Effectiveness of systemic family therapy versus treatment as usual for young people after self-harm: a pragmatic, phase 3, multicentre, randomised controlled trial


Summary

Background Self-harm in adolescents is common and repetition occurs in a high proportion of these cases. Scarce evidence exists for effectiveness of interventions to reduce self-harm.

Methods This pragmatic, multicentre, randomised, controlled trial of family therapy versus treatment as usual was done at 40 UK Child and Adolescent Mental Health Services (CAMHS) centres. We recruited young people aged 11–17 years who had self-harmed at least twice and presented to CAMHS after self-harm. Participants were randomly assigned (1:1) to receive manualised family therapy delivered by trained and supervised family therapists or treatment as usual by local CAMHS. Participants and therapists were aware of treatment allocation; researchers were masked. The primary outcome was hospital attendance for repetition of self-harm in the 18 months after group assignment. Primary and safety analyses were done in the intention-to-treat population. The trial is registered at the ISRCTN registry, number ISRCTN59793150.

Findings Between Nov 23, 2009, and Dec 31, 2013, 3554 young people were screened and 832 eligible young people consented to participation and were randomly assigned to receive family therapy (n=415) or treatment as usual (n=417). Primary outcome data were available for 795 (96%) participants. Numbers of hospital attendances for repeat self-harm events were not significantly different between the groups (118 [28%] in the family therapy group vs 103 [25%] in the treatment as usual group; hazard ratio 1.14 [95% CI 0.87–1.49] p=0.33). Similar numbers of adverse events occurred in both groups (787 in the family therapy group vs 847 in the treatment as usual group).

Interpretation For adolescents referred to CAMHS after self-harm, having self-harmed at least once before, our family therapy intervention conferred no benefits over treatment as usual in reducing subsequent hospital attendance for self-harm. Clinicians are therefore still unable to recommend a clear, evidence-based intervention to reduce repeated self-harm in adolescents.

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Introduction Self-harm in adolescents is a global public health problem, with 10% of adolescents self-reporting self-harm within the past year and suicide the second commonest cause of death in young people aged 10–24 years, after road traffic accidents. Self-harm in adolescents has serious consequences, and those who self-harm have a four times greater risk of death from any cause and a ten times greater risk of suicide than the general population, indicating potentially avoidably high burdens of life-years lost and family and peer distress. Non-fatal repetition occurs in 18% of people who self-harm, according to a recent large multicentre study in England. A single effective intervention has not been identified. A recent systematic review and meta-analysis of 19 randomised controlled trials with 2176 participants found a small overall effect of three specific interventions (dialectical behaviour therapy, mentalisation-based therapy, and cognitive behavioural therapy) on repetition of self-harm. Studies with strong family involvement and substantial treatment dose showed significant reductions in self-harm events. A recent large, retro-spective, registry-based matched cohort study (n=5678) showed lower long-term risk of self-harm in people receiving psychosocial treatments compared with those who did not, but numbers needed to treat were large. Family factors (parent–child interaction, perceived support, expressed emotion, experience of abuse, parental conflict, and parental mental health) are important risk factors associated with self-harm in children and adolescents. Family therapy aims to draw on and mobilise the existing strengths and resources of the child and family and is therefore a logical potential intervention after self-harm.
This trial, termed the Self-Harm Intervention: Family Therapy (SHIFT) trial, reports on a new form of family therapy intervention for self-harm. The trial was done in response to a call by the National Institute for Health Research Health Technology Assessment programme for a study investigating the clinical effectiveness and cost-effectiveness of family therapy for adolescents who self-harm (HTA 07/33). We aimed to assess the effectiveness of family therapy compared with treatment as usual in reducing self-harm repetition in young people.

Methods
Study design and participants
This study is a pragmatic, multicentre, individually randomised, controlled trial of family therapy versus treatment as usual, done at 40 UK National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) in 15 NHS trusts in the UK across Greater Manchester, London, and Yorkshire. The study was approved by the UK NHS National Research Ethics Service in April, 2009 (09/H1307/20), and the protocol is published online.19

Eligible adolescents were aged 11–17 years, living with a primary caregiver (who was willing to take part), and had self-harmed at least twice before being referred to CAMHS for self-harm (index episode). If the self-harm event was caused by alcohol or recreational drugs, the young person had to have stated that they were intending self-harm by use of these substances. In common with UK, European, and Australian practice,2 we defined self-harm as any form of intentional non-fatal self-poisoning or self-injury (eg, cutting, taking excess medication, hanging, self-strangulation, jumping from height, and running into traffic) regardless of suicidal intent; this includes US definitions of non-suicidal self-injury and suicidal behaviour. Exclusion criteria were serious risk of suicide, an ongoing child protection investigation in the family, pregnancy at time of trial entry, usual treatment by a specific specialist service within CAMHS, residence in a short-term foster home, moderate to severe learning disabilities, pregnancy, serious mental illness, serious substance misuse, having self-harmed at least once before, sibling participation in the trial or treatment with family therapy within CAMHS, and insufficient proficiency in English language of either the young person or caregiver to complete study questionnaires (appendix). All patients and carers gave written informed consent to participate in the trial.

Randomisation and masking
Participants were randomly assigned sequentially to receive family therapy or treatment as usual (1:1) via a

For the SHIFT protocol see http://www.trialjournal.com/content/10/1/20
See Online for appendix

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