consistent health practitioner, build up trust and to consider alternative methods for coping with intense psychological distress, while other conditions (such as depression and PTSD) are treated according to evidence-based guidelines. I could find no significant entry throughout his medical records that indicated that this approach was pursued to any meaningful extent. The response to his self-harm was to try and remove items with which he might self-harm, e.g. placing him in ligature free environments. Faced with a lack of available methods, Mr D1527 then took to limiting his dietary intake as a way of self-harming.

16.9.5. NICE guidance (Longer-term management of self-harm: assessment and treatment, 13 April 2017) indicates the following principles for health and social care professionals working with people who self-harm:

i. aim to develop a trusting, supportive and engaging relationship with them
ii. be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
iii. ensure that people are fully involved in decision-making about their treatment and care
iv. aim to foster people's autonomy and independence wherever possible
v. maintain continuity of therapeutic relationships wherever possible
vi. ensure that information about episodes of self-harm is communicated sensitively to other team members.

16.9.6. The NICE guidance also includes best practice notes when working with people who self-harm for whom there may be a language barrier, e.g. providing them information in their preferred language, using independent interpreters, and providing psychological or other interventions in the person's preferred language. Interventions to be considered according to NICE guidance include offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm with the aim of reducing self-harm.

16.9.7. The principles and recommendations noted above are broad but, from the evidence made available to me, it does not appear that the IRC and its staff have met this guidance.

16.9.8. The same NICE document makes recommendations in relation to the training that staff should receive if required to manage individuals who present having self-harmed. This, unfortunately, would not be an unusual presentation for those detained in IRCs and, as the evidence indicates, there is little to suggest that staff had been trained or, if they had, that that training was objectively assessed to be effective.

16.10. Feigning or exaggeration

16.10.1. I note Dr Thomas' opinion in relation to psychological credibility factors and I agree entirely with her view in this regard. I am also mindful of the adverse credibility findings