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

David J Cottrell, Alexandra Wright-Hughes, Michelle Collinson, Paula Boston, Ivan Eisler, Sarah Fortune, Elizabeth H Graham, Jonathon Green, Allan O House, Michael Kerfoot, David W Owens, Eirini-Christina Saloniki, Mima Simic, Fiona Lambert, Justine Rothwell, Sandy Tubeuf, Amanda J Farrin

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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Leeds Institute of Health Sciences (Prof D J Cottrell FRCpsych, P Boston MSW, S Fortune PhD, Prof A O House DM, D W Owens MD, F Lambert PGDip, S Tubeuf PhD) **and Clinical Trials Research Unit** (A Wright-Hughes MSc, M Collinson MSc, E H Graham BA, Prof A J Farrin MSc), **University of Leeds, Leeds, UK; Department of Child and Adolescent Psychiatry, Institute of Psychiatry, Psychology and Neurological Science, Kings College London, London, UK** (Prof I Eisler PhD); **Division of Neuroscience and Experimental Psychology, School of Biological Sciences, University of Manchester, Manchester, UK** (Prof J Green FRCPsych, J Rothwell PhD, Prof M Kerfoot PhD*); **South London and Maudsley NHS Foundation Trust, London, UK** (M Simic MD); **Royal Manchester Children's Hospital, Manchester, UK** (Prof J Green); **and Centre for Health Services Studies and Personal Social Services Research Unit, University of Kent, Canterbury, UK** (E-C Saloniki PhD)

*Prof Kerfoot died in June, 2013

Correspondence to: Prof David J Cottrell, Leeds Institute of Health Sciences, School of Medicine, University of Leeds, Leeds LS2 9NL, UK **d.j.cottrell@leeds.ac.uk**

Introduction

Self-harm in adolescents is a global public health problem, with 10% of adolescents self-reporting self-harm within the past year[1] and suicide the second commonest cause of death in young people aged 10–24 years, after road traffic accidents.[2] 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,[2–4] 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.[5]

A single effective intervention has not been identified.[6] 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.[7] Studies with strong family involvement and substantial treatment dose showed significant reductions in self-harm events.[7–9] 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.[10]

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.[11] 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.[12]

Research in context

Evidence before this study

We searched electronic databases Embase, MEDLINE, PsycINFO, and the Cochrane Database of Systematic Reviews for randomised controlled trials of interventions to address self-harm in people younger than 18 years in which the primary outcome was reduction in self-harm. We included trials published up to March 31, 2007, in any language. Because of the varied nomenclature used in self-harm research, our search used several keywords for self-harm and associated behaviours as follows: "self-harm" OR "deliberate self-harm" OR "suicide" OR "attempted suicide" OR "overdose" OR "suicidal behaviour" OR "drug overdose" OR "self-poisoning" OR "self-injurious behaviour" OR "self-injury" OR, "non-suicidal self-injury" OR "self-destructive behaviour" OR "self-inflicted wounds" OR "self-mutilation" OR "suicidal ideation". We screened abstracts to retrieve full-text articles for assessment of eligibility, and checked reference lists of relevant studies and reviews for additional references.

We identified one trial of a token allowing readmission to hospital, which found no effect, and one trial of group therapy for adolescents, but no other studies in young people (aged 18 years or younger) with a primary outcome of reduction in repetition of self-harm (subsequent replication of the group therapy study did not find a positive effect of group therapy). We identified two studies of family interventions related to self-harm, a study in people with depression that reported suicidal ideation as a secondary outcome, and a study of a home-based intervention designed to improve family communication, powered to detect between-group differences in suicidal ideation, not repeat self-harm.

Added value of the study

We found no evidence that, for adolescents referred to Child and Adolescent Mental Health Services (CAMHS) for self-harm, having self-harmed at least once before, the trial's manualised systemic family therapy conferred any benefits over treatment as usual in reducing subsequent hospital admission for self-harm. Interpretation of health economic and secondary outcomes was limited by significant loss to follow-up, but our data suggest possible significant improvements in secondary clinical outcomes, such as extent of emotional and behavioural problems, and the possibility of cost-effectiveness when considering combined benefits to the caregiver and young person together.

Interpretation

For adolescents referred to CAMHS after self-harm, having self-harmed at least once before, SHIFT family therapy conferred no benefits over treatment as usual in reducing subsequent hospital attendance for self-harm. Young people who self-harm form a varied and heterogeneous group, and self-harm is likely to be the final common pathway for a wide range of problems. Further research is needed to develop a more personalised approach and to identify which interventions are most helpful for which young people.

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.[13]

For the **SHIFT protocol** see http://www.trialsjournal.com/content/16/1/501

See Online for appendix

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, involvement in another study within the 6 months before entry into this trial, 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

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