health interventions, it must be noted that the same evidence base also demonstrates that not everyone will be helped by such interventions. There is currently advice within the guidelines in relation to problem	complexity and multiple aetiology of self-harm and the wide variety of possible approaches that may be helpful. The guideline has not discussed every possible intervention. Instead it makes a strong recommendation that professionals and practitioners should focus on service users needs and intervene accordingly.

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				solving and strengths-based approaches. But we do not see are any direct guidance regarding the exchange of information, support, guidance and potential monitoring in relation to life problems and difficulties that the person reported to be related to their self-harm episode. Reference is made to changeable and current factors, as well as recent and current life difficulties needing to be understood. However, we see that these are not expanded on particularly well in regard to what support/guidance interventions could help to address or mitigate these. A simplistic example would be: If relationship issues are a key factor, explore techniques to improve relationships e.g. couple's counselling, marital guidance, RELATE. If financial difficulties, explore debt management approaches, referrals to agencies that deal exclusively with this area.	

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				If there are problems regarding work or studies – explore what help and support could be given by the person's employer, academic institution, peer/self-help group. There is a potential danger in the guideline focusing too much on interventions related to mental health services, and that we miss the important role that both the individual concerned, as well as their friends, family work colleagues and local communities can play, in helping to support and normalise factors which we see so often see precipitate self-harm.	
Derbyshire Healthcare NHS Foundation Trust	Guideline	33	19	It was refreshing to see the inclusion of the importance of supervision for staff who regularly encounter self-harm; the emotional well-being and safety of staff is an important area.	Thank you for your comment.
Derbyshire Healthcare NHS Foundation Trust	Guideline	35	16 - 24	It is good to have identified the needs of people who have a designated lead responsibility in their setting related to self-harm. We wonder if this could be considered in other settings - not just educational.	Thank you for your comment. The terms used section of the guideline defines terms that have been used in a particular way for this guideline. It is not a recommendation for practice.

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Derbyshire Healthcare NHS Foundation Trust	Guideline	34 36	18-21 11-15	Care plans and safety plans It is good to see the inclusion of safety plans but also an understanding and differentiation to care plans – as both have valuable contributions to make. It may be helpful to add to both descriptions that the careplan is often seen to mainly be led/developed by a healthcare professional in collaboration with the person who has self-harmed, where a safety plan is owned by the person themselves to be further built upon, developed, etc., in whatever way they wish.	Thank you for your comment. The committee are aware that the terms care plan and safety plan are used in a variety of different ways. The guideline has tried to be consistent with the most common usage of these and their underlying principles.
East London NHS Foundation Trust	Guideline	General	General	Given the lack of sufficient evidence of good quality, the recommendations lack adequate recognition of this. Recommendations would benefit from a greater recognition of the primacy of affect in determining actions, including self harm by the patient and of the response by the clinician to this. By definition then recommendations would widen from the current emphasis on CBT and DBT to include psychodynamic approaches.	Thank you for your comment. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles.

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East London NHS Foundation Trust	Guideline	General	General	Paragraph 1.10.2 The recommendations should not state CBT as the only option. This is not borne by the data eg it does not adequately acknowledge the contribution of psychodynamic psychotherapy interventions eg Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., Sanderson, S., Turpin, C., Boddy, G. & Tomenson B. (2001). Randomised controlled trial of brief psychological intervention after deliberate self-poisoning. British Medical Journal, 323: 135-138. Recommendations should acknowledge the contribution of other approaches which have an evidence base in self harm, including Transference Focussed Psychotherapy or Mentalisation Based Therapy	Thank you for your comment. The Guthrie 2001 study was included in the Cochrane review on psychosocial interventions and was analysed as part of comparison 1: Cognitive behavioural therapy (CBT)-based psychotherapy versus TAU or another comparator. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The committee agreed that while there is some promising initial evidence regarding other interventions, the evidence base is not strong enough to recommend these. As a result, research recommendations for psychosocial interventions for self-harm (including MBT) have been made - please see appendix K of evidence review J for more information.
Harmless	Evidence review B	General	General	Evidence review B- Information and support for families and carers of	Thank you for your comment. NICE guidelines apply to England and therefore the

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				people who have self-harmed Reflections: • From a lived experience I can agree with the fact that on the whole this is a good and much needed move in providing appropriate information in a variety of formats that suit individuals needs and recovery journey specific time periods. When caring for someone who is actively self harming it is a very isolating and scary place so information relating to carer peer support is an essential move in the right direction, this also enables the carer to let off steam safely and not inhibit interactions with the person they are caring for! • Is this approach primarily a western centric approach – possibly creating an exclusion for all those living in the UK? – This may be an area that requires further research • Has language and culture been considered in enough depth with regards to	recommendations will be specific for the NHS. As a result we prioritised data from the UK and only searched for evidence from high income countries for the qualitative reviews. We cannot make research recommendations for other countries because we did not search for this evidence. Please refer to recommendations 1.1.3, 1.1.4, and 1.14.2, which cover the need for information and support to be tailored to the person and their individual background and circumstances, and the need for staff to be culturally competent. The kind of considerations outlined are addressed in the relevant NICE guidelines: Shared decision making, Service user experience in adult NHS mental health, Patient experience in adult NHS services, and Babies, children and young people's experience of healthcare. These guidelines explore accessibility and information sharing more widely and have been signposted to in recommendation 1.1.3. Additionally, please note that the training requirements outlined in recommendation 1.14.2 are for all staff who work with people who have self-harmed, which includes educational staff.

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				information giving? In the thematic map, 'availability in multiple languages' is highlighted as a theme. However, are factors such as stigma clearly examined on how they might create barriers to developing or accessing meaningful information and support. There is so much more than just placing information in different languages, there is also understanding the drivers and barriers within different cultures, sex, age, race etc. Are we being too superficial in our guidance? An example within out own service is noting that females will pick up information leaflets but males are much less likely. Therefore, should there be something about the information accessibility that addresses barriers. • How will this be rolled out and evaluated – We should be guiding people to evaluate and measure the success of information giving so it is truly effective	

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				and meaningful, meeting parent/carer needs, rather than becoming benign and even outdated signposting. • Ensuring information is both person-centred and, also, family centred is highly appropriate – moving away from the cookie cutter services and informational handouts • Ad-Hoc support is essential, all information should have service/charity limitation stated within to prevent inadvertent barriers. • Due to the large proportion of time most parents/carers spend, some sources of information/support should require a higher degree of training and information. For example, schools. If non-specialist services are providing information and support, there could be recommendation for mandatory basic training and understanding so those responsible within these settings can develop/implement	

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				evidence-based materials and information that can then be evaluated and updated as a live, flexible form of support. Thus, providing quality care and support to parents and carers rather than tokenistic.	
Harmless	Evidence review C	General	General	Evidence review C- Consent, confidentiality and safeguarding Reflections: The emphasis on the critical 'outcomes that matter most' are well placed and in line with expectations I would have for these guidelines. Focus on self-harm repetition and suicide risk in terms of measuring effectiveness of interventions or support alongside measuring and maintaining service user satisfaction in terms of impact on engagement with the intervention and support are key elements. Benefits & Harms – Consent and Confidentiality – Highlights understanding of concerns that healthcare workers/those providing support may experience however allows and provides confidence via	Thank you for your comment and feedback.

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				signposting to relevant guidance, Acts, and legal advice to ensure that fear of implications can be minimised and potential for negative outcomes for the service user can potentially be mitigated. Alongside this the clear message of empowering the service user wherever possible, even if confidentiality has had to be broken or if capacity is of concern is promising to see and explains the reasons for this to emphasise. Safeguarding – The committee agreement to provide clarity on inclusivity of any service user who has self-harmed regardless of age in terms of safeguarding again is positive, accepting that the level of vulnerability may be the same, in support of this they also signpost healthcare professionals to current guidelines on Domestic Abuse, Child Abuse and neglect along with others as well as guidance on managing a potential disclosure and how to approach questioning.	
Harmless	Evidence review L	General	General	Evidence review L: Harm minimisation strategies…	Thank you for your comment. The introduction to the evidence review has been amended, however

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				Reflecting on the broad range of people who will access this document I think it should be taken into consideration that many people tend to skim read or only focus on the main points. Therefore, I believe the introduction section of harm minimisation could be improved.	this is usually written in advance of the review being conducted and is meant to provide context for why a review of the evidence was important. It is not intended to pre-judge the evidence or any recommendations made, which is why the discussion of the potential benefits and harms of harm minimisation is in the Committee's discussion of the evidence section instead of the introduction.
Harmless	Evidence review L	9 - 11	General	9-11: People who repeatedly self-harm without suicidal intent may find these strategies useful when stopping self-harm is not yet possible, as a way to self-harm 'safely'- The use of the word 'safe' is open to interpretation, one of them being an endorsement (safe from suicide, safe from danger). Or making self harm safe (meaning preventing infection, preventing accidental death) what this can inadvertently enable is the 'caregiver' to create a situation in which they feel comfortable about the actions being carried out without addressing more than the symptom. Our focus should be so much more than this and the NICE Guidelines have a duty to provide exceptionally clear advice. At the very least this should be made clear in the introduction section that motivations for	Thank you for your comment. The introduction has been amended to remove references to self-harming 'safely'. The introduction to the evidence review is written in advance of the review being conducted and is meant to provide context for why a review of the evidence was important. It is not intended to pre-judge the evidence or any recommendations made, which is why the discussion of the potential benefits and harms of harm minimisation is in the Committee's discussion of the evidence section instead of the introduction. The committee agreed that, without strong evidence of effectiveness, it would be inappropriate to recommend 'safer' self-harm strategies. A sentence has been added to the harm minimisation section in the guideline (section 1.11) to clarify this. Additionally, recommendation 1.11.11 states that harm minimisation strategies are not to be used as a standalone intervention, in order to prevent a scenario such as that suggested. However,

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				implementing harm minimisation strategies should be measured by how beneficial they are to the individual who self harms and not be used alone or as the main form of treatment. (Something similar to what is written in sentences 17-20.) Additionally, upon reflection, what does it mean to have a focus on harm minimisation in the NICE guidance and how does it read overall. We speak strongly about the stigma that surrounds self harm, the importance of moving beyond the physical symptom, the panic and fear associated with the physical act. Are we inadvertently encouraging stigma? Especially when we use out of date language such as self harming safely.	removing discussion of 'safer' self-harm strategies would be inappropriate because many health and social care staff still exclusively associate harm minimisation with these strategies. The committee agreed it was important to highlight the utility of other methods of harm minimisation and this is emphasised throughout the Evidence Review and the guideline.
Harmless	Evidence review L	21 - 23	General	21-23: 21 The committee felt strongly that it was important to note harm minimisation was more than just safer self-harm methods, and that often harm minimisation is referring to distraction techniques to prevent harm. – Why does the introduction only focus on safer self harm methods/language. Why aren't we moving forward with terminology? Are not distraction techniques and harm minimisation	Thank you for your comment. The text cited describes the committees deliberations when making the recommendations on harm minimisation - it is not an introduction. The introduction has, however, been amended to remove reference to self-harming 'safely'. The committee agreed that 'safer' self-harm and distraction techniques were very different methods but that both fell under the umbrella term of harm minimisation. The committee also agreed that often people use the term 'harm minimisation' only to

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				techniques very different from one another. Harm minimisation which the focus on 'safety' and distraction techniques a tool supporting emotional regulation and distress reduction.	refer to 'safer' self-harm, and therefore felt it was important to clarify in the introduction that multiple different approaches to harm minimisation, including distraction techniques, had been included when searching for evidence and for consideration when drafting the reviews.
Harmless	Evidence review L	11 -12	General	11-12: However, in existing practice, self-harm prevention is usually seen as the highest priority when providing care for people who have self-harmed – This sentence should be a priority disclaimer before recommending harm minimisation techniques. It should include something from sentences 17-20: The committee considered these benefits and risks before concluding that harm-minimisation strategies should only be suggested to service users after having considered their unique situation, as part of an overall provision of support maintaining the expectation of recovery and not as a standalone intervention.	Thank you for your comment. Recommendation 1.11.11 states that harm minimisation strategies should only be considered 'as part of an overall approach to the person's ongoing recovery-focused care and support, and not as a standalone intervention' and 'after being discussed and agreed in a collaborative way with the person and their family members or carers (as appropriate), and the wider multidisciplinary team'. This recommendation comes ahead of the recommendation to discuss harm minimisation with the person, and should effectively act as a disclaimer.
Harmless	Evidence review R	General	General	Evidence review R- Skills required by staff in non-specialist settings… 8 Non-specialist staff are likely to have less experience working with people who have self harmed and to have less access to appropriate training. – Upon	Thank you for your comment. The introduction has been amended as per this suggestion.

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				reflection we believe it would be beneficial to have in the introduction paragraph a focus on the development of skills for non-specialist staff required to support people who self harm such as, "Staff in non-specialist settings require a range of comprehensive skills in order to ensure high quality of care provision." This would combine with specialist settings who require specific skills and should consider how non-specialist and specialist services compliment one another.	
Her Majesty's Inspectorate of Prisons	Guideline	24	19	Recommendation 1.8.6: This guidance is welcome. It is important that adequate resourcing is provided to make sure this guidance is met in practice because it represents a significant shift from the current practice we see between general hospitals and prisons. Currently, people who have been treated in a general hospital are often discharged back to detention with no associated documentation/aftercare plans. In addition, patients discharged from general hospital are often only seen the next day by prison healthcare staff	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.

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				as a result of reporting structures within prisons, an issue which is further compounded by the large number of self-harm episodes requiring hospital treatment taking place out of hours.	
Her Majesty's Inspectorate of Prisons	Guideline	23 (and 52)	25	Recommendation 1.7.10 and related rationale: It would be helpful if the guidance provided more information on what constitutes a safe location because these decisions may be being made by custody staff with little training. In some cases, the safest location may be for the person to remain in situ until treatment/assessment. This may be because, for example, the person perceives being moved as a punishment or is moved to an unfamiliar area which has the potential to increase distress and subsequent risk. It may therefore be helpful to note that a safe location may be able to be created in situ through risk assessment. It would also be helpful to emphasis not just the need for a safe location but also the need for immediate support to be provided to	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. As such the committee were not able to be specific about what would constitute a 'safe location'. This would be a matter for local implementation.

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				the person to make sure they are not left isolated.	
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	8	13	Rec 1.2.4 – NICE should define this	Thank you for your comment. The committee's view was that all health and social care staff need to be aware of the principles surrounding capacity, appropriate to their role and position in the organisation. It is not the role of NICE guidelines to set out practices defined by law.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	17	14	Rec 1.6.6 – referral to mental health – or acute - services	Thank you for your comment. Your suggested change has not been made because this recommendation is about referral to mental health specialists.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	19	13	Rec 1.6.12 – we are not sure this is realistic	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	20	18	Rec 1.6.19 – we are not sure this is realistic	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage

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					commissioners to fund services to meet these standards.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	25	12	Rec 1.9.2 – we expect this recommendation will prove challenging	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	26	5	Rec 1.10.2 – CGT – this is not commissioned in many areas	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	28	7	Rec 1.10.10 – change to 'self-harm minimisation'	Thank you for your comment. The guideline has been amended to clarify that it does not make any recommendations on the use of safer self-harm. The committee agreed it would not be appropriate to recommend safer self-harm in the absence of good evidence, though they acknowledged other approaches may be helpful and have fewer potential harms. The examples that were initially given in the definition have been removed to clarify these are not specifically being recommended.

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					Instead, the committee agreed to amend the definition to focus on avoiding, delaying or reducing self-harm, to centre the definition of harm minimisation around the aims of the approach rather than giving examples. However, given there is no consensus definition of harm minimisation, no existing quantitative evidence, and no body of work around defining harm minimisation, the committee agreed it would be premature and inappropriate to be more definitive in the terms section without any evidence.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	29	14	Rec 1.11.3 – There needs to be a definition of 'observation' in this context	Thank you for your comment. A definition of observation was already included in the guideline but this has been re-titled to clinical observation for clarity.
Herefordshire and Worcestershire Health and Care NHS Trust	Guideline	30	22	Rec 1.12.1 – amend – 'their recreational drug and alcohol consumption, and the risk of misuse ...and interaction with prescribed treatment'	Thank you for your comment. This addition has been made
Joint response for: British Association of Art Therapists;	Guideline	10	18–- 21	We recommend that when involving parents, consider systemic music therapy (Colgrove et al., 2019), especially where a parent has a trauma history.	Thank you for your comment. There was no evidence to recommend systemic music therapy. The Cochrane review analysing interventions for children and young people who have self-harmed would have included evidence regarding the effectiveness of systemic music therapy if it was

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British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists.				Colgrove VM, Havighurst SS, & Kehoe CE (2019) Emotion regulation during conflict interaction after a systemic music intervention: Understanding changes for parents with a trauma history and their adolescent. Nordic Journal of Music Therapy, 28(5), 405-425. https://doi.org/10.1080/08098131.2019.1616807	available, as the protocol states that "Categorisation of the interventions in this review will be informed by the trials themselves" (Witt 2020). Colgrove 2019 would not have been included in the Cochrane review as the population does not specifically include people who have self-harmed, and also does not investigate the primary outcome of repeat self-harm.
Joint response for: British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK;	Guideline	26	11 -13	Regarding children and young people who self-harm, we believe there is enough preliminary evidence (Plener et al., 2010) to recommend considering arts therapies with a therapist experienced in working with children and young people who self-harm. Although direct evidence of reduction in self-harm is not yet plentiful, some papers provide plausible theoretical explanations, based on the experiences of service users and evidence-based theory, about why arts therapies may be helpful, in that they enable emotional expression or	Thank you for your comment. The Cochrane review analysing interventions for children and young people who have self-harmed would have included evidence regarding the effectiveness of arts-based therapies if they were available, as the protocol states that "Categorisation of the interventions in this review will be informed by the trials themselves" (Witt 2020). The articles linked would not have been included because they are case series, narrative reviews, pilot studies, or a qualitative study, and therefore not compatible with the Cochrane review, which only included quantitative RCTs. Based on the available evidence from this review, the committee were only able to recommend DBT-A for children and young-

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British Association of Dramatherapists.				experiencing in a contained way, which in turn facilitates thinking about and regulating one's emotions and thus reducing the urge to self-harm (Herald, 2019; Hou et al., 2017; Karterud & Urnes, 2004; Springham et al., 2012; Stegemann et al., 2010). If arts therapies are attended in a group, participants also learn about others' emotions and mental states, and have an experience of regulating their own emotions during interactions with others. Herald (2019) Music as a regulator of emotion: Three case studies. Music and Medicine. 11(3), 183-194. https://doi.org/10.47513/mmd.v11i3.644 Hou J, Song B, Chen AC … & Beauchaine TP (2017) Review on neural correlates of emotion regulation and music: Implications for emotion dysregulation. Frontiers in Psychology https://doi.org/10.3389/fpsyg.2017.00501 3 April 2017 Karterud, S., & Urnes, O. (2004).	people with emotional dysregulation difficulties who have frequent episodes of self-harm. However, the committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions - please see appendix K of evidence review J for more information.

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				Short-term day treatment programmes for patients with personality disorders. What is the optimal composition? Nordic Journal of Psychiatry 58, 243249. https://doi.org/10.1080/08039480410006304 Plener PL, Sukale T & Ludolph AG (2010) "Stop cutting-rock!"': A pilot study of a music therapeutic program for self-injuring adolescents. Music and Medicine, 2(1), 2010, 59-65. https://doi.org/10.47513/mmd.v2i1.234 Springham N, Findlay D, Woods A & Harris A (2012) How can art therapy contribute to mentalization in borderline personality disorder? International Journal of Art Therapy. 17(3), 115-129. http://dx.doi.org/10.1080/17454832.2012.734835 Stegemann T, Briiggemann-Etchart A, Badorrek-Hinkelmann A, & Romer G (2010) Die funktion von musik im zusammenhang mit selbstverletzendem verhalten und	

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				suizidalität bei jugendlichen. Praxis der Kinderpsychologie und Kinderpsychiatrie, http://hdl.handle.net/20.500.11780/3251	
Joint response for: British Association of Art Therapists; British Association of Music Therapists; Association for Dance Movement Psychotherapy UK; British Association of Dramatherapists.	Guideline	26	5 -10	Regarding adults who self-harm, we believe there is enough preliminary evidence (Haeyen et al., 2015; Haeyen et al., 2018; Havsteen-Franklin et al., 2018; Kleinlooh et al., 2021; Kleinlooh et al. 2022; Rasmussen et al., 2018) and established practice (Springham et al., 2012) to recommend considering arts therapies with a therapist experienced in working with people who self-harm and/or have a diagnosis of personality disorder (self-harm is common in this group). Although direct evidence of reduction in self-harm is not yet plentiful, some papers provide plausible theoretical explanations, based on the experiences of service users and evidence-based theory, about why arts therapies may be helpful, in that they enable emotional expression or experiencing in a contained way, which in turn facilitates thinking about and regulating one's emotions (Herald, 2019; Hou et al.,	Thank you for your comment. The Cochrane review analysing interventions for children and young people who have self-harmed would have included evidence regarding the effectiveness of arts-based therapies if they were available, as the protocol states that "Categorisation of the interventions in this review will be informed by the trials themselves" (Witt 2020). The articles linked would not have been included because they are case series, narrative reviews, pilot studies, or a qualitative study, and therefore not compatible with the Cochrane review, which only included quantitative RCTs. Based on the available evidence from this review, the committee were only able to recommend DBT-A for children and young-people with emotional dysregulation difficulties who have frequent episodes of self-harm. However, the committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions - please see appendix K of evidence review J for more information.

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				2017; Karterud & Urnes, 2004; Springham et al., 2012). Emotion regulation in turn reduces the urge to self-harm. If arts therapies are attended in a group, people also learn about others' emotions and mental states, and have an experience of regulating their own emotions during interactions with others. Many programmes for people with diagnoses of personality disorders incorporate arts therapies for these reasons (Springham et al., 2012). Kleinlooh, S. T., Samaritter, R. A., Van Rijn, R. M., Kuipers, G., & Stubbe, J. H. (2021). Dance movement therapy for clients with a personality disorder: A systematic review and thematic synthesis. Frontiers in Psychology, 12, 712. Kleinlooh, S. T., Samaritter, R. A., Stubbe, J. H., & Koes, B. W. (2022). A Dance Movement Therapy intervention for people with a Personality Disorder: A Delphi study. The Arts in Psychotherapy, 101883.	

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				Haeyen S, van Hooren S & Hutschemaekers G (2015) Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study. The Arts in Psychotherapy, 45, 1-10. https://doi.org/10.1016/j.aip.2015.04.005 Haeyen, S., van Hooren, S., van der Veld, W., & Hutschemaekers, G. (2018). Efficacy of art therapy in individuals with personality disorders cluster B/C: A randomized controlled trial. Journal of personality disorders, 32(4), 527-542. https://doi.org/10.1521/pedi_2017_31_312 Havsteen-Franklin D, Haeijen S and Karkou V (2018) A Systematic Review on Arts Therapies Interventions in the Treatment of Personality Disorders (PD). The Arts in Psychotherapy, 63, 128- 140 https://doi.org/10.1016/j.aip.2018.10.001 Herald (2019) Music as a regulator of	

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				emotion: Three case studies. Music and Medicine. 11(3), 183-194. https://doi.org/10.47513/mmd.v11i3.644 Hou J, Song B, Chen AC … & Beauchaine TP (2017) Review on neural correlates of emotion regulation and music: Implications for emotion dysregulation. Frontiers in Psychology https://doi.org/10.3389/fpsyg.2017.00501 3 April 2017 Karterud, S., & Urnes, O. (2004). Short-term day treatment programmes for patients with personality disorders. What is the optimal composition? Nordic Journal of Psychiatry 58, 243249. https://doi.org/10.1080/08039480410006304 Rasmussen MK, Donoghue DA & Sheehan NW (2018) Suicide/ self-harm reducing effects of an aboriginal art program for aboriginal prisoners. Advances in Mental Health, 16(2), 141-151. https://doi.org/10.1080/18387357.2017	

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				.1413950 Springham N, Findlay D, Woods A & Harris A (2012) How can art therapy contribute to mentalization in borderline personality disorder? International Journal of Art Therapy. 17(3), 115-129. http://dx.doi.org/10.1080/17454832.2012.734835	
Kent and Medway Partnership Trust	Guideline	General	General	Flowchart or reference of where to get more information about the process following assessment e.g. referring to CMHT/crisis team then to GP. To ensure staff are aware of the steps following the assessment.	Thank you for your comment. What actions to take following assessment are already included in the guideline recommendations (see section 1.9 onwards). A flowchart has not been produced as the recommendations do not lend themselves to this format.
Kent and Medway Partnership Trust	Guideline	5	3	1.1.1 Could include harm reduction strategies e.g., ice cubes, rubber bands, red felt tip pens, toxic sweets	Thank you for your comment. Recommendations about harm minimisation are made in section 1.11.
Kent and Medway Partnership Trust	Guideline	6	5	1.1.2 This feels quite vague. Support around the reasons they might be doing it e.g. difficult relationships in family and how to get support around this. Background to self harm.	Thank you for your comment. The committee asserted that these issues would be raised as part of the comprehensive assessment recommended in the guideline.
Kent and Medway	Guideline	6	7	1.1.2 Include: 'including harm reduction techniques'	Thank you for your comment. Recommendations on harm minimisation are included in section 1.11.

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Partnership Trust					
Kent and Medway Partnership Trust	Guideline	10	21	1.4.3 Also include 'or harm reduction techniques'	Thank you for your comment. Recommendations on harm minimisation are included in section 1.11.
Kent and Medway Partnership Trust	Guideline	11	1	1.4.4 Reiterate that even if person has not consented to involvement, professionals/services can still provide information to families/carers but not about their care	Thank you for your comment. This is what recommendation 1.4.4. says.
Kent and Medway Partnership Trust	Guideline	12	16	1.5.8 Add learning disability	Thank you for your comment. The guideline has been amended to highlight the needs of people with learning disabilities or neurodevelopmental conditions in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure health and social care staff consider any additional needs those with learning disabilities may have.
Kent and Medway Partnership Trust	Guideline	13	11	1.5.10 Add to ask about family history of these conditions as well	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential

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					considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Kent and Medway Partnership Trust	Guideline	13	14	1.5.10 Include information about accommodation/living situation	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Kent and Medway Partnership Trust	Guideline	14	12	1.5.12 Mentions specialist advice from older adult professional, but a specialist around neurodevelopment/learning disability should also be included to provide specialist advice for these groups of people. Team with the specialist intervention for that category should be involved in the assessment process.	Thank you for your comment. An additional recommendation has been made (1.5.13) that people with learning disabilities who have self-harmed, should be assessed by a mental health professional experienced in assessing people with learning disabilities who self-harm.
Kent and Medway Partnership Trust	Guideline	14	23	1.5.13: Left a bit open, what to do if person leaves and their risk is high? Dial 999?	Thank you for your comment. The committee agreed that local services would have local procedures that detail how to deal with this issue.

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Kent and Medway Partnership Trust	Guideline	26	5	1.20.2 Revisit aims of the treatment to see whether the person thinks intervention has been useful or whether referrals are needed for different types of therapy. Also what next steps will be for someone who continues to consistently self harm.	Thank you for your comment. This level of detail would be a manual for how to provide CBT and so has not been included. Consideration of other needs is covered by psychosocial assessment.
Kent and Medway Partnership Trust	Guideline	26	16	1.10.5 Also include harm reduction techniques.	Thank you for your comment. Recommendations on harm minimisation are included in section 1.11.
Kent and Medway Partnership Trust	Guideline	27	1	1.10.6 Add about the use of advocacy	Thank you for your comment. The list of considerations in recommendation 1.11.7 is not intended to be exhaustive.
Kent and Medway Partnership Trust	Guideline	27	13	1.10.7 'Substance use' instead of 'substance misuse'.	Thank you for your comment. Substance misuse is the term used in NICE guidance.
Kent and Medway Partnership Trust	Guideline	28	6	1.10.10 Term 'self cut' assumes the method of self harming and doesn't encompass other techniques	Thank you for your comment. The wording has been changed to self-harm.
Kent and Medway Partnership Trust	Guideline	29	14	1.11.3 Too vague and left open to interpretation. Consider rephrasing to avoid using the negative terms like 'do not use' and 'untrained' e.g. "Use appropriately trained staff in clinical	Thank you for your comment. The committee agree that only staff who are appropriately trained in clinical observation should undertake such observations. However the practice this recommendations is trying to prevent is untrained

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				observations to undertake such observations for people who have self-harmed." Also include about aligning with therapeutic observation policies that state managers should ensure staff understand/are competent of therapeutic observations.	staff doing observation so the recommendation has been phrased accordingly.
Kent and Medway Partnership Trust	Guideline	32	9	1.13.1 Is this about self harm specifically/towards people who self harm or just generally? Should be more specific.	Thank you for your comment. As specified in the recommendation this is about training for staff who work with people who self-harm.
Kent and Medway Partnership Trust	Guideline	32	12	1.13.2 Should also include training around safeguarding	Thank you for your comment. The committee's view was that safeguarding would be encompassed by the existing bullet point on assessing the needs and safety of the person who has self-harmed. Section 1.3. makes specific recommendations on safeguarding, including the need for staff to be aware of various safeguarding principles and acts (recommendation 1.3.1).
Kent and Medway Partnership Trust	Guideline	33	20	1.14.1 Include support in forms of a debrief after an incident (linking it directly to this incident)	Thank you for your comment. The recommendation has been amended to include how best to support staff. It is not possible to recommend a specific method for doing this (such as debriefs) as the guideline has not looked at a review question in this area.

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Leeds and York Partnership NHS Foundation Trust	Guideline	9 -10	24	Rec 1.4.4 & 1.4.5 Guideline to be included in between these points; To complete a communication assessment and communication passport to fully understand the persons preferred communication needs. Such as, Makaton, BSL, PEC's etc. (see NHS accessibility standards regarding flagging patient's communication needs on clinical notes);consider using the communication passport if available. Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	5	17	Accessibility of services (written information and face to face), including out of hours for deaf people using BSL and non-English language speakers	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their

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					communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	5	11	Rec 1.1.1 ND CAMHS provide a list of items to carers that may potentially cause harm which they may wish to remove.	Thank you for your comment. The list from CAMHS has not been critically appraised and so we are not able to include it in a recommendation.
Leeds and York Partnership NHS Foundation Trust	Guideline	6	16	Rec 1.1.3 To include the NHS accessibility standards. This does not include an explicit section regarding people with disabilities and deaf people. Disability is only referred to in relation to neurodevelopmental as physical, mental health or neurodevelopmental conditions – as an add on. It should have a separate consideration and include sensory needs. A suggested example: Accessibility of services for deaf and disabled people. A disabled person may need reasonable adjustments to access health information and services. Information should be available in BSL,	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.

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				deaf people may need a BSL interpreter or other support when accessing health information and services. Reference to: Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/contents	
Leeds and York Partnership NHS Foundation Trust	Guideline	7	1	Rec. 1.1.4 To include deaf people as a linguistic and cultural minority- Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population. Appropriate to be included whenever assessment/interaction is necessary. Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/contents NHS Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.

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Leeds and York Partnership NHS Foundation Trust	Guideline	11	13	Rec 1.5.1 Specific, maximum timescale needs to be stated.	Thank you for your comment. The committee acknowledged that practice is variable in this area but the evidence did not support recommending a specific timescale. However they agreed that it should be carried out as soon as possible.
Leeds and York Partnership NHS Foundation Trust	Guideline	11	22	Rec 1.5.2 – This recommendation requires more clarity/depth. (Different type of medical treatment could be required first due to severity, or alternatively medical treatment required could be long-term) Assessments should not be delayed due to the need to book interpreters (BSL and spoken language interpreters).	Thank you for your comment. People requiring urgent care should not be left untreated, and the committee believe that any healthcare professional would be able to use their judgement to assess this situation. The committee made this recommendation to guard against the practice of not giving any mental health support whilst waiting for medical care. The provision of interpreters is covered by the NICE guidance on service user experience, which is referenced in this guideline.
Leeds and York Partnership NHS Foundation Trust	Guideline	11	24	Rec 1.5.3 – This requires the addition of taking into account any previous existing medical or mental health conditions and the age of the person	Thank you for your comment. This would be covered by 'historic factors' that recommendation 1.5.10 refers to.
Leeds and York Partnership NHS Foundation Trust	Guideline	12	3	Rec 1.5.4 – Please provide rationale for this recommendation	Thank you for your comment. The box at the bottom of this section links to the rationale for this recommendation.

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Leeds and York Partnership NHS Foundation Trust	Guideline	12	5	Rec 1.5.5 – Could this recommendation detail the reasons for being unable to participate in the psychosocial assessment (i.e. mental capacity, unconscious)	Thank you for your comment. The rationale and impact section has been amended to give examples of reasons why someone may be unable to participate in a psychosocial assessment.
Leeds and York Partnership NHS Foundation Trust	Guideline	12	10	Rec 1.5.6. – to add safety plan as well as care plan	Thank you for your comment. This is already covered in recommendation 1.11.7.
Leeds and York Partnership NHS Foundation Trust	Guideline	12	12	Rec 1.5.8 - Bullet point recommended; working with BSL or spoken language interpreters	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	12	26 - 27	Rec 1.5.9 – this recommendation could exclude over 65s who may present with repeated episodes – could 'episode' be clarified within the recommendation? Neglect factor to be considered. NHS Accessible Information Standard	Thank you for your comment. It is not clear from your comment why you believe this recommendation would exclude people over 65, but even when people present with repeated episodes of self-harm they should be assessed every time.

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				https://www.england.nhs.uk/ourwork/accessibleinfo/	
Leeds and York Partnership NHS Foundation Trust	Guideline	13	14	Rec 1.5.10 – Include the following in 'current factors': Change of independence Level of cognition Include linguistic and cultural differences and accessibility barriers, health literacy, barriers to information - NHS Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/# Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Leeds and York Partnership NHS	Guideline	14	12	Rec 1.5.12 – Add 'recognise that people over 65 may be at high risk of negative acts (e.g. not eating/drinking,	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.

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Foundation Trust				not taking medications, self-neglect) as forms of self-harm	
Leeds and York Partnership NHS Foundation Trust	Guideline	14	27	Rec 1.5.14 – Formulation may not be suitable for over 65s, or for the acute nature of some self-harm acts. Would recommend the use of FACE risk assessments prior to formulation (FACE Risk Assessment is more suitable for older people). Formulation is not structured and no word limits.	Thank you for your comment. The committee asserted that although a full risk formulation may not always be possible, it is vital to assess the needs of everyone following an assessment. The committee did not find any evidence to recommend the use of any risk tools.
Leeds and York Partnership NHS Foundation Trust	Guideline	14	8	Rec 1.5.11 Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. Recommendation 1.5.8 sets out that adaptations to assessment should be made for any physical conditions. Consideration for linguistic and cultural needs would be encompassed by 'historic factors' in recommendation 1.5.10, and this has been clarified in Evidence Review F.
Leeds and York Partnership NHS Foundation Trust	Guideline	15	5	Rec 1.5.16 – This recommendation should consider that not all persons will be able to read a care plan, so alternative options for sharing care plans should be considered (e.g. a meeting, video recordings, easy read or large print)	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York	Guideline	15	11	Rec 1.5.17 – Please provide examples of 'appropriate healthcare	Thank you for your comment. Who the appropriate healthcare professional is will depend on the

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Partnership NHS Foundation Trust				professionals'. Not all older people can read or can see properly. Safety plan needs to be shared with the person affected and carers. Needs to be in a format that the individual understands e.g preferred language, pictorial etc.	person who has self-harmed, for example if they are a child then someone from CAMHS might be the best person. However the committee agreed that giving examples in the recommendation would not be helpful as the decision needs to be made on an individual basis. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare. All these guidelines have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account. Recommendation 1.11.8 outlines that a safety plan should be shared with carers as appropriate.
Leeds and York Partnership NHS Foundation Trust	Guideline	15	19	Rec 1.5.18 – Suggested alteration of wording – 'Do not solely use risk assessment tools and scales…'	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction or risk of harm anyway. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify what

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					should be done instead. Therefore your suggested change has not been made.
Leeds and York Partnership NHS Foundation Trust	Guideline	15	19	Rec 1.5.18 – Please provide alternative or additional tools.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction or risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
Leeds and York Partnership NHS Foundation Trust	Guideline	15	21-26	Rec 1.5.19/1.5.20/1.5.21 – Please provide alternative stratification options	Thank you for your comment. There was a strong consensus from the committee that this type of risk stratification is not the optimum way to care for people who have self-harmed. Assessment tools and stratification do not reliably predict risk and can give a false sense of security to those deemed as 'low risk'. The committee have made

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					recommendations to support assessment based on needs and safety and not risk.
Leeds and York Partnership NHS Foundation Trust	Guideline	16	6	Rec 1.6.1 Ensure appropriate language support is sought in order to complete assessment.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	16	20	Rec 1.6.2 Needs a specific, maximum time Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account. The committee acknowledged that practice is variable in this area but the evidence did not support recommending a specific timescale. However they agreed that it should be carried out as soon as possible.
Leeds and York Partnership NHS	Guideline	24	13	Rec 1.8.4 Language access around admission should be sought and support with communication	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young

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Foundation Trust				NHS Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/	people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	24	19	Rec 1.8.6. Care plan and other clinical documents to be shared and in an appropriate format that the individual understands	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	25	12	Rec 1.9.2 Not always achievable within 48 hours (due to weekend or bank holiday). We suggest to add "if it is possible"	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.
Leeds and York Partnership NHS Foundation Trust	Guideline	26	2	Rec 1.10.1 Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their

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					communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	26	5	Rec 1.10.2 Include cognitive and language needs	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Leeds and York Partnership NHS Foundation Trust	Guideline	26	11	Rec 1.10.3 – Include over 65s in this recommendation also	Thank you for your comment. Ten trials investigated the effectiveness of dialectical behaviour therapy (DBT) as compared to either TAU or other forms of alternative psychotherapy in adults (weighted mean age: 27.5 ± 11.3 years). As there was no evidence for effectiveness of DBT in adults over 65 this change has not been made.
Leeds and York Partnership NHS Foundation Trust	Guideline	27	16	Rec 1.10.9 - Assessments of deaf people – to ensure specialist mental health professionals attend to linguistic and cultural needs, as well as considering the increased risk and prevalence of mental health difficulties within this population.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.

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Leeds and York Partnership NHS Foundation Trust	Guideline	28	6	Rec 1.10.10 - Self harm rather than self cut.	Thank you for your comment. The wording has been changed to self-harm.
Leeds and York Partnership NHS Foundation Trust	Guideline	29	6	Rec 1.11.1 – For some service users it can be beneficial to be exposed to different staff due to expertise, for exposure purposes. Also, it is not always achievable for those service users that require daily support.	Thank you for your comment. The committee agreed that the benefits of continuity of care for people who have self-harmed (reduced distress while accessing services, improved communication, creation of a therapeutic alliance, building of trust) outweighed potential harms, for example of insecure attachment. Additionally, the committee understands that the person will likely be exposed to different staff due to necessity (e.g. for care and availability reasons) which is why 'minimising the number of different staff they see' has been recommended.
Leeds and York Partnership NHS Foundation Trust	Guideline	32	2	Rec 1.13.1. Know how to book a registered interpreter (BSL, Spoken Language) How to look up the communication needs on the health care system applied. NHS Accessible Information Standard	Thank you for your comment. Knowing how to book a registered interpreter or to look up communication needs is not specific to self-harm. The committee would expect that healthcare professionals should know how to do this as part of their job and have therefore not made recommendations on this issue.

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				https://www.england.nhs.uk/ourwork/accessibleinfo/	
Leeds and York Partnership NHS Foundation Trust	Guideline	32	12	Rec 1.13.2 – Include in list: Training to consider age related factors in self-harm (e.g. negative acts in over 65s such as not eating/drinking, self-negligence, not taking medication)	Thank you for your comment. The range of different behaviours which can be considered self-harm has been added to the recommendation.
Leeds and York Partnership NHS Foundation Trust	Guideline	32	23	Rec 1.13.2 – in aspects of being culturally competent could this recommendation highlight the importance of using interpreters to speak to those who have self-harmed in place of using families or carers NHS Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account. This is a recommendation about training and so it would not be appropriate to make your suggested change here.
Leeds Institute of Health Sciences	Guideline	001 - 005	001 - 005	Here and elsewhere in the document it needs to be explicit about which groups have protected characteristics, and that the Equality Act ,2010 means there are legal requirements to make reasonable adjustments to services for those people – including provision of accessible information. The Act should be cited, as others are in the	Thank you for your comment. Recommendation 1.1.4 in the final guideline refers to a number of protected groups: '1.1.4 Recognise that support and information may need to be adapted for people who may be subject to discrimination, for example, people who are physically disabled, people with neurodevelopmental conditions or a learning disability, people from underserved groups, people

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				document, as providing further guidance	from Black, Asian and minority ethnic backgrounds, and people who are LGBTQ+.' The legislation mentioned in the guideline is mentioned because it is relevant to specific recommendations, for example around consent. The Equality Act 2010 is relevant throughout all NICE guidelines. This is why we do not generally include specific references to it. For details of NICE's equality considerations, we would refer you to the equality impact assessment forms on the webpage for the self-harm guideline. These detail how we have taken account of the Equality Act 2010 in producing the guideline, including relevant recommendations made.
Leeds Institute of Health Sciences	Guideline	005	017	This section lists "Topics to discuss", which for one of the bullets on the list is too vague a recommendation. In relation to third sector organisations and eg "online forums" the guidance should make it clear that if such resources are mentioned in discussion, then providing details is not the same as endorsing or making a recommendation, but rather – something that might be tried and might be helpful or not.	Thank you for your comment. We agree that providing details of such resources is not the same as endorsing them. However, we do not think it is necessary to say this in the recommendation as professionals will already be aware of this. The purpose of the bullet is simply to remind professionals to cover the subject of non-NHS sources of support under the heading of information and support. This may well take the form of suggesting a person contacts a national charity etc. The information for the public tab on the webpage for the published NICE guideline may also point people towards such resources.

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Leeds Institute of Health Sciences	Guideline	006	011	As for the previous comment	Thank you. We would refer you to our response to your previous comment.
Leeds Institute of Health Sciences	Guideline	008	013 - 014 and 020 - 021	These comments on the "limits of confidentiality" and when it is necessary to breach confidentiality should at least cross-refer to a later recommendation 1.6.4. and that recommendation should back-refer to this one. In HIN/SIM and related services it is part of the process to share clinical information with police in joint care planning meetings. The guidelines are forthright about the undesirability of the use of criminal proceedings but need also to include a statement about data sharing with police and other agencies.	Thank you for your comment. We do not think a cross-reference between the recommendations you mention is needed. Indeed, we think this might be confusing since 1.6.4 covers things to be avoided, such as aversive treatment and punitive approaches, which are not directly related to the subject of 'limits to confidentiality.' We have not included a statement about data sharing with police and other agencies since it is not the role of NICE guidelines to restate legal requirements.
Leeds Institute of Health Sciences	Guideline	012	017 - 018	During OOH work it simply may not be possible to provide the option of a same sex professional; this should say "when it is possible"	Thank you for your comment. The stem of the recommendation already includes the words 'as much as possible.' We think this addresses the point you are making.
Leeds Institute of Health Sciences	Guideline	013	008 and 016	Use of the word "trauma" here is unhelpful. It has come to be used in a rather uninformed way to mean no more than "life adversity of any sort". However, exploration of adverse life experiences is already in both lists. If	Thank you for your comment. The recommendation in question has been simplified in response to stakeholder feedback and no longer includes the word 'trauma.'

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				the recommendation is to ask about trauma in the specific sense then the recommendation needs to be clearer – what exactly is the assessor supposed to be asking about, especially when a phrase like "ongoing trauma" is used?	
Leeds Institute of Health Sciences	Guideline	013	021	The reference to "current" suicidal thoughts is ambiguous. The question about suicidal thinking can mean [a] in relation to a particular act of self-harm and therefore relating to the idea of intent [b] in a more general sense, as part of the individual's day-to-day experience. The answers may differ eg a person may entertain quite strong recurrent suicidal thoughts while a specific act may be "non-suicidal" or even be designed to protect against suicide. Both need to be explored. It would be particularly helpful in this context if there were a specific comment about method of self-harm not being a useful indicator of suicide risk – stereotypes about non-suicidal self-injury (NSSI) abound.	Thank you for your comment. The recommendation in question has been simplified in response to stakeholder feedback and no longer includes the phrase 'current suicidal thoughts.'
Leeds Institute of Health Sciences	Guideline	014	008 - 011	Recommendation 1.5.11 should include specific reference to use of social media and the degree to which it is found to be supportive or is a source	Thank you for your comment. Recommendation 1.5.11 now refers to 'the use of social media and the internet to connect with others and the effects of these on mental health and wellbeing.'

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				of risk (cyberbullying, revenge porn etc)	
Leeds Institute of Health Sciences	Guideline	014	025	In view of a very active social media discussion about this issue, this recommendation could usefully state explicitly that mental capacity alone should not be used as sufficient grounds to allow somebody to leave eg if they are distressed and expressing thoughts about further self-harm or suicide	Thank you for your comment. This recommendation has been amended to highlight the need to prioritise an assessment of the person's safety and any mental health problems in the event they leave, but the committee agreed each service will have different policies and procedures in place about what to do in the event someone does want to leave - please refer to recommendations 1.7.18-19. The recommendation referred to is not intended to be about whether people should be allowed to leave services as this is not an issue that is exclusive to people who have self-harmed, and the NICE guideline on violence and aggression is signposted to here for further guidance with regards to restraint.
Leeds Institute of Health Sciences	Guideline	014	027	It would be extremely helpful if the section on risk formulation included a specific comment that neither diagnosis, especially one of "personality disorder", nor method of self-harm should be used as the basis for judging risk.	Thank you for your comment. The committee agreed risk formulation requires a holistic understanding of the person's needs, safety, vulnerabilities, and strengths, and how they are interconnected. The committee's discussion of the evidence and the definition of risk formulation in the 'Terms used in this guideline' section have been amended to clarify this.
Leeds Institute of Health Sciences	Guideline	017	004 - 007	Excellent! Also, see earlier comment about confidentiality. This recommendation should have the most immediate **impact** because it is	Thank you for your comment. We agree this is an important recommendation.

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				specific and already backed by NHS England.	
Leeds Institute of Health Sciences	Guideline	017	008-	This section should have an additional component which is that the GP should outline possible outcomes of referral with a person they are referring. It is a source of recurring distress and complaint that people accept referral only to find that the mental health service won't take them on, or are referred and know already that the likely outcome will be non-acceptance for therapy. So the GP discussion should include a plan to review outcome of referral with the patient.	Thank you for your comment. It is expected that this would be covered under information and support – please see recommendation 1.1.1, specifically 'support and treatments available', 'who will be involved in their care and how to get in touch with them', and 'where appointments will take place'.
Leeds Institute of Health Sciences	Guideline	026	005	Recommendation 1.10.2 is misleading by virtue of being linked to a narrow definition of CBT (P.35 lines 1-15) which does not accord with the approach taken to defining CBT in the Cochrane review upon which the recommendation rests. That review took a broad definition of CBT that included interventions with a significant interpersonal component, where consideration of interpersonal problems does not always involve modifying thoughts and (assumed dysfunctional) behaviours, but on	Thank you for your comment. The interventions that have been recommended are those which have shown evidence of effectiveness, as identified in the Cochrane reviews of interventions for adults and for children and young people who self-harm. The committee acknowledged that evidence from the Cochrane review for adults was based on a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT, however it did show a potential benefit of psychological interventions which were structured, person-centred, manualised, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3

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				making practical changes. For example interpersonal problem solving (Owens et al 2020) involves more than treating an individual's problem-solving skills as deficient, and Guthrie et al's (2001) trial of psychodynamic interpersonal therapy could by no means be described as meeting the definition used in the current guideline. There is substantial evidence that different therapeutic modalities have comparable effects in a range of clinical conditions (see reference 1-14 below) and there is no reason to think the picture should be different for self-harm. This could be recognized by a recommendation that therapy needs to be brief, standardised and oriented towards present problems and the place of self-harm in the individual's life. It is over-definite to name only CBT (as defined here) as fitting the bill. A further problem is that no mention is made of self-harm history. While it may be reasonable to suggest as few as 4 sessions of a CBT-type therapy for somebody seen after a first or second	has therefore been amended to highlight that other treatment modalities (and not only CBT) might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of this section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not for CBT to be the only intervention offered to/considered for adults who have self-harmed, however the available evidence limits what can be recommended. While other interventions might be indicated for a person who has self-harmed and has a co-existing condition, no other interventions in the Cochrane reviews showed evidence of effectiveness for people who self-harm. Recommendation 1.11.3 has been amended to highlight that more sessions might be needed depending on the individual's needs. Please note recommendation 1.11.3 was based additionally on the results of the guideline economic analysis, in particular one-way sensitivity analysis, according to which the intervention becomes marginally cost-effective at 9-10 sessions

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				lifetime episode, something different is needed for somebody with (say) a 10-year history of repeated self-harm who now presents asking for therapeutic help. There may be little useful evidence, but at least the problem should be acknowledged. These suggestions – that generic (transferable) features of therapy should be considered rather than concentrating on specific modality, and that interpersonal factors need to be considered – are supported by patient reports of what they find helpful in recovery after self-harm (References 15-16 below). Recommendations on therapy are likely to have the biggest **cost and other implications** because self-harm are currently so rudimentary. CMHT and IAPT won't see most of those affected and most liaison psychiatry services offer only acute care with no clinic follow up. Major investment and training would be required to make these recommendations real.	(at 10 sessions it exceeds the NICE lower cost-effectiveness threshold of £20,000/QALY but is still below the upper cost-effectiveness threshold of £30,000/QALY). Please see the discussion of the expected resource impact in the relevant Rationale and Impact section of the guideline, with further detail available in the Committee's Discussion of the Evidence section in Evidence Report J. Recommendation 1.11.5 outlines that staff should be appropriately trained and supervised to deliver the offered therapy, and recs 1.14.1-1.14.2 outline staff training guidance.

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Leeds Institute of Health Sciences	Guideline	026	011	Recommendation 1.10.3 suggests that DBT-A should only be offered to children and young people with "significant emotional dysregulation difficulties" who have frequent episodes of self-harm. The evidence is weak, and no doubt the recommendation is made because some therapy should surely be offered to any child or young person with already established repeated self-harm and DBT-A looks like the best candidate. Under the circumstances the guidance to restrict it to those with purported emotional dysregulation should be dropped. It isn't the recommendation in the cited Cochrane review, there isn't good evidence that such a characteristic (if indeed it could be measured reliably in routine clinical practice) predicted outcomes, and it carries with it an unfortunate (implicit) connotation that the affected young people are emerging into a state that could attract a diagnosis of borderline personality disorder.	Thank you for your comment. The authors of the Cochrane review on psychosocial interventions for children and young people who have self-harmed outline that the evidence base for DBT-A is stronger than the current evidence base for any other intervention in this population; however, the evidence is still somewhat weak. The recommendation is therefore based on limited evidence from the Cochrane review as well as the profiles of the participants included in the 4 studies which assessed the effectiveness of DBT-A. The committee discussed whether this recommendation should be expanded to include other populations but agreed the evidence was not strong enough and that it would not be appropriate to extrapolate this evidence to be applicable to additional populations. Please note the intention is not that DBT-A would be the only intervention offered to/ considered for children and young people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. The committee agreed that further evidence was needed to assess the effectiveness of various interventions for people of all ages who have self-harmed, and therefore made research recommendations for psychosocial interventions -

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					please see appendix K of evidence review J for more information.
Leeds Institute of Health Sciences	Guideline	028	005 - 020	This section should refer not just to self-cutting but to any form of self-injury. More importantly it conflates two different issues [1] reducing or stopping further episodes; [2] the much trickier question of helping somebody think about how to continue self-injury (if they are certain that's what they'll do) while reducing the risk of serious and irreversible damage including scarring. The first meaning surely applies to anybody as part of a care plan and should appear later, so this section would be better restricted to the second.	Thank you for your comment. The wording has been changed to self-harm. With respect to your point about the focus of the section, the guideline defines 'harm minimisation' as follows: 'Harm minimisation is an approach to self-harm that accepts the person's continued urge to self-harm while aiming to keep long-term damage and frequency of injury to a minimum. It can include suggestions to avoid, delay or reduce self-harm.' We think this definition already restricts the section to the section issue you mention.
Leeds Institute of Health Sciences	Guideline	032	001	Training should include recognizing and responding to the needs of people with protected characteristics, including learning disability and autism. This comment also applies to Supervision – next page.	Thank you for your comment. We believe this is already covered by recommendation 1.14.2 which says '"• recognising the impact of other diagnoses and comorbidities, and how they interact with self-harm".
Leeds Institute of Health Sciences	Guideline	033	019	The section on training mentions the need to avoid judgemental attitudes but the section on supervision says nothing about them. One of the commonest critical comments (from patients) about self-harm assessment	Thank you for your comment. Recommendation 1.15.1 has been amended to specifically include the need to 'promote the delivery of compassionate care'. This recommendation also includes a 'focus on ongoing skill development', which the committee intended would encourage staff to continually refer

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				is about negative attitudes and the behaviour driven by such attitudes. It should be an important part of supervision to pick up on those attitudes, both as a way in to trying to change them and as a way of ensuring the patient gets a high level of professional care. Doing something about attitudes to self-harm, and specifically to attitudes towards those given a diagnosis of personality disorder, would be an important step in the direction of helping users **overcome barriers** to receiving good care.	to the guidance on training (which includes exploring and improving staff attitudes towards self-harm).
Leeds Institute of Health Sciences	Guideline	038	002 - 003	This sentence is unclear. There seem to be two questions conflated:- [1] effectiveness of specific psychological therapies. Here, there is an important question about comparative effectiveness of therapies. It has been hard enough to get funding for therapy research when the comparator is Usual Care (an important question) and beyond that there is a need to ask about targeting or individualising therapies.	Thank you for your comment. A detailed explanation of the research which the committee would like to see done is given on pages 103-104 of Evidence Review J.

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				[2] comparative effectiveness of different delivery platforms eg face-to-face (individual or group), supported self-management, IT-based interaction and blended variations thereof – no doubt a particular issue brought to the fore in the **COVID-19 pandemic**.	
Leeds Institute of Health Sciences	Guideline	057	015	The statement that the proposed aspects of safety plans "would prevent further self-harm" is too strong. In truth the evidence on safety planning is not strong and while it is reasonable to recommend that a safety plan is drawn up, the best that can be said is that it may be helpful - and working on one conveys a useful message about genuine and practical concern. 1.Cuijpers, P., et al A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments.Can J Psychiatry,2013.58(7): p. 376-85. 2. Baardseth, T.P., et al., Cognitive-behavioral therapy versus other therapies: redux.Clin Psychol Rev, 2013.33(3): p. 395-405.	Thank you for your comment. The sentence in question accurately records the committee's belief that the aspects of safety plans which it has recommended are important and will prevent further self-harm. The committee's view is based not only on the included evidence but also on its experience. As the first sentence in the paragraph states: 'The safety planning recommendations were based on the committee's knowledge and experience that safety plans equip people who have self-harmed with the ability to identify and use their strengths and sources of support to overcome crisis moments and prevent repeat self-harm.' We are pleased that you agree it is reasonable to recommend that a safety plan is drawn up. The purpose of the rationale is to explain the positive reasons for the recommendations made with the aim of promoting their implementation. The more detailed evidence reports underpinning this section of the guideline provide a full assessment of the quality of the included evidence.

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				3. Fluckiger et al Enduring effects of evidence-based psychotherapies in acute depression and anxiety disorders versus TAU at follow-up--a meta-analysis.Clin Psychol Rev,2014.34(5): 367-75. 4. Wampoldet al., Evidence-based treatments for depression and anxiety versus treatment-as-usual: a meta-analysis of direct comparisons. Clin Psychol Rev,2011.31:1304-12. 5. Cuijpers et al., Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies.J Consult Clin Psychol,2008.76: 909-22. 6. Wampold et et al A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes".Psychological Bulletin,1997.122:203-215. 7. Wampold et al., A meta-(re)analysis of the effects of cognitive therapy versus 'other therapies' for depression.J Affect Disord,2002.68(2-3):159-65. 8. Barth et al Comparative efficacy of seven psychotherapeutic interventions for patients with	

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				depression: a network meta-analysis.PLoS Med, 2013.10(5): p. e1001454. 9. Budge et al The Effectiveness of Psychotherapeutic Treatments for Personality Disorders. Canadian Psychology-Psychologie Canadienne,2015.56(2): p. 191-196. 10. Kline et al Long-term efficacy of psychotherapy for posttraumatic stress disorder: A meta-analysis of randomized controlled trials Clin Psychol Rev, 2018.59: p. 30-40. 11. Benish et al The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons Clin Psychol Rev2008.28:1281-86. 12. Powers et al A meta-analytic review of prolonged exposure for posttraumatic stress disorder. Clinical Psychology Review, 2010.30(6): p. 635-641.	
Mental Health Matters	Guideline	26	6	It's not always possible for a CBT intervention to start as soon as possible due to waiting lists. The document states session amount is typically between 4-10 sessions.	Thank you for your comment. The committee agreed that 'as soon as possible' would take into account the effect of waiting lists on the timing of the intervention being offered while still emphasising the need for treatment to be

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				There is no a stand alone CBT intervention for self harm, usually coping skills is offered either in a depression intervention or a PTSD treatment.	prioritised. The recommendation is not for standalone CBT it is for CBT-informed psychotherapy. The recommendation has been reworded for clarity.
Mental Health Matters	Guideline	28	6	States 'is not yet in a position to resist the urge to self-cut' this should be 'self-harm' as people often use other methods of self-harm that requires harm minimisation techniques e.g. self poisoning, head banging	Thank you for your comment. The wording has been changed to self-harm.
Mental Health Matters	Guideline	35	9	DBT-A is not routinely offered for all young people who self harm in all CAMHS services	Thank you for your comment. The terms used section of the guideline defines terms that have been used in a particular way for this guideline. It is not a recommendation for who should be offered a treatment.
Mind	Guideline	General	General	Mind welcomes this guideline on supporting people who self-harm. In particular, we welcome the emphasis on understanding why people self-harm, involving people in decisions about their care and ensuring people receive the support they need.	Thank you for your comment.
Mind	Guideline	General	General	At Mind we unfortunately still hear stories about people being judged for self-harm and being denied treatment on the basis of this judgement. Whilst	Thank you for your comment. The committee recognises that this can be a problem and as such recommend that training should cover: 'education about the stigma and discrimination usually

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				dignity and respect is mentioned in these guidelines, we believe it is important to add a recommendation that staff should not judge anyone who has self-harmed nor should they let this influence their approach to support. This recommendation should apply to all staff, including non-health and social care professionals.	associated with self-harm and the need to avoid judgemental attitudes.'
Mind	Guideline	General	General	It is positive to see references to trauma in recommendation 1.5.10, as many people who self-harm may have had traumatic experiences that continue to impact their mental health. Mind encourages NICE to take a trauma informed approach to all parts of the guidance on self-harm, from information and consent to assessment and interventions. Staff working with people who have self-harmed should be able to recognise the signs that someone may have experienced trauma, understand the wide-ranging impacts of trauma, avoid re-traumatisation and take a trauma informed approach to providing care. It is important that this approach is embedded in the guidance to ensure	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However, many of the general principles of care included in the guideline would be consistent with trauma-informed care.

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				people who have experienced trauma receive the right care.	
Mind	Guideline	7 - 8	22 -9	Recommendation 1.2.2 – We encourage NICE to add to this recommendation that young people should have their rights disclosed to them, particularly around confidentiality. This should be standardised and provided up front, rather than when requested or after the fact.	Thank you for your comment. Disclosing young people's rights to them at the start is encompassed within the principles of the legislation that the guideline recommends all health and social care staff need to understand. As such this should be a consequence of implementing this recommendation and does not need to be stated explicitly.
Mind	Guideline	21-22	19 -11	Recommendation 1.7.1 – As well as treating people who have self-harmed with respect, dignity and kindness, we recommend that NICE adds a guideline about being non-judgemental and empathetic to a person's reason for self-harming. We know that often the fear of being judged can prevent people from disclosing self-harm. We also suggest that the guidelines encourage non-health professionals to provide positive reinforcement and reassurance to people who disclose that they have self-harmed for talking the first step in seeking support.	Thank you for your comment. The concepts you raise are already covered by the first bullet and so no change has been made.
Mind	Guideline	24 - 25	19 – 4	Recommendation 1.8.6 – Mind supports recommendation 1.8.6, it is important that people who have self-	Thank you for your comment. The committee agree and this is why they made this recommendation.

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				harmed and are admitted to hospital are discharged with an appropriate care plan in place. Care plans should be personalised and developed with the person who has self-harmed. A multi-agency discharge planning meeting is essential to ensure that aftercare is properly coordinated and people can be effectively supported in the community.	
Mind	Guideline	32 - 33	12-10	Recommendation 1.13.2 – We are supportive of this recommendation, particularly the focus on culturally competent care and respecting and appreciating the cultural contexts of people's lives. This plays an important part in addressing the inequalities experienced by many people from racialised communities in mental health services. As with our comment on section 1.5, we believe it is important that staff are aware of lesser-known methods of self-harm to ensure people are receiving the support they need. We encourage NICE to add understanding different forms of self-harm to this recommendation on training.	Thank you for your comment. The range of different behaviours which can be considered self-harm has been added to the recommendation.

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Mind	Guideline	5	3 - 18	Recommendation 1.1.1 – There are many positive elements of this recommendation, however we feel there is an imbalance in the type of information staff are encouraged to provide to people who self-harm in recommendation 1.1.1 compared to family members and carers in recommendation 1.1.2. Recommendation 1.1.2, on information to provide family members and carers, includes points on 'advice on how to cope', 'how to assist and support', 'recognising signs' and 'reducing the risk'. However, recommendation 1.1.1 doesn't contain similar points around self-management or self-care for individuals who self-harm. This could feel disempowering for individuals, if their loved ones are given information on how to manage risks but they are not. We suggest adding similar points around self-management and self-care to recommendation 1.1.1, for example 'how to cope with urges to self-harm', 'what to do if you feel like self-harming', 'managing difficult feelings'	Thank you for your comment. The committee agreed that self-care was an important component of information provision, and that information about self-care should not be limited to people already on a care path (recommendation 1.11.12), so this has been added to recommendation 1.1.1. The point about managing scars and injuries has also been separated out into two separate points, and the point about what to do about concerns or in an emergency have also been separate out into two separate points.

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				'distraction and self-care techniques', 'identifying triggers', 'spotting warning signs'. We also suggest separating out points on managing injuries and managing scars. An injury may require immediate or emergency support. Scar management, on the other hand, can be more long term and people will make different choices about whether they want or need to do anything about their scars. Finally, we recommend separating out 'what to do if they have any concerns' from 'what to do in an emergency'. Concerns may relate to many things, from a person's treatment to their living situation. An emergency is a distinct and important situation that warrants its own dedicated information and support.	
Mind	Guideline	6	16 - 25	Recommendation 1.1.3 – Mind supports this recommendation and suggests adding a line stating that information should be non-judgemental. Specifically, information should be non-judgemental around	Thank you for your comment. The guideline promotes a non-judgemental approach throughout and the recommendations are worded to focus on the positives, rather than the negatives. Being non-judgemental is implied by the bullets about being

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				people feeling the need to self-harm and struggling to stop doing so. If people feel like they will be judged for how much they self-harm, they are less likely to be honest about it or ask for support.	sensitive and empathetic, supportive and respectful and conveyed in the spirit of hope.
Mind	Guideline	7	7 -18	Recommendation 1.2.1 – At Mind we have concerns about how mental capacity is assessed in inpatient mental health services. Mental capacity is a decision-specific concept that can differ on a decision-by-decision bases. The 2018 NICE guidelines on decision making and mental capacity echo good practice in supporting people to build capacity to make decisions. However, the recent CQC annual Mental Health Act monitoring report emphasised that while people may not always have capacity to fully engage in shared decision making, it is important that they're not labelled as 'lacking capacity' overall. In an effort to prevent people from being labelled as 'lacking capacity' and excluded from shared decision making as a whole, we suggest that NICE adds further detail to this recommendation, emphasising	Thank you for your comment. The need for capacity to be assessed on a decision by decision basis is already encompassed within the Mental Capacity Act 2005 and has therefore not been restated here.

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				that capacity should be assessed on a decision by decision basis.	
Mind	Guideline	7	1 -5	Recommendation 1.1.4 – Mind welcomes the recommendation for staff to recognise the potential need to adapt information and support for communities that have been subject to discrimination. It is important that staff understand the impact discrimination can have on our mental health and are able to provide culturally competent support. For this recommendation to be successful, NICE should provide guidance on how information and support should be adapted to support different communities. This guidance should be developed in collaboration with people who have lived experience of discrimination. We also suggest changing the wording in this recommendation from 'people with physical disabilities' to 'people who are physically disabled' to be in line with the social model of disability.	Thank you for your comment. The guideline has not looked at the evidence on how to adapt information and support and so no recommendations have been made in this area. Your suggested wording change has been made.
Mind	Guideline	8	16-19	Recommendation 1.2.5 – Involving a person's family or carer can be helpful and supportive to many people who have self-harmed, so it is positive that	Thank you for your comment. Section 1.4 sets out recommendations for how to appropriately involve families. In addition, the guideline refers to the NICE guidance on Patient experience in adult NHS

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				the recommendation seeks to ensure staff are aware of these benefits. However, we also know that conversations around the involvement of family members and carers can be challenging and distressing if not dealt with sensitively. In addition to recommendation 1.2.5, NICE should include a recommendation that staff working with people who self-harm should be aware of the challenges and sensitivities around consenting to involving family members or carers. The recommendation should ask staff to be considerate of these challenges when having conversations about consent.	services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on the person's rights in relation to confidentiality and involving families and carers.
Mind	Guideline	8	20-22	Recommendation 1.2.6 – Mind supports this recommendation. It is important that people who have self-harmed are involved in decisions about their care. Staff should aim to enable shared decision making with the person who has self-harmed wherever possible. Where a breach of confidentiality is necessary, this should not be a reason to exclude someone from decisions about their care.	Thank you for comment.

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Mind	Guideline	10	11 – 13	Recommendation 1.4.2 – At Mind we know it is important to young people to have autonomy when it comes to their own care. Young people who have self-harmed should be involved in decisions about their treatment and not left out of these important discussions. We therefore welcome the recommendation to balance the need to involve family members or carers with the need to give young people autonomy.	Thank you for your comment.
Mind	Guideline	10	16-29	Recommendation 1.4.3–- We support recommendation 1.4.3 and hope it will encourage a collaborative and supportive approach to involving family members and carers. We would like to emphasise the importance of the final bullet point in this recommendation – that a person's consent to share information with their family members or carers should be regularly reviewed. We know that, at times, issues around the involvement of family members or carers in someone's care can be challenging. It is important that people who have self-harmed are made aware of their rights and their ability to withdraw their consent at any time.	Thank you for your comment and support for recommendation 1.4.3. The recommendation has been amended to include empowering the person who has self-harmed. Making recommendations about the support required for carers of people who self-harm is outside the scope of this guideline.

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				In addition, we recommend adding a point on ensuring that loved ones or carers have support in place for themselves, as we know that supporting a loved one who has self-harmed may be distressing or challenging at times. We also suggest that NICE emphasises the importance of loved ones and carers empowering and supporting individuals with their own care and recovery, rather than taking full control of the situation or trying to push through changes.	
Mind	Guideline	11	10	Section 1.5 – At Mind we know that there are many ways in which people self-harm, beyond the better-known methods. Less well-known forms of self-harm include over-exercise, self-neglect, getting into fights in order to get hurt, or having unsafe sex. There is a risk that these lesser-known methods may not be identified or may be mistaken for, or suggested as, a positive coping method (particularly with over-exercise). We recommend that NICE includes a guideline on	Thank you for your comment. We have added text at the start of the guideline to clarify how it uses the term 'self-harm'. The issues you have raised were not specifically investigated by the guideline and so recommendations cannot be made in this area. However the recommendation for a full psychosocial assessment should identify the issues you refer to.

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				understanding the breadth of self-harm and ensuring professionals are aware that there are many ways to self-harm. We are also aware that methods of self-harm can differ between males and females, particularly among young people. For example, studies suggest that women may be more likely to self-harm by cutting, while men may be more likely to hit objects with the intention of hurting themselves. We recommend that NICE adds a guideline on understanding how self-harm methods may differ between men and women to ensure self-harm is always identified and people receive the right support.	
Mind	Guideline	11	13 - 21	Recommendation 1.5.1 - Mind supports recommendation 1.5.1 and the focus on therapeutic relationships and care. A comprehensive psychosocial assessment that moves beyond a standard risk assessment and focuses on building collaborative therapeutic relationships, understanding why someone has self-harmed and ensuring they receive the care that they need should lead to	Thank you for your comment.

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				more personalised approaches to treatment. This is vital to ensuring people are involved in decisions about their care, receive the right support and aren't denied the treatment they need.	
Mind	Guideline	12	19 - 29	Recommendation 1.5.9 – Alongside recognising that each person who self-harms does so for their own reasons, we suggest adding a point on being open and acknowledging the temporary release that self-harm brings to some people.	Thank you for your comment. This bullet encompasses the broad range of functions of self-harm including the point you raise. Therefore we have not made the change you suggest.
Mind	Guideline	13	4 -5	Recommendation 1.5.10 – It is positive that the recommendation references 'vulnerabilities, including those related to age, gender identity, sexual orientation and cultural factors'. However, this does not go far enough to fully explore the experiences that may have contributed to someone self-harming. There is considerable evidence that experiencing discrimination can have a significant impact on someone's mental health. This is compounded by the discrimination many face within mental health services, particularly people from racialised communities. It is vital	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.

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				that the guidelines recognise discrimination as a risk factor to explore, both in terms of historic factors and current factors. Mind recommends adding a line to the historic factors and current factors sections on experiences of discrimination based on the protected characteristics in the Equality Act.	
Mind	Guideline	14	1	Mind suggests amending this line to read 'limit, avert or delay self-harm'	Thank you for your comment. All aspects relevant to the person should be considered and the assessment should always be comprehensive. However, for brevity the list has been reduced to the overarching headings as it would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Mind	Guideline	14	8 -11	Recommendation 1.5.11 – It is important that psychosocial assessments of children and young people who have self-harmed are age appropriate and factor in the circumstances that are unique to children and young people. Recommendation 1.5.11 goes some way to achieve this in outlining additional topics to discuss. Mind	Thank you for your comment. The recommendation has been amended to clarify that assessment should be undertaken by a mental health professional experienced in assessing children and young people who self-harm.

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				believes that this should go further to recommend that children and young people are assessed by a specialist mental health professional experienced in assessing children and young people. This would bring the recommendation in line with 1.5.12 which recommends the equivalent for people over the age of 65. We also suggest that potential caring responsibilities are added as a topic to explore in this recommendation.	
Mind	Guideline	15	19-26	Recommendation 1.5.18 – 1.5.21 Mind strongly supports these recommendations. Risk assessment tools should not be used to determine who needs treatment, who should be offered it and who should be discharged. Too often this can lead to people being denied the treatment they need because they have not met a particular threshold. Decisions about treatment are complex and personal to each individual and their circumstances. It is, therefore, essential that a personalised approach to decision making is taken following a comprehensive psychosocial	Thank you for your comment. The committee agree that assessment and care should be based on needs and safety and not risk.

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				assessment. It is vitally important that specialist mental health professionals work closely with people who have self-harmed and their family or carers (where appropriate) to reach a shared decision about the person's needs and treatment plan.	
Mind	Guideline	18	18-22	Recommendation 1.6.9 – It is important that people who have self-harmed can access the support they need at the time they need it, and that people experiencing a mental health crisis are not left with nowhere to turn if they don't require urgent physical care. When considering whether the person can be treated by an appropriate alternative service, ambulance staff and paramedics should assess the immediate risk of further self-harm or suicide, as well as the availability and accessibility of alternative services at that time.	Thank you for your comment. The guideline has been amended to state in the Principles for assessment and care by healthcare professionals and social care practitioners section that the person should be assessed for any immediate concerns about further self-harm or suicide. In addition, a recommendation has been added to clarify that the availability and accessibility of alternative services should be explored.
Mind	Guideline	21	15	Section 1.7 – Mind recommends that this section emphasises the importance of advocating for choice and control when it comes to young people, as we know that young people often fear that this will be removed if they disclose self-harm.	Thank you for your comment. Working collaboratively with the person in decision making to ensure their views are listened to has been added to recommendation 1.8.1.

Self harm: assessment, management and preventing recurrence

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Mind	Guideline	22	13-18	Recommendation 1.7.2 - Mind supports the recommendation that educational settings should have guidance in place for staff to support students who self-harm. However, NICE should add further detail on who should create this guidance and consider how to ensure consistency of guidance across educational institutions. In line with our comments on section 1.5, we encourage NICE to recommend that guidance for staff should include information on different methods of self-harm and how self-harm may present differently among males and females.	Thank you for your comment. The committee agreed that it was not within the remit of a guideline to give more specific advice about how the policies should be created, and that any differences in policies would reflect the fact that needs would differ in each educational setting. Recommendation 1.14.2 has been amended to include 'the range of different behaviours which can be considered self-harm' as a training requirement for all staff who work with people who have self-harmed.
Mind	Guideline	11 & 12	24 – 7	Recommendations 1.5.3 – 1.5.5 - As part of the Making Every Adult Matter (MEAM) coalition, Mind welcomes these recommendations. It is important that people are not denied assessments or the support they need on the basis of drug or alcohol use.	Thank you for your comment.
Mind	Guideline	25	12 - 14	Recommendation 1.9.2 – Mind supports this recommendation and the focus on continuity of care. Continuity of care better enables people to build	Thank you for your comment.

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				up a trusting therapeutic relationship with mental health professionals. It also avoids the need for someone who has self-harmed to repeat their story multiple times, which can often be distressing.	
Mind	Guideline	26	11 -13	Recommendation 1.10.3 - We suggest this recommendation is adapted to apply to both young people with significant emotional dysregulation difficulties and any young person who may benefit from dialectical behaviour therapy adapted for adolescents (DBT-A). It is important to ensure that access to DBT-A isn't limited to young people with a diagnosis of 'significant emotional dysregulation difficulties' as we know that many young people do not identify with diagnostic labels so may not have sought out the diagnosis.	Thank you for your comment. The existing recommendation is based on limited evidence from the Cochrane review and the profiles of the participants included in the 4 studies which assessed the effectiveness of DBT-A. The committee discussed whether this recommendation should be expanded to include other populations but agreed the evidence was not strong enough and that it would not be appropriate to extrapolate this evidence to be applicable to additional populations.
Mind	Guideline	26	5 -10	Recommendation 1.10.2 – Cognitive Behavioural Therapy (CBT) can be a helpful and effective treatment for people who have self-harmed, so we welcome the recommendation that CBT based psychological interventions are offered to people who self-harm. We also know that dialectical	Thank you for your comment. There was insufficient evidence from the Cochrane review to recommend DBT for adults: "the evidence remains uncertain as to whether DBT reduces absolute repetition of SH by the post-intervention assessment" (Witt 2021). The Cochrane review also investigated the effectiveness of psychodynamic psychotherapy versus treatment as

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				behavioural therapy and psychotherapy can be helpful for adults who self-harm and encourage NICE to explicitly reference these in the guidelines as options to consider.	usual or another comparator (comparison 5) and found no evidence of an effect on repeat self-harm. Without sufficient evidence, the committee could not recommend these interventions. Please note that recommendation 1.11.2 points practitioners to other guidance for information on interventions that might be more appropriate depending on any coexisting conditions the person might have, while recommendation 1.11.3 has been amended to highlight that other treatment modalities might be effective as long as they meet the principles of CBT-based psychotherapies as set out in the recommendation and the evidence. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended.
Mind	Guideline	26	16 -29	Recommendation 1.10.5 – Mind supports the recommendation to consider developing a safety plan with the person who has self-harmed, this is a crucial step in helping people to manage their recovery. We encourage NICE to strengthen this recommendation beyond simply asking professionals to consider developing a safety plan to requiring that a safety plan is created or updated after any	Thank you for your comment. The use of the word consider in this recommendation reflects the strength of the evidence underlying the recommendation. Whilst the committee acknowledge that safety plans are increasingly common practice, limited evidence was found for their effectiveness, and this evidence did not analyse safety plans as a standalone intervention. The recommendation has been worded in line with the evidence. Extra detail about the content of a

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				incident of self-harm. We also recommend that NICE expands the information on what a safety plan should do. For example, the guideline should include identifying individual methods of distraction as a coping technique as well as social distraction. In addition, when coping with difficult feelings, we know that different emotions may require different actions to cope with them. We suggest that a safety plan should identify emotions that are difficult to cope with and plan alternative coping techniques for each feeling.	safety plan has not been included as this would be too prescriptive.
Mind	Guideline	27	13 -14	Recommendation 1.10.7 – As part of the Making Every Adult Matter (MEAM) coalition, we understand the difficulties people can encounter trying to access mental health services when they also experience substance misuse. An unwillingness to support the mental health of individuals experiencing substance misuse has knock on consequences, often making it harder for them to engage with any substance misuse support that is on offer. We are, therefore, pleased to see the	Thank you for your comment.

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				guidelines recommend that substance misuse cannot be used as a reason to withhold psychological interventions for self-harm.	
Mind	Guideline	29	6 - 8	Recommendation 1.11.1 – As with recommendation 1.9.2, Mind supports the focus on continuity of care for people who have self-harmed.	Thank you for your comment.
Mind	Guideline	29	14 -16	Recommendation 1.11.3 – Mind supports this recommendation. It is important that observations of people who have self-harmed are only conducted by those who are clinically trained to do so. Observations carried out by untrained staff are not only less safe, but can be inappropriate in an environment that is supposed to be focused on care and support. For example, being observed by security staff could leave people feeling as if they have done something wrong.	Thank you for your comment.
Mind	Guideline	32	2 -11	Recommendation 1.13.1 – Mind welcomes all elements of recommendation 1.13.1, in particular the involvement of people with lived experience in planning, delivering and evaluating training. Involving people with lived experience throughout the development of training is the only way	Thankyou for your comment. Elements of support considered important by people who have self-harmed, their parents or carers, and staff who work with them as shown in the qualitative evidence (such as compassionate communication, cultural competency, and open discussion) are addressed in recommendation 1.14.2. Therefore no change has been made to the recommendations.

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				to truly ensure the training reflects the needs of a diverse range of people who have self-harmed. Involving people with lived experience will make the training more meaningful, engaging and relatable for staff. It can also help to validate people's experiences and allow them to use these positively to make improvements to support for other people. At Mind, we know that there are some key differences that staff should be mindful of when working with young people, particularly regarding power dynamics, trust and comfortability disclosing information to people who are older or in a position of care. We recommend that training for staff who support people that self-harm should include a specific element focused on understanding how to support young people who self-harm.	
Mind Business Consultancy	Guideline	26	13	• Rec 1.10 refers to intervention being tailored to the person's needs and preferences – such an intervention should tailor to the person's needs, currently met by self-harming, so that a	Thank you for your comment. The committee agree the existing wording of the recommendation adequately covers these factors. In addition, the assessment recommendations in section 1.5 ensure these factors would be investigated.

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				better understanding of how else they could meet that need or purpose with matched strategies. For example, if they self-harm to feel calm, what else meets this need or if they self-harm to feel in control, what else meets this need and so on.	
Mind Business Consultancy	Guideline	26	21	'Coping strategies including trouble shooting' –coping strategies cannot work effectively if reliance is on random suggestions without any matching process between the strategy and the purpose the harming has for the person each time.	Thank you for your comment. The committee agreed that coping strategies should be specific and appropriate for the person, and therefore the recommendation has been amended to clarify coping strategies should be individualised.
Mind Business Consultancy	Guideline	36	4	This refers to advice on alternatives to self-harm and gives the example of ice cubes on the skin or use of red marker pens. Again, this could be read as try these randomly. An ice cube on the skin or a red marker pen will only be effective for certain needs that self-harm meets. Examples from practice with ice cubes were found to be useful where the sensation of pain was needed by the person self-harming, or the experience of the dripping of the ice as it melts can simulate dripping	Thank you for your comment. The examples that were initially given in the definition have been removed to clarify these are not specifically being recommended.

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				blood (e.g. as in coloured ice cubes using something like cranberry juice). This particular example was the ingenious idea of a woman who repeatedly cut and watched the dripping blood to feel calm and in control and she also liked the sticky way that congealed blood formed hence the cranberry juice was a very good match for her. Within 8 sessions of working with the overall approach and with such matched examples she was discharged from very long-term use of mental health services (acute and community) after 20 years. She did not return for a period of over 1 year (not been able to establish what happened after that time as no longer work there). Examples from practice with red marker pen (only soft tipped) where the need to see the red marks is key or the need to experience a visual impact meets the need. Where an ice cube is recommended and the person's need is to feel release or a sense of calm may not be as effective.	

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				Where the red pen is used and the person needs to experience an adrenalin rush or a sense of chastisement may not work as effectively either. These ideas are based on the APEX model designed by Diane Clare which has 4 phases: Attitude (sensitive and collaborative) Purpose (identifying the purpose or need each time) Emotional First Aid Kit (collating a range of matched strategies to those purposes) X factor or XYZ contract: a self-contract the client makes in due course to use 3 of those matched strategies before harming each time (before I self-harm to meet the following need - e.g. to feel in control – I will first use X then Y and then Z. This is a delay tactic and all examples would need to be SMART to maximise effectiveness.	

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				Reduced risk, increased hope, a consistently broader range of effective skills and a better understanding of the harming and the needs it meets are regular themes of feedback from clients over a period from 2005 to date, across a range of settings both in groups and individually in UK and in NZ. Papers on this approach have been published and references can be provided if there is interest. This includes a book chapter as part of the STEPPS programme (a CBT-based approach to working with emotional intensity difficulties). Presentations have been provided internationally. Training has also been provided on this simple model for staff who are specialists as well as those who are not with promising outcomes.	
Mind Business Consultancy	Guideline	36	8	Regarding a comprehensive evaluation of needs should include routine evaluation of the needs met by harming itself as this enables a collaborative safety plan to emerge	Thank you for your comment. The terms used section of the guideline defines terms that have been used in a particular way for this guideline. It is not a recommendation for what this evaluation should include.

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				and can be informed by matched strategies that meet those needs effectively most of the time as evidenced by the use of the APEX model.	
Ministry of Defence	Guideline	21	21	Include Military setting	Thank you for your comment. Military settings are outside the scope of this guideline and so have not been included.
Ministry of Defence	Guideline	22	9	Combat Stress helpline	Thank you for your comment. This has been added to the recommendation.
Ministry of Defence	Guideline	23	29	Assessment and care in Military settings 1.7.11 Staff in the military setting need to be aware that the Military has a unique duty of care for Service Personnel (SP) and in some cases such as overseas locations, civilian staff and families. This is because of the environments in which the Military operates which may deny the SP support from friends and family due their service location. For this document the abbreviation SP will be used but will incorporate other entitled people on occasions. 1.7.12 Staff in the Military setting need to be aware of how to:	Thank you for your comment. Military settings are outside the scope of this guideline and so have not been included.

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				• how to identify self-harm behaviours. • how to assess the needs of SP. • what do to if they suspect SP are self-harming. 1.7.13 Staff in the Military setting all need to be aware of the arrangements for: • transferring SP to a military or NHS healthcare setting when necessary. • support arrangements for SP when overseas. • Staff should follow the relevant single service (Army, Royal Navy and Royal Air Fforce) guidance on assessment and management to ensure a safe and supportive location if immediate health support is not available. 1.7.14 For SP who have self-harmed, staff should seek the advice of mental health professionals to develop a support plan with the SP, their family	

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				members, immediate friends and peer group, welfare support and carers (as appropriate). This should include guidance from other agencies involved in the SP's care, as appropriate. 1.7.15 Staff should consider how the SP's self-harm may affect their immediate friends and peer group, and provide appropriate support to reduce distress to them and the SP.	
Ministry of Defence	Guideline	25	3	a discharge planning meeting with all appropriate agencies (if SP is military this must be communicated with Defence Medical Services)	Thank you for your comment. Military settings are outside the scope of this guideline and so have not been included.
Ministry of Justice	Guideline	General	General	Within the guidelines, it is sometimes difficult to ascertain if references to "staff" also includes criminal justice staff or if these sections apply only to healthcare staff. Section 1.2 is a good example where "staff" and "healthcare professionals" seems to be used interchangeably, as well as section 1.4, involving family members and carers – difficult for probation practitioners/prison staff to understand if this applies to them or not? This comment also applies to some of the generic sections towards the end e.g. sections 1.9 (initial after care after an	Thank you for your comment. Text has been added to the start of the guideline to clarify that the recommendations apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group.

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				episode of self-harm), 1.10 (interventions for self-harm) and 1.11 (supporting people to be safer after an episode of self-harm). Perhaps it would better to specify in the section about non healthcare professionals which other sections of the guidelines also apply to these other settings, or making it clear that only the section about criminal justice applies to those staff and that the rest of the guidance does not apply, if that is the case.	
Ministry of Justice	Guideline	General	General	More clarity is needed about which recommendations do not apply to all settings unless the intention is standardising the approach and the guidelines bring all settings into one document. If this is the case, the guidelines have friction points with existing instructions including; observations with people who self-harm in prison conducted by HMPPS staff as part of the ACCT process references to harm minimisation strategies.	Thank you for your comment. The recommendations in the guideline represent best practice based on the best available evidence. As such the committee intended that the recommendations made in the guideline should apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group. The guideline has been amended to make this clearer. However, the evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple

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				Page 52 "The committee agreed that people who have self-harmed in secure settings need onsite support or, where that is not possible, transfer to healthcare settings. As a result, the committee agreed that staff in these settings should be aware of the arrangements in place, so they can facilitate appropriate care and support if a person does self-harm". This could apply to many people in our care given the recorded instances and people in our care who self-harm and could have a disproportionate impact on certain groups.	criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
Ministry of Justice	Guideline	General	General	More clarity is needed when an individual from a CJS setting presents to a community health setting such as A&E. There may need to be more steps in gaining information, identifying risks and needs, sharing information and collaborative working with the institution that will be responsible for managing risk, as the guidance does not address this.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations about gaining information, identifying risks and needs, sharing information and collaborative working when an individual from a criminal justice system setting presents to a community health setting.
Ministry of Justice	Guideline	General	General	There are no references throughout the document regarding expectations of liaison and collaboration with	Thank you for your comment. The recommendations in the guideline represent best practice based on the best available evidence. As

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				criminal justice staff – it is hard to tell whether these guidelines apply (beyond the small 1.7 section) to healthcare staff in prison but even if not, that probation or AP staff will have critical information for a community psychosocial assessment. This should be more specific given the extensive evidence about risk in community samples.	such the committee intended that the recommendations made in the guideline should apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group. The guideline has been amended to make this clearer. Collaboration between healthcare professionals, social care practitioners and other professionals is a theme that runs throughout the guideline. See for example recommendations 1.7.1, 1.7.25, 1.11.8, 1.11.14, 1.12.4)
Ministry of Justice	Guideline	General	General	There seems to be an assumption that the person will present with self-harm which requires emergency medical assistance although the definition of self-harm is far more inclusive. It would be beneficial is this can be specified especially for institutional settings where the presentation of self-harm may be more varied.	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.
Ministry of Justice	Guideline	General	General	More could be done to develop the tone to reflect a more person-centred approach where the person takes ownership of their own safety planning, with support for instance.	Thank you for your comment. The committee think that current wording of the guideline recommendations adequately reflects a person-centred approach and covers the concepts you have raised. Therefore, no changes have been made based on your comment.

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Ministry of Justice	Guideline	General	General	For recommendations within the 'criminal justice settings' in addition to prison specific recommendation, there needs to be equal focus on community references e.g. how to access to community health and crisis services.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
Ministry of Justice	Guideline	General	General	There were no references highlighting adaptations for those who have protected characteristics e.g. gender, neurodiversity etc. which may be helpful for staff.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and support needs and preferences taken into account. In addition, this guideline makes a recommendation (1.1.4) about ensuring support and information is adapted for people who may be subject to discrimination.
Ministry of Justice	Guideline	General	General	When the recommendation references MDT, it rarely indicates MDT working with non-healthcare professionals, but we know there is real benefit in including non-medical staff and taking a person-centred approach. Within the prison context, MDT could include	Thank you for your comment. The recommendation (1.5.17) has been amended to specify that those involved with the person's care and support should be involved in the multidisciplinary review.

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				chaplaincy, teachers, key workers, caseworkers, substance misuse workers etc. In AP settings, this could include probation practitioners, drugs workers, mentors, employment workers etc.	
Ministry of Justice	Guideline	General	General	There is one very important general point which is that the guidelines consistently refer to 'criminal justice settings' which as we know includes Approved Premises, courts, probation offices etc. although the guidance itself is clearly only thinking and referring to secure or institutional settings. This is important to be specified since the guidance is not suitable for all of these settings, especially since none of these other settings will have on-site access to health services but will have responsibilities for some aspects e.g. they still need to do an assessment and observe plus will do aspects such as remove items and hold medication; and rely on health services to respond appropriately on other aspects e.g. not seeing AP as a safe place where high risk can be managed.	Thank you for your comment. The recommendations in the guideline represent best practice based on the best available evidence. As such the committee intended that the recommendations made in the guideline should apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group. The guideline has been amended to make this clearer. However, the evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
Ministry of Justice	Guideline	33/34	20	1.14.1 This cannot be implemented in a criminal justice setting. It would	Thank you for your comment. The committee agreed it is very important that all staff who work

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				require significant resource and substantial implications for many commissioned services in prisons and possibly APs. This is a significant step up from the guidelines set out in March 2017 to "give all staff involved in direct care, training (as part of induction training and continuing professional development) and supervision to support them in."	with people who self-harm have the opportunity for supervision so that they can be provided with appropriate and effective support. The recommendation does not specify the form or frequency of the supervision, nor does it require the supervisor to have in-depth knowledge related to self-harm; providing support could be at the level of sign-posting to external resources. The committee did recognise that implementation of the recommendation may have cost implications across different settings. Potential resource implications of the guideline were considered by NICE when preparing the guideline's Resource impact summary report.
Ministry of Justice	Guideline	11	13	1.5.1 This recommendation will be challenging in practice within the criminal justice system (CJS) as it refers to every episode of self-harm requiring a psychosocial assessment by a specialist mental health professional. However, Approved Premise (AP) Care Interviewers and Assessment, Care in Custody and Teamwork (ACCT) Assessors are not mental health professionals. We suggest amending to 'appropriate mental health support'.	Thank you for your comment. It was the committee's view that the full psychosocial assessment should be conducted by a trained mental health specialist.
Ministry of Justice	Guideline	13	1	1.5.10 The psychosocial assessment does not include some key	Thank you for your comment. The list of factors to consider has been removed from recommendation

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				considerations which are relevant for criminal justice populations (both in terms of risk and management in prison and the community) e.g. risk of violence and aggression; criminal/forensic history, risk to others. These factors are well evidenced as needs which should be considered when developing an assessment and care plan.	1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Ministry of Justice	Guideline	15	7 -17	1.5.17 The recommendation states that a mental health professional should coordinate a multi-disciplinary review and safety planning. It might be beneficial to include non-health professional involvement in the multi-disciplinary team, especially for those in contact with the CJS.	Thank you for your comment. The recommendation wording has been changed to appropriately trained professional or practitioner.
Ministry of Justice	Guideline	21	19	1.7.1 Based on this guidance, the responsibility of a non-healthcare professional is essentially to address any immediate physical health needs, seek advice from a health or social care professional and ensure the person is made aware of sources of support. We suggest adding 'follow own individual guidance in establishments' which may provide further guidance on how to handle the	Thank you for your comment. Text has been added to the guideline to clarify that, because of the need to take other national guidance into account, the recommendations may need to be tailored for certain criminal justice system settings during implementation.

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				situation directly with the person concerned so as to not give the impression that the practitioners responsibility is always to "refer onto other agencies for support".	
Ministry of Justice	Guideline	22	5	1.7.1 The issue of "seeking advice from a health or social care practitioner" needs clarity – within community probation settings, who should the practitioner consult for such generic advice, if the person isn't already under the care of a mental health professional or social care practitioner? Do these agencies provide "generic advice" and if so, perhaps this should be made clearer? Is the guidance here more about making a referral to a mental health service, to seek such advice about how to manage the person's situation, or to call mental health services for generic advice? Some probation areas have a psychologist who can be consulted, others do not.	Thank you for your comment. This recommendation is about seeking generic advice - specialist advice is covered elsewhere in the guideline. It is not possible for the recommendation to specify who to get advice from as this would be dictated by local arrangements/policy.
Ministry of Justice	Guideline	22	11	1.7.1 Expand to include 'address any safeguarding issues or refer to correct team for safeguarding'.	Thank you for your comment. This change has been made.
Ministry of Justice	Guideline	23	27	1.7.10 'Safe location' is unclear – often people who self-harm either remain in	Thank you for your comment. The evidence identified that was specific to the criminal justice

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				their usual location, are re-located to single rooms on a wing (non-therapeutic) or in the care and separation units.	system was very limited and qualitative in nature. As such the committee were not able to be specific about what would constitute a 'safe location'. This would be a matter for local implementation.
Ministry of Justice	Guideline	23	14-16	1.7.7 We suggest adding 'staff should be aware of support services available to them to support their own wellbeing' to demonstrate care and recognise the difficulty in working in this area.	Thank you for your comment. This change has been made.
Ministry of Justice	Guideline	23	14-28	1.7.7 – 1.7.10 All these sections, perhaps with the exception of staff being aware of NICE guidelines on mental health, appears only to apply to prison settings, e.g. the transfer of people to a healthcare setting; on-site support; having a safe location to await assessment or treatment following an episode of self-harm. This doesn't necessarily apply to community probation settings. We recommend that all community probation staff are aware of local processes to deal with urgent issues relating to self-harm or the guidance needs to be clearer that these sections apply only to prison environments.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
Ministry of Justice	Guideline	23	17-20	1.7.8 We think this can be expanded to include the need for staff to be aware of:	Thank you for your comment. The recommendation has been amended in line with your suggestion.

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				their responsibilities for information sharing how to access health services at the establishment	
Ministry of Justice	Guideline	29	14	1.11.3 There are statements here around observations being completed only by trained health staff and not 'security staff' – this may need clarification in terms of what counts as 'observations' and their relevance for people completing observations in the CJS. If it does apply to any CJS setting, then some clarification of the level at which trained health staff are required and whether other staff can be trained to complete them.	Thank you for your comment. The recommendation relates to clinical observation, which has been defined in the Terms used section of the guideline.
NASUWT The Teachers' Union	Guideline	22-23	26-28 and 1-3	Rec 1.7.4 The term 'guidance' is not appropriate to use for schools. It would be more appropriate to use 'policies and procedures'	Thank you for your comment. This change has been made.
NASUWT The Teachers' Union	Guideline	32-33	1-30 and 1-10	Rec 1.13.1 and 1.13.2 It isn't clear from the draft guidance whether these points relate to the training of specialists who support people who self-harm or whether it also includes training for any member of staff in an organisation that may have people	Thank you for your comment. These recommendations apply to all staff working with people who self-harm, including healthcare professionals and social care practitioners and non-health professionals such as educational staff. Recommendation 1.14.2 already covers the training you have suggested.

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				who self-harm (e.g. a school). We believe that the guidance should make it clear that 1.13.1 refers to health and care professionals and settings working with those who self-harm. It would however, be appropriate for the NICE guidance to emphasise the importance of staff in schools and other non-specialist settings receiving training so that they understand their roles and responsibilities in relation to children and young people who self-harm. The187uidancee might also make reference to the importance of training for non-specialist settings addressing the stigma and discrimination associated with self-harm and the importance of avoiding judgmental attitudes and discrimination, of respecting the individual and being culturally sensitive, and of responsibilities in respect of equalities and human rights legislation. It may	

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				also be appropriate for such training to address some of the triggers and underlying factors that may cause a person to self-harm.	
NASUWT The Teachers' Union	Guideline	14	8 -11	Rec 1.5.11 – It may also be appropriate to seek information from the school or education setting about the CYPs engagement in education activities	Thank you for your comment. The committee have amended the recommendation to state that the educational context should be considered by the mental healthcare professional. However they did not think it feasible for them to contact the school as this assessment may be taking place out of hours or at the weekend.
NASUWT The Teachers' Union	Guideline	22	1-11	Rec 1.7.1 The guidance needs to recognise that schools will usually have systems in place that involve a class teacher or other member of staff liaising this and referring a pupil to the member of staff who leads on pupil's mental health and wellbeing, e.g. the senior mental health lead, head of inclusion or a senior leader within the school. The guidance should include a bullet point that makes it clear that a teacher or other member of staff should refer their concerns to the appropriate member of staff within the school or setting. We suggest that 1.7.1 is split into two paragraphs and that the first paragraph	Thank you for your comment. The general principles described in recommendation 1.8.1 do apply to educational settings. Recommendation 1.8.3 covers educational settings having policies and procedures so staff know how to support students who self-harm. If the school policy is to refer to the member of staff who leads on pupil's mental health and wellbeing, this will be documented in their policy. Therefore it should be possible for staff to do what is in recommendation 1.8.1 whilst still complying with their organisational policy. The changes you suggest to recommendation 1.8.1 have therefore not been made.

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				states the following: 1.7.1 When a person who has self-harmed presents to a non-health professional, for example, a teacher or member of staff in the criminal justice system, the non-health professional should: treat the person with respect, dignity and kindness address any immediate physical health needs resulting from the self-harm, in line with locally agreed policies.. The new paragraph should pick up the remaining bullets. The introduction to this paragraph might say: 1.7.(*) In line with agreed policies, an appropriate member of staff in the school or setting should call 111 or 999 or seek other external medical support if needed seek advice from a health or social care professional, which may include	

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				referral to a healthcare or mental health service ensure that the person is aware of sources of support such as local NHS urgent mental health helplines, local authority social care services, Samaritans, NHS111 and Childline, and that people know 9 how to seek help promptly address any safeguarding issues	
NASUWT The Teachers' Union	Guideline	22	13-18	Rec 1.7.2 The term 'guidance' is not appropriate to use for schools. It would be more appropriate to use 'policies and procedures'. We recommend that all subsequent references to 'guidance' in the sections for non- health professionals are amended to say 'policies and procedures'.	Thank you for your comment. This change has been made.
NASUWT The Teachers' Union	Guideline	22	13-18	Rec 1.7.2 It is important that the NICE guidance recognises that particular members of school staff may be responsible for implementing some of the procedures and that other staff do not need detailed knowledge of those procedures. Teachers and other school staff need to know what they should do and who to refer to when	Thank you for your comment. The guideline recommends that all educational staff are aware of the policies and procedures referred to in recommendation 1.8.3 and know how to implement them. The bullets in recommendation 1.8.3 specify what policies and procedures need to contain, not that all staff need to be able to do all of the things in the bullets themselves - who will act will be

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				particular circumstances arise. For example, it is not appropriate for the NICE guidance to be worded in a way that suggests that all staff in a school will assess the needs of students who self-harm. The draft guidance should be amended so that it is clear that there is somebody in the school who does the assessment and for teachers and other staff in the school need to know who the person or persons is/are and what they need to do if they think a pupil needs to be assessed.	governed by the content of the policies and procedures.
NASUWT The Teachers' Union	Guideline	22	19-25	Rec 1.7.3 The term 'guidance' is not appropriate to use for schools. It would be more appropriate to use 'policies and procedures'.	Thank you for your comment. This change has been made.
NASUWT The Teachers' Union	Guideline	22	19-25	Rec 1.7.3 After this paragraph, the NICE guidance should include an additional paragraph that makes reference to the Department for Education's statutory guidance, Keeping Children Safe in Education and the DfE's advice, What to do if you're worried a child is being abused: advice for practitioners. These documents address what should happen if a child is self-harming.	Thank you for your comment. These documents do not provide specific advice on what to do if a child is self-harming - the DfE advice 'What to do if you're worried a child is being abused' only makes reference to self-harm as a potential indicator for neglect, while 'Keeping Children Safe in Education' only mentions self-harm twice: once as an indicator for involvement in serious violent crime, and later in reference to online safety. Safeguarding is addressed in the guideline in section 1.3, including acknowledgement that self-harm can be linked to safeguarding concerns such as domestic abuse,

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					violence, and exploitation (see recommendation 1.3.1). The potential harms and benefits of social media are discussed in the Committee's Discussion of the Evidence section in Evidence Review F as a factor to consider when assessing people who have self-harmed. The suggested advice has not been linked to in the guideline because it is not specific to self-harm and does not provide guidance further to that already recommended in the guideline.
NASUWT The Teachers' Union	Guideline	22	21-22	In the case of the second bullet point under 1.7.3, it would be appropriate to say, 'ensuring that the policies and procedures relating to self-harm are regularly reviewed and kept up-to-date in line with current national guidance'. It is important to recognise that school teachers and leaders are not health or care experts and that they may need to seek advice and guidance from others when reviewing and updating policies and procedures. We would expect the DfE or other relevant body to interpret professional guidance and this will guide what schools do.	Thank you for your comment. 'National' has been added to the recommendation as suggested.
NASUWT The	Guideline	23	7	Rec 1.7.5. The term 'guidance' is not appropriate to use for schools. It would	Thank you for your comment. This change has been made.

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Teachers' Union				be more appropriate to use 'policies and procedures'	
NASUWT The Teachers' Union	Guideline	23	4 -8	Rec 1.7.5 The NASUWT acknowledges the importance of schools seeking advice from mental health professionals to develop a support plan for a pupil who has self-harmed. However, we reiterate our concerns about the difficulties that schools are experiencing in obtaining this support.	Thank you for your comment. The committee acknowledge this issue and think it is important for this recommendation to be included in the guideline to highlight the need for this support to be provided.
NASUWT The Teachers' Union	Guideline	33 and 34	19-22 and 1/14	Rec 1.14.1 and 1.14.2 We believe that the NICE guidance should include an additional paragraph which makes it clear that non-specialist settings such as schools should ensure that all staff should have access to support, including support or signposting to emotional support services as appropriate where the teacher, leader or other member of school staff has taught, worked with or supported a pupil or member of staff who has self-harmed.	Thank you for your comment. Recommendation 1.15.2 already makes this recommendation for all staff.
NASUWT The Teachers' Union	Guideline	33 and 34	19-22 and 1-14	Rec.1.14.1 and 1.14.2 It isn't clear whether the guidance in 1.14.1 and 1.14.2 covers health and care staff in specialist settings or whether it also covers non-specialists working in	Thank you for your comment. This recommendation relates to all staff. The qualitative evidence clearly showed that non specialist staff, including non-healthcare staff wanted similar supervision to that of clinical staff.

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				schools for example. We believe that the guidance is most appropriate to those working in specialist settings and that the draft guidance should be updated to make this clear.	
National Patient Safety Team – NHS England and NHS Improvement	Guideline	General	General	Overall, from a patient safety perspective, there is a lot to commend this guidance. Specific comments below	Thank you for your comment.
National Patient Safety Team – NHS England and NHS Improvement	Guideline	17	1	1.6.3 Guidance currently states 'For immediate first aid for self-poisoning, see the BNF's guidance on poisoning, emergency treatment, TOXBASE and the UK National Poisons Information Service. Please consider rewording to make clear that staff should have access to Toxbase 24/7 to obtain immediate supportive information.	Thank you for your comment. Making recommendations about access to TOXBASE are outside the scope of this guideline.
National Patient Safety Team – NHS England and	Guideline	17	14	1.6.6 3rd bullet point states 'Make referral to mental health services a priority when … the physical consequences of self-harm cannot be managed in primary care'. Consider rewording as	Thank you for your comment. This bullet point has been deleted.

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NHS Improvement				potentially, if physical consequences of self-harm can't be managed in primary care, patient may need referral to an ED department initially.	
National Patient Safety Team – NHS England and NHS Improvement	Guideline	20	28	1.6.21 The guidance appears to accept prolonged stays in paediatric wards. Applying the limited safety protection of daily ward round/access to liaison psychiatry has potential for very real and significant safety risks in this environment. We can share incident data relating to this issue.	Thank you for your comment. The recommendation doesn't advocate prolonged stays in paediatric wards – the least intensive and restrictive principles apply. The purpose of this recommendation is to ensure that if a child or young person is admitted to a paediatric ward they receive person-centred care.
National Patient Safety Team – NHS England and NHS Improvement	Guideline	23	2	1.8 The guidance has clear content on planned discharge, but nothing on follow-up of self-discharge from general wards (which is common, and unlikely to mean rejection of all offers of help, just that being in a general hospital is not something they want) including assessment of whether they have capacity to self-discharge/needs for assessment or treatment under MHA	Thank you for your comment. The guideline recommends in section 1.7 that policies and procedures are in place for instances when the person wishes to leave or leaves before assessment and care had been given.
National Patient Safety Team – NHS	Guideline	24	3	1.8.1 Real safety worries where guidance suggests admission to a general hospital should take place even when	Thank you for your comment. This recommendation provides detail in the bullets about the circumstances in which general hospital admission should be considered. It does not

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England and NHS Improvement				no need for physical healthcare. We believe is an inherently unsafe environment and can share the very worrying levels of serious harm and death that can follow (review done for MH SIP). This recommendation appears likely to do more harm than good based on patient safety incident data; leaving aside impact on general hospital capacity. In addition, guidance states levels of observation needed must be determined jointly by MH and acute staff but without 24/7 support that can't happen (as currently if unable to assess patient will also not provide advice on what observation they need)	recommend admission for everyone who self-harms. Amendments have been made to clarify that this recommendation does not apply to those who need psychiatric admission. The rationale and impact text describes that admission to hospital carries a greater risk of distress to people of all ages but that there are some cases where it can be helpful to give the person time to recover.
National Patient Safety Team – NHS England and NHS Improvement	Guideline	24	16	1.8.5 The guidance states "If a person self-harms during a hospital admission, follow the local hospital policy for investigating untoward incidents and undertake a full investigation." The guidance needs to reference the new NHSE/I PSIRF policy – patient safety team happy to help rephrase if helpful.	Thank you for your comment. We have added reference to the PSIRF in the recommendation
National Patient Safety Team	Guideline	31	4	1.12.2 Guidance currently states 'Use shared decision making to discuss limiting the	Thank you for your comment. Weekly prescriptions have been added as an example.

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– NHS England and NHS Improvement				quantity of medicines supplied to people with a history of self-harm …' – please be aware we are currently working with DHSC colleagues in relation to an issue where a patient was at risk of self-harm and advised to receive weekly prescriptions. However due to the increase cost of weekly prescriptions (compared to monthly prescriptions) this was not possible, and the patient went on to take an overdose. Any support you can offer on this issue to drive for a change in the prescription pricing structure would be welcomed.	
National Patient Safety Team – NHS England and NHS Improvement	Guideline	31	8	1.12.3 The guidance states 'Consider carrying out a medicines review after an episode of self-harm.' - please consider rewording to 'should carrying out' if the self-harm involved a medicines overdose.	Thank you for your comment. This recommendation is phrased as a consider recommendation which reflects the strength of the evidence.
National Patient Safety Team – NHS England and NHS Improvement	Guideline	45	26	We support the rejection of risk assessment tools but the guidance is then not clear how assessment of levels of observation needed are determined nor when/if admission to a MH unit might be beneficial after self-harm (whereas for when GPs should	Thank you for your comment. The committee have added a recommendation to the Principles for assessment and care sections to give some guidance on what factors should be considered when deciding if they need to refer onto a Mental health service and what the person needs.

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				refer to MH services, the guidance is really helpful and has clear pointers).	
NHS England and Improvement	Guideline	General	General	From our policy perspective there isn't anything specific that we would comment on, however it would be good to reference Universal Personalised Care: Implementing the Comprehensive Model it's components have been developed to support people to have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. In particular we feel that Social Prescribing initiatives and Personal Health Budgets could play a part in supporting people in their management and recovery from self harm; we expect our colleagues working on those components to comment separately on the consultation. We note that shared decision making is featured but perhaps could be promoted more strongly and wonder if care plans should be referred to as personalised care and support plans, but again the teams who work on these areas are likely to comment on these subjects.	Thank you for your comment. This guideline is focused on the assessment, management and prevention of recurrence of self-harm. The policies you cite are relevant to a wide variety of people but they are not specific to those who self-harm. Therefore we have not referenced them in the guideline.

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NHS England and Improvement	Guideline	General	General	We welcomed this updated guidance which was clear to read and included useful materials and resources to support clinical practice with a focus on a psychosocial interventions approach combined with family interventions. There were a few areas which we felt that on balance could be strengthened.	Thank you for your comment.
NHS England and Improvement	Guideline	General	General	The person assessing should have access to interpreting services including BSL.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
NHS England and Improvement	Guideline	6	18	We think it is important that information should also be tailored to the levels of health literacy of the person.	Thank you for your comment. The committee agree but have not mentioned health literacy in the recommendation because this is inherent in the existing wording 'tailored to the individual needs of the person'
NHS England and Improvement	Guideline	11	22	1.5.2 "Do not delay the psychosocial assessment until after medical treatment is completed"- We agree with this however there should be further advice regarding situations where a psychosocial assessment	Thank you for your comment. People requiring urgent care should not be left untreated, and the committee believe that any healthcare professional would be able to use their judgement to assess this situation. The committee made this recommendation to guard against the practice of

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				cannot not take place due to medical treatment.	not giving any mental health support whilst waiting for medical care.
NHS England and Improvement	Guideline	12	3	1.5.4 "Do not use breath or blood alcohol levels to delay the psychosocial assessment" We support this as blood alcohol levels can be misleading, however, there needs to be guidance provided for staff to assess persons decision making capacity whilst intoxicated.	Thank you for your comment. The assessment of a person's decision making capacity whilst intoxicated is not specific to self-harm. The committee would expect that healthcare professionals should know how to do this as part of their job and have therefore not made recommendations on this issue.
NHS England and Improvement	Guideline	12	15 - 16	We think appropriate adjustments should be made for levels of health literacy as well.	Thank you for your comment. The focus of this bullet is about adaptations that may be needed to the psychosocial assessment as a result of the person having a particular condition so the committee did not think it was appropriate to add it here.
NHS England and Improvement	Guideline	12	21 & 23	To take a more personalised approach to assessment it would be good to swap lines 21 & 23. If what matters to the person is discussed first this can immediately build a clearer picture of the person as a whole person, rather than just focussing on what is the matter with them. It may seem a small change but it can make a significant difference.	Thank you for your comment. This change has been made.

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NHS England and Improvement	Guideline	13	1	1.5.10 - Person's risk factor list should consider adding: Evidence or exploitation - financial/sexual Experience of bullying including online	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
NHS England and Improvement	Guideline	15	1	We would recommend the development of a personalised care and support plan (PCSP), which is a key factor in people having more choice and control over their care and would align with developments in community mental health that has replaced the care programme approach with PCSPs	Thank you for your comment. In using the term 'care plan' the committee have aimed to future proof the guideline as terminology changes over time. 'Care plan' as the committee mean it has been defined in the glossary to ensure it is clear what is meant regardless of the name it is given.
NHS England and Improvement	Guideline	15	15 &16	We would recommend replacing care plan with a PCSP and including a safety plan as part of that PCSP, rather than having two separate plans.	Thank you for your comment. In using the term 'care plan' the committee have aimed to future proof the guideline as terminology changes over time. 'Care plan' as the committee mean it has been defined in the glossary to ensure it is clear what is meant regardless of the name it is given.
NHS England and Improvement	Guideline	26	16	We recommend the development of a safety plan as part of a personalised care and support plan	Thank you for your comment. The committee have used the term 'care plan' throughout the guideline in order to future proof the guideline as terminology changes over time. 'Care plan' as the committee

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					mean it has been defined in the glossary to ensure it is clear what is meant regardless of the name it is given. A definition of 'Safety plan' has also been given, to clarify the difference between the two plans.
NHS England and Improvement	Guideline	28	5	Harm Minimisation: The recommendations reads as if harm min strategies should only be used for episodes of self- cutting although it is acknowledged that harm min approaches are not always effective for everybody the approaches could be used more widely for other forms of self-harm.	Thank you for your comment. The wording has been changed to self-harm.
NHS England and Improvement	Guideline	29	1	Add in here' and what matters to them'	Thank you for your comment. This has been amended in line with your comment.
NHS England and Improvement	Guideline	30	7	1.11.6 'Balancing the need for restrictions' this phase seems to weigh towards restrictive practices, consider rephrasing to "use least restrictive interventions"	Thank you for your comment. The recommendation has been amended to incorporate involving the person in the decision about removing items. Use of the least restrictive measures has also been added.
NHS England and Improvement	Guideline	30	16	Safer Prescribing: Should be much clearer that where there are multiple prescribers involved in a person's care, communication and liaison between all parties should be strengthened. This is more fully explained in the rationale	Thank you for your comment. A bullet about effective communication when there are multiple prescribers has been added to the recommendation.

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				and impact section on safer prescribing, but I think it needs to be explicit in the recommendations.	
NHS England and Improvement	Guideline	30	1 & 2	There is a new digital PCSP DAPB information standard that supports/ requires the sharing of information between all the services in a person's life where appropriate to avoid them having to share information repeatedly.	Thank you for providing this information.
NHS England and Improvement	Guideline	32	1	1.13 Training the consultation should consider recommending Trauma informed training.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
NHS England and Improvement	Guideline	33	19	Supervision: Ongoing clinical supervision is critical to support effective and safe practice, including the use of debriefs after an episode of self-harm which should include the person. There is a missed opportunity to reference the different models of supervision and specifically restorative clinical supervision which is being	Thank you for your comment. The recommendation has been amended to include how best to support staff. It is not possible to recommend a specific method for doing this (such as debriefs) as the guideline has not looked at a review question in this area. Restorative supervision has been mentioned in the recommendation but not 'clinical' because this guideline applies to settings other than just healthcare.

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				implemented across all health services via the implementation of PNA.	
NHS England and Improvement	Guideline	34	18 - 21	As previously stated we would recommend the use of the term personalised care and support plan rather than care plan. A PCSP would include all the information referenced in lines 18-21 but would also include information about what matters to the person, which works to ensure the treatment & support offered to the person is more holistic.	Thank you for your comment. In using the term 'care plan' the committee have aimed to future proof the guideline as terminology changes over time. 'Care plan' as the committee mean it has been defined in the glossary to ensure it is clear what is meant regardless of the name it is given.
NHS England and Improvement	Guideline	36	17	Use of Observations: The guidelines talk about observation on wards as an intervention to reduce self-harm but this should include the therapeutic aspect of therapeutic engagement and observations and the ongoing training and clinical supervision needs of staff to be effective.	Thank you for your comment. The committee have clarified in the terms section that clinical observation is meant to be a therapeutic intervention. The committee agreed that one of the ways to ensure observation is therapeutic in nature is to ensure the person providing the observation has been trained to do so. The training recommendations then specify this
NHS England and Improvement	Guideline	45	5 & 6	We would suggest a personalised care and support plan would ensure a greater degree of engagement	Thank you for your comment. In using the term 'care plan' the committee have aimed to future proof the guideline as terminology changes over time. 'Care plan' as the committee mean it has been defined in the glossary to ensure it is clear what is meant regardless of the name it is given.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	General		Welcome this single updated guideline but need to make explicit in the headlines that this applies to people of all ages.	Thank you for your comment. The text at the start of the guideline has been amended to clarify that it relates to children, young people and adults.
NHS England CYP Mental Health Policy Team & AMH	Guideline	General		A standalone section on children in care would have been potentially helpful. Potentially that would also apply to adult care settings, in addition to the (short) section on social care.	Thank you for your comment. No evidence was found to support making separate recommendations for children in care and so this change has not been made. However the principles recommended here would apply to everyone including children in care.
NHS England CYP Mental Health Policy Team & AMH	Guideline	General		The CGDG should take on board the recent paper (Simon et al, JAMA February 15, 2022 Volume 327, Number 7). This paper reports an RCT with digital remote intervention with a very large sample (N≈19,000) of outpatients with frequent suicidal ideation and self-harm that offering care management did not significantly reduce risk of self-harm, and offering brief dialectical behaviour therapy (DBT) skills training significantly increased risk of self-harm, compared with usual care. The study aimed to answer if an evidence based clinical intervention,	Thank you for your comment. This study would not have been included in the Cochrane review on psychosocial interventions for adults because it was published after the Cochrane review was published in April 2021 and after the guideline went for consultation in January 2022. Additionally, the population does not match the PICO specified in the Cochrane review protocol, because it is not stated whether the participants included in the study have self-harmed. The committee discussed the findings regarding potential harms caused by remote DBT but agreed they are unlikely to affect the recommendations in section 1.11 because the mode of delivery of the interventions is not specified, based on a lack of any available evidence regarding this at the time of

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				DBT, could be scaled by being delivered largely online and serve to reduce self-harm and suicide attempts and suicidal ideation. The sample was a group of outpatients with significant frequent suicidal ideation. The percentage with nonfatal or fatal self-harm was 3.1% in the treatment as usual group. The figure was slightly but not significantly higher (3.3%) in a groups offered a care management intervention, modelled after collaborative care programs and the Henry Ford Health System Perfect Depression Care (Zero-Suicide) program and included regular outreach for assessment of suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS) leading to guideline based recommendations regarding outpatient follow-up. The third group received a skills training program based on the skills training in traditional DBT including an interactive online program supported by a skills coach (video instruction with demonstrations of mindfulness, mindfulness of current emotion, opposite action, and paced breathing). The skills training did not	drafting the recommendations. The committee agreed that this might be something to consider for the next update but were hesitant to amend the recommendations on the basis of one study that hasn't been analysed as part of a review, especially because the study referenced had a low adherence and uptake rate, and there is likely to be an evolving evidence base on remote interventions in light of the effects of the COVID-19 pandemic. The committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions (including remote interventions) - please see appendix K of evidence review J for more information. The committee agreed that building therapeutic relationships is vital when providing care for people who self-harm, based on qualitative evidence outlined in evidence reviews P and R. Recommendation 1.14.2 outlines training that all staff working with people who self-harm should receive, including 'communicating compassionately and facilitating engagement with people who have self-harmed, including using active listening skills'. The committee agreed these skills would enable staff to build therapeutic relationships with patients,

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				include psychotherapy but were delivered by coaches with a mental health bachelor's degree coursework and received intervention specific training followed by twice-monthly supervision teleconferences with investigators. The rate of nonfatal or fatal self-harm in this group was 3.9% which was significantly higher than in usual care. This reflects a hazards ratio of 1.29 (increase in risk 29%) for total self harm and 1.34 (increase in risk 34%) for severe self-harm. The care management package based on the Zero-Suicide model represented no improvement in the risk of self-harm over TAU although it involved significant additional effort compared with usual care. The additional effort for represented by dialectical behaviour therapy skills training significantly increased risk for this group. The study represents a warning that psychological interventions when administered remotely at what are likely to be subclinical doses can cause harm. It also suggests that skills training delivered mechanistically,	reducing the risk that treatment would be delivered mechanistically.

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				when not delivered in the context of a relationship with the treater can be unhelpful for individuals with severe problems even when we know that when delivered in the context of a trusting therapeutic relationship these skills are very beneficial (literally life savers). The appeal of the cost-effectiveness of digital interventions should be moderated by these findings which underscore the importance of the collaborative development of interventions with those with lived experience.	
NHS England CYP Mental Health Policy Team & AMH	Guideline	1	7	'People of all ages' may be preferable phrase to 'all people' to underline the inclusion of CYP.	Thank you for your comment. Text has been added to the start of the guideline to clarify that the recommendations apply to all people who have self-harmed, unless a recommendation specifically states that it is for adults or children and young people only.
NHS England CYP Mental Health Policy Team & AMH	Guideline	6	1	Paragraph 1.1.4 – should acknowledge autism and learning disabilities as well.	Thank you for your comment. The guideline has been amended to highlight the needs of people with learning disabilities or neurodevelopmental conditions in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure healthcare professionals and social care practitioners consider

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					any additional needs those with learning disabilities may have.
NHS England CYP Mental Health Policy Team & AMH	Guideline	7	1-5	Adaptations for 'other forms of discrimination'?' support should (a) be tailored to the age and developmental competence of the child, (b) reflect their sensory circumstances where appropriate and their learning disability and/or autism or specific learning needs.	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
NHS England CYP Mental Health Policy Team & AMH	Guideline	7	7	Paragraph 1.2.1 – does there need to be something more explicit about children in care? Contacting social workers?	Thank you for your comment. The focus of this recommendation is consent and confidentiality related to children and young people who self-harm, not what actions to take following an episode of self harm. It would be part of standard practice to contact social workers if a child in care self-harms and does not need to be specified in a recommendation.
NHS England CYP Mental Health Policy Team & AMH	Guideline	7	20	If appropriate here, should this section signpost to Consensus Statement and ZSA supporting guidance 'SHARE'?	Thank you for your comment. We have added a link to the consensus statement which includes a cross reference to the SHARE document.
NHS England CYP Mental	Guideline	7	22	Paragraph 1.2.2. – should also understand Deprivation of Liberty orders.	This recommendation is about children and young people who self harm. Deprivation of Liberty orders

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Health Policy Team & AMH					apply to adults and have therefore not been included here.
NHS England CYP Mental Health Policy Team & AMH	Guideline	7	22	Ref to CYP please clarify age (under 16/18years)?	Thank you for your comment. For consistency across guidelines, NICE only specify an age when the guideline relates to a particular group.
NHS England CYP Mental Health Policy Team & AMH	Guideline	8	11	Liaison psychiatry is an adult model/language – may want to consider other terms which are all age e.g. crisis/liaison or home treatment services	Thank you for your comment. This has been amended to 'age-appropriate liaison psychiatry' to encompass the number of different names services are called across the country.
NHS England CYP Mental Health Policy Team & AMH	Guideline	9	7	Assess for risk of online harm as well as implementing actions to reduce risk – see guidance for staff developed by Samaritans	Thank you for your comment. The use of social media and the internet would come under 'changeable and current factors' in recommendation 1.5.10.
NHS England CYP Mental Health Policy Team & AMH	Guideline	9	18	Paragraph 1.3.2 – does this need to mention CETRs?	Thank you for your comment. Since CETRs are only relevant to those with learning disabilities, autism or both it is not appropriate to mention them because the population of people who self-harm is broader than this.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	9	23	Section 1.4 – can social workers be explicitly mentioned.	Thank you for your comment. This section relates to involving families and carers and so would not be appropriate to refer to social workers. The recommendations do not specify that these actions should be carried out by any specific person, and therefore could be used by social care practitioners.
NHS England CYP Mental Health Policy Team & AMH	Guideline	9	23 etc	It would be beneficial to have more nuanced guidance about information sharing with and to parents & carers in particular – for those under 18, under 16 (and potentially young adults too). This is addressed in following pages but perhaps without sufficient focus on the critical age group.	Thank you for your comment. Whilst the committee acknowledges that this can be a difficult issue, it is not one that is wholly specific to self-harm. The guideline has been amended to make reference to the NICE guidance on 'Babies, children and young people's experience of care' which makes extensive recommendations about how to address the issues of consent, privacy and confidentiality of children and young people, and the appropriate way to involve their parents or carers.
NHS England CYP Mental Health Policy Team & AMH	Guideline	10	4 etc	For children who are not Fraser competent, then those with parental responsibility will need to be informed, whether or not the child consents.	Thank you for your comment. Whilst the committee acknowledges that this can be a difficult issue, it is not one that is wholly specific to self-harm. The guideline has been amended to make reference to the NICE guidance on 'Babies, children and young people's experience of care' which makes extensive recommendations about how to address the issues of consent, privacy and confidentiality of children and young people, and the appropriate way to involve their parents or carers.
NHS England	Guideline	10	9	Add consideration of neurodevelopmental needs (mental	Thank you for your comment. The guideline has been amended to highlight the needs of people

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CYP Mental Health Policy Team & AMH				capacity may imply learning needs underestimating other risks and vulnerabilities e.g. social comm needs)	with learning disabilities or neurodevelopmental conditions in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure healthcare professionals and social care practitioners consider any additional needs those with learning disabilities may have.
NHS England CYP Mental Health Policy Team & AMH	Guideline	10	29	Paragraph 1.4.3, does this need to be nuanced for CYP?	Thank you for your comment. Recommendation 1.4.2 gives guidance on things to consider when thinking about involving families and carers. One of these factors to consider is age.
NHS England CYP Mental Health Policy Team & AMH	Guideline	11	13	Paragraph 1.5.1– can it mention them being age appropriately trained.	Thank you for your comment. Recommendations on training are made in section 1.14. These cover that the training should be specific to the staff member's role, which would encompass being age appropriately trained. Recommendation 1.5.11 also states that the psychosocial assessment should be conducted by a mental health professional experienced in assessing children and young people who self-harm.
NHS England CYP Mental Health Policy Team & AMH	Guideline	11	13	Need to consider the resource implication if a specialist MH assessment is required immediately after each episode as self harm is common in CYP (ONS Survey 5.5% of	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to

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				11-16year olds and 15.5% of 17-19year olds)	assess the help they need is to conduct a full assessment.
NHS England CYP Mental Health Policy Team & AMH	Guideline	12	17	Paragraph 1.5.8– is it possible to include other protected characteristics?	Thank you for your comment. The groups cited in this recommendation are those where adaptations may be needed to the psychosocial assessment. The committee did not think adaptations may be needed for all protected characteristics and so have not made this change.
NHS England CYP Mental Health Policy Team & AMH	Guideline	12	21	Paragraph 1.5.9– add education / training in.	Thank you for your comment. Recommendations about training are made in section 1.14.
NHS England CYP Mental Health Policy Team & AMH	Guideline	13		Psycho-social assessment for CYP should explicitly include domestic violence and/or conflict, child protection/safeguarding issues here as well as in later safeguarding section, including the presence of a child protection plan, whether a young carer and reference a child's legal status (e.g. if a child in care/LAC, special guardianship) and who the legal parent is. Specifically explore bullying / cyber-bullying and exploitation.	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
NHS England	Guideline	13	14	Specify suicidal intent to suicidal thoughts and behaviours, For CYP	Thank you for your comment. The list of factors to consider has been removed from recommendation

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CYP Mental Health Policy Team & AMH				consider other risks themes identified by NCMD and NCISH (long term physical health needs, loss of key relationships, contact with the criminal justice system etc). Suggest an additional consideration of whether the person has an 'uncertain immigration status within the UK'	1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
NHS England CYP Mental Health Policy Team & AMH	Guideline	13	22	Paragraph 1.5.10– including bereavements including deaths by suicide	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
NHS England CYP Mental Health Policy Team & AMH	Guideline	13	26	Paragraph 1.5.10 - please add 'educational'	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	14		Insert as for older people, "For people under 18 years who have self-harmed, ensure that a specialist mental health professional, trained and experienced in assessing children and young people who self-harm carries out the psychosocial assessment". This may be the best place to introduce or re-emphasise relevant CYP aspects - as above. Practitioners assessing children should have a good knowledge of learning disabilities and/or autism and of CYP specialist mental health pathways including accessing specialist mental health in-patient care.	Thank you for your comment. Ensuring the assessment is undertaken by a mental health professional who is experienced in assessing children and young people who self-harm has been added to recommendation 1.5.11.
NHS England CYP Mental Health Policy Team & AMH	Guideline	14	8	For CYP please see key themes from recent NCMD report (poor household functioning- parental MH/SM needs, loss of key relationships, conflict and arguments at home etc)	Thank you for your comment. This would be encompassed within 'home situation' and so no change has been made to the recommendation.
NHS England CYP Mental Health Policy Team & AMH	Guideline	15	7	Paragraph 1.5.17– please add in 'and those who should be involved in their care, but may not have been up to this point.'	Thank you for your comment. This concept has been added to the recommendation.
NHS England	Guideline	15	16	Sharing safety plans with parents/carers	Thank you for your comment. This is covered by recommendation 1.11.8.

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CYP Mental Health Policy Team & AMH					
NHS England CYP Mental Health Policy Team & AMH	Guideline	16	6	Amend to "When a person of any age … "(for emphasis – in our experience it is helpful to reiterate 'of any age' and 'for all ages' in all ages mental health documents.)	Thank you for your comment. Text has been added to the start of the guideline to clarify that the recommendations apply to all people who have self-harmed, unless a recommendation specifically states that it is for adults or children and young people only.
NHS England CYP Mental Health Policy Team & AMH	Guideline	16	12	Consider insert, " … appropriate clinical support (eg from a specialist CYPMH clinician), … "	Thank you for your comment. This change has not been made as the most appropriate clinical support will vary.
NHS England CYP Mental Health Policy Team & AMH	Guideline	16	15	Paragraph 1.6.1 – do social workers need to be added?	Thank you for your comment. The recommendation is already addressed to healthcare professionals and social care practitioners.
NHS England CYP Mental Health Policy Team & AMH	Guideline	16	18	Consider insert "discuss with the person, and/or for children and young people, their parent or carer …"	Thank you for your comment. Discussion with families/carers has been added to the recommendation.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	17		Assessment of CYP in primary care (and secondary care) should consider enquiry of or referral to children's social care.	Thank you for your comment. Referral to social care would be dependent on individual circumstances and therefore has not been recommended here. Recommendations on safeguarding are included in section 1.3 and so have not been repeated here.
NHS England CYP Mental Health Policy Team & AMH	Guideline	17	14	Also seek specialist consultation and advice if concerned about risk	Thank you for your comment. This change has been made.
NHS England CYP Mental Health Policy Team & AMH	Guideline	17	20	Consider insert, "levels of concern or distress … "	Thank you for your comment. The guideline attempts to move away from labelling the person with a level of risk, but rather encourages clinicians to think about the needs of the person. This recommendation does that by setting out the factors that might indicate that the person made need further help.
NHS England CYP Mental Health Policy Team & AMH	Guideline	18	18	Consider referencing leading practice where ambulance services proactively involve crisis response services in attending known self-harm (and MH) incidents. Insert also "… discuss with the person or/and, for CYP, their parent or carer …"	Thank you for your comment. Discussion with families/carers has been added to the recommendation. No evidence was identified for this review question, so it is not possible to make more specific recommendations.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	19	7 etc	Two comments ref. "Liaison psychiatry services": (i) "(paediatric) mental health liaison services is preferred term in CYPMH context and (ii) suggest insert "… liaison or, for children and young people, crisis response service …" The latter are the predominant specialist (in-reach rather than on-site) response service for CYP and should be specifically referenced.	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	19	13	Resource implication – LTP CYP crisis services to be delivered by 2023/2024	Thank you for your comment. The committee are hopeful that the LTP for CYP crisis will help to deliver the recommendations for improvement to services that this guideline has made.
NHS England CYP Mental Health Policy Team & AMH	Guideline	19	13	Mental health liaison - rather than 'psychiatry'.	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy	Guideline	19	9	Paragraph 1.6.11– add in 'including CYP equivalent' – This needs to be added in every line liaison psychiatry is mentioned.	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to

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Team & AMH					these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	20	12	What are the criteria to admit a CYP or adult?	Thank you for your comment. This is covered in recommendation 1.9.1.
NHS England CYP Mental Health Policy Team & AMH	Guideline	20	12 etc	As above re 'mental health liaison' and CYP crisis response service	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	20	18 etc	As above	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	20	28	Please define age for CYP	Thank you for your comment. For consistency across guidelines, NICE only specify an age when the guideline relates to a particular group.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	21	1 etc	The context here is that many self harm issues are identified through a safeguarding concern. So, it is important to assert that 'where issues of self harm have been identified during either a social care assessment (whether of a child or adult) or through ongoing work, advice should be sought or a referral made to the local urgent and emergency mental health service'	Thank you for your comment. A recommendation (1.7.26) to this effect has been added to the guideline.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	1	Children and young people's mental health services (CYPMHS) is preferred to CAMHS and describes a wider specialist service offer. As above, "age appropriate (paediatric) mental health liaison or in-reach crisis response service …"	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	1	Resource implication for delivery – for LTP CYP crisis to be available by 2023/2024	Thank you for your comment. The committee are hopeful that the LTP for CYP crisis will help to deliver the recommendations for improvement to services that this guideline has made.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	3	"… CYP mental health team"	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	21	5	"… and CYP mental health services"	Thank you for your comment. There is significant variation across the country for how these services are delivered, and what they are called. Therefore, the committee have amended the reference to these services to 'age-appropriate liaison psychiatry'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	7&11	Paragraph 1.6.22 and 1.6.23 – please be explicit that this includes CYP.	Thank you for your comment. Through out the guideline, the term 'people' refers to adults, children and young people. The first page of the guideline has been amended to clarify this.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	11	This is important CYP context. Expand "do not withhold" to "… or withdraw…" Better to couch this positively: "Continue to offer social care support and involvement, particularly for CYP who may be looked after or have ongoing social care needs."	Thank you for your comment. This change has been made.
NHS England CYP Mental Health Policy Team & AMH	Guideline	21	19	What is the advice on historical disclosures of self harm?	Thank you for your comment. The guideline makes recommendations for when people present with self-harm. Many of the principles will apply to historical episodes of self-harm but management of historical episodes is outside the scope.
NHS England CYP Mental	Guideline	22	1 etc	Consider insert along lines, "For CYP under 16 years and with agreement for those over 16 years, contact the young	Thank you for your comment. Whilst the committee acknowledges that this can be a difficult issue, it is not one that is wholly specific to self-harm. The

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Health Policy Team & AMH				person's parent, carer or legal guardian, if necessary following a call to emergency medical support."	guideline has been amended to make reference to the NICE guidance on 'Babies, children and young people's experience of care' which makes extensive recommendations about how to address the issues of consent, privacy and confidentiality of children and young people, and the appropriate way to involve their parents or carers.
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	1 etc	Consider insert or new line: "seek advice from or referral to the local urgent and emergency mental health service" These help lines are now established and publicised locally and nationally and should be the first port of call.	Thank you for your comment. Seeking advice is covered in the subsequent 2 bullets and so has not been repeated here.
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	12 etc	In addition to the comments above, the Designated Mental Health Lead should liaise with the Designated Safeguarding Lead and consider a referral to Children's Social Care	Thank you for your comment. The committee did not believe it is their role to give very detailed guidance to educational settings, but rather to identify principles to which they should work to.
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	12 etc	Reference MHSTs (although not 100% coverage currently) for schools and colleges. Although terminology has evolved, from 'designated mental health leads', DfE guidance for schools and colleges refers to "Senior mental health leads" for which non-mandatory training is provided and who will be expected to understand local MH	Thank you for your comment. The term 'designated lead' has been used to allow flexibility for different roles to undertake this function in different settings.

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				services and pathways. It will be helpful to identify/reference this specific CYP terminology / guidance. https://www.gov.uk/guidance/senior-mental-health-lead-training#overview	
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	16	Please specify what types of needs	Thank you for your comment. A recommendation has been added (1.8.2) to clarify this.
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	19	Designated lead – how does align to Green paper and introduction of MH leads in every school/college?	Thank you for your comment. The term 'designated lead' has been used to allow flexibility for different roles to undertake this function in different settings.
NHS England CYP Mental Health Policy Team & AMH	Guideline	22	25	Should there be reference to training on mental health as well as suicide prevention	Thank you for your comment. Recommendations on training are made in section 1.14.
NHS England CYP Mental Health Policy	Guideline	23	4 etc	Consider specific reference and nuancing of thew involvement of and support from parents and family for young adults over 18 years.	Thank you for your comment. Whilst the committee acknowledges that this can be a difficult issue, it is not one that is wholly specific to self-harm. The guideline has been amended to make reference to the NICE guidance on 'Babies, children and young

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Team & AMH					people's experience of care' which makes extensive recommendations about how to address the issues of consent, privacy and confidentiality of children and young people, and the appropriate way to involve their parents or carers.
NHS England CYP Mental Health Policy Team & AMH	Guideline	23	14 etc	It would be helpful to specifically reference Youth Justice settings and the need to consider the role of parents and the specific vulnerabilities of children in custody. It may be helpful to have referenced children in Secure Welfare settings here as well.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
NHS England CYP Mental Health Policy Team & AMH	Guideline	23	24	For CYP please reference Secure Health Care Standards which includes risk assessment including self harm	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.
NHS England CYP Mental Health Policy Team & AMH	Guideline	24	8	Admission to a ward that meets their needs- I wondered whether helpful to specify what that means e.g. staff training/ward environment etc? Is it necessary to also state that U16s	Thank you for your comment. Different areas will have different settings for teenagers and young adults so the recommendation has been written with this in mind. It is therefore not possible to be more prescriptive. The committee want to ensure that teenagers and young adults are not admitted

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				should be admitted to a paediatric ward?	to adult wards that are not appropriate to their needs (for example geriatric wards)
NHS England CYP Mental Health Policy Team & AMH	Guideline	25	1	Paragraph 1.8.6– care plan drawn up with all relevant agencies including social care where appropriate.	Thank you for your comment. The recommendation has been amended to clarify that all appropriate agencies and people should be involved in creating the plan for further management.
NHS England CYP Mental Health Policy Team & AMH	Guideline	26	11	Paragraph 1.10.3– please add in what should be put in place for CYP who don't have frequent episodes of self-harm. Useful to add that CYP who self harm have varied diagnosis/co-morbidities including depression. Anxiety, complex PTSD/ASD/ADHD etc – treating other conditions also important?	Thank you for your comment. The existing recommendation is based on limited evidence from the Cochrane review and the profiles of the participants included in the 4 studies which assessed the effectiveness of DBT-A. The committee discussed whether this recommendation should be expanded to include other populations but agreed the evidence was not strong enough and that it would not be appropriate to extrapolate this evidence to be applicable to additional populations. However, the committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions - please see appendix K of evidence review J for more information. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and

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					conditions should be considered first and used to inform planning of the person's treatment, including any interventions received.
NHS England CYP Mental Health Policy Team & AMH	Guideline	26	26	Paragraph 1.10.5– please add in the NHS urgent MH lines.	Thank you for your comment. The recommendation already states that the safety plan should 'include contact details for the mental health service, including out-of-hours services and emergency contact details'
NHS England CYP Mental Health Policy Team & AMH	Guideline	27	9	Paragraph 1.10.6 – please add in education professionals	Thank you for your comment. The wording of this recommendation has been changed to 'relevant professionals and practitioners'.
NHS England CYP Mental Health Policy Team & AMH	Guideline	27	18	Consider adding NICE ADHD Guidance	Thank you for your comment. This change has been made.
NHS England CYP Mental Health Policy Team & AMH	Guideline	28	18	Paragraph 1.10.11– does social media use need to be added here?	Thank you for your comment. This recommendation is about discussing harm minimisation strategies. As such we have not added social media use to the recommendation.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	29	14	Staff should have some understanding of patients needs including MH needs. Consider insert re CYP: "Observations of CYP who have self-harmed should be undertaken by staff who are trained and experienced in clinical observations of CYP."	Thank you for your comment. The committee agree that only staff who are appropriately trained in clinical observation should undertake such observations. However the practice this recommendations is trying to prevent is untrained staff doing observation so the recommendation has been phrased accordingly.
NHS England CYP Mental Health Policy Team & AMH	Guideline	31	18	Should there be a recommendation about giving prescriptions and medications for psychotropic meds to CYP under 16years- particularly with known history of self harm?	Thank you for your comment. No evidence was identified for this review question so it is not possible to make such a prescriptive recommendation.
NHS England CYP Mental Health Policy Team & AMH	Guideline	32		Suggest include a paragraph referencing training for specialist practitioners working with CYP (and also older adults) who self harm.	Thank you for your comment. Recommendation 1.14.2 already states that the training should be specific to the staff members role.
NHS England CYP Mental Health Policy Team & AMH	Guideline	32	1	How does this align with HEE Self harm and suicide prevention competency framework?	Thank you for your comment. The previous NICE guidance and the research evidence base informed all 3 HEE competency frameworks. Therefore there will be some consistency. These frameworks were published in 2018, but the committee are not aware of any plans to update them.
NHS England CYP Mental	Guideline	32	2	Good to see, "… people of any age …"	Thank you for your comment.

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NHS England CYP Mental Health Policy Team & AMH	Guideline	32	12 and 20	Unclear which staff groups are being referred to?	Thank you for your comment. These recommendations relate to all staff who work with people who self harm.
NHS England CYP Mental Health Policy Team & AMH	Guideline	33	19 etc	Supervision for staff working with CYP (and also older adults) should be offered for senior staff who are trained and experienced in working with this age cohort. Similarly, staff should have access to consultation or supervision in relation to co-existing conditions including autism and /or learning disability.	Thank you for your comment. The recommendations for supervision relate to all staff who work with people who self-harm
NHS England CYP Mental Health Policy Team & AMH	Guideline	34	16 etc	If some of above amends made, some 'terms' guidance may require updating.	Thank you for noting this.
NHS England/Improvement Mental	Guideline	6	20	Languages other than English	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young

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Health Clinical Advisers					people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	7	13	and competence in those under 16	Thank you for your comment. Recommendation 1.2.2 covers competence in children and young people.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	11	13	Should this be more specific to establish a threshold level/type of incident that requires a specialist assessment. The recommendation could be a challenge where there is repeated self injurious behaviour as part of a known pattern for the individual.	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	11	14	After every episode of self-harm? Needs more description – either a serious episode or were there a pattern of repeated self-harm or may be when self-harm occurs in conjunction with something else to cause concern.	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to

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					refuse consent to an assessment if they do not wish to have one.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	11	15	Would be useful to say something about the overall purpose of a psychosocial assessment and to explicitly say that its not intended to be productive, but also develop a plan to support the person and their family.	Thank you for your comment. The Terms Used section of the guideline already contains a definition of psychosocial assessment which explains what it is. Recommendation 1.5.15 already states that a care plan should be developed based on what is identified during the psychosocial assessment.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	12	17	The recommendation to offer a same gender person to undertake the psychosocial assessment is likely to compromise the ability to respond without delay. Also, there is a question in my mind that this might require some review to ensure trans and non-binary people are not excluded.	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	13	2	I am anxious that the construction of the assessment as pertinent to establishing risk and protective factors might give the impression that there is a predictive element to the risk assessment, notwithstanding the clarity on page 15. Also, there is ongoing uncertainty whether a risk factor is the converse of a protective factor, whether these buffer each other directly, or represent independent	Thank you for your comment. The committee agreed regarding refocusing assessment of risk towards assessment of need and safety. The wording of the recommendation has been amended to discuss strengths and vulnerabilities instead of 'risk factors'. The section title on 'risk assessment' has been kept the same to acknowledge this wording is still used and people will look to the guideline for recommendations regarding this.

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				variables which influence the risk equation. This section potentially misleads by reflecting the established practice of assessment as if based in scientific rigour that may not be applicable. A form of words such as 'vulnerabilities' and 'strengths' might enable a more therapeutic approach to safety planning in line with adoption of Structured Professional Judgement approaches as recommended elsewhere. Following a rubric that reflects an SPJ tool might be more helpful than this list presented here. Also, this list lacks attention to social factors.	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	14	12	I would suggest this should relate to people in later life without specifying an age threshold. 65 is currently working age for most adults.	Thank you for your comment. This change has been made.
NHS England/Improvement Mental Health	Guideline	14	10	school	Thank you for your comment. Education has been added to the recommendation.

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Clinical Advisers					
NHS England/Improvement Mental Health Clinical Advisers	Guideline	14	19	Role as a carer relevant to all, especially those under 16	Thank you for your comment. The committee thought it was particularly important to highlight role as a carer for children and young people. The same issue for adults would be encompassed under 'changeable and current factors'.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	14	25	Is it possible to say here that don't use capacity as an excuse to deny the person help?	Thank you for your comment. Reference to mental capacity has been removed from the recommendation.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	14	26	And talked to, if possible, any accompanying family member/carer (don't have to give them info if no consent etc but certainly can ask them for info)	Thank you for your comment. Recommendations on involving families/carers have been made in section 1.4.
NHS England/Improvement Mental Health	Guideline	15	6	May be important to share plan with family, especially if plan relies on family to keep person safe; subject to capacity/consent etc and something if	Thank you for your comment. Recommendations on involving families/carers have been made in section 1.4.

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Clinical Advisers				P is under 16, lives at home with parents/people with PR	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	15	20	This is key – needs to be more prominent I think.	Thank you for your comment. The committee agree that assessment and care should be based on needs and safety and not risk. These recommendations have been put into their own section (1.6) to make them more prominent.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	16	20	Is concurrent the correct word here?	Thank you for your comment. The committee wanted to convey that the treatment of physical and mental health should be done at the same time, rather than not providing any mental health support until the person has received physical care, which is the committee's experience of current practice in many places across the country. Therefore, the felt 'concurrent' was the most appropriate word to use here.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	17	9	This consideration of a referral to a specialist appears to contradict the recommendation that a psychosocial assessment should happen following all episodes of self harm. The construction of this whole section as relating to a referral between services is somewhat anachronistic when considering the development of ARRS roles, specialist primary care mental	Thank you for your comment. The committee appreciate that primary care is currently going through significant changes, particularly in relation to mental health provision and wanted to make the recommendations as inclusive as possible for both the current situation, and for any changes that may come to services. The committee asserted that even once there are specialist primary care mental health services fully implemented, the GP will still need to hand over or refer a patient, and therefore felt this recommendation would still be relevant.

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				health services and the ambitions of the CMHTF.	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	17	6	Suggest 'frequent' rather than 'high'	Thank you for your comment. The committee think that the term 'high service use' will be understood and avoids having the word 'frequent' in the recommendation twice.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	17	20/21	Why is there no mention of consideration of level of distress in older family members	Thank you for your comment. The recommendation has been amended to include adults.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	17	20/21	Whilst page 16 correctly recognises that people over 65 have a higher risk of suicide after an episode of self-harm this set of recommendations on page 17 seems not to acknowledge the increased risk in older adults and also that older adults are less likely to ask for further support from mental health services	Thank you for your comment. This recommendation applies to all people who self-harm, including older adults. The last bullet has been amended to include specific mention of adults.
NHS England/Improvement	Guideline	19	1	This appears to contradict the (appropriate) section of the guidance which indicates that risk stratification is	Thank you for your comment. The guideline has been amended throughout to focus on the needs and safety of the person.

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Mental Health Clinical Advisers				not possible and should not be undertaken.	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	21	8	'foster a collaborative approach' leaves a lot of room for interpretation! Is there a more specific direction that relates to the role of the local authority in bringing together these parties?	Thank you for your comment. The limited evidence in this area means that it is not possible to make more detailed recommendations. The committee hope that these general principles will be helpful as well as the recommendations that focus on other settings.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	21	15	Is the NICE guideline applicable outside of health and care settings? How would the guidance reach these groups? The section relating to people who present with self injurious behaviour in non health and care settings is relevant but does this rather relate more to how services (health and care) should set themselves up to support these pathways.	Thank you for your comment. As specified in the scope and at the start of the guideline, these recommendations are for:• Healthcare professionals and social care practitioners, commissioners and providers • Staff in educational settings • Third sector organisations • The criminal justice system • People using self-harm services, their families and carers
NHS England/Improvement Mental Health Clinical Advisers	Guideline	24	4	I am worried about this – hospital should be a place for purposeful treatment not somewhere that a person goes when there are 'concerns' about what might happen next. This section appears to return to a pseudo predictive approach to risk assessment which then determines access to a	Thank you for your comment. Changes have been made to the recommendation to clarify that this is specific to safeguarding concerns rather than general concerns.

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				service. This is completely at odds with the section above which (rightly) says not to do this.	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	24	6	The person may decline a psychosocial assessment – not a reason to admit. This section worries me because general hospitals are generally very poor at managing self-harm, they aren't design for that.	Thank you for your comment. The recommendation is that admission should be considered if the person is unable to engage in the psychosocial assessment. This would not apply if the person declines the psychosocial assessment. It is hoped that implementing the recommendations in this guideline will improve practice in helping people who have self-harmed in general hospitals.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	25	8	What is the aftercare? Is it f/u of the physical injury or something else? This is fine for those in care of MH services but what about those who haven't a mental disorder? One episode of self-harm is unlikely to be reason enough for MH services input.	Thank you for your comment. The available evidence did not enable the committee to recommend a specific type of aftercare. Instead recommendation 1.10.1 specifies that the purpose and format of the aftercare should be agreed in collaboration with the person.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	27	11	But if the plan relies on family, they do need to see it as they cant do their part otherwise.	Thank you for your comment. The recommendation clarifies that the safety plan should 'be shared with the family, carers and relevant healthcare professionals and social care practitioners as decided by the person'. It cannot be shared if the person doesn't give consent for this to happen.
NHS England/Improvement	Guideline	28	22	Will this be appropriate for under – 16s?	Thank you for your comment. The guideline has been amended to clarify that it does not make any recommendations on the use of safer self-harm.

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Mental Health Clinical Advisers					The committee considered that harm minimisation could be appropriate for all ages – this would be dependent on individual circumstances.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	29	1	Here the terminology is potentially misleading: coping strategies are a subset of strengths.	Thank you for your comment. The committee agree that there are overlaps between these two concepts but decided to keep them separate in the recommendation.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	29	6	This section appears to be mainly for inpatient services. Do we need to say something pragmatic about the fact that most self-harm will happen in the community and most people will not need a hospital admission?	Thank you for your comment. This is already mentioned in context section of the guideline and so has not been repeated here.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	30	22	This seems out of place	Thank you for your comment. The committee's view was that assessment of recreational drug and alcohol consumption would be necessary to check if anything prescribed reacts badly with it.
NHS England/Improvement	Guideline	30	23	Again a reference to predictive risk assessment influencing access to treatment. This should be reframed to	Thank you for your comment. Reference to assessing risk of suicide or self-harm has been removed from the recommendation.

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Mental Health Clinical Advisers				avoid ambiguity with the emphasis on identification of vulnerabilities which might be mitigated rather than categorisation of risk level.	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	31	2/3 and 1.12.2	Hyperlink to https://www.nice.org.uk/advice/ktt24... This link (as at Feb 2022) states that " we have withdrawn our medicines optimisation: key therapeutic topics. "… Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide..Key therapeutic topic [KTT24]Published: 01 March 2019 Last updated: 01 September 2019. Comment: This is disappointing to find the link is no longer relevant. However in the absence of detail within the hyperlink to the former KTT may I strongly suggest that the details previously contained in this KTT should now be included within the self harm guidance. In particular recommendation 1.12.2 requires additional content to include reference to limitation of supply, consideration of prescribing/storage of medicines to	Thank you for your comment. The content of the former KTT is very different to that of a clinical guideline. In addition there is no mechanism in the process for developing guidelines to enable this KTT content to be kept up to date. Therefore it has not been added to the guideline. Instead a cross reference has been added to the NICE guidance on Preventing suicide in community and custodial settings.

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				others within the household of someone at risk of self harm -	
NHS England/Improvement Mental Health Clinical Advisers	Guideline	31	8	Remove the word "consider" – Medication review should be undertaken following all episode of self harm that may be impacted by medication/prescribing.	Thank you for your comment. The use of the word consider in this recommendation reflects the strength of the evidence underlying the recommendation.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	31	14	Whilst the sentiments of making sure community pharmacy staff have "awareness" may be reasonable – This recommendation needs re-writing to reflect the actions that would be expected of community pharmacy staff beyond "being aware" e.g confidentiality, signposting, refusal to supply, ? referral etc.	Thank you for your comment. The actions to be taken are reflected in the general principles for assessment and care in section 1.7.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	31	18	In line with my previous comment – this recommendation should be strengthen to include guidance on "actions" following review.	Thank you for your comment. The actions to be taken are reflected in the general principles for assessment and care in section 1.7.

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NHS England/Improvement Mental Health Clinical Advisers	Guideline	32	Section 1.13	The target group for training should be made more explicit. " Training for all staff who work with people of any age who self-harm" …. Given the earlier section on prescribing I think it important to include specific reference to this recommendation covers all pharmacists – working as community contractor pharmacists as well as those who in acute/general hospitals, community and in-patient mental health services. Many of these pharmacists will see people who may self harm as part of their wider duties and they may feel that they are outside of the scope of this recommendation, given that they may feel that they don't specifically "work with" someone on the self-harm elements of their care.	Thank you for your comment. The wording of the recommendation already states that it applies to all staff working with people who self-harm.
NHS England/Improvement Mental Health Clinical Advisers	Guideline	32	General training section	Despite acknowledging that in p45 that there are additional factors to include for children, young 10 people and older adults, There is no mention of training in relation to the different presentations in older adults	Thank you for your comment. Age related factors would be encompassed by the bullet about education about the underlying factors, triggers or motives that lead people to self-harm.

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NHS England/Improvement Mental Health Clinical Advisers	Guideline	33	13	Again the implication is that a RA can be a predictive tool; also: early detection of what?	Thank you for your comment. The wording of the recommendation has been amended to change 'assessment' to 'formulation'. The phrase 'including early detection' has been deleted.
NHS Wales Health Collaborative	Guideline	General	General	We welcome the new guidance and the emphasis placed on the importance of the psychosocial assessment, and a collaborative approach with the person who self-harms expressed throughout	Thank you for your comment.
NHS Wales Health Collaborative	Guideline	General	General	While accepting the 'clinical' nature of NICE guidance, the broader scope of the target audience for this guideline creates a distance between evidence or research based recommendations, and practical help or direction to a range of workers. Queries from those on the front-line included clarification on the components of effective 'services' (minimum requirement), or a 'systems' approach/response (and associated training provision), and the contributions of sectors beyond health and care (eg: housing). NICE invites comment on how to help people to overcome challenges to	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.

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				implementation, and an implementation 'toolkit' might help to guide front-line workers in developing their response to people who self-harm	
NHS Wales Health Collaborative	Guideline	General	General	We welcome the scope of the guidance with regard to specialist mental health professionals, health and social care professionals, and non-health and care professionals, but wonder whether the term 'other professionals', or 'professionals from other sectors' might be more positive than 'non'-health and care (ie: describing people by something they are not); and whether line 8 on page 16 'treat the person with respect, dignity and kindness' could be applied to all groups, including mental health professionals	Thank you for your comment. We have changed the text of the heading to 'professionals from other sectors'. Recommendation 1.6.1 has also been amended to reflect the language used in recommendation 1.7.1.
NHS Wales Health Collaborative	Guideline	9	4	While recognising that the NICE guidance has been prepared for the English Health and Care system, there is a commitment to implementing NICE recommendations in Wales by Welsh Government. Comments were received from practitioners in Wales, that reference to the Social Services and Well-being (Wales) Act 2014 would be helpful. While the breadth of	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy. Recruitment to the committee is based on speciality rather than geographical location.

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				experience on the Committee is acknowledged and appreciated, it is also noted that there is no representation from Wales	
NHS Wales Health Collaborative	Guideline	11	27	We welcome the recommendation to conduct a risk formulation as part of the psychosocial assessment but would like the difference between risk assessment and formulation better articulated in the guidance, and for the whole process to be explained in more detail	Thank you for your comment. As a mental health specialist, the professionals delivering this care, and making the risk formulation should have a sound understanding of how to do this as part of their training and competency.
NHS Wales Health Collaborative	Guideline	13	12	Recognition of the needs of people over 65 is welcomed, as increases in the presentations of self harm in this age range is being observed by staff. Perhaps the renewed guidance provides an opportunity to further recognise self-harm across the life-course, including possible occupations or adult groups at higher risk, where evidence is available	Thank you for your comment. Unfortunately evidence to support this was not identified by the committee and so additional recommendations in this area have not been made.
NHS Wales Health Collaborative	Guideline	22	12 -19	We have been aware of a concurrent NICE consultation on social, emotional and mental wellbeing in primary and secondary education [GID-NG10125], (replacing PH12/PH20) and wonder whether an opportunity presents itself for the self-harm guidance for schools	Thank you for your comment. Whilst the committee acknowledge there are self-harm presentations within educational settings, social, emotional and mental wellbeing in education is a broader issue that is not specific to self-harm. Therefore a cross-reference has not been added.

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				and educational settings to be referenced within it, or for some cross-referencing between the two sets of guidance to occur, given the frequency of self-harm presentations within educational settings, particularly as the guidance for education includes further education colleges (up to age 25)	
NHS Wales Health Collaborative	Guideline	26	5	The recommendation to offer CBT is noted, but with a query regarding the range of between 4 and 10 sessions, requiring clarification or rationale for the range, as this may not be considered typical currently, and may have cost implications for service delivery	Thank you for your comment. The recommended number of sessions was based on a) the reported resource use of the RCTs included in the meta-analysis that informed the guideline economic analysis, which was 6 intended sessions on average, with a range of 4-10 intended sessions; b) the results of the guideline economic analysis, in particular one-way sensitivity analysis, according to which the intervention becomes marginally cost-effective at 9-10 sessions (at 10 sessions it exceeds the NICE lower cost-effectiveness threshold of £20,000/QALY but is still below the upper cost-effectiveness threshold of £30,000/QALY) and c) the committee's expert advice on the optimal delivery of the intervention to people self-harming in current routine practice. The recommendation has now been modified to suggest that more sessions may be required dependent on individual needs, but this is expected to be relevant to a sub-group of adults who self-harm.

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NHS Wales Health Collaborative	Guideline	37	1	The recommendations for research do not fully reflect all areas where the guidance observes insufficient evidence available, though a better understanding of the most effective responses to self harm across settings and groups would be welcomed. Would there be scope for further recommendations for research?	Thank you for your comment. These were the areas that the committee agreed were a priority for further research. The justifications for this are provided in the relevant evidence reviews.
NHS Wales Health Collaborative	Guideline	33 32	19 1	Recognition of the needs of staff who work with people who self-harm is welcomed, as front-line workers continue to observe increases in use of crisis services and help-lines from people who self-harm, and those with suicidal ideation, with some staff experiencing vicarious trauma. It would be helpful if references to staff training included, not just training required to help those who self-harm, but also training for those in managerial or supervisory positions to be trained in supporting people experiencing the impact of working with individuals who self-harm.	Thank you for your comment. This is the purpose of recommendation 1.15.1.
NHSEI	Guidance	26	1.10.2	reads as though EVERYONE could be offered CBR "structured for adults who self harm". Suggest it is reworded to	Thank you for your comment. This recommendation is aimed at adults, as indicated by the use of the term 'adults' in the recommendation.

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				say "For adults, offer a CBT-based ….etc	
NHSEI	Guidance	26	1.10.2	suggest need mention of differentiating a CBT or other package and the safety plan, to be appropriate for those with a learning disability (or other disability such as hearing or sight loss)	Thank you for your comment. The recommendation has been amended to clarify that the safety plan needs to be in accessible format.
NHSEI	Guidance	31	1.12.5	Suggest include mention of people buying medication online here. Also mention STOMP STAMP principles in prescribing for those who are autistic or have a learning disability, the medication review for them should follow those principles	Thank you for your comment. This has been added to recommendation 1.13.3.
NHSEI	Guideline	6	1.1.13	We suggest that a specific mention is made of tailoring communication style and materials to autistic individuals and those with a learning disability where appropriate - I think this point is different from the one below in 1.1.4 Suggest also need to make mention of reasonable adjustments for those with a disability of any kind as per equality act 2010	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
NHSEI	Guideline	7	1.2.2	suggest that this sentence should read " also should be able to" because professionals will need to use MCA principles for those ages 16-17 years.	Thank you for your comment. This change has been made.

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NHSEI	Guideline	12	1.5.8	it is good to see another reminder here of making adjustments for those with other conditions	Thank you for your comments.
NHSEI	Guideline	13	1.5.10	line 28. Suggest make this more explicit and really talk about the "online life" that a person has; this is really important especially for children and young people	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
NHSEI	Guideline	15	1.5.16	line 6. Should it not be shared with the wider system too? Such as the person's Social worker for instance?	Thank you for your comment. Relevant social care practitioners have been added to the recommendation.
NHSEI	Guideline	15	1.5.16	line 5. Doesn't read quite right, might be better to say "share the plan" rather than "share them".	Thank you for your comment. This has been amended.
NHSEI	Guideline	18	1.6.10	suggest inserting a specific comment about reception staff treating people who self harm with respect kindness and dignity. It's mentioned in the above section but for clinical staff. Patients often are distressed by the offhand or dismissive attitude of admin and reception staff- a need for training is there. It is flagged in the section 1.7.1	Thank you for your comment. Recommendation 1.7.1 applies to all health and social care staff and would therefore include reception staff in healthcare settings. Recommendations 1.14.1 - 1.14.2 also cover training for all staff working with people who self-harm, including the need to explore staff attitudes, values, beliefs and biases.

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				for assessment by non-health professionals but not admin staff	
NHSEI	Guideline	22	1.7.2	suggest inserting a specific comment about education staff (including non-teaching staff such as administrators) treating young people who self harm with respect kindness and dignity.	Thank you for your comment. The term non-health professional would encompass non-teaching staff and administrators.
Nottinghamshire Healthcare NHS Foundation Trust	Evidence review Q	18	44 - 46	This seems unhelpful and judgemental. Does it reflect a particular individual, situation or experience?	Thank you for your comment. There was some qualitative evidence from mental health professionals that inadequate support for themselves could sometimes affect their ability to provide quality care (see Evidence Review P, Table 9 and Evidence Review Q, table 7). The committee agreed it was important that staff working with people who self-harmed received emotional support because of the sensitive nature of self-harm but wanted to acknowledge that it was unhelpful and inaccurate to imply that people who have self-harmed are at fault. The committee also felt it was important to clarify that the support needs of staff should not affect the quality of support and care provided to the person who has self-harmed. This paragraph has been amended to make this clearer, and recommendation 1.15.1 has been amended to separate out the support needs of staff from the promotion of compassionate care delivery.
Nottinghamshire Healthcare	Evidence review Q	19	4 -7	I felt that the discussion around litigation probably alluded to blame cultures where staff fear investigations	Thank you for your comment.

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NHS Foundation Trust				or, censure in relation to an event that they were involved in or of making a decision that had a negative outcome.	
Nottinghamshire Healthcare NHS Foundation Trust	Evidence review Q	19	27 - 30	Resources are always limited and there will always be a tendency to prioritise other things over supervision. I feel that the guidelines should be clear that provision should reflect the needs of the area or organisation. Presumably there no evidence base or best practice guideline to help with this?	Thank you for your comment. The recommendations made are based on the qualitative evidence outlined in evidence reviews Q and S, which showed that specialist and non-specialist staff consider adequate supervision to be highly important when working with people who have self-harmed, although there was no evidence to indicate the best frequency or mode of supervision. In the guideline, the Rationale and Impact section for supervision clarifies that provision should be determined according to setting: "There was limited evidence to determine the regularity of formal self-harm supervision, and the committee agreed this would be decided on setting-specific factors, such as the rates of self-harm, the acuteness of self-harm and available resources."
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	There is not a lot of focus on women's secure services where self harm is prolific and severe.	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation. However,

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					the recommendations in the guideline are intended to apply to all people who have self-harmed and therefore would apply to women's secure services.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	In respect of staff skills, the report seems to suggest that some skills could be developed over time. This seems to refer to tacit skills. My issue with this is that tacit skills leave organisations with the person who has them and with high attrition rates in terms of burnout sickness and staff turnover, it would be beneficial to distil some of those skills into something that could be taught, trained, or used as part of supervision.	Thank you for your comment. The committee agree that retention of skills is important, however how this is achieved will be a matter for local implementation.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	There were comments from some patients about dependence and the risk of patients either not trusting staff or becoming dependent on them which might increase the likelihood of self-harm to elicit care, e.g. "If I self-harm more they will care for me". I think this is a sensitive area, the self-harm may relate to issues around trauma and, attachment difficulties expressed as part of the motivation to self-harm and, that this would need to be handled carefully within the team as	Thank you for your comment. The issues around attachment and therapeutic relationships are complex and often unique to the individual. In a clinical guideline, recommendations are made about management strategies that the research evidence suggests will be helpful to the majority of people who self-harm. The recommendations also outline the general principles that staff should follow. However, it is not possible to make recommendations at the level of each individual who self-harms. The committee agree that attitudes such as labelling people as attention seeking are unhelpful.

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				this can lead to unhelpful attitudes (i.e. attention seeking).	
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	I note that there isn't any reference to staff debriefs following self-injury, particularly in settings where self-harm can be life threatening and interventions to prevent self-harm have led to assaults on staff.	Thank you for your comment. Recommendation 1.15.1 has been amended to include how best to support staff. It is not possible to recommend a specific method for doing this (such as debriefs) as the guideline has not looked at a review question in this area.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	There is very little about inpatient care and clinical approaches. This is needed and highlights the limited evidence available. It would be helpful to have further detail on how to support people in inpatient settings and harm minimisation in inpatient environments.	Thank you for your comment. Recommendations about support for people in inpatient settings are in section 1.12. Given the limited evidence identified in this area, it is not possible to provide the additional detail you have requested.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	There doesn't seem to be much evidence to support anything other than a CBT approach/psychosocial assessment and safety planning.	Thank you for your comment. The committee made the recommendations based on the available evidence and their own knowledge and experience. However they agreed that evidence is lacking regarding other psychosocial interventions and non-specialist assessment for self-harm. As a result, research recommendations for psychosocial interventions (including remote interventions) and assessment in non-specialist settings have been made - please see appendix K of evidence review J and appendix K of evidence review E for more information.

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Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	There are clear recommendations for what not to do in relation to risk assessment, tools and stratification ('Risk assessment tools and scales' provides a list of do not do's), but limited detail regarding recommendations for risk assessment.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	It appears that the recommendation for medical admission overnight for under 16's following self-harm has been removed. Concerns had been raised by colleagues previously regarding this having been a recommendation and the lack of evidence for it. It is good to see this as a research recommendation.	Thank you for your comment.

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Nottinghamshire Healthcare NHS Foundation Trust	Guideline	7	13	It may be helpful for further detail re 'assess mental capacity' within the guidance in light of feedback that people with lived experience can give re assessment of capacity and how this is communicated.	Thank you for your comment. The committee's view was that all health and social care staff need to be aware of the principles surrounding capacity, appropriate to their role and position in the organisation. Assessment of capacity is not the focus of this guideline and so making detailed recommendations about how to assess capacity is outside the scope.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	26	5 -10	I feel that the recommendation of 10 sessions of CBT bear no relevance to the women's service and to the needs of women in secure settings.	Thank you for your comment and providing this information.
One In Four	Guideline	7	5	LGBTQ should be changed LGTBQIA+	Thank you for your comment. This has been changed to LGBTQ+ in line with the NICE style guide.
One In Four	Guideline	35	General	There is evidence that dissociation is correlated with self harm and used either to induce a dissociative state or to come out of dissociation. As such it is a significant factor in emotional dysregulation. Requisite treatment planning and training b=needs to incorporate this.	Thank you for your comment. Recommendation 1.14.2 has been amended to include the range of different behaviours which can be considered self-harm, and already covers the impact of other diagnoses and comorbidities and how they interact with self-harm. The details of what training would involve would be specific to the role of the staff being trained and it would not be possible to list all the elements training should cover here.
One In Four	Guideline	35	General	There is evidence of a link between self harm and sexual trauma,	Thank you for your comment. A full psychosocial assessment is recommended after every episode

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				especially sexual related trauma, (CSA, CSE, sexual trafficking, sexual violence or rape). This needs to be clearly specified	of self-harm (section 1.5) which would facilitate exploration of these issues. History of trauma, including sexual violence, would come under 'historic factors' in recommendation 1.5.10.
One In Four	Guideline	35	General	No mention of severe self-mutilation of sexual parts of the body as a result of sexual trauma, CSA, CSE, sexual violence or rape.	Thank you for your comment. A full psychosocial assessment is recommended after every episode of self-harm (section 1.5) which would facilitate exploration of these issues. History of trauma, including sexual violence, would come under 'historic factors' in recommendation 1.5.10.
One In Four	Guideline	35	General	There is evidence that self-harm is a way of managing emotional dysregulation and that the teaching of emotional (affect) regulation skills can reduce the need to self-harm. There is no mention of affect regulation and stabilisation skills for adults (although acknowledged in DBT-A). CBT focuses primarily on thoughts, beliefs, and behaviour. it is necessary to incorporate research evidence on affect regulation to reduce emotional dysregulation and gain mastery of aversive, less adaptive strategies such as self harm. This equips the individual to develop valuable emotional self-regulation skills to manage overwhelming feelings or dissociative states concomitant with self-harm	Thank you for your comment. While DBT-A has been recommended for children and young people with emotional dysregulation difficulties who have frequent episodes of self-harm on the basis of evidence from the Cochrane review on interventions for children and young people who self-harm (Witt 2021), there was insufficient evidence to recommend DBT for adults: "the evidence remains uncertain as to whether DBT reduces absolute repetition of SH by the post-intervention assessment" (Witt 2021). The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by

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					cognitive behavioural therapy. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has also been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT-informed psychotherapy or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended.
One In Four	Guideline	35	General	There is evidence that shame t can induce self-harm and occur after self-harm has occurred. It is essential that the role of shame is addressed as commonly underpins much of self harming behaviour	Thank you for your comment. The terms used section of the guideline defines terms that have been used in a particular way for this guideline. A full psychosocial assessment is recommended after every episode of self-harm which would facilitate exploration of this issue.
One In Four	Guideline	35	General	There is evidence that compulsive sexual behaviour and ChemSex link to self-harming behaviour which is not alluded to in the document	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.
Pennine Care NHS	Guideline	12	19	1.5 , 1.5.9	Thank you for your comment. This change has been made.

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Foundation Trust				Page 12 line 19: Should refer to the 'functions' not just the 'meaning' of self harm	
Pennine Care NHS Foundation Trust	Guideline	14	23	1.5, 1.5.13 Page 14 line 23: Add: 'and make plans to revisit psychosocial assessment at another time'	Thank you for your comment. The committee considered your suggestion but decided that the course of action that needs to be taken will be very variable and therefore did not amend the recommendation as you suggested.
Pennine Care NHS Foundation Trust	Guideline	26	3	1.10 Page 26 line 3: Add: 'in line with a formulation of the functions of self harm'	Thank you for your comment. Formulations of the functions of self-harm are encompassed within the psychosocial assessment and so this change has not been made.
PTSD UK	Guideline	12	12	It would also be wise to take into account any other diagnosis which may be relevant in how somebody needs care – for example, if they have PTSD, this is more than just 'preferences' but they may need a certain place (an open room, or smaller 'safer' room), format or options (such as facing a door to ease hypervigilance) when being assessed.	Thank you for your comment. The persons needs have been added to the recommendation.
PTSD UK	Guideline	12	19	Also suggest adding take into account previous traumas they have experienced (as their self harm may be a comorbidity of PTSD for example) as	Thank you for your comment. This would be covered by 'historic factors' in recommendation 1.5.10.

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				it may impact their reaction to speaking about their self harm etc.	
PTSD UK	Guideline	13	8	Just to note that they may not see 'traumas' as that – so it would need to be worded carefully, such as asking them about 'moments in their life that have impacted them, or shaped who they are' etc. Many traumas don't feel 'worthy' or the label, so they may be missed, but might be vitally important in the assessment.	Thank you for your comment. As mental health professionals it would be down to their clinical judgement, expertise and competence to navigate these difficult conversations.
PTSD UK	Guideline	13	14	Also worth asking if they have a diagnosis of any mental health issues as this will impact care ongoing	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
PTSD UK	Guideline	13	16	Just to note that they may not see 'traumas' as that – so it would need to be worded carefully, such as asking them about 'moments in their life that have impacted them, or shaped who they are' etc. Many traumas don't feel 'worthy' or the label, so they may be	Thank you for your comment. As mental health professionals it would be down to their clinical judgement, expertise and competence to navigate these difficult conversations.

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				missed, but might be vitally important in the assessment.	
PTSD UK	Guideline	27	1	Take into account any previous traumas – this ensures a level of trust and willingness which may otherwise be lacking if this isn't taken into account.	Thank you for your comment. The list of considerations in recommendation 1.11.7 is not intended to be exhaustive.
Royal College of Emergency Medicine	Evidence F	11	4	The evidence discusses a therapeutic assessment and shows an increased engagement with treatment if not a reduction in reattendances with self-harm. I guess this is not strong enough to recommend? Could there be more emphasis on safety planning as part of the Psychosocial assessment?	Thank you for your comment. The committee agreed that the available evidence did not allow them to make strong recommendations on the overall benefit or potential harms of specific models of assessment (please see Evidence Review F for further information about the committee's decision). However, the committee recognised the importance of safety plans and therefore they have been recommended in the interventions section (recommendations 1.11.7-1.11.8). A research recommendation about psychosocial assessments has been made, specifically including assessments with integrated safety plans/ therapeutic interventions - please see appendix K of evidence review J for more information.
Royal College of Emergency Medicine	Guideline	11	24	This statement is very welcome, Psychiatric colleagues can give very useful advice on behaviour management whilst waiting for a person to be fully accessible. Some services decline to get involved at all until the person is sober.	Thank you for providing this information.

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Royal College of Emergency Medicine	Guideline	11	16	We think that safety planning should be on the list of functions of the Psychosocial assessment	Thank you for your comment. The committee regard safety planning as a distinct intervention and have defined it as such in the Terms used section of the guideline.
Royal College of Emergency Medicine	Guideline	14	23	"If a person wants to leave before full assessment, assess risks, capacity etc." This should say TRY to assess risks as often the person is on their way out of the door as we are trying to do this. We could add to attempt to do a brief safety plan with this person. If a person does leave, should they not have the option of a 48 hr follow up as NICE is recommending for a patient who underwent full assessment?	Thank you for your comment. It is hoped that implementation of the recommendations made earlier in section 1.5 should ensure that psychosocial assessment will happen as soon as possible. This would minimise any delay during which the person may leave.
Royal College of Emergency Medicine	Guideline	15	7	What if this person who self-harms repeatedly has no healthcare professional involved? Some patients who attend frequently with self-harm have no health care professional involved other than the GP.	Thank you for your comment. The recommendation has been changed to include those who need to be involved.
Royal College of Emergency Medicine	Guideline	15	23 and 25	We understand that the use of risk assessment scales and tools is not safe or helpful but we are all assessing in order to consider risk and if someone is at high risk of suicide then we will describe this and MH teams will offer admission or crisis team. Perhaps it would be better to say that attempting	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without

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				to stratify risks into low medicine and high is not easy or accurate but risks should be weighed up along with protective factors to determine who needs a higher level of care.	these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
Royal College of Emergency Medicine	Guideline	18	18	We think NICE should specifically endorse telephone triage service, 111 option 2 where they are linked to all local MH services and can offer face to face assessment where needed.	Thank you for your comment. The committee did not have evidence to support making such a specific recommendation.
Royal College of Emergency Medicine	Guideline	18	25	RCEM are calling this Mental Health Triage so it is a recognised process, maybe NICE could refer to this as ED MH triage to distinguish it from other forms of MH triage? I think you could be more specific – we are trying to evaluate the risk of a person deciding to leave before assessment and treatment are complete. This is more overt than willingness to accept treatment.	Thank you for your comment. This recommendation is about physical health as well as mental health so your suggested change has not been made. This recommendation does not specifically address the risk of the person leaving as that is not its intent, but the other factors, such as levels of distress and concerns over the person's safety would inform the likelihood that the person might leave. Recommendation 1.7.19 covers the need for policies and procedures regarding what to do in the event someone leaves.
Royal College of	Guideline	19	13	It is really helpful to recommend that frequently attending patients get seen	Thank you for your comment. The committee asserted that each episode of self-harm can have

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Emergency Medicine				by MH professionals every time they self-harm, but we feel there is too much emphasis on full Psychosocial assessment and not enough on how a professional should review a patient who has had several recent assessments. Patients do not want to be assessed every time if it does not change anything. They want a meaningful engagement with someone. Could this be emphasised more in the formulation part?	its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment.
Royal College of Emergency Medicine	Guideline	20	4	This is a bit vague- have a procedure for when someone leaves before assessment – lots of places still ask police to do a welfare check, and rightly many police forces now righty decline unless risks are really high. What is a sensible procedure for when patients leave before assessment? RCEM has a guideline, so maybe NICE does not need to detail this?? https://rcem.ac.uk/wp-content/uploads/2021/10/RCEM_Absconding_Guidance_V2.pdf A sensible approach would be 1. Review the initial MH triage by the ED nurse. 2. If high risk, call security / police immediately. 3. If lower risk, call	Thank you for your comment. The committee agree this a very important issue but the course of action will need to be determined locally as circumstances will be different.

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				the patient. 4. Inform the GP and consider asking them to make contact. 5. Ask MH services to make contact if they know the patient. 6. Consider calling next of kin.	
Royal College of Emergency Medicine	Guideline	20	1	We have spotted that NICE has not quite tackled the inequality of services for children and young people (CYP)!! You have dodged the issue by saying that CYP on the ward should have access to 24/7 CAMH / LP but have not mentioned the Emergency Department. You should say that CYP both in ED or on the ward should have 24/7 access to CAMH / LP. Then what does this mean? Access for advice? Ability to assess a young person?? NICE has a role in driving service provision by using your experts to recommend good clinical practice. RCEM would recommend that a young person deserves assessment at least until 2200, even though this is not yet parity with adult services it may acknowledge that assessing a CYP in the middle of the night has challenges as there is a need to have family there too etc.	Thank you for your comment. The committee agree that ready access to appropriate mental health services for children and young who present in ED is very important and this is covered by recommendation 1.7.13. The purpose of access is to get advice and assessment as necessary. The committee agree that children and young people need ready access to assessment, however there are sometimes additional challenges in ensuring the availability of family members and other involved agencies. These general principles are covered in recommendations 1.5.1 and 1.5.5.

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Royal College of Emergency Medicine	Guideline	29	5	This title is a bit vague – do you mean care in ED and on acute wards? – in which case better to state this. Looking at the recommendations this is what you mean.	Thank you for your comment. The committee agree that ED and acute wards are important settings for continuity. However the committee wished to emphasise the importance of continuity across health and care settings, including those in the community.
Royal College of Emergency Medicine	Guideline	32	2	There is an opportunity to be specific here detailing who should be trained about self-harm. All clinical staff who look after patients who self-harm including ED staff, ward staff, health care assistants, security staff in hospitals, teachers and teaching assistants, social workers, peer support workers etc. By spelling out that HCAs and security need training, there is an opportunity to change the status quo!	Thank you for your comment. The recommendations state that all staff working with people who self-harm should receive training.
Royal College of Emergency Medicine	Guideline	55	25	Recommending a follow up contact 48 hrs after self-harm is a positive and therapeutic thing to offer but has massive implications for GPs and Liaison Psychiatry. So we would disagree that the recommendations are in line with current practice. I would expect community MH services are doing this routinely but there are many patients who self-harm who are not taken on by services.	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hr timeframe where there are ongoing concerns about their safety.

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Royal College of General Practitioners. Clinical Adviser network	Guideline	33 - 34	20 - 22, 1 - 6	Rec 1.14.1 - Whist supervision is very important and the RCGP supports this, if this recommendation is left as it stands, primary care will be required to provide supervision for all staff who look after patients who have self-harmed. This will require a step change in primary care as no "supervision", as occurs in mental health services, currently exists. This will require significant investment to create a new structure and therefore will have financial and service impacts. If this is not the intention, could the committee consider changing this recommendation to "all staff in secondary care" rather than "all staff who work with people if any age.	Thank you for your comment. The committee think it is very important that all staff have supervision so that they can be provided with appropriate and effective support. Most staff will already have a supervisor in place who can do this. The recommendation does not specify the form or frequency of the supervision, nor does it require the supervisor to have in-depth knowledge related to self-harm; providing support could be at the level of sign-posting to external resources. The committee recognise that some additional information may need to be provided as a result of the recommendation but do not consider that this would have significant resource implications.
Royal College of General Practitioners. Clinical Adviser network	Guideline	18	22	In primary care we work on relationship-based care and always use shared decision making. This recommendation does not reflect the relationship that patients have with their primary care teams where patients can be encouraged to make appointments, but we cannot mandate this. We also work as a primary care team, and it is no longer only a GP who will see a patient. Can we strongly	Thank you for your comment. The committee did include a GP as one of its core members. When considering the points you have raised with the committee they agreed that the guideline as a whole is working towards an individualised approach to care whatever the setting. Shared decision making should be used in all interactions, and the guideline makes numerous references to the NICE guideline on shared decision making. In relation to regular follow-up appointments, it was the committee's view that for some conditions, such

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				recommend this recommendation is changed to include the following amendments? We are happy to provide a representative to attend the committee to explain how primary care works to ensure this recommendation can be implemented. Please consider the following changes: If the person who has self-harmed is being supported and given care in primary care, their primary care team should use shared decision making to determine the most appropriate follow up care. This may include that the person has: regular follow-up appointments with their GP primary care team. (Please note, "regular follow ups" is not a term used in primary care. Follow up appointments are determined on an individual basis and relay on the patient booking those due to the nature of the primary care relationship). regular Reviews of self-harm behaviour determined by an individualised approach to ongoing	as diabetes or hypertension, GPs do actively arrange, either themselves or through the wider practice team, future appointments for patients to support continuity of care and to avoid loss to follow-up. The committee therefore felt it appropriate for a GP to do similarly for someone who has self-harmed and who is being managed in primary care. The committee noted that practice teams do now consist of a range of primary care professionals: self-harm is a complex problem, and the committee feel GPs remain best placed to lead this care in general practice.

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				care a medicines review information, social care, voluntary and non-NHS sector support and self-help resources where appropriate	
Royal College of General Practitioners. Clinical Adviser network	Guideline	24	19	Rec 1.8.6 - Please add to this recommendation, 'clear written communication with the primary care team/ GP practice'. Very often patients are discharged with little information, leaving the primary care team in the dark regarding the future plan of care	Thank you for your comment. This has been added to the recommendation.
Royal College of General Practitioners. Clinical Adviser network	Guideline	25	12 -14	Rec 1.9.2 - It is not realistic to assume that every patient who has self-harmed who is seen in any part of the health care system can be followed up within 48 hours by a primary care team. Can we suggest the following amendment: Within 48 hours of the psychosocial assessment after an episode of self-harm, if required and agreed by the person, provide initial aftercare from the mental health team, GP or by the team who carried out the psychosocial assessment. This could be by primary, community, secondary care or the mental health team. If the recommendation is left in its current form, the reality is that all	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.

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				patients from anywhere within the health service will be told to see their primary care team within 48 hours of assessment which would be inappropriate. Any follow up should be based upon shared care decision making and based on an individualised care plan, rather than a simple blanket instruction for all patients, without including the person in the decision and is likely to lead to confusion in the system and patient frustration if they are unable to achieve an appointment within 48 hours.	
Royal College of General Practitioners. Clinical Adviser network	Guideline	29	14 - 16	Rec 1.11.3 - This recommendation that excludes medical students from being involved in this part of patient care is concerning. If we do not train the next generation of doctors, then we risk poorer care for this cohort of patients in the future. Medical students usually have more time to undertake consultations which is often considered positive by patients. Can the committee consider removing medical students from this recommendation?	Thank you for your comment. The committee would support medical students being involved in all aspects of the assessment and management of people who have self harmed so long as there is appropriate supervision. However medical students should not be doing clinical observation by themselves. The wording of the recommendation has been changed to remove explicit reference to medical students.
Royal College of General	Guideline	34	7 - 14	Rec 1.14.2 - Please see comment above. Primary care works in a different way to mental health and	Thank you for your comment. The committee think it is very important that all staff have supervision so that they can be provided with appropriate and

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Practitioners. Clinical Adviser network				secondary care services. For this recommendation, access to senior staff would require a change in the way primary care is configured. Can the committee consider whether it means, for junior staff and those in training should be offered this support or whether they mean "all staff"? If the recommendation stays as it is this will require significant investment to create a new structure for primary care and therefore will have financial and service impacts.	effective support. Most staff will already have a supervisor in place who can do this. The recommendation does not specify the form or frequency of the supervision, nor does it require the supervisor to have in-depth knowledge related to self-harm; providing support could be at the level of sign-posting to external resources. The committee recognise that some additional information may need to be provided as a result of the recommendation but do not consider that this would have significant resource implications.
Royal College of Nursing	Guideline	General	General	We do not have any comments on this consultation, many thanks for the opportunity to contribute.	Thank you for your comment.
Royal College of Occupational Therapists	Guideline	General	General	It will be challenging to implement this guideline at a time when not all of the mental health work force is adequately prepared to work with behaviours that result in self injury. Decades on from No Longer a Diagnosis of Exclusion, the stigma around "personality disorder" remains high and plays a large part in people who self harm feeling unwelcome in services.	Thank you for your comment. You raise a number of interesting points. The committee would like to emphasise that this is a guideline on self-harm rather than personality disorder, although they accept that the two are sometimes conflated in clinical services. The overarching principles of care outlined in the guideline emphasise a collaborative approach to assessment and management of people who self-harm. Some of the recommendations (1.12.6, 1.14.2) have been amended to make it clear that least restrictive practices should be adopted where possible.

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				These guidelines do try to balance care with autonomy but there are times (remove items that could be used to self harm) when they fall back to the default of restrictive practice. As suggested by Sir Simon Wessley in his review of the mental health act we need to identify that some clinicians are frightened of the consequences of working with this client group and create a national initiative to allow for practice that can allow people to keep their shoelaces (for example) without a practitioner being perceived as negligent. This might involve legislation to embed positive risk into current practice. Some occupational therapists; work has sadly involved people who have gone into hospital and as the restriction increased, the lethality of self harm escalated enormously. Should any of these patients have died, the coroners report would have identified how they should have been watched more, not that they should have been removed from this	

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				environment as soon as the impact on their safety became clear. Too often we hear MDTs agree risk has escalated since admission who will not discharge because of what it would look like in the papers. While the impact of worried clinicians on restrictive practice has been explored, none of the concerns about this made it into the proposed changes to the mental health act. With the current wording of the MHA discharge criteria being (that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself) it is currently impossible to discharge anyone who recurrently self harms.	
Royal College of Occupational Therapists	Guideline	6	25	'Expectation of recovery': what does this mean? Whose expectation is it? What does recovery mean? Perhaps "an expectation of self harm reducing/ceasing" might be a more concrete aim.	Thank you for your comment. This phrase has been changed to "optimism".
Royal College of Occupational Therapists	Guideline	8	11 and 12	The availability, quality and effectiveness of liaison psychiatry services varies across the country.	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role

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				Might we consider other services where expertise might be available?	of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. The recommendation does also state that it could be liaison psychiatry or 'a suitably skilled mental health professional'.
Royal College of Occupational Therapists	Guideline	10	21	'Prevent recurrence' appears to be forceful language and is potentially controlling; this could be changed to 'minimise recurrence'. Encouragement to prevent could result in restrictive practice.	Thank you for your comment. The aim of this recommendation to encourage a collaborative approach that is empowering and supporting. It is not intended to encourage restrictive practice. The wording of the bullet has been changed to make this clearer
Royal College of Occupational Therapists	Guideline	5 and 6	General	Guidance should also include consideration of the consequences of ceasing self-harming; what will this be replaced with? Not all staff have the knowledge, skills and experience to do this. The risk of miscellaneously encouraging self-harm should also be considered.	Thank you for your comment. The recommendations in the guideline will hopefully lead to a comprehensive assessment that will identify the person's needs and the best course of action or treatment for them. This should support them to stop self-harming when they feel able to do so.
Royal College of Occupational Therapists	Guideline	11	6	The use of 'meaningful' activities could be added here.	Thank you for your comment. The section you seem to be referring to relates to using non-verbal means of communication and therefore your suggestion would not be appropriate here.
Royal College of Occupational Therapists	Guideline	11	13	Occupational therapy assessments focussing on PEO (Person, Environment, Occupation) concepts alongside the psychosocial	Thank you for your comment. This recommendation is about what needs to happen immediately after an episode of self-harm. Psychosocial assessment should take the

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				assessment would be beneficial to explore the relationship between the self-harm and the environment (social, physical etc.). Also, certain activities/occupations can be triggering.	environment into consideration and can identify if an OT assessment is needed (as part of the longer term plan). Therefore we have not made your suggested change.
Royal College of Occupational Therapists	Guideline	12	19	Self-harm itself can be seen as an occupation (an activity that is meaningful to the person). The reasons why a person is self-harming need to be explored. Occupational therapists are skilled in using occupation as a therapeutic tool, focussing on what is important and meaningful to the person. We will likely not engage with people if self harm is seen only as a 'bad' activity to be stopped.	Thank you for your comment. The need for occupational rehabilitation is already included in the recommendation.
Royal College of Occupational Therapists	Guideline	13	14-16, 31	The exploration of the person as a full occupational being rather than just as a person who self-harms must be considered. Sensory needs should be explored in more depth. There needs to be a specific occupational focus; e.g. engaging in	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.

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				purposeful and meaningful activities. (not just vocational ones)	
Royal College of Occupational Therapists	Guideline	14	4-7, 17-19, 27-29	Risk assessment should be standard for everyone, but consideration of formulation may itself be a risk factor. Formulation means different things to different people and it is possible to list risk factors, predisposing factors and triggers withing providing a narrative of why self harm makes sense for someone. It is this understanding that will lead to change and consideration should be given regarding if this is within every mental health practitioners skill set at present.	Thank you for your comment. The committee agree that risk formulation is an important part of the process. Recommendation 1.6.6 recommends having risk formulation as part of every psychosocial assessment.
Royal College of Occupational Therapists	Guideline	28	6	Why is harm minimisation only linked to people who self-cut? Could this approach be used for other methods of self injury?	Thank you for your comment. The wording has been changed to self-harm.
Royal College of Occupational Therapists	Guideline	28	9	Does 'an expectation of recovery' put added pressure on the person who self-harms? What does recovery mean in terms of a behaviour rather than disease/illness?	Thank you for your comment. The committee's experience was that people can be 'given up on' and not given any hope of recovery and reducing self-harm if they are using harm minimisation techniques. The committee wanted to ensure this is not seen as the end of the person's treatment journey with no hope for them.
Royal College of	Guideline	28	24	Therapeutic risk taking is a main guiding principle of RCOT's publication	Thank you for your comment.

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Occupational Therapists				Embracing Risk; Enabling Choice Guide (Members Only) - RCOT	
Royal College of Occupational Therapists	Guideline	29	2	Focus on positive outcomes and what is important to the person.	Thank you for your comment. What matters to the person has been added to the bullet about drawing on the person's strengths and coping strategies.
Royal College of Occupational Therapists	Guideline	29	14-16	15. The term 'untrained in clinical observation' needs clarification. Our experience is that there is no standardised training around observations in mental health and this is often a task left to the least trained and least rewarded members of the work force. Why can't medical students do this? Isn't this part of their training when out on clinical practice placements?	Thank you for your comment. The committee would support medical students being involved in all aspects of the assessment and management of people who have self harmed so long as there is appropriate supervision. However medical students should not be doing clinical observation by themselves. The wording of the recommendation has been changed to remove explicit reference to medical students.
Royal College of Occupational Therapists	Guideline	30	4	Staff shouldn't just be visible; they must be fully engaged in observation and communicating with the person deemed to be at risk.	Thank you for your comment. The recommendation says visible and accessible, not just visible. The rationale and impact section and the Committee's discussion of the evidence section in Evidence review N already describe why this recommendation is needed.
Royal College of Occupational Therapists	Guideline	30	7 - 9	We are concerned that "remove items that may be used for self harm" encourages the highest level of restrictive practice and that the act of	Thank you for your comment. The recommendation has been amended to incorporate involving the person in the decision about removing items. Use

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				taking something away should always be in proportion to the assessed level of risk. Anything can be used for self-harm. The current wording would mean the guidelines were breached if every patient was allowed a pen or did not have their shoe laces removed.	of the least restrictive measures has also been added.
Royal College of Occupational Therapists	Guideline	54	19	Occupational therapy practice is patient centred; it focuses on the person, the environment and their occupations (activities).	Thank you for providing this information.
Royal College of Occupational Therapists	Guideline	54	25	'highest risk of self-harm 2-3 days after': occupational therapists working with people with eating disorders have commented that they haven't experienced this. They reported that self-harm is normally an individual event which is not linked to other episodes. It is often triggered by a specific experience, which then leads to the person using self-harm as a coping mechanism	Thank you for your comment. The text you cite is from the rationale and impact section of the guideline. It describes the opinion of the committee.
Royal College of Occupational Therapists	Guideline	55	13	The continuity of staff is vitally important.	Thank you for your comment.

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Royal College of Occupational Therapists	Guideline	57	21-23	Assessment of the social environment is part of occupational therapy interventions.	Thank you for providing this information.
Royal College of Occupational Therapists	Guideline	64	5	Effective supervision is vital to safe and reflective practice yet rarely prioritised.	Thank you for your comment. The committee agree and this why they made this recommendation.
Royal College of Paediatrics and Child Health	Guideline	General	General	Some acknowledgement that mental health problems are more prevalent in deaf children would be beneficial. Peter A, Hindley,. Mental health problems in deaf children, Current Paediatrics, Volume 15, Issue2, 114-119 This article provides a useful summary and includes the difficulty that children with psychotic disorders may have disordered language which even through signing may be misinterpreted	Thank you for your comment. This guideline is focused on self-harm and therefore the issues you raise would be outside the scope.
Royal College of Paediatrics and Child Health	Guideline	General	General	In children – It is essential to manage this systemically 'the problem child is a child with a problem,' (Sula Wolff). Many of these CYP are distressed without significant mental health issues – they are reacting appropriately to dreadful circumstances and bad	Thank you for your comment. The committee agrees with the points you have made and hopes that the recommendations made to improve access to psychosocial assessment and interventions will result in better care for these children and young people.

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				relationships. The CYP cannot mend these themselves and needs things around them to change.	
Royal College of Paediatrics and Child Health	Guideline	General	General	Comments relate to the Children and Young persons element, however we agree with the overall principals in care received by appropriate teams.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	General	General	In particular, we would like to see care plans extended to the children under CAHMS service.	Thank you for your comment. As stated in the psychosocial assessment recommendations (section 1.5), everyone should have an assessment following an episode of self-harm, and that assessment should be used to formulate a care plan detailing, among other things, any necessary treatment.
Royal College of Paediatrics and Child Health	Guideline	General	General	Often liaison from A&E is not extended to under 16s, resulting in unnecessary admission to inpatient beds. – Service planning issue I guess	Thank you for your comment. It is the aim of the guideline to ensure everyone receives an assessment from age-appropriate liaison psychiatry services.
Royal College of Paediatrics and Child Health	Guideline	General	General	An excellent guide through this minefield, where the service capacity is very stretched. Perhaps there should be some mention of where "in person" assessment needs to take place rather than digital?	Thank you for your comment. The committee recognised that this could vary across the country, and therefore would be a matter for local implementation.
Royal College of	Guideline	General	General	We would also like to see an attempt at a definition of self-harm or the	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined

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Paediatrics and Child Health				different kinds. The different categories of child abuse helped expose them, so it might a "classification" of self-harms.	as intentional self-poisoning or injury irrespective of the apparent purpose of the act.
Royal College of Paediatrics and Child Health	Guideline	General	General	Thank you for sending this draft for consultation. We are happy with this draft guideline on self-harm	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	General	General	Any reference to specialist mental health services should include National Deaf Children and Young People Mental Health Services (CYPMHS), previously Deaf CAMHS	Thank you for your comment. There are many services that may need to be involved in a young person's care and it is not possible to list them all within this guidance which needs to focus on self-harm.
Royal College of Paediatrics and Child Health	Guideline	General	1	Title, Who for There should be clarity that the guidance covers under 16's, in particular for service planners. As in practice the guideline often tends to be followed only for over 16/18's	Thank you for your comment. The wording about who the guideline covers has been amended to clarify it is relevant for adults, children and young people.
Royal College of Paediatrics and Child Health	Guideline	20 - 21	28	1.6.21 We agree with this statement.	Thank you for your comment.
Royal College of Paediatrics	Guideline	5	3	1.1.1 I think the importance of using translation services or involving those from the same cultural background in	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young

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and Child Health				the care of the patient is very important. We have sadly seen several cases of young patients (under 18) with self-harm/thoughts of self-harm brought to the ED by Police in handcuffs. The situation was very quickly defused through the use of a translator or someone with insight into the cultural background who was able to engage the young person and de-escalate challenging behaviours that had resulted from misunderstanding of concerns / processes	people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Royal College of Paediatrics and Child Health	Guideline	7	1	1.1.4 Reference to information. We suggest signposting to internet and especially sign language interpreted video information to enable equality of access: Vicci Ackroyd & Barry Wright (2018). Working with British Sign Language (BSL) interpreters: lessons from child and adolescent mental health services in the U.K., Journal of Communication in Healthcare, 11:3, 195-204,	Thank you for your comment. The guideline refers to the NICE guidance on Patient experience in adult NHS services, Service user experience in adult mental health and Babies, children and young people's experience of healthcare, all of which have comprehensive recommendations on ensuring care is person-centred with their communication, information, access and care needs and preferences taken into account.
Royal College of Paediatrics	Guideline	9	9	1.4 Could a separate section be considered for involving family members and carers of under 16s?	Thank you for your comment. The guideline did look for evidence for specific subgroups but did not find any evidence about family members/carers of

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and Child Health				These are a different group when it comes to family involvement, competency and consent.	under 16s. Therefore it is not possible to make specific recommendations for this group.
Royal College of Paediatrics and Child Health	Guideline	11	13	1.5.1 We could not see any definition of self-harm: Is this causing physical injury – including overdose – does it include alcohol intoxication use of drugs etc. Does it focusses on internalising behaviour – ignoring externalising behaviour – e.g., the CYP who is violent to others may be exhibiting different behaviours from a similar origin. Is a child who thumps a wall self-harming? – we would suggest they are. In its widest context up to 10% of children are self-harming – perhaps more is every child to have specialist MHP assessment – would be amazing but unrealistic – so presume there is some threshold.	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.
Royal College of Paediatrics	Guideline	15	General	1.5.17 Who will the lead HCP be and why an HCP – in many cases a youth worker	Thank you for your comment. The recommendation wording has been changed to appropriately trained professional or practitioner.

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and Child Health				or social worker will be more appropriate	
Royal College of Paediatrics and Child Health	Guideline	16	General	1.6.2 If risk assessment tools are of no value how does the non-specialist manage self-harm?	Thank you for your comment. The committee have added a recommendation to the Principles for assessment and care sections to give some guidance on what factors should be considered when deciding if they need to refer onto a Mental health service and what the person needs.
Royal College of Paediatrics and Child Health	Guideline	18	25	1.6.10 There is no mention of the use (or not) of physical +/- chemical restraint. We are seeing an increasing number of patients brought to the ED by the Police in handcuffs "for their own safety" – what are the guiding principles ED clinicians (and the Police) should be following around when to use handcuffs / when to remove them / legal grounds for their use?	Thank you for your comment. The committee agree that restrictive practice is an important issue but one that pervades all of mental health care and is not specific to self-harm. Therefore recommendations on the broader issue of restrictive practice have not been made on this issue in this guideline. However a recommendation has been added to section 1.7 that mechanical restraint should not be used in emergency departments.
Royal College of Paediatrics and Child Health	Guideline	18	General	1.6.10 The sentence about 'dignity and respect' should be extended to the Emergency room staff. People who have self-harmed have overheard "here's that frequent flyer" and have been deprioritised in the queue for assessment, or when having immediate dressings "I don't know why	Thank you for your comment. The committee agree that this is unacceptable behaviour from staff. The recommendation referred to (now recommendation 1.7.1) is under the heading 'Principles for assessment and care by healthcare professionals and social care practitioners' and therefore applies to all staff, including those in the emergency department.

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				someone like you cuts/burns themselves" and other inappropriate and hurtful comments.	
Royal College of Paediatrics and Child Health	Guideline	20	28	1.6.21 What is meant by 'access'? No paediatric service is going to have access to CAMHS for self-harm OOH but technically they are available for psychiatric problems.	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.
Royal College of Paediatrics and Child Health	Guideline	22	13	1.7.2 The sentence about dignity and respect applies in all settings.	Thank you for your comment. The committee agree which is why this has been included as a general principle in both sections 1.7 and 1.8.
Royal College of Paediatrics and Child Health	Guideline	23	14	1.7.7 There is a mention about care in the criminal justice system and other secure settings but no reference to the Police service – we are seeing an increasing number of patients who are brought to the Emergency Department by the Police as a result of self-harm (or thoughts of such) – not helped by how stretched the ambulance services	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations for multiple criminal justice system settings. Text has been added to the guideline to clarify that the recommendations may need to be tailored for certain criminal justice system settings during implementation.

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				are. They are also involved in the section 136 pathway.	
Royal College of Paediatrics and Child Health	Guideline	11 & 16	1 & 2	1.5.1 and 1.6 People who self-harm often first present in primary care, either as a feature of a mental health problem or often incidentally when consulting about another problem, 1.6 is a more common presentation and should come first?	Thank you for your comment. The committee discussed moving the sections around so non-specialist assessment came first, but ultimately agreed to leave the structure as is. This is because the committee formulated the specialist recommendations (section 1.5) to be about establishing how and when the assessment happens, then intended for the non-specialist recommendations (sections 1.7 and 1.8) to come after, to provide specifics about what should happen in different settings.
Royal College of Paediatrics and Child Health	Guideline	28	6	1.10.10 Self-cut is common but so is self-burn	Thank you for your comment. The wording has been changed to self-harm.
Royal College of Psychiatrists (RCPsych)	Evidence review J	General	General	The College believes evidence has been missed to support interventions other than CBT. does not take into account the systematic review by Hetrick and colleagues (Hetrick et al, Effective psychological and psychosocial approaches to reducing repetition of self-harm: a systematic review, meta-analysis and meta-regression. BMJ Open;6: e011024) that recommended CBT and	Thank you for your comment. Please note that only RCTs were included in the Cochrane review and therefore systematic reviews would not have been included, as outlined in the protocol (Witt 2020). Any studies included in the cited reviews would have been included if they met the Cochrane review inclusion criteria. Hetrick 2016 heavily refers to the 2016 version of the Cochrane review used to inform this guideline, and concludes that "Our study is consistent with the updated Cochrane review" (Hetrick 2016). The studies included in the 2016

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				Psychodynamic Interpersonal Therapy as brief interventions for self-harm. The guidance refers to the Cochrane Review in para 1.9.2 but fails to comment that within the 'CBT branded trials' in the Cochrane review is a trial of Psychodynamic Interpersonal Therapy. (Guthrie E et al, randomised controlled trial of brief psychological intervention after deliberate self-poisoning. BMJ, 2001. 323:1-5). The trials labelled in the review as 'CBT' are therefore clearly not all CBT. There is also overwhelming evidence from a series of systematic reviews comparing bonafide psychological treatments with CBT that there is little or no differences between CBT and any other bonafide psychological treatments for very many psychological conditions. There is no reason to think intervention for self-harm is different. 1. Cuijpers, P., et al A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison,	Cochrane review were also included in the 2021 review, however the available evidence base has since changed. The study with psychodynamic interpersonal therapy as part of the intervention (Guthrie 2001) was included under the comparison for CBT because the intervention also explicitly had CBT elements: "Intervention: individual CBT-based psychotherapy consisting of weekly (50 minute) sessions of home-based psychodynamic interpersonal therapy" (Witt 2021). Please note that psychodynamic psychotherapy was included as a comparison within this review under Comparison 5: Psychodynamic psychotherapy compared to TAU or another comparator, however there was no evidence of an effect on repetition of self-harm. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review, however the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural therapy. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has also

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				with other treatments. Can J Psychiatry, 2013. 58(7): p. 376-85. 2. Baardseth, T.P., et al., Cognitive-behavioural therapy versus other therapies: redux. Clin Psychol Rev, 2013. 33(3): p. 395-405. 3. Fluckiger et al Enduring effects of evidence-based psychotherapies in acute depression and anxiety disorders versus TAU at follow-up--a meta-analysis. Clin Psychol Rev, 2014. 34(5): 367-75. 4. Wampold et al., Evidence-based treatments for depression and anxiety versus treatment- as-usual: a meta-analysis of direct comparisons. Clin Psychol Rev, 2011. 31:1304-12. 5. Cuijpers et al., Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. J Consult Clin Psychol, 2008. 76: 909-22. 6. Wampold et al A meta-analysis of outcome studies comparing bona fide	been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT-informed psychotherapy or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. The Committee's discussion of the evidence section in Evidence review J has also been updated to reflect the above.

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				psychotherapies: Empirically, "all must have prizes". Psychological Bulletin, 1997. 122:203-215. 7. Wampold et al., A meta-(re)analysis of the effects of cognitive therapy versus 'other therapies' for depression. J Affect Disord, 2002. 68(2-3):159-65. 8. Barth et al Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. PLoS Med, 2013. 10(5): p. e1001454. 9. Budge et al The Effectiveness of Psychotherapeutic Treatments for Personality Disorders. Canadian Psychology-Psychologie Canadienne, 2015. 56(2): p. 191-196. 10. Kline et al Long-term efficacy of psychotherapy for posttraumatic stress disorder: A meta- analysis of randomized controlled trials. Clin Psychol Rev, 2018. 59: p. 30-40. 11. Benish et al The relative efficacy of bona fide psychotherapies for treating	

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				post-traumatic stress disorder: A meta-analysis of direct comparisons. Clin Psychol Rev 2008. 28:1281-86. 12. Powers et al A meta-analytic review of prolonged exposure for posttraumatic stress disorder. Clinical Psychology Review, 2010. 30(6): p. 635-641. 13. Laird et al Comparative efficacy of psychological therapies for improving mental health and daily functioning in irritable bowel syndrome. Clin Psychol Rev, 2017. 51: p. 142-152. 14. Imel et al Distinctions Without a Difference: Direct Comparisons of Psychotherapies for Alcohol Use Disorders. Psychology of Addictive Behaviours, 2008. 22(4): p. 533-543.	
Royal College of Psychiatrists (RCPsych)	Guideline	General	General	Evidence & Algorithm for managing self-injurious behaviour Please refer to the following recommended publications for a thorough coverage of Self-injurious behaviour in people with	Thank you for your comment. The references you cite have not been included as part of the guideline evidence base because they are books and do not meet the inclusion criteria of the review protocols.

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				neurodevelopmental disorder or a learning disability: Book by Furniss F & Biswas A B (2020) 'Self-injurious behavior in individuals with neurodevelopmental conditions', Springer Nature, Switzerland AG. ISBN-13: 978-3030360153 Book by Murphy G & Wilson B (1985) 'Self-injurious behaviour a collection of published papers on prevalence, causes, and treatment in people who are mentally handicapped or autistic, British Institute of Mental Handicap. UK. ISBN 0 906054 49 4	
Royal College of Psychiatrists (RCPsych)	Guideline	General	General	Reference (please also refer to secondary references listed in the books) Please refer to the following recommended publications for a thorough coverage of Self-injurious behaviour in people with neurodevelopmental disorder or a learning disability: Book by Furniss F & Biswas A B (2020) 'Self-injurious behavior in individuals with neurodevelopmental conditions', Springer Nature, Switzerland AG. ISBN-13: 978-	Thank you for your comment. The references you cite have not been included as part of the guideline evidence base because they are books and do not meet the inclusion criteria of the review protocols.

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				3030360153 Book by Murphy G & Wilson B (1985) 'Self-injurious behaviour a collection of published papers on prevalence, causes, and treatment in people who are mentally handicapped or autistic, British Institute of Mental Handicap. UK. ISBN 0 906054 49 4	
Royal College of Psychiatrists (RCPsych)	Guideline	28-29	General	The College suggests further clarification for the sections Harm Minimisation and Therapeutic risk taking (1.10.10-1.10-13). The guideline acknowledges that this is an evidence free area. We have concern that 'therapeutic risk taking' can sometimes be used as a reason not to offer help. It is also likely that professionals, and patients, will have different views about what harm minimisation and therapeutic risk-taking means in practice. To be included, there needs to be a much better definition and also what exactly is the expectation of professionals if they advocate these practices. How do evaluate whether these approaches have been helpful? By what means to we measure this? There is a high risk of poor outcomes.	Thank you for your comment. The committee agreed about the current misunderstanding of therapeutic risk taking and potential for harm if people use it as a means to withhold treatment. However it was also clear through qualitative evidence that therapeutic risk-taking, when done correctly, gave people a higher degree of autonomy which was highly valued. As a result the committee provided a definition in the 'terms' section which has been amended to clarify that inappropriately withholding or withdrawing care without adequate assessment is not considered therapeutic risk taking. The rationale and impact text already describes this issue. A definition was already included for harm minimisation. The recommendation states that ongoing assessment should be used to revisit the decision to use therapeutic risk-taking.

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Royal College of Psychiatrists (RCPsych)	Guideline	1	7	Self-injurious behaviour in people with neurodevelopmental disorder or a learning disability is completely missing in the document apart from where it says the guideline covers (line 7).	Thank you for your comment. The guideline has been amended to highlight the needs of people with learning disabilities or neurodevelopmental conditions in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure health and social care staff consider any additional needs those with learning disabilities may have.
Royal College of Psychiatrists (RCPsych)	Guideline	3	3,5,6,7,8,9.1 0.11, 12, 13, 14, 15, 16, 17,19,20,21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33	Content A section each is needed on Self-injurious behaviour in people with neurodevelopmental disorder or a learning disability, in each of the subtopics. Definition of self-injurious behaviour needs to be included. The guidance does not draw any distinction from, or deal with accidental self-harm or repetitive self-stimulation or self-injurious behaviour. It does not deal with self-harm in the context of Learning Disability or neurodevelopmental disorder, notably autism, other than directing readers to the NICE guidance on ASD. The areas that need covering in the guideline include: Conceptualization and Taxonomy of	Thank you for your comment. The guideline has been amended to highlight the needs of people with learning disabilities or neurodevelopmental conditions in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure health and social care staff consider any additional needs those with learning disabilities may have. Accidental self-harm or repetitive self-stimulation or self-injurious behaviour is outside the of scope of this guideline.

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				Self-Injurious Behavior in people with learning disability and/or neurodevelopmental disorder Assessment of Self-Injurious Behavior in people with learning disability and/or neurodevelopmental disorder Psychosocial and Psychopharmacological Interventions for Self-Injurious Behavior in people with learning disability and/or neurodevelopmental disorder Self-Injurious Behavior in Persons with Autism Spectrum Conditions Current Developments in the treatment of Self-Injurious Behavior in people with learning disability and/or neurodevelopmental disorder	
Royal College of Psychiatrists (RCPsych)	Guideline	11	10	The College supports recommendations for a comprehensive psychosocial and risk assessment by specialist mental health professionals. However, if all the items currently advised are covered then this will require significant increase in staffing and time. To make the recommendations more achievable we suggest section 1.5.9 is moved to consideration in follow up sessions.	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.

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Royal College of Psychiatrists (RCPsych)	Guideline	12	17	It is unlikely to always be possible to provide a professional of the same sex, but this is reasonable to offer where possible.	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.
Royal College of Psychiatrists (RCPsych)	Guideline	16	20	The College supports the advice to undertake medical and psychosocial healthcare in parallel, if possible, clinically	Thank you for your comment.
Royal College of Psychiatrists (RCPsych)	Guideline	18	23	The College supports the need for Emergency department professional to undertake initial assessment. It would be helpful to include assessment for evidence of mental illness and assessment of risk of self-harm, dehydration or absconding whilst in the hospital. Staff should be aware of factors that increase risk, for example acute psychosis increasing the risk of self-harm, an older adult with severe depression increasing the risk of dehydration following self-harm.	Thank you for your comment. The guideline has been amended to recommend that the person's emotional and mental state, and whether there are any immediate concerns about self-harm is assessed when they present to a healthcare professional or social care practitioner.
Royal College of	Guideline	19	7	If a specialist mental health professional is expected to assess every person presenting to an	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own

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Psychiatrists (RCPsych)				Emergency Department or minor injury unit with self-harm this will have huge resource implications and is unlikely to offer large gains for every case of self-harm, for example people with known emotionally unstable personality disorder under a community mental health team who self-present for suturing after an episode of distress are more likely to be better managed by seeing their own team after they leave. It would be more realistic to offer assessment where acute sector staff	assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one. There is also a recommendation that states that if a person presents to services frequently then a multidisciplinary review should be conducted to better assess how to help them. The recommendation that people who have self-harmed should have access to age-appropriate liaison psychiatry in emergency departments and general hospital settings should not have a cost or resource impact because this should already be standard practice. Potential resource implications of the guideline were considered by NICE when preparing the guideline's Resource impact summary report.
Royal College of Psychiatrists (RCPsych)	Guideline	19	22	The College advises on the need for a clear statement regarding the need to retain confidentiality but also to share information with other professionals according to local safeguarding, legal and other agreed frameworks for safety of others.	Thank you for your comment. This is already covered by recommendation 1.2.4.
Royal College of Psychiatrists (RCPsych)	Guideline	20	21	The College advises that the guideline is clearer about initial assessment of risk and observation is needed by the ward team. This should be reviewed in conjunction with Liaison Psychiatry	Thank you for your comment. The need for psychosocial assessment and supporting people's safety in ward environments are covered in recommendations 1.7.21 - 1.7.22 and section 1.12 respectively.

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				professionals after their assessment. Without this caveat there is a risk people admitted overnight have no assessment of ward risks until seen the next day by specialist mental health teams.	
Royal College of Psychiatrists (RCPsych)	Guideline	24	4	It is unrealistic to expect acute hospital admission in the absence of physical need for treatments. This statement could be re-phrased as consideration should be given to delaying a discharge overnight if a safe discharge cannot be effected so as to avoid unnecessary admission.	Thank you for your comment. This recommendation provides detail in the bullets about the circumstances in which general hospital admission should be considered. It does not recommend admission for everyone who self-harms. Amendments have been made to clarify that this recommendation does not apply to those who need psychiatric admission. The rationale and impact text describes that admission to hospital carriers a greater risk of distress to people of all ages but that there are some cases where it can be helpful to give the person time to recover.
Royal College of Psychiatrists (RCPsych)	Guideline	26	5	The College supports offering CBT but strongly disagrees that this should be the only psychosocial intervention. There is good evidence for other approaches (e.g., Solution focussed therapy, motivational interviewing for substance misuse, interpersonal psychotherapy). If follow up psychotherapy is to be offered to all adults presenting with self-harm this will require huge increase in staff,	Thank you for your comment. The authors of the Cochrane reviews on psychosocial interventions for people who have self-harmed outline that the evidence bases for CBT-based psychotherapies for adults, and DBT-A for children and young people are stronger than the current evidence base for any other intervention. The committee acknowledged that a the wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily

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				training and supervision. There also needs to be clarity as to who monitors risk or mental disorder such as depression whilst the therapy is occurring. The College suggests all these functions should come from the same mental health team.	typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural therapy. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. Additionally, the recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT-informed psychotherapy or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. Recommendation 1.11.2 signposts to a number of existing relevant NICE guidelines for the treatment of co-existing conditions, including depression. Evidence from the economic analysis shows the provision of CBT would be cost-effective, and the impact of training and supervision needs has been further considered in the Committee's Discussion of

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					the Evidence section in Evidence Review J. Recommendation 1.12.1 addresses the importance of continuity of care.
Royal College of Psychiatrists Addictions Faculty Executive Committee	Guideline	11	24	1.5.3 We agree with and commend the recommendation that "if the person who has self-harmed is intoxicated by drug or alcohol use, agree with the person and colleagues what immediate assistance is needed, for example, support and advice about medical assessment and treatment".	Thank you for your comments.
Royal College of Psychiatrists Addictions Faculty Executive Committee	Guideline	12	3	1.5.4 We agree with and commend the recommendation that "breath or blood alcohol levels should not be used to delay the psychosocial assessment" and agree with their statement that "breathalysers/blood alcohol levels do not accurately assess the ability of a person to meaningfully engage with an assessment".	Thank you for your comment.
Royal College of Psychiatrists Addictions Faculty	Guideline	13	1	1.5.10 The guideline states "During the psychosocial assessment, explore the following to identify the person's risk factors and needs " and lists a set of "changeable and current factors" which	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to

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Executive Committee				includes the "harmful or hazardous use of alcohol or recreational drugs" but not dependence on alcohol or recreational drugs. By omitting dependence there is a risk that professionals reading such a document would assume that dependence syndromes are not modifiable or treatable and thus perpetuate treatment nihilism. We suggest to amend as "harmful, hazardous or dependent use of alcohol or recreational drugs".	professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Royal College of Psychiatrists Addictions Faculty Executive Committee	Guideline	19	22	1.6.15 Addictions consultation and liaison services are increasingly implemented in general hospitals, are often separate from psychiatric liaison, and are usually staffed by general nurses. Suggest adding a bullet 'jointly agreed referral pathways for concurrent mental health and addictions care'.	Thank you for your comment. This recommendation is about joint governance arrangements to facilitate medical care and mental health care being delivered in emergency departments. As addictions care sits outside this setting it is not appropriate to make this addition here.
Royal College of Psychiatrists Addictions Faculty Executive Committee	Guideline	27	13	1.10.7 We agree with and commend the recommendation that "do not use…substance misuse…as reason(s) to withhold psychological interventions for self-harm".	Thank you for your comment.

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Royal College of Psychiatrists Addictions Faculty Executive Committee	Guideline	28	16	1.10.11 We agree with and commend the recommendation that harm minimisation strategies should include the impact of alcohol and recreational drugs on the urge to self-harm.	Thank you for your comment.
Royal Pharmaceutical Society	Guideline	17	8	We are delighted that the work on community pharmacy has been included in this guidance. This section, however, seems most relevant to general practice rather than primary care, which incorporates community pharmacy, dental & opticians as well. The editorial https://econtent.hogrefe.com/doi/10.1027/0227-5910/a000817 on the role of primary care in suicide prevention might be noteworthy.	Thank you for your comment. The first two recommendations in this section could apply to professionals working in primary care, with the remaining recommendations specifically referring to GPs where it is most relevant to them. The committee appreciate that primary care is currently going through significant changes, particularly in relation to mental health provision and wanted to make the recommendations as inclusive as possible.
Royal Pharmaceutical Society	Guideline	23	10	Rec 1.2.3 Please define how community pharmacy teams can access and refer to specialist teams. There is no infrastructure currently in place to support this.	Thank you for your comment. This recommendation was primarily aimed at those working in hospital settings. Community pharmacists and those working outside hospital settings will rarely need to make urgent decisions about capacity to receive treatment. For individuals with acute mental health needs, staff should follow existing local policies and care pathways. For example, referral to the ED or GP in order to access mental health assessment and treatment.

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Royal Pharmaceutical Society	Guideline	31	18	Rec 1.12.5 Almost all community pharmacy staff with patient-facing roles completed the Zero Suicide Alliance training in 2021. Additional, specific training might be valuable.	Thank you for your comment. Recommendations on training are made in section 1.14.
Royal Pharmaceutical Society	Guideline	31	4 -14	Rec 1.12.2-1.12.4 This is an appropriate recommendation. However, more work is needed to improve two-way communication between prescribers and community pharmacy so that pharmacists and their teams can support individuals. Pharmacists working in GPs and PCNs are well placed to have these discussions. This 2-way communication was identified in the work (Gorton, 2019), which has already been cited in evidence. Can we also direct you to these works https://doi.org/10.1211/CP.2019.20206034 in which t the concept of 'circle of care' is discussed and https://www.sciencedirect.com/science/article/pii/B9780128193785000064?via%3Dihub . In this book chapter preliminary data relating to attitudes and experience of pharmacy staff who accessed additional training on suicide awareness is included (hosted by the	Thank you for your comment and for providing this information. Please note the additional works cited would not have been included in evidence review O because they are not comparative studies and therefore do not meet the inclusion criteria as set out in the protocol. The need for effective communication where multiple prescribers are involved has been added to recommendation 1.13.1. The committee agreed a strong recommendation about limiting prescription quantities could not be made in the absence of evidence. Discussing the option of limiting the quantity of medicines with the person has been recommended to emphasise the importance of person-centred care, based on the individual's strengths and vulnerabilities.

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				Centre for Pharmacy Postgraduate Education (CPPE)). The analysis has now been completed and we can share a draft manuscript on request. It is noteworthy, however, that there is limited research on the extent and effectiveness of restricting prescription quantities. Restriction of OTC paracetamol pack size has been proven to be an effective intervention, and this is implemented by law. Restriction of prescription quantities seems pragmatic but we must be vigilant to any potential unintended harm.	
Royal Pharmaceutical Society	Guideline	32	1	Rec 1.13 It is indicated that this will include pharmacist, pharmacy technicians and their teams working in community pharmacy and general practice. It would be helpful to indicate the extent of training expected of these teams. The HEE framework of core mental health competencies for all healthcare professionals https://www.hee.nhs.uk/sites/default/files/documents/Pharmacy%20Framework%202020.pdf might be useful	Thank you for your comment. Recommendation 1.14.2 says training should be specific to their role. It is not possible to specify the level of training for all the different staff groups who work with people who self-harm.

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Royal Pharmaceutical Society	Guideline	33	19	There are no formal clinical supervision pathways in place for community pharmacy. A framework/model of how this might be achieved would be useful.	Thank you for your comment. The guideline has not included a review question on what framework for formal clinical supervision should be used for community pharmacy so cannot make recommendations on this.
Samaritans	Guideline	General	General	Please note that this response by Samaritans is formulated in two parts. One part of the response marked 'Lived experience group' is based on the feedback of 6 people with lived experience of having self-harmed or having supported someone who has self-harmed. Samaritans undertook a dedicated workshop with these six people to gain their views and opinions on the draft guidance. The feedback produced by the workshop has been summarised and relayed as faithfully as possible in this document. The second part marked 'Samaritans' is the organisation's own feedback where we have additional points on the guidance, not covered by the 'lived experience group' feedback. Samaritans' feedback is based on our research and policy development, built on what people with lived experience	Thank you for your comments.

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				of self-harm have told us about their experience of engaging with clinical support and services.	
Samaritans	Guideline	General	General	Lived experience group: Noted that it is very important that this guidance, when published, is made truly accessible to all – including for people who are neurodivergent, dyslexic or don't have English as a first language.	Thank you for your comment. The committee have passed your comment on to the NICE publishing team for further consideration.
Samaritans	Guideline	1	7	Lived experience group: Noted that after the first page, no direct reference is made to the needs of people with learning disabilities who self-harm. This group is often thought of as having less capacity to make decisions, and so decisions are often made on behalf of this group. It is important that this guidance recognises the unique challenges they face in terms of getting support for self-harm.	Thank you for your comment. The guideline has been amended to highlight the needs of people with learning disabilities in a more inclusive way. Recommendations have been amended relating to information and support, assessment and any hospital admissions to ensure health and social care staff consider any additional needs those with learning disabilities may have.
Samaritans	Guideline	6	27	Lived experience group: The decision to link to shared decision making guidance is strongly supported.	Thank you for your comment.
Samaritans	Guideline	9	23	Lived experience group: Rec. 1.4 – concerned that this guidance does not acknowledge the fluidity of experience that often exists between someone	Thank you for your comment. Recognition of this issue has been added to the rationale and impact text

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				who is acting as a carer and the person who is cared for. This guidance currently presents them as two static groups which do not overlap, but a carer could also be someone who self-harms. It is also important to recognise that a carer's time could be limited by other commitments including work. The guidance should recognise these limitations on their time. It is important that these recommendations acknowledge that carers should not be expected to pick up where mental health services cannot support. In some cases children act as de facto carers for an adults who self-harming.	
Samaritans	Guideline	9	23	Lived experience group: Rec. 1.4 – important to note that for many people, including those who have immigrated to England or are homeless, family members or carers might not capture who the person would want involved in their care. There is for many people a wider network of people, including friends or neighbours, on whom they rely for their care.	Thank you for your comment. The committee acknowledges that this support could be given by someone who is not a family member or carer.

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Samaritans	Guideline	10	4	Lived experience group: Rec. 1.4.2 – this recommendation should include taking into account the views and values of parents/carers regarding self-harm.	Thank you for your comment. This is covered by recommendation 1.4.3.
Samaritans	Guideline	11	4	Lived experience group: Rec. 1.4.5 – this guidance should make it clear that there should be more support for carers of people who self-harm to better understand their triggers. Also that there should be more communication between services and carers (based on the consent of the person who self-harms).	Thank you for your comment. Making recommendations about the support required for carers of people who self-harm is outside the scope of this guideline.
Samaritans	Guideline	11	19	Samaritans: Rec. 1.5.1 – Samaritans welcomes the emphasis on psychosocial assessments for anyone who has self-harmed and comes into contact with medical professionals. However, it is noted that this requirement already exists in NICE guidelines. It is crucial that the assessment leads to appropriate care for the person being assessed – our research indicates that this does not currently happen consistently. Therefore, we would like to see strengthened language to illustrate that such assessments are an essential	Thank you for your comment. The committee appreciates that implementation of the recommendations is not always standardised across the country. The recommendations do clearly state that an assessment should be given at the earliest opportunity and state 'Do not delay', therefore the committee believe they are worded with sufficient strength, whilst adhering to the NICE format of guidelines.

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				part of the care for a person who has self-harmed which should never be missed because of a lack of capacity or expertise on behalf of health professionals or a service.	
Samaritans	Guideline	12	23	Lived experience group: Rec. 1.5.9 - it is important that this recommendation specifically acknowledges the need for anti-racist practice within the NHS. In terms of psychosocial assessments this will involve culturally specific understanding as to why a person may be self-harming. Mental health staff must be able to understand and support people if there are culturally specific reasons for self-harm, alongside any other drivers.	Thank you for your comment. This would be covered by 'historic factors' in recommendation 1.5.10. Please also refer to recommendation 1.14.2, which covers the need for staff to receive training to be culturally competent, and recommendation 1.1.4, which covers the interaction between self-harm and discrimination. Further recommending anti-racist policy is out of scope of this guidance because it applies to all health and social care, and is not specific to self-harm.
Samaritans	Guideline	13	8	Samaritans: Rec. 1.5.10 – there is a strong, evidenced link between trauma and self-harm (Samaritans, 2019). This recommendation should note that any proposed therapeutic intervention based on the psychosocial assessment must be trauma-informed. This therapeutic intervention should help the person who has self-harmed understand the underlying drivers for the behaviour.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.

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Samaritans	Guideline	14	23	Lived experience group: Rec. 1.5.13 - this recommendation should acknowledge that vulnerability does not equal a lack of capacity.	Thank you for your comment. Reference to assessing mental capacity has been removed from this recommendation.
Samaritans	Guideline	14	27	Lived experience group: Rec. 1.5.14 - this recommendation should take into account that NHS services tend to think about risk that a person poses to themselves, before they think about the care they need. This can be quite dehumanising and leaves little room for positive risk taking, which can be empowering Samaritans: This recommendation must take care not to further entrench attitudes around risk and self-harm which can lead to exclusion from support. Our research has shown that many NHS talking therapy services such as IAPT view people who self-harm based on a blanket judgement of their suicide risk which does not take into account individual drivers and motivations. This can lead to exclusion from services, even if these services would be beneficial to the person, and without an alternative source of support necessarily being offered.	Thank you for your comment. The recommendations in section 1.6 clarify that risk assessment tools and scales should not be used to predict risk or to determine who should receive treatment. An additional recommendation (1.6.5) has been added to clarify that assessment should focus on the person's needs and how to support their immediate and long term psychological and physical safety.

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				Therefore, this assessment of risk posed to themselves must be highly personalised rather than blanket.	
Samaritans	Guideline	16	2	Lived experience group: Rec. 1.6 - it is concerning that being culturally and racially sensitive is not mentioned in terms of best practice when it comes to undertaking assessments, regardless of setting. It would be useful if the guidance made reference to staff belief's and biases, including stigma, and how to mitigate the impact of these on assessments. The drivers for self-harm can be culturally specific and this must be understood and taken into account within assessments. This impacts the treatment which minoritized groups receive.	Thank you for your comment. Awareness of cultural sensitivity has been added to the recommendation.
Samaritans	Guideline	16	4	Lived experience group: These principles do not take into account that people who self-harmed may have been pressured into an assessment by family or carers – issues of consent to assessment should form part of these principles.	Thank you for your comment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one. No treatment of any kind should be conducted without consent, and therefore the committee did not feel it necessary to include your suggestion here.
Samaritans	Guideline	16	12	Lived experience group: This recommendation should note that	Thank you for your comment. The recommendation has been amended to highlight the need for

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				there needs to be space for the person being assessed to disagree with the analysis of a medical professional. The clinician and person being assessed should have equal power in terms of the assessment and the treatment which comes out of the assessment. This should be the basis of person centred care.	professionals and practitioners to be aware and accept that the person may have a different view and that this needs to be taken into account.
Samaritans	Guideline	16	12	Lived experience group: Rec. 1.6.1 - this recommendation doesn't acknowledge that healthcare professionals often dismiss the opinion of the person they have analysed in their assessment. The person who has self-harmed is often dismissed as vulnerable and unable to make a decision if they challenge the conclusions of an assessment. The recommendation should acknowledge the power imbalance that can exist in such assessments.	Thank you for your comment. The committee hope that implementation of the guideline recommendations will build a positive culture, in which people who self-harm can be cared for. Doing so would address issues around power imbalance. An addition has been made to the third bullet to acknowledge that the person's views may differ from those of the professional or practitioner, but they still need to be taken into account.
Samaritans	Guideline	17	24	Samaritans: Rec. 1.6.7 – Samaritans research (2019) found that 1/3 of people who saw their GP after recent self-harm were not offered any advice or follow up. The same research found that 1/3 of people did not seek support from their GP after their most recent	Thank you for your comment. The recommendations on training are aimed at all staff based on the qualitative evidence which showed that there is significant overlap in what specialist and non-specialist staff want training on. Therefore the recommendations include but are not specifically targeted at GPs. There was some

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				episode of self-harm as they thought they would not or could not help them. It is crucial that GPs have a robust understanding of self-harm and its drivers. The training outlined in rec. 1.13 should be proactively targeted at GPs. As part of this, GPs need to be made aware of the support for people who self-harm which exists locally, both through the NHS and within community-based organisations, so they can provide warm referrals. This includes for social prescribing. GPs also need more time in order to undertake comprehensive psychosocial assessments for people who have self-harmed. A recommendation that special dispensation be made for longer appointments to facilitate assessments by GPs would be welcome.	qualitative evidence that GPs and people who have self-harmed find longer appointments useful (see Evidence Review R), and this evidence was used to inform recommendation 1.14.2, which states that all staff should be trained in "involving people who self-harm in all discussions and allowing sufficient time for decision making about their treatment and subsequent care". Making a stronger recommendation specifically for GP appointments was not possible without effectiveness and economic evidence.
Samaritans	Guideline	22	13	Lived experience group: Rec. 1.7.2 - concern that there are implicit assumptions made in this guidance, including that students will disclose to teachers rather than each other. It also doesn't acknowledge that students	Thank you for your comment. Provision of support to close friends and peer groups is already covered in the last bullet of recommendation 1.8.3 and in 1.8.7.

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				may disclose on behalf of another they are concerned about, so support should also be recommended for students who receive a disclosure.	
Samaritans	Guideline	22	26	Samaritans: Rec 1.7.4 – this should include specific reference to Mental Health Support Teams. As these teams are rolled out across school settings in England, it is crucial that those teams have the capacity and expertise to support students who self-harm as part of a whole school approach to tackling the issue.	Thank you for your comment. Reference to specific teams has not been made in order to future proof the guideline as policy changes over time.
Samaritans	Guideline	23	14	Lived experience group: Rec. 1.7.7 – concerned that there is no acknowledgement of the particular power imbalance which exists between staff and inmates at prisons and other secure settings. The power imbalance in secure settings can lead to adverse treatment so should be addressed in guidance. People who self-harm in these settings must be treated with dignity but often are not. Anecdotal evidence that following an episode of self-harm in prison, officers will check on the inmate on suicide watch every twenty minutes by banging on their door, waking other inmates up in turn.	Thank you for your comment. The recommendations made in the section on 'Principles for assessment and care by professionals from other sectors' include ' treating the person with respect, dignity and compassion with an awareness of cultural sensitivity and working collaboratively with the person to ensure their views are listened to in decision making. These principles apply to all settings in this section of the guideline including the CJS.

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				This is not a trauma informed way to support the person who has self-harmed.	
Samaritans	Guideline	26	1	Samaritans: Rec. 1.10 - Samaritans' research has found that there are four key support needs for people who self-harm: Distraction from immediate self-harm urges Emotional support in times of stress Developing alternative coping strategies Addressing the underlying reasons for self-harm It is essential that therapeutic interventions for self-harm are able to meet at least one of these and it could be useful to make reference to these within guidance. It is suggested that our research report is referenced in the guideline: Samaritans (2019) Pushed from pillar to post; improving the availability and quality of support after self-harm in England.	Thank you for your comment. The guideline does highlight the importance of the suggested factors: recommendation 1.11.7 addresses distraction techniques, coping strategies, and the identification of family members or friends to provide support (also see section 1.1), while recommendations 1.5.1 and 1.14.2 address the importance of exploring the reasons for self-harm. Qualitative evidence was systematically reviewed and used to support the recommendations regarding the provision of support in section 1.1 - please see Evidence Review A for more information. Unfortunately the research cited was published in October 2020 and therefore could not have been included in the evidence review as the searches for this review were conducted in August 2019.

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Samaritans	Guideline	26	9	Samaritans: Rec. 1.10.2 – it is important to note that the APPG on suicide and self-harm prevention, in their inquiry into support available for young people who self-harm, found that the support of a trusted, consistent figure who the young person feels understands what they are going through is more important than the specific type of intervention. Therefore, the recommended 4-10 sessions of a therapeutic intervention risks being inadequate. Instead, a minimum of 10 sessions should be available to help build a consistent and trusted relationship with health professionals, increasing the chance of the therapeutic intervention making a positive impact.	Thank you for your comment. It is noted that this intervention is for adults who have self-harmed. There is a specific recommendation for children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm for DBT-A. The recommended number of sessions was based on a) the reported resource use of the RCTs included in the meta-analysis that informed the guideline economic analysis, which was 6 intended sessions on average, with a range of 4-10 intended sessions; b) the results of the guideline economic analysis, in particular one-way sensitivity analysis, according to which the intervention becomes marginally cost-effective at 9-10 sessions (at 10 sessions it exceeds the NICE lower cost-effectiveness threshold of £20,000/QALY but is still below the upper cost-effectiveness threshold of £30,000/QALY) and c) the committee's expert advice on the optimal delivery of the intervention to people self-harming in current routine practice. The recommendation has now been modified to suggest that more sessions may be required dependent on individual needs, but this is expected to be relevant to a sub-group of adults who self-harm.
Samaritans	Guideline	26	10	Samaritans: Rec. 1.10.2 – Samaritans' research report (2019) found that	Thank you for your comment. The committee acknowledge the issue you raise. However as the

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				people who self-harm are often excluded from NHS talking therapies on the basis of their self-harm and their potential suicide risk. It is important that access to talking therapies which would otherwise be useful in treating their mental health issues is not automatically jeopardised by past or present self-harm. Samaritans research also indicates that some people who self-harm are allowed to access some NHS talking therapies on the proviso that they do not mention or discuss self-harm. This means that current provision often simply does not meet the needs of people who self-harm in terms of the four key support needs identified above. Services must find safe ways that people who self-harm can discuss their experiences within group settings and explore alternative coping strategies. The guidance must make it clear that self-harm should not be a barrier to a person accessing mental health support which would otherwise be beneficial to them.	guideline has not looked at the evidence about people with other conditions who also self-harm, it is not possible to make any recommendations on this.

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Samaritans	Guideline	26	14	Samaritans: Rec. 1.10.4 – co-production is missing as an empowering measure that can help the person who has self-harmed become more equal partners in the care they are receiving. More emphasis should be given on how to re-balance agency in terms of interventions offered.	Thank you for your comment. The recommendation already says that a safety plan should be developed in partnership with people who have self-harmed, which is equivalent to co-production.
Samaritans	Guideline	28	24	Lived experience group: Rec. 1.10.13 – this recommendation should reflect that positive risk-taking must take place in the context of a person-centred relationship between a medical professional and the person who has self-harmed. The clinician should know and understand the person well to facilitate positive risk taking. At present there isn't enough time to develop relationships between NHS clinical staff and people who self-harm, so positive risk-taking conversations don't happen.	Thank you for your comment. The committee acknowledge that this can be an issue. However the purpose of the recommendations made in the guideline is to improve care for people who self harm, not to maintain the status quo. This recommendation provides guidance about how to effectively undertake a therapeutic risk taking approach and it is hoped that implementation of these recommendations should ensure that these conversations do happen. The wording of the recommendation has been amended to clarify that mental health professionals should be discussing harm minimisation strategies
Samaritans	Guideline	32	1	Lived experience group: Rec. 1.13 – concerned that there is no mention of the need for continuous professional development (CPD) for staff. Noted that there is a very high turnover of staff within each of the settings which this guidance is set for and so training	Thank you for your comment. The recommendations state that all staff should receive training. There wasn't evidence to be more specific about how this should happen but it should mitigate the risks associated with high staff turnover. The committee consider that smaller organisations or individuals with smaller budgets can use this

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				should be continually available and refreshed. Also noted that for many of the smaller organisations or individuals with smaller budgets, CPD will be difficult to resource. It should be recommended that support is given to these organisations/individuals to meet their training needs. This could include online training modules.	recommendation to request the necessary support. Providing training in a range of formats, including online, is already covered in the second bullet.
Samaritans	Guideline	32	1	Lived experience group: Rec. 1.13 – Concerned that there is no mention of the involvement of people with lived experience involved in training. Noted that peer support workers are often able to better understand, without stigma, what the person who self-harms is going through. Training, with appropriate support measures in place, should be co-facilitated and co-produced with people with lived experience of self-harm, who may be better placed to suggest alternative coping mechanisms.	Thank you for your comment. Involving people with lived experience in the planning, delivery and evaluation of training is already included in the first bullet of recommendation 1.14.1.
Samaritans	Guideline	32	9	Lived experience group: Rec. 1.13.1 – this should acknowledge that staff may	Thank you for your comment. The committee think that the concepts you mention are encompassed

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				have their own experience of self-harm which could influence their approach	within exploring staff attitudes and so they have not been mentioned explicitly.
Samaritans	Guideline	32	9	Lived experience group: Rec. 1.13.1 – staff biases should explicitly reference minority identities such as care leavers, ethnic minorities, people with disabilities.	Thank you for your comment. The committee think that the concepts you mention are encompassed within exploring staff attitudes and so they have not been mentioned explicitly.
Samaritans	Guideline	32	12	Lived experience group: Rec. 1.13.2 – noted that this does not include training about the different behaviours that can be considered self-harm. It is important that anyone supporting a person who self-harms should be aware of the range of different behaviours that can constitute it and how these alter according to co-existing morbidities.	Thank you for your comment. The range of different behaviours which can be considered self-harm has been added to the recommendation.
Samaritans	Guideline	32	12	Lived experience group: Rec. 1.13.2 – training needs to include an understanding that the 'severity' of self-harm in terms of physical damage does not equate to the seriousness of the distress driving it. Anyone supporting a person who self-harms needs to focus on the distress underlying the behaviour. Healthcare professionals tend to see self-harm on a scale of severity, which	Thank you for your comment. Motives have been added to the bullet about underlying factors to address this issue. Y

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				can incentivise more 'serious' physical damage on the part of the person who has self-harmed in an attempt to get support	
Samaritans	Guideline	32	27	Samaritans: Rec. 1.13.2 – This training around stigma must include a clear understanding about self-harm as a reaction to trauma and distress. It should teach an understanding of self-harm as the physical manifestation of that distress. It317uidand also include an understanding of the relationship between self-harm and suicide, including the importance of understanding individual motives, rather than a blanket understanding of the risk that self-harm represents.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
Solent NHS Trust	Evidence review J	General	General	Were the various CAMS studies reviewed please – Comtois et al 2011, Jobes et al 2017, Ryberg et al 2019, Brown 2020 and the current Danish trial with DBT - https://clinicaltrials.gov/ct2/show/NCT01512602)?	Thank you for your comment. Two studies assessing the effectiveness of CAMS (O'Connor 2015, O'Connor 2020) were included in the Cochrane review on psychosocial interventions for adults who have self-harmed, under comparison 8.1: 'Brief Collaborative Assessment and Management of Suicidality (CAMS)-based intervention'. There was no evidence of effect on repetition of self-harm or any other outcome. Other studies assessing the effectiveness of CAMS,

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					including those referenced, were considered for inclusion but ultimately excluded because of the population (<100% of participants had self-harmed). Brown 2020 was not included as it is not a comparative study (assuming reference is to this study: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7399800/). Please note the link given leads to information regarding a study completed in 2014.
Solent NHS Trust	Guideline	15	19 – 22	1.5 18/10 Risk assessment tools I am aware of the evidence suggesting these generally have not improved our ability to predict risk and suicide. Has the latest evidence regarding CAMS been examined, as I do think this is a different quality of risk assessment tool compared to checklists and can be extremely informative in both assessing risk and informing treatment decisions?	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction or risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this. Two studies assessing the effectiveness of CAMS

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					(O'Connor 2015, O'Connor 2020) were included in the Cochrane review on psychosocial interventions for adults who have self-harmed, under comparison 8.1: 'Brief Collaborative Assessment and Management of Suicidality (CAMS)-based intervention'. There was no evidence of effect on repetition of self-harm or any other outcome. Other studies assessing the effectiveness of CAMS were considered for inclusion but ultimately excluded because of the population (<100% of participants had self-harmed).
Solent NHS Trust	Guideline	26	1	1.10.1 I am concerned that CBT is the only intervention which is recommended as in clinical practise (not trials) manualised CBT is not always found to be successful at engaging our highest risk patients. There is also, for example, a small body of evidence for the benefit of brief contact interventions. Indeed, one large WHO trial across 5 continents (Fleischmann et al 2008 – included in your evidence) is one of the few studies that have shown reduced deaths by suicide (rather than suicide attempts or ideation), though the Cochrane update (Witt et al 2021) concluded there was insufficient evidence of difference from TAU. Early	Thank you for your comment. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural therapy. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of this section (1.11.2) to emphasise that existing diagnoses and conditions

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				reviews such as Milner et al 2015 found insufficient evidence to recommend BCIs. However later reviews (Riblet et al 2017, Inegaki et al 2019) concluded these interventions should be provided within 6 months after ED self-harm presentations, the time of highest risk of death by suicide. Whilst BCIs have a lower evidence base, they are less dependent on patients attending or engaging and therefore, in routine clinical settings, more inclusive of patients at risk. Similarly, CAMS is more inclusive as it can be delivered by generic mental health staff rather than CBT therapists. Without claiming equivalent evidence, would the group consider mentioning that other approaches have additional merits over and above CBT and preliminary evidence.	should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT-informed psychotherapy or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. Relevant studies from the Riblet 2017 and Inegaki 2019 reviews which met the inclusion criteria were included in the Cochrane review, however the reviews themselves "tended to statistically pool results from very different interventions together and so the results are largely meaningless for clinical practice as they provide little insight into which approach may be most beneficial for particular clinically relevant subgroups of patients" (Witt 2021). Overall, the Cochrane study found that there was no evidence of a difference for psychodynamic psychotherapy, case management, general practitioner (GP) management, remote contact interventions, and other multimodal interventions, or a variety of brief emergency department-based interventions. Without sufficient evidence, the committee were not able to recommend BCIs. However, follow-up initial aftercare after a person has presented for self-

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					harm has been recommended (see recommendations 1.10.1-1.10.2), as has the provision of information and support (see recommendations 1.1.1-1.1.4). These recommendations are in accordance with the Fleischmann trial, which investigated a brief contact intervention whereby information and support was provided to people following presentation at the ED for self-harm. The committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions - please see appendix K of evidence review J for more information.
Solent NHS Trust	Guideline	26	5 - 10	1.10.2 Does the guideline state details of the CBT to be provided i.e. levels of training and supervision? This could be very helpful. In particular tightly-manualised approaches as delivered in step 2 IAPT are less likely to engage patients or be experienced as sufficiently personalised for them. Timing and prioritisation of problems is critical as patients may present with acute crises which unless addressed	Thank you for your comment. A recommendation has been added to clarify that therapy needs to be delivered by an appropriately trained and supervised person. It is not the role of NICE guidelines to write training manuals and so details of how to provide CBT have not been included. Consideration of other needs such as housing, financial problems or relationships crises would be covered by psychosocial assessment.

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				may prevent them effectively engaging in CBT. May I suggest an additional bullet points Is delivered by qualified CBT therapists with suicide-prevention training and regular supervision Is considered alongside other needs patients present with such as housing, financial problems or relationships crises. Obstacles to effective engagement in therapy should also be identified and where possible addressed.	
Solent NHS Trust	Guideline	26	1, 16	1.10.1 and 1.1.0.5 The guidance seems not to have considered the varying level of responsibility across services. For example, currently many mental health liaison teams in general hospital/ emergency department settings only provide assessment (in line with the last NICE guidance) and not treatment. I believe these services should have a duty of care to provide both safety planning (the current draft uses the term 'consider providing a	Thank you for your comment. The use of the word consider in this recommendation reflects the strength of the evidence underlying the recommendation. Whilst the committee acknowledge that safety plans are increasingly common practice, limited evidence was found for their effectiveness, and this evidence did not analyse safety plans as a standalone intervention. The recommendation has been worded in line with the evidence. The committee agree that existing liaison psychiatry teams may be well placed to offer aftercare and intervention. However it was not

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				safety plan') and psycho-social interventions. However, a non-professional / third sector service may not be deemed as being required to provide either in which case 'consider' may be appropriate guidance for an intervention or safety plan.	possible to recommend who should deliver interventions as there was no evidence in this area.
Solent NHS Trust	Guideline	27	24	1.10.9 Should this list say EUPD or BPD given we use EUPD in the UK?	Thank you for your comment. Borderline personality disorder is the title of the NICE guideline which this list refers to. Therefore it is not possible to change it to EUPD.
South London and Maudsley NHS Foundation Trust	Evidence review J	General on this Appendix	General	The draft does not differentiate between psychosocial interventions [deliverable by generic CMHT staff] and formal psychological therapies [deliverable by trained and registered psychotherapists]. Whereas (Table 1) all examples given are of formal therapies. This draft proposes only 2 approaches CBT and DBT: we are concerned that evidence for brief (4-10 session) CBT alone for self harm in adults and modified DBT for adolescents is not sufficiently strong – in short or long term outcomes – to recommend these	Thank you for your comment. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review, however the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural therapy. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to

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				to the exclusion of other approaches. The research quoted – within the actual papers – is cautious about its outcomes. A significant proportion of those presenting with self harm have personality and relationship difficulties such that brief interventions are contraindicated (see NICE guidelines for Borderline Personality Disorder) – or indicated only following clinical evaluation. Psychoanalytic psychotherapy, psychodynamic psychotherapy, Transference-Focused Psychotherapy, Mentalisation-based Psychotherapy, Dialectical Behaviour therapy, Dynamic Interpersonal Therapy, Child Psychotherapy, Systemic Psychotherapy all have an evidence base in this area and should be included.	inform planning of the person's treatment, including any interventions received. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. Recommendation 1.11.2 signposts to the existing NICE guideline on Borderline Personality Disorder as well as other guidelines for related conditions for further information. The committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions (including remote interventions) - please see appendix K of evidence review J for more information.
South London and Maudsley NHS	Evidence review J	6	General	Selection of studies: We can understand the statistical justification for exclusion of studies in which self-harm was not a primary outcome measure, however it skews the results	Thank you for your comment. The guideline utilised 2 published Cochrane reviews of interventions for children/young people and adults who have self-harmed, as the objectives and PICOs between the guideline respective protocols and the Cochrane

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Foundation Trust				away from studies that focus on personality integration as a primary outcome and which may most effectively treat self-harm in the longer-term. Failure to include population of people who self-harm but who do not present to services. Could have approached user support groups, or any studies accessing GP databases, to search for relevant studies. Furthermore, qualitative studies are not represented in this analysis. The following studies relate to these points: A systematic review of psychoanalytic psychotherapy for self-harm and additional papers cited below: - Briggs, S et al (2019) "The effectiveness of psychoanalytic / psychodynamic psychotherapy for reducing suicide attempts and self-harm: a systematic review". BJPsych. 214, 320 328.	review protocols were very similar. Detailed inclusion and exclusion criteria for the reviews used to inform guideline recommendations were thus set by the authors of the Cochrane reviews. The Cochrane reviews that informed the guideline included RCTs of interventions for people who have self-harmed, consistently with the guideline review protocol criteria, as this is the golden standard study design for measuring efficacy. Approaching user support groups, studies accessing GP databases, and qualitative studies were not considered appropriate or suitable for this purpose. A qualitative review of views and preferences of people who have self-harmed, their families and carers, and staff working with people who have self-harmed, about the best ways of involving family and carers in the management of people who have self-harmed has been undertaken separately to inform the NICE guideline, with results presented in Evidence Review D. Briggs et al. is a systematic review of RCTs of psychoanalytic/psychodynamic psychotherapy. The Cochrane reviews have considered this intervention and searched specifically for individual studies within this review by Briggs et al., so if any RCTs included in Briggs et al. have met the inclusion criteria for the Cochrane review, they will

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				-the first systematic review and meta-analysis of RCT's evaluating psychoanalytic/ psychodynamic interventions for suicidal behaviour, self-harm, and self-injury. A total of 12 trials were included in the meta-analysis. Briggs et al (2019) review suggested that service providers could consider the use of psychoanalytic psychotherapy as an intervention, which could be offered to individuals at risk of, or with a history of, suicidal or self-harming behaviour. No cost data were available with the trials included in the review, except one. Leichsenring, F (2011) "Long- term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis". BJPsych, Jul vol, (1), p15-22. Dose effect data and LTPP superior to less intensive forms of psychotherapy in complex mental health disorders. Cully, G., Corcoran, P., Leahy, D., Cassidy, E., Steeg, S., Griffin., E.,	have been included in the Cochrane review and, subsequently, considered as part of the evidence in the NICE guideline. The review by Leichsenring is not specific to self-harm, but if RCTs specific to self-harm were included in this published review, they have been considered for inclusion in the Cochrane reviews. The Cully et al. study is not an RCT, and is not even a comparative study and therefore does not meet inclusion criteria for the Cochrane review and the guideline review protocol.

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				Shiely., F., & Arensman, E. (2021) "Factors associated with psychiatric admission and subsequent self-harm repetition: a cohort study of hight risk hospital presenting self-harm". Journal of Mental Health, vol 30, (6), p 751-759. (High risk self-harm, HRSH – not evidence base however points out high risk self-harm relevant to tertiary prevention)	
South London and Maudsley NHS Foundation Trust	Evidence review J	8	General	Inclusion criterion of 'Max f/up period of 2 years' excludes well-designed longer-term studies that may follow patients for longer. Similar criterion was used to exclude the Tavistock Depression Study in the first draft of the [still being redrafted] Depression guidelines. Again, statistical position is valid, but clinical reality is skewed as relapse not uncommonly occurs beyond the two-year deadline.	Thank you for your comment. This was an inclusion criterion regarding the primary outcome. According to the Cochrane reviews that informed the guideline: "The primary outcome measure in this review was the occurrence of repeated SH over a maximum follow-up period of two years." This criterion did not preclude otherwise eligible RCTs with a longer follow-up period from being considered in the reviews, as long as they reported either the primary outcome within a follow-up period of 2 years or any other of the secondary outcomes (such as treatment adherence, depression, hopelessness, general functioning, social functioning, suicidal ideation, and suicide). It is quite unlikely that any otherwise eligible, longer-term RCTs (i.e. longer than 2 years) will not have measured and reported self-harm repeat outcomes

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					within the first 2 years, so it is unlikely that they will have been excluded from the review. It is true that this inclusion criterion may have missed relevant data beyond 2 years, but evidence suggests that, for people who have not self-harmed beyond 12 months, the risk of repeating self-harm is considerably reduced (see Lilley et al., Br J Psychiatry 2008, 192, 440–445). It is noted that no such criterion was used in the Depression guideline to exclude the Tavistock Depression study (Fonagy et al. 2015). This study was only excluded from first-line review as the study was on a treatment-resistant population, and from the chronic depression review as that review was limited to first-line or maintenance treatment of people with chronic depression. The Tavistock Depression study was included in the further-line treatment review of the Depression guideline.
South London and Maudsley NHS Foundation Trust	Guideline	General	General	We welcome the guidance and in particular the advice that individuals who have self-harmed are assessed by suitably qualified mental health professionals and offered psychological interventions. Self harm covers a spectrum of	Thank you for your comment. The guideline tries to be explicit that self-harm is a range of behaviours with a wide variety of possible underlying causes and antecedents. Text has been added to the start of the guideline to clarify this, however this 'definition' was used when developing all review protocols. The committee agree that previous versions of the guideline were largely focused on management in Emergency Departments and secondary care. However this guideline has

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				behaviours from one-off presentations to those who repeatedly harm themselves and are at serious risk – often people who would be described as having personality disorder and /or experiencing complex trauma. It would be helpful if the guidelines were clear about this range. The focus in these guidelines seems to be on episodes that present to the Emergency Department. It would be helpful if the guidance could more explicitly state what the limits are. For example the National Self Harm Service at the Maudsley sees people with a history of recurrent attempts and often personality disorder, for whom brief interventions would be inappropriate (and have not been successful in the past). The guideline does not currently address the clinical needs of such patients with high levels of service use. The NICE guidelines for psychological therapy for Borderline Personality Disorder acknowledge the importance of continuity of	widened the scope and includes sections on assessment in a variety of healthcare settings, social care, education and the criminal justice system. The committee also acknowledge that guideline does not unduly focus on people with multiple episodes of self-harm because it is a guideline intended for the full spectrum of behaviours. However these recommendations would also be appropriate for people with high levels of service use. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of the interventions section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. Recommendation 1.11.2 signposts to the NICE guideline on BPD for further information. The number of sessions recommended has been informed by the effectiveness evidence and the cost effectiveness evidence as laid out in Evidence

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				relationships in their care and the need for longer-term planning. Pitman, A & Tyrer, P (2008) "Implementing clinical guidelines for self -harm highlighting key issues arising from NICE guidelines for self-harm". Psychology and Psychotherapy: Theory, Research and Practice. 81, 377-397. There is reference made to other guidelines for possible underlying conditions but without a more general acknowledgment that the treatment of self-harm may require longer-term evidence-based therapies.	Review J. The committee agreed that there will be occasions when patients will need a different number of sessions, and recommendation 1.11.3 has been amended to clarify this.
South London and Maudsley NHS Foundation Trust	Guideline	General	General	Assessment: Para 1.5.17 The advice for people who have had frequent episodes of self-harm is limited to assessment and review. Instead this is a group who are likely to have complex needs, including the presence of a comorbid personality	Thank you for your comment. Recommendation 1.11.1 states that co-existing conditions and the psychosocial assessment (which should identify other conditions not previously picked up) should be taken into consideration when planning treatment for self-harm. An additional recommendation (recommendation 1.11.5) has been added that healthcare staff need to be appropriately trained and supervised - so it would be possible for the staff member to identify an

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				disorder, and whose pattern of behaviour is likely to benefit from a more therapeutic and less procedural approach, including assessment and referral to specialist self-harm services. Para 1.5 and Para 1.10.2 Guidance rightly outlines need for comprehensive assessment after episode of self harm (defined as assessing environmental and psychological factors) but not enough emphasis is placed on diagnosis before taking action. Diagnosis is not advised in single encounters when a patient is in crisis – assessment should be serial and diagnosis over time. If the emphasis is on offering treatment as soon as possible, patients will potentially be offered inappropriate or ineffective treatment without robust assessment, with negative cost and health outcome implications. For example there is a risk with these recommendations that patients with (as yet undiagnosed) Borderline Personality Disorder are offered a	undiagnosed condition during treatment. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended.

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				short course of CBT, which is both counter-therapeutic (as outlined by NICE guidelines on Borderline Personality Disorder) and ineffective, rather than being referred for psychodynamic psychotherapy, DBT, schema, Transference Focussed Psychotherapy or Mentalisation Based Therapy after adequate assessment, as per evidence.	
South London and Maudsley NHS Foundation Trust	Guideline	General	General	Committee Composition: The composition of the committee is such that there is much expertise in CBT and DBT but a gap in terms of expertise in other formal psychotherapies. The Consultant Psychiatrist in Psychotherapy in the group is a CBT specialist. The vast majority of Consultant Psychiatrists in Psychotherapy in the UK, including those leading Personality Disorder services, are psychodynamically trained.	Thank you for your comment. The committee members are selected for their general expertise rather than because they represent a particular branch of psychotherapy. The recommendations about interventions (section 1.11) are based on the evidence, rather than the expertise of the committee.
South London and Maudsley	Guideline	General	General	Points specific to addictions: We welcome the guidelines that relate to addictions, that alcohol and drug use	Thank you for your comment. Assessment of the level of severity of drug/alcohol use would be encompassed within 'changeable and current

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NHS Foundation Trust				are clearly mentioned as contributing factors. We welcome the following points: clear guidance that alcohol and drug use shouldn't exclude people from assessment explicit guidance that alcohol and drug use should be explored in the assessment - though could be more detailed as to what professional needs to look for (see below) clear mention that professionals should have a conversation around the role of alcohol and/or drugs in suicidal acts with the patient clear guidance that alcohol and drug use shouldn't exclude people from appropriate psychological treatment people prescribing medication to those who self-harm should take alcohol and drug use into account The only concern is that in the	factors' in recommendation 1.5.10. The longer list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person.

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				assessment portion we suggest that it is made explicit that there is assessment of the level of severity of alcohol/drug use disorder as this will determine appropriate treatment pathway/what the focus of the care plan should be.	
South London and Maudsley NHS Foundation Trust	Guideline	General	General	Why the draft guidelines would be hard to implement: While we recognise that for many who present initially with self-harm, a Tier 1 approach of a limited number of psychotherapy sessions is a reasonable first step, it is not sufficient for the broader population with recurrent self-harm. Currently services for self-harm are provided by clinicians who have a range of trainings in psychotherapy. This guidance suggests that only those trained in CBT (or DBT for adolescents) should be treating this group (see above point). This would have significant cost implications to train all first contact staff in these modalities. There is not compelling	Thank you for your comment. The guideline recommended interventions that have shown evidence of efficacy, as identified in relevant Cochrane reviews of interventions for adults and children and young people who self-harm. Tyrer 2003 investigated the effectiveness of CBT-based psychotherapy and was included in the Cochrane systematic review, which was used to inform recommendation 1.11.3. The committee acknowledged that evidence from the Cochrane review was based on a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT, however it did show a potential benefit of psychological interventions which were structured, person-centred, manualised, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities (and not only CBT) might be effective as long as they meet these principles.

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				evidence that these modalities are superior to other psychotherapy trainings. This would result in the exclusion of approaches focused primarily on listening, understanding and building a relationship over time, which in the context of repeated self-harm, and self-destructive behaviour more broadly, many studies have shown to be of value (Tyrer). NHS staff groups potentially excluded would include some of the following: medical psychotherapists, psychotherapists in school settings, child psychotherapists, honorary psychotherapists volunteering in NHS Trusts, clinical psychologists, adult psychotherapists, mental health nurses, school counsellors. Clinical psychology, mental health nursing, psychotherapy and psychiatry already have recruitment and retention difficulties in many areas nationally in	The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of this section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not for CBT for adults and DBT-A for children and young people to be the only interventions offered to/considered for people who have self-harmed, however the available evidence limits what can be recommended, as no other interventions considered in Cochrane reviews showed evidence of effectiveness. A recommendation has been added to clarify that therapy needs to be delivered by an appropriately trained and supervised person (1.11.5). Recommendation 1.11.3 has also been amended to clarify that CBT-informed psychological therapies, and not CBT, are being recommended, which could encompass a number of different therapies. Depending on the therapy being provided, many NHS staff will be able to deliver the intervention, provided they have the appropriate training. It is acknowledged that provision of these interventions may have resource implications, if

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				the NHS, yet these guidelines would seek to redefine an increasing number of Psychology and Psychotherapy roles within a more limited CBT/DBT remit. This would risk losing many well qualified, experienced psychotherapists trained in other modalities. By emphasising in national guidelines the priority for cognitive or behavioural approaches alone, an opportunity cost is left unanalysed in terms of the roles that will be lost due to fixed local Trust budgets. Without sufficient experienced therapists to provide care to those with more complex presentations, the outcomes for this population (as they move to Tier 2 and Tier 3) will suffer. Tertiary prevention will be less effective, admissions to hospital and other use of crisis services will rise. The lower Tier and non-medical aspects of the ICS and Place Based Care will not be sufficient to provide the interventions required for this complex, vulnerable and risky population.	some settings do not currently offer the recommended therapies, and that additional training and staffing may be required in this case. Potential resource implications of the guideline were considered by NICE when preparing the guideline's Resource impact summary report.

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				Has NICE analysed this risk and quantified the size and needs of the population affected with complex self-harm? Has NICE considered and quantified the effect at Tier one of only recommending one modality? Many school counsellors use other well established and empirically supported approaches to helping distressed and self-destructive adolescents. They would be one group potentially affected by an over-zealous application of these guidelines.	
South London and Maudsley NHS Foundation Trust	Guideline	General	General	Para 1.5.12 The advice around older adults is confined to the over 65 year old age group and appears to be motivated by the artificial nature of our service configurations, rather than clinical need. The additional risk factors noted in the first bullet point are relevant to individuals in mid-life who self-harm. Note also that rate of suicide following self-harm (bullet 4) increases well before age 65.	Thank you for your comment. The recommendation was not worded based on service configurations but based on the committee's experience that specific, additional consideration is needed for older adults. However the recommendation has been amended to refer to older adults rather than those over 65. The wording of the first bullet is based on the committee's knowledge that older people tend to be at higher risk for poor physical or mental health. The committee agreed that paying additional attention to these factors for older people who had self-harmed would reduce the potential for inappropriate interventions or follow-up to be offered because of an incomplete assessment. This is documented in the Committee's discussion of the evidence section for Evidence review F.

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South London and Maudsley NHS Foundation Trust	Guideline	General	General	Psychological Treatments for Self Harm: Para 1.10.1 The advice to offer a psychological treatment after self-harm episodes is welcome. However, the limitation of this advice to CBT is problematic. The evidence synthesis includes the Cochrane review (Witt 2021) of interventions following self-harm. It is clear that the trials included under CBT are diverse and include "problem solving", "interpersonal problem solving", "acceptance and commitment therapy", and so on. One of the most strongly "positive" trials (Guthrie 2001) is assigned to the CBT group, but is described in the original paper as a "brief psychodynamic interpersonal therapy". In the Cochrane Review forest plot of self-harm repetition at 6 months (Witt 2021), this was one of only two trials out of 12 "CBT-based psychotherapy" trials which showed a statistically significant benefit, and indeed had the strongest effect size supporting brief psychological	Thank you for your comment. With regards to the quality of the evidence, although there was imprecision in the effect estimate, data showed that individual CBT-based psychotherapies may reduce repetition of self-harm by the end of the intervention. At longer follow-up time points, there was more robust evidence of effect for this intervention. There was also evidence of a positive effect on several important outcomes, including hopelessness, suicidal ideation, and depression scores at various follow-up time points. The Cochrane review authors outline that the evidence base for CBT-based psychotherapies (as they have defined them) is stronger than the current evidence base for any other intervention. The committee acknowledged that a wide definition of 'CBT-based psychotherapies' which included therapeutic elements not necessarily typical to CBT was used in the Cochrane review. However the evidence did show a potential benefit of psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3 has therefore been amended to highlight that other treatment modalities might be effective as long as they meet these principles. The recommendation that cross-references guidance on how to treat co-existing conditions has

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				interventions. Thus, the trial which provides the best evidence for CBT, was not a trial of CBT. The risk here is that service planners dismiss non-CBT based treatments or therapists, and instead insist dogmatically that CBT is the only valid treatment to be offered for self-harm. Para 1.10.2 The Cochrane review cited outlines evidence for CBT interventions as low grade criteria. The review outlined higher grade (although fewer studies) for Mentalisation Based Therapy. There is no clear justification then for offering CBT over MBT in light of this evidence. This is important as an MBT approach (and other psychotherapeutic approaches) is markedly different from CBT. In MBT a therapist would initiate a functional analysis rather than attempted to address the behaviour specifically. By only recommending CBT this guideline undermines other therapeutic approaches including those with	been moved to the top of this section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT-informed psychotherapy or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended. In addition, a recommendation has been added (1.11.5) that healthcare staff delivering interventions should be appropriately trained and supervised. The committee agreed that further evidence was needed to assess the effectiveness of various interventions for people who have self-harmed, and therefore made research recommendations for psychosocial interventions (including MBT) - please see appendix K of evidence review J for more information.

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				potentially better evidence base and which may be better a reducing self harm and other destructive behaviours over the longer term. We therefore suggest a more nuanced recommendation along the lines that brief psychological treatments should be offered, but that the modality offered is less important than the fact that the therapist is working to a coherent model and provided with suitable supervision.	
South London and Maudsley NHS Foundation Trust	Guideline	General	General	Para 1.10.1 and 1.10.9 It is welcome to note that where self-harm takes place in the context of other disorders, the treatment of those disorders should be taken into account. However, the guidance needs to make this point more assertively at 1.10.1, ahead of the section on treatments. Our concern here is that there are specialist services providing longer-term treatments (including psychodynamic, interpersonal psychotherapy, Transference focussed psychotherapy or longer-term CBT) for people who	Thank you for your comment. The recommendation that cross-references guidance on how to treat co-existing conditions has been moved to the top of this section (1.11.2) to emphasise that existing diagnoses and conditions should be considered first and used to inform planning of the person's treatment, including any interventions received. The intention is not that CBT or DBT-A for children and young people would be the only intervention offered to people who have self-harmed, depending on coexisting conditions, however the available evidence limits what can be recommended.

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				repeatedly self-harm, many of whom have personality disorders and will have experienced multiple episodes of care including brief treatments with CBT and related therapies. The guidance could be taken, if read cursorily, to indicate that such individuals should only be offered brief CBT (i.e. recommendation at 1.10.2). It may then be used by those commissioning services in this way, even though this may not be the intention of the authors of these guidelines.	
South West London and St George's Mental Health NHS Trust	Guideline	General	General	The guideline is very long and not very user friendly for busy clinicians – it would benefit from a supporting one page infographic, summary or flow chart with the key points.	Thank you for your comment. The content of the recommendations do not lend themselves to inclusion in the formats you suggest so no change has been made.
South West London and St George's Mental Health NHS Trust	Guideline	General	General	On the whole, we strongly agree with the direction of travel in these new guidelines, as well as with the specific recommendations they.	Thank you for your comment.
South West London and St George's	Guideline	General	General	It would be helpful and informative to include a section on what constitutes self-harm as many people focus on	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of

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Mental Health NHS Trust				cutting alone – should also consider headbanging, inviting others to harm them, burning, inserting, swallowing objects, drinking poison etc.	the apparent purpose of the act. The treatment and care of repetitive, stereotypical, self-injurious behaviour (such as head banging) is not covered by this guideline.
South West London and St George's Mental Health NHS Trust	Guideline	15	18	1.5.18/19/20/21 The guideline states how not to evaluate or communicate risk evaluations, including not using stratification. It would be helpful if the guideline can suggest how risk should be reported and/or communicated in the absence of stratification. We think stratification can be a useful communication tool as long as its limits are understood, in particular, that risk is dynamic.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
South West London and St George's Mental Health NHS Trust	Guideline	15	18	1.5.18 Actuarial-based risk assessment tools can be helpful in directing attention within an overall psychosocial assessment to known patterns of risk and key moderators. A blanket DO NOT is unhelpful here.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee

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				The guideline recognises the value of actuarial indicators, for example, 1.5.12 (p14, line 21) that over 65 have a higher risk of suicide after an episode of self-harm. Hence a blanket ban on the use of risk assessment tools also contradicts other parts of the guideline. Our advice would be to moderate 1.5.18 as "Do not use…in isolation to predict…", or alternatively rephrase "only use risk assessment tools and scales as part of a psychosocial assessment"	discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
South West London and St George's Mental Health NHS Trust	Guideline	17	4	1. 6.4 The guideline should refer to exceptions to the blanket DO NOT against involving criminal justice, for example, where there is damage to property or harm to others caused as a result of self harming behaviour	Thank you for your comment. This recommendation does not advise against involving criminal justice. It says that criminal justice approaches should not be used as an intervention for frequent self-harm episodes.
South West London and St George's Mental Health NHS Trust	Guideline	17	4	1.6.4 It might be helpful to specify specific approaches this refers to, in particular, Serenity Integrated Mentoring (SIM),which has been widely rolled out across the NHS but lacks any published evidence base.	Thank you for your comment. No evidence was identified to support recommending any specific approaches.
South West London and St George's Mental	Guideline	19	13	1.6.12 The direction that people should be offered to meet a liaison psychiatry professional at every admission should be qualified with "unless previously	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help

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Health NHS Trust				agreed within their multidisciplinary care plan/safety plan". Rarely, for some people they will not agree to go to A&E if they know they will get another repetitive assessment and are already under a MH team	every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one.
South West London and St George's Mental Health NHS Trust	Guideline	20	18	1.6.19 The direction that people should be offered to meet a liaison psychiatry professional at every admission should be qualified with "unless previously agreed within their multidisciplinary care plan/safety plan". Rarely, for some people they will not agree to go to A&E if they know they will get another repetitive assessment and are already under a MH team	Thank you for your comment. The committee asserted that each episode of self-harm can have its own meaning and triggers and requires its own assessment. People who are in distress need help every time they present to services and the way to assess the help they need is to conduct a full assessment. The person is, of course, able to refuse consent to an assessment if they do not wish to have one.
South West London and St George's Mental Health NHS Trust	Guideline	26	11	Insert after 1.10.3 as a similar point. "For adults with significant emotional dysregulation difficulties who have frequent episodes of self-harm, consider assessment for Borderline Personality Disorder and offer Dialectical Behaviour Therapy (See NICE Guideline for Borderline Personality Disorder)	Thank you for your comment. The recommendations in this section have been re-ordered to emphasise the importance of considering coexisting conditions when planning treatment. The NICE guidelines for a number of associated conditions have been signposted to in recommendation 1.11.2 so that guidance on appropriate interventions for these conditions can easily be found. The intention is that conditions associated with self-harm would be considered first and treated appropriately, with the understanding this may help to reduce self-harm.

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South West London and St George's Mental Health NHS Trust	Guideline	28	6	1.10.10 should use term self-harm, not self-cut, to remain consistent	Thank you for your comment. The wording has been changed to self-harm.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	Short executive summary at beginning of document would make it easier to communicate main themes	Thank you for your comment. Unfortunately the format of NICE guidelines does not contain an executive summary and so this change has not been made
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	We understand that NICE guidelines can be applied in Wales and so reference to Welsh documentation / policy would be useful alongside the English documents and needs to take into account different legal acts ie MH Measure Include reference to relevant welsh guidelines.	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Specialist Children & Adolescent Mental Health,	Guideline	General	General	Would be useful to clarify the term 'self-harm' at the beginning of the document and in an executive summary	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.

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Hywel Dda University Health Board				Clear definition of what they consider self-harm to be at the start	
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	The term 'psychosocial' is used all the way through and it isn't clear why this term is used; doesn't appear that social context is weighted enough to describe it as this; we consider 'psychological' assessment may be more appropriate	Thank you for your comment. The committee were of the view that social context is very important and think the recommendations adequately convey this. Therefore your suggested change has not been made.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	Although there is reference to capacity, it would be helpful to indicate how assessment of any capacity decision is integrated into this assessment and which practitioners would be appropriate to undertake that assessment and provide example of this for clinicians	Thank you for your comment. The committee's view was that all health and social care staff need to be aware of the principles surrounding capacity, appropriate to their role and position in the organisation. Assessment of capacity is not the focus of this guideline and so making detailed recommendations about how to assess capacity and who should do this is outside the scope.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	Although reference to the requirement for appropriate training is made, there is no specific training suggestion; recommendations for mandatory relevant training would be useful e.g. the WARRN risk assessment training required across mental health training in Wales. Expectations of education to have	Thank you for your comment. It is not the role of NICE guidelines to write training manuals, and the guideline did not identify any specific evidence based training to recommend. Rather, recommendations have been made (section 1.14) relating to the principles that training should deliver.

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				trained staff, who would this be and what training would they undertake? Important to maybe specify the different levels of assessment in different settings formal v informal	
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	We would like clarification of who 'specialist mental health professionals' includes and define which discipline would be a minimum standard	Thank you for your comment. We have removed reference to specialist mental health professionals. Mental health services are multidisciplinary by nature so the guideline has not defined a particular discipline.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	Differences between CAMHS and AMHS services – different roles i.e liaison role.	Thank you for your comment. Unfortunately it has not been possible to determine which part of the guideline your comment relates to or what change you are suggesting is made.
Specialist Children & Adolescent Mental Health, Hywel Dda	Guideline	General	General	Need to ensure there is a way to disseminate the recommendations in this guideline to all of the relevant stakeholders who may not be aware of what the requirements are.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.

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University Health Board					
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	Little recommendations reference the criminal justice system.	Thank you for your comment. The recommendations in the guideline represent best practice based on the best available evidence. As such the committee intended that the recommendations made in the guideline should apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group. The guideline has been amended to make this clearer.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	General	General	No reference to how to support people who self harm and pose a risk to others e.g. such as arsonist may be open to the criminal justice system Need to include support from the Third sector and voluntary organisations	Thank you for your comment. The evidence identified that was specific to the criminal justice system was very limited and qualitative in nature. It was therefore not possible to make detailed recommendations about how to support people who pose a risk to others or how to work with third sector and voluntary organisations.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	7	12	Add Welsh legislation	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.

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Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	9	5	Add Welsh legislation	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	10	29	Suggest add 'unless there is significant harm to themselves where the requirement to share information to keep the person safe would override confidentiality'.	Thank you for your comment. A cross reference to section 1.2 has been added, which makes recommendations about confidentiality and consent.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	11	22	Within a mental health crisis team, our experience is a very different assessment – completing immediately after vs. allowing some time for the person to sit and reflect. Completing the assessment until after the medical treatment is completed often means the young person is in a more relaxed state and more amenable for reflecting on future support and engagement	Thank you for your comment. It was the consensus of the committee that delaying a psychosocial assessment could result in the person receiving inappropriate treatment, and so made recommendation 1.5.2. They discussed that if the person is not able to meaningfully engage in the assessment (for example, if the person is unconscious or has very high levels of intoxication), they should be regularly reviewed so that it can take place as soon as appropriate,
Specialist Children & Adolescent	Guideline	14	1&2	Add a point about protective factors related to a person's cultural and/or spiritual beliefs and support system	Thank you for your comment. The list of factors to consider has been removed from recommendation 1.5.10 to emphasise that this list was not intended

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Mental Health, Hywel Dda University Health Board					to be exhaustive. All aspects relevant to the person should be considered and the assessment should always be comprehensive. It would be down to professional judgement as to what is relevant to each person. A longer list of potential considerations is still available in Evidence Review F but this is not intended to be exhaustive.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	15	23	Within our CAMHS crisis team we will assess risk based on a risk stratification process linked to WARRN and in daily practice, we use the RAG rating to identify low/medium and high risk. This global stratification is based on a risk formulation but allows us to monitor 'the board' , provides a visual representation and decide who needs intervention on a daily, bi-daily etc basis. It would be difficult to completely dismiss this stratification. Or it would be useful to have guidance on how teams monitor and 'hold in mind' all of the clients they are supporting at one time, on a daily basis.	Thank you for your comment. There was a strong consensus from the committee that this type of risk stratification is not the optimum way to care for people who have self-harmed. Assessment tools and stratification do not reliably predict risk and can give a false sense of security to staff categorising people as 'low risk'. The committee have made recommendations to support assessment based on needs and safety and not risk.
Specialist Children & Adolescent Mental Health, Hywel Dda	Guideline	15	25	Add 'risk assessment should be based on a formulation that considers severity, probably and imminence'	Thank you for your comment. The guideline is trying to move away from this sort of attempt at precision since it is not evidence based and gives the impression that these things can be accurately assessed/measured when in reality they can't.

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University Health Board					
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	16	20	Add a point about being careful not to inadvertently reinforce unhelpful behaviour, particularly if persons behaviour may be operant e.g. the dbt model is careful not to reinforce unskilful behaviour by responding in a way that inadvertently provides reinforcement following self harm behaviour, clear careplan in place, this recommendation needs to consider who's need is being met by this	Thank you for your comment. There are hypotheses around self-harm which frame self-harm as being operant behaviour and that compassion and care will reinforce this behaviour. However investigations about punishment and inattention as 'care' for people who have self-harmed have shown that this approach is not helpful and does not reduce repeat self-harm. The committee felt strongly that it was not appropriate to imply that compassionate care (whereby staff share an understanding of why the person has self-harmed) could reinforce self-harming behaviours. The DBT model is not indicated for people who have self-harmed (please see Evidence Review J), although it is for some associated conditions. Recommendation 1.11.2 directs people to guidance for condition-specific treatments.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	19	16	1.6.13 - This is not always possible as there is no designated area to complete mental health assessments in A&E. 1.6.14 – who are these appropriate staff and what type of care are you referring too? Also, is this achievable and realistic?	Thank you for your comment. The committee understand the challenges in many ED environments and are not suggesting that there is a dedicated area within EDs that is used solely for the purpose of conducting psychosocial assessments. However the committee's view was that having an appropriate area available is a pre-requisite for the assessment of people after self-harm. Such facilities should already exist but may be used for other purposes. The word 'appropriate'

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					has been removed from the recommendation. The aim of this recommendation is to ensure that there is someone there if the person needs them. The rationale and impact text explains that this is because "people who have self-harmed may feel neglected when asked to wait in isolated areas of the emergency department, and that people who have self-harmed may need support during a time of potential distress."
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	21	1	Corrections 'CAHMS' should read CAMHS. Also query whether this should be 'specialist CAMHS' as its referring to a secondary service.	Thank you for your comment. The typo has been corrected and the recommendation amended to clarify that this about access to specialist CAMHS.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	22	12	Is the expectation that schools will be implementing this into policies and procedures? We would suggest that there is a specific recommendation about education accessing support from appropriate professionals such as specialist CAMHS for the training needs in relation to this.	Thank you for your comment. Recommendation 1.8.4 covers having a designated lead who would be responsible for ensuring the training needed to implement recommendation 1.8.3 is in place. How this is achieved will vary and so we have not recommended specialist CAMHS do this.
Specialist Children & Adolescent Mental	Guideline	24	8	This is very vague 'ensure it's the ward that can meet the needs of the child'; it needs to be clear whether this means a paediatric ward or not. Also it would	Thank you for your comment. Different areas will have different settings for teenagers and young adults so the recommendation has been written with this in mind. It is therefore not possible to be

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Health, Hywel Dda University Health Board				be useful for guidance for children who are age 16 as it can be difficult to find a bed as no one will take responsibility for which ward they can be admitted too – as 16 is on the cusp of the Paediatric ward	more prescriptive. The committee want to ensure that teenagers and young adults are not admitted to adult wards that are not appropriate to their needs (for example geriatric wards)
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	25	2	Is the recommendation that this meeting should take place before the patient is discharged home? Trying to co-ordinate diaries of other professionals and services with CAMHS is very difficult and can take time. At times, patients would potentially need to wait for a considerable amount of time for this to occur.	Thank you for your comment. The purpose of the meeting is to ensure information is shared and read/understood by attendees. The recommendation specifies "all appropriate agencies" which doesn't mean all agencies have to attend - just those that are needed.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	25	12	Is this reducing to 48 hours? As it is currently 72 hours	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety.
Specialist Children & Adolescent Mental Health,	Guideline	28	7	The word 'only' may be misleading e.g. only using harm minimisation approach would rule out DBT A for a young person who continues to act on urge to self-harm	Thank you for your comment. Recommendation 1.11.11 specifically outlines that harm minimisation should not be provided as a standalone intervention.

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Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	30	4	Staff being visible to the person who has self harmed – this may not be appropriate when the presence of these care giving staff may be reinforce the behaviour. It may be worth referring to a care plan for patients who are already known to a service, as this could outline how to avoid the possible impact of unskilful behaviour being reinforced.	Thank you for your comment. The recommendation says visible and accessible, not just visible. The rationale and impact section and the Committee's discussion of the evidence section in Evidence review N already describe why this recommendation is needed.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	30	10	This seems only applicable in a hospital setting and would be helpful to note.	Thank you for your comment. This recommendation is relevant to any clinical setting in which someone is being cared for.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	35	8	Reference for the DBT-A model	Thank you for your comment. The terms used section of the guideline defines terms that have been used in a particular way for this guideline. As such there is no reference to include

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Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	35	10	Typically 16 week program – check the evidence base for this; most programmes would be significantly longer. The risk of suggestion its typically 16 weeks may minimise the level of distress experienced by these young people and families Length of DBT involvement is not 16 weeks	Thank you for your comment. The committee recognise that many DBT-A programmes are longer than 16-weeks, but the evidence that was used in this guideline was based on RCTs that demonstrated the efficacy of this intervention. The average duration of those interventions was 16-weeks.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	35	12	'peer supervision' group should be replaced with peer consultation group to use DBT terminology	Thank you for your comment. This change has been made.
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	35	13	'DBT aims to equip young people' (add 'and their parents / carers')	Thank you for your comment. This change has been made.
Specialist Children & Adolescent	Guideline	36	1	The use of the word 'need' to self harm suggests that they need to do it; it may be more appropriate to use 'continued	Thank you for your comment. The guideline has been amended as suggested.

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Mental Health, Hywel Dda University Health Board				self harm behaviour' or 'continued urge to self harm'	
Specialist Children & Adolescent Mental Health, Hywel Dda University Health Board	Guideline	18 19	25 7	1.6.10 - Point 10: Says A&E staff responsible for initial assessment e.g. severity etc. (So is the expectation that A&E staff will complete this?). who will train then and provide supervision in respect of risk management and safety planning? 1.6.11 - Point 11: Says a referral to liaison psychiatry services should be made to do the same assessment as point above. The two points are contradictory of each other and it is not clear. It needs to be clarified who needs to make the assessment. It also needs to be clarified whether this is a different process for children.	Thank you for your comment. The guideline recommends that the Emergency Department staff carry out an initial assessment or triage as they would for anyone presenting to the Emergency Department with any problem. The person should then be fully assessed by liaison psychiatry services, regardless of their age.
Specialist Children & Adolescent Mental Health, Hywel Dda	Guideline	51	14	This makes the assumption there is a specialist mental health worker in an education provision; need to clarify the qualifications required for this and what schools actually provide.	Thank you for your comment. There is an existing government initiative for eligible state funded schools and colleges in England to train a senior mental health lead. The content of this training is determined by the government and therefore recommendations have not been made on this.

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University Health Board					
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	General	General	General comment re. CBT/ DBT-A We have concerns about the recommendation re. CBT – there is no more evidence for CBT as opposed to PIT or other psychological therapies. The recommendations should not be so restrictive on the 'type' of psychological therapy – who would be responsible for this provision?	Thank you for your comment. The Cochrane review investigated the effectiveness of psychodynamic psychotherapy versus treatment as usual or another comparator (comparison 5) and found no evidence of an effect on repeat self-harm. On the other hand, the evidence did show a potential benefit of CBT-based psychological interventions which were structured, person-centred, time-limited, and informed by cognitive behavioural elements. Recommendation 1.11.3 has been amended to highlight that other treatment modalities might be effective as long as they meet these principles, in line with the evidence. A new recommendation has been added to clarify that psychological therapies need to be delivered by appropriately trained and supervised staff (recommendation 1.11.5).
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	12	10 - 11	Under the section 1.5.7 – Providing the option of a heath professional of same sex to carry out Psychosocial assessment may not be feasible all the time as it depends on the staff available on the day/night.	Thank you for your comment. The stem of the recommendation clarifies that the needs or preferences of the person who has self-harmed should be taken into account as much as possible. This would apply to providing the option to have a healthcare professional of the same sex carry out the psychosocial assessment, because the committee recognised that it would not always be possible to do this.

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Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	14	16 – 17	1.5.12 – Psychosis also needs to be explored in this section – in "pay particular presence of depression, cognitive impairment, and physical ill health".	Thank you for your comment. Psychosis is not known to be a significant risk factor for older people self-harming. Therefore we have not added it to the recommendation.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	14	23 – 26	Under the section 1.5.13 – person has self-harmed and wants to leave before a full psychosocial assessment has taken place, assessment of immediate risks, mental capacity and any mental health problems need to be assessed. The challenges in this clinical situation are sometimes the person does not wait for Liaison Professionals to arrive to do this task and it is left to the Accident and Emergency staff where training needs to be provided consistently.	Thank you for your comment. It is hoped that implementation of the recommendations made earlier in section 1.5 should ensure that psychosocial assessment should happen as soon as possible. This would minimise any delay during which the person may leave.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	15	7 – 17	Section 1.5.17 -The challenges are when the person with frequent self-harm declines to attend multi-disciplinary team meetings.	Thank you for your comment. The committee acknowledge that there may be instances when the person doesn't want to attend the MDT review. However, in these instances, they would expect clinicians to make every effort to include and involve the person.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	15	19 – 26	1.5.18-1.5.21 – positive to see this in here. There is often still a push from acute Trust and a mistaken belief that having a risk matrix can 'measure' risk and the move away from low/ med/	Thank you for your comment. The committee agree that assessment and care should be based on needs and safety and not risk.

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				high risk is good. Having a narrative risk assessment is considerably more informative and needs to remain a core part of any risk assessment and documentation.	
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	17	4 - 7	1.6.4 – positive to see this in here. This will support Liaison teams in educating acute colleagues in what should/ shouldn't, can/ can't be done with repeat attenders and emphasises the need to NOT withhold treatment or treat in a punitive way following self-harm in the mistaken belief this will prevent future self-harm.	Thank you for your comment.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	18	4 - 22	1.6.8-9 – positive to see this in here. We need to encourage ambulance services and primary care to consider alternatives to the Emergency Department for any self-harm UNLESS there is a physical health need.	Thank you for your comment.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	19	19 - 21	1.6.14 – outwith the remit of any Liaison team or mental health team to change. The majority of Emergency Departments are chaotic, busy, and badly designed without any 'safe' space for patients to remain pending assessment, still good to see as a recommendation. Emergency Departments/ acute hospitals could	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be

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				consider as part of their overall mental health strategy.	considered by NICE where relevant support activity is being planned.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	25 and general	12 - 14 and general	1.9.1-2 "within 48 hours of the psychosocial assessment after an episode of self-harm, provide initial aftercare from the mental health team, GP or team who carried out the psychosocial assessment." General comment re. workforce implications: The proposed psychosocial assessment including family members will have an impact on the time taken to assess in the Emergency Department (and in other settings) which will have a knock-on effect on workforce – the majority of Liaison and Crisis teams are functioning at the very limit of their capacity with the current demand on services, and there are significant recruitment and retention issues in Liaison teams across the country. Our Liaison consultants and Liaison nursing staff were in favour or the recommendations on time taken to	Thank you for your comment. The committee acknowledge that this recommendation may be difficult to achieve. Therefore, it has been amended to state that whilst everyone should have aftercare following an assessment, this only needs to be provided within the 48 hour timeframe where there are ongoing concerns about their safety. Any adjustments that are needed to KPIs as a result of this guideline will be a matter for local implementation.

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				assess, 48-hour follow up, and the suggested thoroughness of the psychosocial assessment, including family members where feasible. However, the concerns about workforce implications are very real. This will also have an impact on the majority of Liaison teams' KPIs – to assess within 1 hour of referral and have an 'onward plan' within 4 hours of the initial presentation at the Emergency Department for every presentation for every patient following every episode of self-harm will inevitably result in breaches, not just of these KPIs but of the Emergency Department 4-hour standards without significant investment in Liaison teams across the country.	
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	29	6 - 8	1.11.1 – "Ensure continuity of care…in the staff caring for people who have self-harmed by minimising the number of different staff they see." – problematic with how services are currently set up. By their nature, patients who self-harm will see Liaison, then Crisis then CMHT if follow up is required – this will be at the very least	Thank you for your comment. The committee agreed that the benefits of continuity of care for people who have self-harmed (reduced distress while accessing services, improved communication, creation of a therapeutic alliance, building of trust) outweighed potential harms, for example of insecure attachment. Additionally, the committee understands that the person will likely be exposed to different staff due to necessity (e.g.

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				3 services with numerous clinicians involved.	for care and availability reasons) which is why 'minimising the number of different staff they see' has been recommended.
Tees, Esk and Wear Valleys NHS Foundation Trust	Guideline	32	12 -14	1.13.2 – "All staff who work with people of any age who self-harm should have training specific to their role so that they can provide care and treatment outlined in this guideline." – who would be responsible for providing this training?	Thank you for your comment. This will be a matter for local implementation.
The School of Health and Social Care	Evidence Review P	34	15	Thematic Chart of Specialist Staff Skills to be more specific w/r/t 'being strong' for example by stating upskilling in distress tolerance principles/practices	Thank you for your comment. The thematic chart is intended as a resource to briefly provide an overview of the themes and sub-themes at a glance. The GRADE tables provides further detailed information about each sub-theme; please refer to Table 9 for information about the data contributing to the sub-theme 'being strong'. Specific references to distress tolerance practices were not found in the data and therefore cannot be included in the description of the sub-theme.

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The School of Health and Social Care	Guideline	General	General	The guidance is said to be for all professionals who come across self harm, yet the guidance appears to be more specific towards those working in specialist services. Maybe additional guidance needed that is specific for non specialists who come across self harm.	Thank you for your comment. The guideline covers 7 settings in addition to mental health services and there are 2 sections specific to non-specialist mental health professionals.
The School of Health and Social Care	Guideline	5	6	Needs link to the definition of self harm here.	Thank you for your comment. Text has been added to clarify that in the guideline, 'self-harm' is defined as intentional self-poisoning or injury irrespective of the apparent purpose of the act.
The School of Health and Social Care	Guideline	5	General	Where it states 'as appropriate', a link/ cross reference to the actual meaning of as appropriate.	Thank you for your comment. It is not possible to define 'as appropriate' as this will vary from situation to situation and should be down to clinical judgment to decide.
The School of Health and Social Care	Guideline	7	18	Be helpful to give instructions of how staff could do this.	Thank you for your comment. The committee's view was that all health and social care staff need to be aware of the principles surrounding capacity, appropriate to their role and position in the organisation. Assessment of capacity is not the focus of this guideline and so making detailed recommendations about how to assess capacity is outside the scope.

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The School of Health and Social Care	Guideline	7	22	Refers to 'All health and social care professionals who have contact with children and young people who self-harm should be able to' do a number of things… see below	Thank you for your comment. We have responded to your related comments individually.
The School of Health and Social Care	Guideline	7	7-18	Non specialist services may not consider these points to be relevant to their professional roles	Thank you for your comment. The committee's view was that all health and social care staff need to be aware of the principles surrounding capacity, appropriate to their role and position in the organisation.
The School of Health and Social Care	Guideline	8	4	Non mental health service practitioners would not have the right to apply the Mental Health Act, therefore understanding how to apply it will not be particularly relevant to them.	Thank you for your comment. This recommendation intends that all health and social care staff should have an understanding of the overarching principles of these pieces of legislation, appropriate to their role and position in the organisation, and how to apply them (not in depth knowledge of the duties and powers contained in the legislation). At this level the Mental Health Act 2007 is applicable to all health and social care staff.
The School of Health and Social Care	Guideline	8	13	Limits of confidentiality could be cross referenced with link to page 41 line 9.	Thank you for your comment. The box at the bottom of this section links to the page you are referring to.
The School of Health and Social Care	Guideline	8	10, 13, 16, 20	Refers to what 'staff' should do and this appears broad and generic. Some points sets standards that may be unachievable.	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that

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					should be expected, and to encourage commissioners to fund services to meet these standards. The committee did not add a timescale to accommodate the variation in practice that does exist across the country.
The School of Health and Social Care	Guideline	9	24	There is no specific reference to children or young people and advice for parents	Thank you for your comment. The guideline did look for evidence for specific subgroups but did not find any evidence about family members/carers of under 16s. Therefore it is not possible to make specific recommendations for this group.
The School of Health and Social Care	Guideline	9	General	Where there is guidance to do something, more specific guidance on how to would be helpful.	Thank you for your comment. NICE guidelines are not intended to provide fully comprehensive recommendations on all aspects of care, but to make recommendations to address areas of uncertainty or variation in practice.
The School of Health and Social Care	Guideline	10	11	'the balance between autonomy (in young people, their developing independence and maturity)' In respect of this guideline, there is a need to consider children and young people under the age of 14 who would not apply to Gillick/ Fraser competence and the rule around parental responsibility for those children.	Thank you for your comment. We have added children to the brackets to make it clearer that this applies to all under 18. A cross reference to section 1.2 has been added, which makes recommendations about confidentiality and consent, including Gillick competence.
The School of Health and Social Care	Guideline	10	16	Specific advice for non specialist to offer parents of children who have self harmed	Thank you for your comment. We have added children to the brackets to make it clearer that this applies to all under 18. A cross reference to section 1.2 has been added, which makes

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					recommendations about confidentiality and consent.
The School of Health and Social Care	Guideline	11	10	'Psychosocial assessment, risk assessment and care by specialist mental health professionals', Non specialists may think this section is not directed to them but only mh specialists. It may deter non specialists from believing they are capable of performing a psychosocial assessment. Perhaps we need to build confidence of non specialists also who could ask psychosocial questions for assessment and give a specific guide to them to help them do this.	Thank you for your comment. Sections 1.7 and 1.8 give guidance about the types of assessment and care non-specialists can offer a person who has self-harmed. However, it was the committee's view that the full psychosocial assessment should be conducted by a trained mental health professional.
The School of Health and Social Care	Guideline	11	13	'At the earliest opportunity after an episode of self-harm, a specialist mental health professional should carry out a psychosocial assessment'	Thank you for your comment, but it is not clear what change you are requesting.
The School of Health and Social Care	Guideline	12	3	It is good advice to not delay assessment due to blood alcohol levels	Thank you for your comment.
The School of Health and Social Care	Guideline	14	23	There is a policy in Wales that's states all children under 16 who present at A&E having self harmed, should be admitted to a ward until they are reviewed by Psychiatric team.	Thank you for your comment. NICE guidance is specifically written for England. Other devolved administrations have different agreements regarding how NICE guidance applies to or will be used within their areas. Therefore we have only referred to English legislation and policy.

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The School of Health and Social Care	Guideline	14	8 & 12	In line 12 it asks for people over 65 to be assessed by specialist yet does not specify this for children and young people in line 8.	Thank you for your comment. The recommendation has been amended in line with your suggestion.
The School of Health and Social Care	Guideline	15	18	For risk assessment tolls, it tells you what not to do, but doesn't stipulate what to do.	Thank you for your comment. The committee agreed that in general, risk assessment has become unhelpful in many settings, and risk and prediction needs to be reframed as assessing a person's individual needs and safety, including their strengths and vulnerabilities. The committee discussed the fact that health and social care staff may be concerned about how to assess without these tools, but agreed that risk tools and scales are unlikely to give an accurate answer regarding prediction/ risk of harm anyway. Instead, the committee outlined a number of principles and considerations in the recommendations, to help staff identify pertinent questions to ask in order to assess the person's needs as well as how to support their immediate and long term safety. An additional recommendation (1.6.5) has been added to the risk assessment tools and scales section to clarify this.
The School of Health and Social Care	Guideline	16	10	Clarification regarding the meaning of 'negotiation'	Thank you for your comment. The term 'negotiation' means discussion aimed at reaching an agreement. The committee think readers of the guideline would be familiar with this term and it does not need further clarification.

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The School of Health and Social Care	Guideline	17	12	The phrase 'with agreement' may lead to confusion between professionals are to what is necessary to share to ensure collaborative working.	Thank you for your comment. This has been amended to 'consent'.
The School of Health and Social Care	Guideline	18	3	Positive to see this included within guidelines. However, it is felt that the guidelines need to be more specific. E.g. line 6 says discuss with the person the best way that the ambulance service can help them. However, the person may not know how they need to be helped and would like that guidance from the paramedic. There needs to be an additional guideline that encourages all ambulance staff to receive training and education about self harm and the services that they can be referred on to. Ideally this could be delivered and shared practice with mental health specialists where the ambulance staff would have the opportunity to discuss / reflect on the self harm that they deal with.	Thank you for your comment. Having a discussion would cover what the ambulance service are able to do to help the person, and any preferences the person would have. The recommendations on training in section 1.14 are aimed at everyone working with people who self-harm and so include ambulance staff.
The School of Health and Social Care	Guideline	19	6	An explicit statement to the effect of not denying (and instead actively offering) analgesia due to the cause of injury and/or to offer analgesia	Thank you for your comment. The committee considered your suggestion but believed this point to be covered in the recommendation that states: Do not use aversive treatment, punitive

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				proactively in the same way to SH patients as to other patients in the A&E setting (anti-stigma provision)	approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes.
The School of Health and Social Care	Guideline	19	7	I think we need to skill up by giving A&E practitioners the guidance of how to carry out a psychosocial assessment, rather than always thinking they need to refer on because 'it is not their business'	Thank you for your comment. The committee agree that every healthcare professional and social care practitioner has a role to play in the assessment and management of people who self-harm, and this is reflected in the recommendations. However the committee do not think it is feasible for every ED professional to be skilled in carrying out full psychosocial assessment as this would have significant training implications.
The School of Health and Social Care	Guideline	20	12	Again, advice is to refer on, which is why staff in general hospitals get frustrated, because there is nowhere to refer on to.	Thank you for your comment. Implementation of the recommendations in this guideline should ensure that the situation you describe is addressed.
The School of Health and Social Care	Guideline	20	21	MH staff will not always be on hand within general hospitals to make joint decisions	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards.
The School of Health and Social Care	Guideline	21	6	I imagine that self harm is extremely prevalent in social care homes. More	Thank you for your comment. The limited evidence in this area means that it is not possible to make more detailed recommendations. The committee

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				guidance on management of self harm would be essential in this section	hope that these general principles will be helpful as well as the recommendations that focus on other settings.
The School of Health and Social Care	Guideline	21	17	Guidance needed for teachers and other non health professionals working with children who self harm in terms of informing parents.	Thank you for your comment. It is not possible to make specific recommendations about informing parents and this would vary depending on the educational setting/policy.
The School of Health and Social Care	Guideline	22	12	As above	Thank you for your comment. It is not possible to make specific recommendations about informing parents and this would vary depending on the educational setting/policy.
The School of Health and Social Care	Guideline	22	13	A link or cross reference to guidance used by staff in educational settings may be helpful	Thank you for your comment. Different education settings may use different guidance so it is not possible to link to any.
The School of Health and Social Care	Guideline	23	14	This point would apply to all those who work with people who pose higher risks, LGBT, LAC, Veterans, etc	Thank you for your comment. This section of the guideline makes recommendations about assessment and care in the criminal justice system and other secure settings. Therefore the recommendations only comment on the higher rates of self-harm and suicide in these settings.
The School of Health and Social Care	Guideline	24	3	What about children and young people under 16?	Thank you for your comment. This recommendation is aimed at anyone who has self-harmed.
The School of Health and Social Care	Guideline	25	1	A Care plan or safety plan/ contract?	Thank you for your comment. The recommendation has been amended to clarify that this relates to a plan for further management.

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The School of Health and Social Care	Guideline	26	13	A statement on the care offered to patients transitioning from CAMHs to Adult services, are they to continue DBT or begin CBT? The change of treatment paradigm may disrupt their care	Thank you for your comment. This has been added to recommendation 1.11.3.
The School of Health and Social Care	Guideline	28	18&19	Some examples be useful here	Thank you for your comment. The committee decided not to include any examples because what is considered to be 'risk-taking' for one person might be standard care for another, and some risk-taking approaches might have a greater potential to cause harm for some people and therefore would not be appropriate for everyone.
The School of Health and Social Care	Guideline	29	7	Maybe not always appropriate if person develops insecure attachment to the professional.	Thank you for your comment. The potential for insecure attachment to professionals has been considered by the committee and training in how to end therapeutic relationships has been recommended for all staff working with people who have self-harmed for this reason. The committee agreed that the benefits of continuity of care for people who have self-harmed (reduced distress while accessing services, improved communication, creation of a therapeutic alliance, building of trust) outweighed potential harms of insecure attachment. Additionally, the committee understands that the person will likely be exposed to different staff due to necessity (e.g. for care and availability reasons) which is why 'minimising the

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					number of different staff they see' has been recommended.
The School of Health and Social Care	Guideline	29	14	Clarification needed for term 'clinical observation' (link to) as it can mean different things to different health care professionals	Thank you for your comment. A definition of observation was already included in the guideline but this has been re-titled to clinical observation for clarity.
The School of Health and Social Care	Guideline	32	11	Yes 100%	Thank you for your comment.
The School of Health and Social Care	Guideline	32	12	Specific training for staff to include upskilling in distress tolerance where appropriate (e.g. regular exposure to SH) for the benefit of the staff member's resilience, confidence and confidence and subsequently the confidence of the service-user in that staff member	Thank you for your comment. Distress tolerance training would only be relevant for certain roles. This is a recommendation about training for all staff and so it is not appropriate to include it here. In addition whilst some qualitative evidence was identified about distress tolerance training it was too limited to base a recommendation on.
The School of Health and Social Care	Guideline	33	19	Excellent addition	Thank you for your comment.
The School of Health and Social Care	Guideline	36	11	Definition of 'Safety Plan' would meet criteria of self-harm care plans from an inpatient MH perspective, so the differentiation between the two seems arbitrary, may lead to task duplication and risk contradiction between documents. There may be value in	Thank you for your comment. The committee agree that there is sometimes overlap between different types of plans. Distinctions are sometimes arbitrary - these terms and how they are used in this guideline are included in the Terms used section.

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				having one plan for the self-harm behaviour	
The School of Health and Social Care	Guideline	44	19	A delay can result in person not receiving appropriate treatment, but if we could skill up/ provide guidance for the health professionals who are coming across self harm regularly then the delay would not be so prominent. There is a wait for services and often self harm is not considered a mental illness and meeting criteria of services, therefore non specialists struggle to signpost/ access services to carry out an immediate psychosocial assessment.	Thank you for your comment. The purpose of the recommendations made in the guideline is to provide guidance for all staff who work with people who self-harm. Implementation of the recommendations in this guideline should reduce the delays experienced by people who have self-harmed. The guideline also recommend that all people who have self-harmed should have a psychosocial assessment.
University College London	Evidence review L	8-9	35-42, 1-4	The committee's decision not to prioritise harm minimisation as a topic for research recommendations is deeply disappointing. Their justification that "very few people who have self-harmed are offered this support" seems very circular. There is low awareness of harm minimisation in clinical services and no trials have been conducted to date. However, the published evidence of acceptability to patients and clinicians (Davies et al., 2020, Holley et al., 2012; Hosie and Dickens, 2018; Preston and West,	Thank you for your comment. A new research recommendation has been added on harm minimisation (please see Appendix K of Evidence Review L for more information).

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				2021) and a perceived need for training amongst clinicians (Haris et al, in submission; Hosie and Dickens, 2018), does suggest that this should be prioritised as a topic for research, and in turn should be prioritised as a topic for research recommendations. One study in a clinical setting has reported that 3% (693 / 22,736) of patients with a history of self-harm in a London mental health trust had been offered harm minimisation (Cliffe et al., 2021). This study examined clinical notes where harm minimisation had been documented however, this is likely to be an underestimate due to a multitude of reasons including 1) harm minimisation may not be asked in routine assessments by clinicians so clinical records may underreport its true prevalence, 2) clinicians may be reluctant to use harm minimisation techniques due to concerns about safety, a lack of local or national guidelines, a lack of training and support, and due to uncertainty around its efficacy, 3) a lack of time or documentation may restrict the	

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				information available on clinical records 4) findings from one London trust are not generalisable to the rest of the UK or population samples. We have also conducted an online survey with clinicians (Bamber et al, in submission) and found that 84% (76/90) had recommend harm minimisation strategies to people in their care who self-harm. Similarly, an online survey we conducted with people who self-harm found 76% (111/146) had used harm minimisation strategies for self-harm. Harm minimisation practices are also being used in some third sector organisations. We conducted a qualitative study with Mind and Body (now called 'With You') (Davies et al, 2020) a charitable organisation that supports young people who self-harm and use harm minimisation strategies. Our analysis of interview transcripts indicates that there is a need and desire from people with lived experience, clinicians and third sector organisations for more research into this topic and guidelines to support its	

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				use. Harm minimisation strategies have been previously driven by user-led organisations such as 'Self-injury Support' and the (now disbanded) 'National Self-Harm Network' (Pembroke 2002). The committee has overlooked the user-led movement toward harm minimisation strategies and contributes to the gap in guidance which leaves people with lived experience of self-harm accessing information on harm minimisation vis word of mouth or online. The committee has focused on the logistical difficulties of conducting randomised controlled trials of harm minimisation approaches. However, the research priorities for harm minimisation could include focusing on assessing the acceptability and perceived effectiveness of harm minimisation for self-harm, using propensity scores to analyse routine data held in electronic health records on patients who self-harm who do and do not receive harm minimisation, or	

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				conducting studies with a cluster randomised stepped-wedge trial design. Davies et al, 2020 https://www.tandfonline.com/doi/abs/10.1080/13811118.2020.1823916 Holley et al, 2012 https://pubmed.ncbi.nlm.nih.gov/22787971/ Hosie and Dickens, 2018 https://onlinelibrary.wiley.com/doi/abs/10.1111/jpm.12498 Preston and West, 2021 https://journals.sagepub.com/doi/abs/10.1177/21677026211049367 Cliffe et al, 2021 https://www.cambridge.org/core/journals/bjpsych-open/article/harm-minimisation-for-the-management-of-selfharm-a-mixedmethods-analysis-of-electronic-health-records-in-secondary-mental-	

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				healthcare/30E5B9D93592C5E48D327AEDB7914792	
University College London	Evidence review L	6	7 - 9	The definition of harm minimisation provided suggests that elastic band pinging and holding ice (substituting for other behaviours) would be an 'alternative' strategy to self-harm. However, in Table 1 (Summary of the PICO table), they state that elastic band pinging is considered a distraction strategy. The definition of harm minimisation and its various subgroups could be more clearly outlined by NICE so there is less confusion and more consistency in how harm minimisation is applied and researched. Not to do so is a missed opportunity. When defining harm minimisation and its categories of strategies it is worth acknowledging that there is no consensus as yet on the categorisation of harm minimisation, and that previous research studies have given rise to a number of similar taxonomies (Wadman et al, 2020; Cliffe et al,	Thank you for your comment. The guideline has been amended to clarify that it does not make any recommendations on the use of safer self-harm. The committee agreed it would not be appropriate to recommend safer self-harm in the absence of good evidence, though they acknowledged other approaches may be helpful and have fewer potential harms. The examples that were initially given in the definition have been removed to clarify these are not specifically being recommended. Instead, the committee agreed to amend the definition to focus on avoiding, delaying or reducing self-harm, to centre the definition of harm minimisation around the aims of the approach rather than giving examples. However, given there is no consensus definition of harm minimisation, no existing quantitative evidence, and no body of work around defining harm minimisation, the committee agreed it would be premature and inappropriate to be more definitive in the terms section without any evidence. Additionally, the examples given in the PICO are taken directly from the review protocol. At the time the protocol was drafted, these examples were used for reference so the technical team knew what kind of studies could be included, this was not

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				2021). Research studies and clinical work continue to identify innovative approaches developed by patients, based on works for them in minimising harm, and taxonomies are likely to evolve as creative new approaches emerge. Clinical services will need to keep abreast of new approaches, as other patients may benefit from having access to a range of methods. Wadman et al, 2020 https://www.tandfonline.com/doi/full/10.1080/13811118.2019.1624669 Cliffe et al, 2021 https://www.cambridge.org/core/journals/bjpsych-open/article/harm-minimisation-for-the-management-of-selfharm-a-mixedmethods-analysis-of-electronic-health-records-in-secondary-mental-healthcare/30E5B9D93592C5E48D327AEDB7914792	intended to be an exhaustive list and was not intended to inform the final recommendations. Studies assessing the effectiveness of any harm minimisation techniques that met the other criteria outlined in the review protocol would have been included if found.
University College London	Evidence review L	8	12 - 31	The critical outcomes identified by NICE demonstrate a discrepancy between the aim of the intervention and how we conceptualise and	Thank you for your comment. Your feedback has been noted and has been used to inform the research recommendations made regarding this area (please see Appendix K of Evidence Review L

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				measure effectiveness for harm minimisation. The 'critical outcomes' identified by the committee were 'frequency of self-harm', 'distress' and 'suicide'. Frequency of self-harm does not align with the primary aim of harm minimisation interventions, which is to reduce the risks associated with self-harm, without necessarily reducing the use of self-harm. This may be appropriate as secondary outcomes, but the critical outcomes should be more consistent with what the intervention is trying to achieve, such as reductions in serious injury, infection or permanent scarring.	for more information). Please note that in light of the lack of evidence, the inclusion of studies which assessed different outcomes would have been considered, however no evidence that otherwise met the inclusion criteria were found.
University College London	Evidence review L	9	24-31	The conclusion that "it would be inappropriate to recommend providing safer self-harm methods to people who have self-harmed, especially in light of a lack of evidence" is an example of why more research is important in this area. In our online survey with people who self-harm and had used harm minimisation strategies (Ball et al., in submission), participants identified learning anatomy as the second most	Thank you for your comment. A new research recommendation has been added on harm minimisation (please see Appendix K of Evidence Review L for more information).

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				recommended harm minimisation strategy, ranked after learning wound care. Although these strategies may not be widely used by clinicians currently, there is mismatch evident between what clinicians recommend and what some people with lived experience find helpful. It is important to investigate whether safer self-harm methods (with clinical support and guidance) are acceptable, effective and feasible to implement, rather than dismissing this as inappropriate. Many people may not be in a position to stop self-harming to manage their distress and a more realistic goal may be to reduce the risks associated with self-harm. However, the current system often excludes them from services for continuing to self-harm. Excluding people who self-harm from support and treatment is inappropriate and could augment their risk. Conversely, practising harm minimisation may serve as an intermediary intervention while therapeutic alliance is developed, and crisis situations are managed. More research is needed to investigate this topic.	

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Voyage Care	Evidence review A	45	27,28	We are concerned on how the decision not to specifically refer to the provision of advice on self-help would impact on people who have no other form of support available to them or feel unable to access it. This may lead to an over reliance on using search engines to seek advice which may result in people accessing information that is at least unhelpful and at worst damaging.	Thank you for your comment. Recommendation 1.1.1 now includes information on self-care and the Committee's Discussion of the Evidence section has been amended accordingly.
Voyage Care	Evidence review A	45	50	This rationale places a lot of emphasis the existing care plan is right for the individual. We agree consistency is important but at the same time it is important to review and evaluate existing care plans.	Thank you for your comment. Recommendations 1.5.6, 1.5.15, 1.5.16, and 1.5.17 address reviewing and amending care plans.
Voyage Care	Evidence review A	46	40	Staff training on how to deal with time constraints will inevitably result in the person feeling rushed however, we would like to add there is evidence to support training on how to achieve successful communication for example non- verbal communication, tone of voice etc. It is important to create a safe space for people to feel able to be open.	Thank you for your comment. Recommendation 1.14.2 includes 'involving people who self-harm in all discussions and allowing sufficient time for decision making about their treatment and subsequent care' and 'communicating compassionately and facilitating engagement with people who have self-harmed, including using active listening skills' as aspects of training for all staff who work with people who have self-harmed.
Voyage Care	Evidence review B	20	34	There is evidence that training on trauma informed approaches can be	Thank you for your comment. The guideline has not explicitly referenced trauma-informed

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				helpful when supporting someone who engages in self-harm.	approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
Voyage Care	Evidence review C	9	42,43	We agree this is an important recommendation and we would like to add advice should be given regarding record keeping of how such decisions are reached to protect professionals, patients and their families.	Thank you for your comment. Good record keeping of decisions made should be part of standard practice and therefore has not been repeated in the guideline recommendations.
Voyage Care	Evidence review C	10	37,38	There is evidence that using trauma informed approaches is effective when dealing with people who are experiencing acute distress. We would recommend this is highlighted in the guidance.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
Voyage Care	Evidence review D	32	47,48	We agree the person should be asked if they want family and friends involved and feel the need to keep this under	Thank you for your comment. Recommendation 1.4.3 refers to a situation in which family members or carers are already being involved, so consent

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				constant review should be emphasised, this includes the individual changing their minds either way i.e. withdraw consent for involvement or give consent for involvement. This is perhaps covered adequately later in the document.	could only be withdrawn and not given again. Recommendation 1.4.1 states that the person's decision should be regularly reviewed, which would apply to scenarios in which consent to include family members or carers has not been given. This has been clarified in the Committee's Discussion of the Evidence of Evidence Review D.
Voyage Care	Evidence review F	12	17,18	The use of trauma informed approaches could be cited here as an important consideration regarding the environment and humanistic approach.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
Voyage Care	Evidence review F	12	31,32	The challenge with developing a protocol for people who leave before they are assessed or any treatment is delivered is the immediacy of the follow up required, is there a system in place to alert out of hours crises teams when this happens? Can this be a recommendation.	Thank you for your comment. What to do in the event someone leaves before an assessment has been provided and there are safety concerns for the person is addressed by recommendations 1.5.14 and 1.10.2.
Voyage Care	Evidence review F	13	30	We feel the guidance section for social care needs to take into consideration the increasing number of people who	Thank you for your comment. The limited evidence in this area means that it is not possible to make more detailed recommendations. The committee

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				self- harm who are living in supported accommodation which is delivered under social care. Whilst there is access to healthcare professionals this varies widely nationally, and often social care staff, majority of whom are not qualified, are solely supporting the person for long periods of time.	hope that these general principles will be helpful as well as the recommendations that focus on other settings.
Voyage Care	Evidence review F	15	14	The use of trauma informed approaches could be cited here as an important consideration regarding the environment and humanistic approach.	Thank you for your comment. The guideline has not explicitly referenced trauma-informed approaches as there is no current developed and tested model for systematised trauma informed interventions that could be recommended. It is currently unknown what the elements of such an intervention would be, as well as how to implement this, or what the potential harms are for patients. However many of the general principles of care included in the guideline would be consistent with trauma-informed care.
Voyage Care	Evidence review G	13	26	We agree with the recommendation for risk formulation but wish to point out this will be challenging given the level of training required for this to become a routine risk intervention.	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.

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West Midlands Ambulance Service	Guideline	General	General	We are concerned that this update to the CG16 and CG133 does not update practice in relation to the management of overdose, and this has been removed from the document to be replaced only with signposts to BNF, Toxbase and NPIS. This weakens the strength of the guidance in this area and lessens the impetus on organisations to work within a safe and holistic framework for the assessment and management of such presentations. As a result this also removes audit and monitoring recommendations.	Thank you for your comment. The scope for the guideline states that this area is explicitly excluded from the update and therefore recommendations have not been made in this area.
West Midlands Ambulance Service	Guideline	General	General	We are concerned that recommendations surrounding the monitoring and clinical audit of patients presenting following self-harm are not included within the document to support the ongoing delivery of safe care and further developments in practice.	Thank you for your comment. Monitoring and clinical audit were not areas that were prioritised for inclusion in the guideline. The evidence in these areas has not been reviewed and therefore no recommendations can be made.
West Midlands Ambulance Service	Guideline	15	19-20	Whilst we welcome the inclusion of a statement that clearly outlines the need to not use risk assessment tools and scales, the inclusion of this within the section relating to specialist management of those who have self-	Thank you for your comment. The committee agree that assessment and care should be based on needs and safety and not risk. These recommendations have been put into their own section (1.6) to clarify that they relate to all staff.

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				harmed may infer that such tools and scales may be used in other areas, including within the ambulance domain. This should be clarified at a higher level within the document.	
West Midlands Ambulance Service	Guideline	18	3-22	We are concerned that the section relating to the ambulance service management of patients presenting following self-harm is extremely limited in its scope in that: • It does not consider and provide guidance to support circumstances where patients do require urgent physical care in the context of self-harm • There is an assumption that where a person is conveyed this will be to the emergency department, and the inclusion of this as part of 1.6.8 infers that this may also occur where no urgent physical care is required. This section fails to recognise the availability of other services to which patients may be conveyed (including crisis assessment services). It also fails to	Thank you for your comment. The committee considered your suggestion but agreed that the points you raise would be a part of training and competencies of ambulance staff and paramedics. NICE guidelines focus on areas that need improvement. Therefore, the committee did not deem it necessary to detail the steps that should be taken by ambulance staff when a person needs urgent physical care. The guideline has been amended to include a new recommendation (1.7.11), in relation to your point regarding the availability of other services. A recommendation (1.7.2) has also been added to the Principles for assessment and care by healthcare professionals and social care practitioners section to highlight that staff need to assess the person's emotional and mental state, and any immediate concerns about self-harm, suicide or safeguarding. In addition, the reference to relaying information to emergency staff has been amended so that it encompasses staff from any relevant service.

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				consider the limitations of emergency departments in delivering the required care to such patients including evidence to support poor patient experience of care delivery in emergency departments, such as that produced by Mind, despite reference to this in this supporting evidence for this section. • The information to be recorded by ambulance staff as described in lines 13-17 does not describe a safe and holistic assessment of need which would provide the assurance of appropriate non-conveyance, in that there is no consideration of wider elements of the patient's mental state, nor any relevant risk factors, including protective factors to support such a clinical decision. • Additionally, the scope of this information does not reflect expectations around the scope	

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				of practice and clinical competencies of staff within the ambulance service, including those described in the Mental Health Core Skills Education and Training Framework. • There is nothing within this section of the guideline to support appropriate safety netting when discharging a patient on scene and referring them to an alternative service. Reference within this section to 1.10.5 and 1.10.6 of the guideline may be beneficial to make clear that appropriate safety planning is required when ambulance staff are referring patients to other services but not conveying them. • There is no recommendation to support the monitoring of frequent self-harm presentations to the ambulance service and multi-disciplinary approaches to care management with mental	

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				health services or other professionals involved in the patient's care, whereas such recommendations are found in other sections of the document. There is no guidance or recommendation to support the assessment and management of children presenting with self-harm needs to the ambulance service.	
West Sussex County council	Evidence review A	44	22 - 26	additional training is required for staff to ensure that staff are culturally competent	Thank you for your comment. Recommendation 1.14.2 includes 'being culturally competent through respecting and appreciating the cultural contexts of people's lives' as an aspect of training for all staff who work with people who have self-harmed.
West Sussex County council	Guideline	General	General	In the contents sections 10 and 28 refer specifically to non-health and social care professionals. Are we to assume that all other areas are not recommendations or expectations of said non health care professionals? Further clarification or explanation within the document would be beneficial.	Thank you for your comment. Text has been added to the start of the guideline to clarify that the recommendations apply to staff from all sectors that work with people who have self-harmed, unless a recommendation or section specifically states that it is for a certain group.
West Sussex County council	Guideline	5	11	There are a number of different services/schools using different forms of care and safety plans. Would the expectation be that within the training	Thank you for your comment. How this will be delivered will be a matter for local implementation.

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				to schools' staff there is one care/safety plan template that is to be used within your local authority?	
West Sussex County council	Guideline	6	13	I am not sure this is something that our education staff would necessarily know – would the expectation be that all staff in schools are made aware of formal assessments (care assessments) for parents/carers and are fully confident in signposting effectively. This is listed within information and support and is this relevant to all stakeholders or just MH professionals.	Thank you for your comment. The committee would expect that the general principles of the things contained within this recommendation should be known by staff across all sectors so that they can provide this information. However, they do not expect all staff to have detailed knowledge in all the areas - the level of detail should be commensurate with the individual's role. Education providers are moving towards providing mental health support in every school and so the committee would expect someone within a school setting to know about carers assessment. This may be the designated lead referenced in section 1.8.
West Sussex County council	Guideline	7	1	1.1.4 - the requirement for adapted information may present as a challenge, for example, for those who are sight impaired and/or have a learning disability	Thank you for your comment. Adapting information for those who need it would be in line with the NHS Accessible Information Standard.
West Sussex County council	Guideline	8	10	We may see a capacity issue here with how long it may take for the school staff to be able to access this support after initial enquiry for help. This is listed within consent, is this relevant to all stakeholders or just MH professionals.	Thank you for your comment. The committee agreed that it was important that all staff working with people who self harm have access to specialist advice and legal advice if there are issues relating to capacity and consent. They considered that systems should already be in place to get specialist advice at all times. The wording of

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					the recommendation has been amended to clarify that access to legal advice would be 'as needed' rather than 'at all times'
West Sussex County council	Guideline	9	18	1.3.2 – This is currently under way with our A&E & education care plan pathway however it may take a significant time develop a pathway for all local health and social care pathways...	Thank you for your comment. It is encouraging to hear that your organisation is setting standards similar to the recommendations the guideline has made.
West Sussex County council	Guideline	11	4	–1.4.5 - This recommendation implies that all staff working within educational setting will have the confidence and competency to deliver methods of nonverbal communication. To note that this will take additional resource to ensure all feel capable of communicating non-verbally.	Thank you for your comment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards.
West Sussex County council	Guideline	21	1	this may not be the case over the weekend? – what would the expectations be in this scenario? Would this be for all YP or the ones that need assessment and further intervention ?	Thank you for your comment. It is the intention of the recommendations that every person that has self-harmed that has been admitted to a general hospital ward should have a psychosocial assessment. The committee appreciates that it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be

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					considered by NICE where relevant support activity is being planned.
West Sussex County council	Guideline	26	16	Is the expectation through these recommendations that all staff have knowledge on how to create a safety plan with a child and young person or that that this is competed by the designated lead within each school? – more understanding around this would help us to develop and implement training appropriately across our educational settings	Thank you for your comment. The committee agreed this recommendation is for all staff because it can be appropriate for a number of different healthcare, social care, and staff from other sectors to develop a safety plan with the person. The committee acknowledged there may be settings or situations where it may not be realistic or appropriate to develop a safety plan in the moment, however they did not want to limit the settings in which a safety plan could be offered
West Sussex County council	Guideline	28	6	Although there is a guide on when to consider harm minimisation strategies, we, as a county council would like a specific statement here that clearly states harm minimalization techniques such as how to self-harm safely should not be recommended in isolation between a staff member working with the education sector and a child and/or young person. As this is our current understanding of harm minimisation. If this is not the case we feel there should be more in depth guidance on when and how this is an appropriate form of intervention delivered by a non-clinical professional	Thank you for your comment. The wording of the recommendation has been amended to clarify that mental health professionals should be discussing harm minimisation strategies. The definition of how harm minimisation is used in this guideline has also been amended to clarify that it does not include safe ways to self-harm.

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West Sussex County council	Guideline	33	15	1.13.4 - Does this/should this also include staff working in educational settings who have witnessed or witness young people engaging in self-harming behaviours within the school setting? – is this section universal?	Thank you for your comment. This recommendation is intended to apply to all staff who are observing. The wording has been changed to reflect this.
West Sussex County council	Guideline	33	20	1.14.1 - This would be ideal but may prove to be a capacity issue within our local authority	Thank you for your comment. The committee appreciates that, for some services, it may be a challenge to implement the recommendations with the current funding and staffing levels. However, it is the role of NICE guidelines to set the standards of care that should be expected, and to encourage commissioners to fund services to meet these standards. Implementation issues will be considered by NICE where relevant support activity is being planned.
West Sussex County council	Guideline	33	20	1.14.1 - Is this an expectation of all staff i.e. non mental health professional, designated lead, pastoral school staff and if so there may be capacity and staffing/resource issues? Currently school staff receive limited supervision.	Thank you for your comment. The committee agreed it is very important that all staff have the opportunity for supervision so that they can be provided with appropriate and effective support. Most staff will already have a supervisor in place who can do this. The recommendation does not specify the form or frequency of the supervision, nor does it require the supervisor to have in-depth knowledge related to self-harm; providing support could be at the level of sign-posting to external resources. The committee recognise that some additional information may need to be provided as a result of the recommendation but do not consider

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					that this would have significant resource implications, although there may be some cost implications across different settings. Potential resource implications of the guideline were considered by NICE when preparing the guideline's Resource impact summary report.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*