APPENDIX 17A – GRADE EVIDENCE PROFILES FOR PSYCHOSOCIAL INTERVENTIONS

7.1.2a

Question: Should Psychological therapy versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Psychological therapy	TAU	Relative (95% CI)	Absolute		
Per protocol repetition of DSH 0-6 months												
3	randomised trials	no serious limitations	no serious inconsistency	serious[1,2]	serious[3]	none	8/93 (8.6%)	22/78 (28.2%)	RR 0.33 (0.15 to 0.72)	189 fewer per 1000 (from 79 fewer to 240 fewer)	⊕⊕OO LOW	CRITICAL
								27.9%		187 fewer per 1000 (from 78 fewer to 237 fewer)		
Per protocol repetition of DSH 6-12 months												
5	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness[4]	serious[5]	none	148/537 (27.6%)	165/530 (31.1%)	RR 0.89 (0.76 to 1.06)	34 fewer per 1000 (from 75 fewer to 19 more)	⊕⊕⊕O MODERATE	CRITICAL
								24.4%		27 fewer per 1000 (from 59 fewer to 15 more)		
Per protocol repetition of DSH over 12 months												
2	randomised trials	no serious limitations	no serious inconsistency	serious[1]	serious[3]	none	16/57 (28.1%)	27/48 (56.3%)	RR 0.5 (0.31 to 0.82)	281 fewer per 1000 (from 101 fewer to 388 fewer)	⊕⊕OO LOW	CRITICAL
								53.8%		269 fewer per 1000 (from 97 fewer to 371 fewer)		
Per protocol repetition of DSH last follow up (follow-up 0-18 months)												
9	randomised trials	no serious limitations	no serious inconsistency[6]	serious[1,2]	no serious imprecision	none	172/675 (25.5%)	211/648 (32.6%)	RR 0.76 (0.61 to 0.96)	78 fewer per 1000 (from 13 fewer to 127 fewer)	⊕⊕⊕O MODERATE	CRITICAL
								27.9%		67 fewer per 1000 (from 11 fewer to 109		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

										fewer)		
Depression scores at 6 months (Better indicated by lower values)												
4	randomised trials	no serious limitations	serious[7]	no serious indirectness[4]	serious[5]	none	332	328	-	SMD 0.33 lower (0.71 lower to 0.05 higher)	⊕⊕OO LOW	IMPORTANT
Depression scores at 12 months (Better indicated by lower values)												
5	randomised trials	no serious limitations	serious[8]	no serious indirectness[4]	serious[5]	none	329	327	-	SMD 0.54 lower (1.01 to 0.07 lower)	⊕⊕OO LOW	IMPORTANT
Depression scores over 12 months (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	serious[1]	serious[5]	none	114	111	-	SMD 0.22 lower (0.48 lower to 0.05 higher)	⊕⊕OO LOW	IMPORTANT
Depression scores at last follow up (Better indicated by lower values)												
7	randomised trials	no serious limitations	serious[7]	serious[1,2]	no serious imprecision	none	441	437	-	SMD 0.43 lower (0.73 to 0.12 lower)	⊕⊕OO LOW	IMPORTANT
Hopelessness scores during 0-6 months (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[9]	none	83	66	-	SMD 0.52 lower (0.86 to 0.18 lower)	⊕⊕⊕O MODERATE	IMPORTANT
Hopelessness scores at 12 months (Better indicated by lower values)												
2	randomised trials	no serious limitations	serious[7]	serious[1]	serious[9]	none	61	60	-	SMD 0.7 lower (1.76 lower to 0.35 higher)	⊕OOO VERY LOW	IMPORTANT
No. of participants with improved problems at 4 months												
2	randomised trials	no serious limitations	no serious inconsistency	serious[1]	serious[3]	none	99/119 (83.2%)	72/112 (64.3%)	RR 1.28 (1.09 to 1.49)	180 more per 1000 (from 58 more to 315 more)	⊕⊕OO LOW	IMPORTANT
								61.3%		172 more per 1000 (from 55 more to 300 more)		
No. of participants with improved problems at last follow up												
2	randomised trials	no serious limitations	serious[8]	serious[1]	serious[3,5]	none	88/103 (85.4%)	66/108 (61.1%)	RR 1.32 (0.89 to 1.96)	196 more per 1000 (from 67 fewer to 587 more)	⊕OOO VERY LOW	IMPORTANT
								64.5%		206 more per 1000 (from 71 fewer to 619 more)		
Suicide ideation scores during 0-6 months (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	serious[1,2]	serious[9]	none	80	62	-	SMD 0.54 lower (0.92 to 0.16 lower)	⊕⊕OO LOW	IMPORTANT
Suicides at last follow up												
8	randomised					none	2/532 (0.38%)	7/511	not pooled	not pooled		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

	trials							(1.4%)				
								0%		not pooled		

[1] Treatment conducted in different settings (home or outpatient); No. of sessions varies
[2] Also, treatment modalities differ across studies (Problem-solving; Psychodynamic interpersonal; Cognitive behavioural therapies)
[3] Total sample size is lower than 300 participants
[4] Majority outpatient based treatments
[5] Not statistically significant
[6] 30% heterogeneity
[7] Moderate heterogeneity (50 to 79%)
[8] High heterogeneity (over 80%)
[9] Total sample size is lower than 400 participants

7.1.2b(i)

Question: Should Intensive intervention versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Intensive intervention	TAU	Relative (95% CI)	Absolute		
Per protocol repetition of DSH at last follow up												
2	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	25/125 (20%)	28/120 (23.3%)	RR 0.67 (0.18 to 2.49)	77 fewer per 1000 (from 191 fewer to 348 more)	⊕⊕OO LOW	CRITICAL
								15.8%		52 fewer per 1000 (from 130 fewer to 235 more)		
Suicides during F/U												
1	randomised trials					none	3/76 (3.9%)	1/74 (1.4%)	RR 1.24 (0.21 to 7.3)	3 more per 1000 (from 11 fewer to 85 more)		CRITICAL
								1.4%		3 more per 1000 (from 11 fewer to 88 more)		
Attendance at treatment at 12 mths												
1	randomised trials					none	119/140 (85%)	64/143 (44.8%)	not pooled	not pooled		
								44.8%		not pooled		
Attendance (Better indicated by lower values)												
1	randomised trials					none	140	134	-	not pooled		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

Depression (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[2,3]	none	94	50	-	SMD 0.31 lower (0.66 lower to 0.03 higher)		
Hopelessness (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[2,3]	none	94	50	-	SMD 0.26 lower (0.61 lower to 0.08 higher)		

[1] Moderate heterogeneity (50-79%)
[2] Not statistically significant
[3] Total sample size is lower than 400 participants

7.1.2b(ii)

Question: Should Emergency card versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Emergency card**	**TAU**	**Relative (95% CI)**	**Absolute**		
Repetition of DSH at 12 months												
2	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	95/518 (18.3%)	89/521 (17.1%)	RR 0.83 (0.35 to 1.97)	29 fewer per 1000 (from 111 fewer to 166 more)	⊕⊕OO LOW	
								14.8%		25 fewer per 1000 (from 96 fewer to 144 more)		
Suicides												
2	randomised trials					none	2/518 (0.39%)	1/521 (0.19%)	not pooled	not pooled		
								0.1%		not pooled		

[1] Moderate heterogeneity (50-79%)
[2] Not statistically significant

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

7.1.2b(iii)

Question: Should Telephone contact versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Telephone contact	TAU	Relative (95% CI)	Absolute		
Suicide at last follow up												
2	randomised trials					none	2/400 (0.5%)	3/421 (0.71%)	not pooled	not pooled		
								0.8%		not pooled		
Repetition of DSH - Between 3-12 months												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	34/253 (13.4%)	74/421 (17.6%)	RR 0.72 (0.45 to 1.16)	49 fewer per 1000 (from 97 fewer to 28 more)	⊕⊕⊕O MODERATE	
								18.9%		53 fewer per 1000 (from 104 fewer to 30 more)		
Repetition of DSH - Between 1-12 months												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	38/254 (15%)	74/421 (17.6%)	RR 0.95 (0.48 to 1.87)	9 fewer per 1000 (from 91 fewer to 153 more)	⊕⊕⊕O MODERATE	
								13.8%		7 fewer per 1000 (from 72 fewer to 120 more)		
Attendance (at least once during 12 months follow up)												
1	randomised trials					none	60/83 (72.3%)	58/89 (65.2%)	not pooled	not pooled		
								65.2%		not pooled		

[1] Not statistically significant

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

7.1.2b(iv)

Question: Should Postcards plus TAU versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Postcards plus TAU	TAU	Relative (95% CI)	Absolute		
Repetition of DSH - During 12 months after study												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	98/531 (18.5%)	115/568 (20.2%)	RR 0.92 (0.73 to 1.18)	16 fewer per 1000 (from 55 fewer to 36 more)	⊕⊕⊕O MODERATE	
								22.1%		18 fewer per 1000 (from 60 fewer to 40 more)		
Repetition of DSH - After 24 months after study												
1	randomised trials	no serious limitations			serious[1]	none	80/378 (21.2%)	90/394 (22.8%)	RR 0.93 (0.71 to 1.21)	16 fewer per 1000 (from 66 fewer to 48 more)		
								22.8%		16 fewer per 1000 (from 66 fewer to 48 more)		
Suicide - During 12 mths after study												
1	randomised trials	no serious limitations				none	2/378 (0.53%)	4/394 (1%)	not pooled	not pooled		
								0%		not pooled		
Suicide - After 24 mths after study												
1	randomised trials					none	2/378 (0.53%)	5/394 (1.3%)	not pooled	not pooled		
								0%		not pooled		

[1] Not statistically significant

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

7.1.4a

Question: Should Interpersonal Problem Solving versus Brief problem-orient therapy be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal Prob Solv	Brief prob-orient therapy	Relative (95% CI)	Absolute		
Repetition within 1 year of treatment												
1	randomised trials	no serious limitations			serious[1,2]	none	4/19 (21.1%)	5/20 (25%)	RR 0.84 (0.27 to 2.67)	40 fewer per 1000 (from 183 fewer to 418 more)		
								25%		40 fewer per 1000 (from 183 fewer to 418 more)		
Hopelessness during 6 months (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,3]	none	17	16	-	SMD 0.07 higher (0.62 lower to 0.75 higher)		
Attendance												
1	randomised trials	no serious limitations				none	17/19 (89.5%)	17/20 (85%)	not pooled	not pooled		
								85%		not pooled		

[1] not statistically significant

[2] Total sample size is lower than 300 participants

[3] Total sample size is lower than 400 participants

7.1.4b

Question: Should Inpatient behaviour therapy versus insight oriented therapy be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient behaviour therapy	Insight oriented therapy	Relative (95% CI)	Absolute		
Repetition during 24 months follow up												
1	randomised trials	no serious limitations			serious[1,2]	none	2/12 (16.7%)	3/12 (25%)	RR 0.67 (0.13 to 3.3)	82 fewer per 1000 (from 218 fewer to 575 more)		
								25%		82 fewer per 1000 (from 218 fewer to 575 more)		
Depression at 24 weeks (Better indicated by lower values)												

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

1	randomised trials	no serious limitations			serious[2]	none	12	12	-	SMD 0.98 lower (1.84 to 0.12 lower)		

[1] not statistically significant
[2] total sample size is below 300

7.1.4c

Question: Should long term therapy versus short term therapy be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Long term therapy**	**Short term therapy**	**Relative (95% CI)**	**Absolute**		
Repetition at 12 months												
1	randomised trials	no serious limitations			serious[1,2]	none	9/40 (22.5%)	9/40 (22.5%)	RR 1 (0.44 to 2.26)	0 fewer per 1000 (from 126 fewer to 283 more)		
								22.5%		0 fewer per 1000 (from 126 fewer to 283 more)		

[1] not statistically significant
[2] total sample size smaller than 300

7.1.4d

Question: Should Same versus different therapist be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Same**	**Different therapist**	**Relative (95% CI)**	**Absolute**		
Repetition at 12 months												
1	randomised trials	no serious limitations			serious[1,2]	none	3/70 (4.3%)	9/66 (13.6%)	RR 0.31 (0.09 to 1.11)	94 fewer per 1000 (from 124 fewer to 15 more)		
								13.6%		94 fewer per 1000 (from 124 fewer to 15 more)		
Depression at 12 mths (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	65	62	-	SMD 0.17 lower (0.52 lower to 0.18 higher)		
Attendance at least once												

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

1	randomised trials	no serious limitations				none	49/68 (72.1%)	36/73 (49.3%)	not pooled	not pooled		
								49.3%		not pooled		
Suicide												
1	randomised trials	no serious limitations				none	2/70 (2.9%)	3/66 (4.5%)	RR 0.63 (0.11 to 3.64)	17 fewer per 1000 (from 40 fewer to 120 more)		
								4.6%		17 fewer per 1000 (from 41 fewer to 121 more)		

[1] not statistically significant
[2] total sample size smaller than 300

7.1.4e

Question: Should Home versus Outpatient interventions be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Home**	**Outpatient interventions**	**Relative (95% CI)**	**Absolute**		
Repetition												
1	randomised trials	no serious limitations			serious[1,2]	none	5/48 (10.4%)	7/48 (14.6%)	RR 0.71 (0.24 to 2.09)	42 fewer per 1000 (from 111 fewer to 159 more)		
								14.6%		42 fewer per 1000 (from 111 fewer to 159 more)		
Attendance in treatment												
1	randomised trials	no serious limitations				none	45/48 (93.8%)	35/48 (72.9%)	not pooled	not pooled		
								72.9%		not pooled		

[1] not statistically significant
[2] total sample size is smaller than 300

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

7.1.4f

Question: Should General hospital admission versus discharge be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	General hospital admission	Discharge	Relative (95% CI)	Absolute		
Repetition at 4 months												
1	randomised trials	no serious limitations			serious[1,2]	none	3/38 (7.9%)	4/39 (10.3%)	RR 0.77 (0.18 to 3.21)	24 fewer per 1000 (from 84 fewer to 227 more)		
								10.3%		24 fewer per 1000 (from 84 fewer to 228 more)		
Suicide ideation at 4 mths (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	27	25	-	SMD 0.28 higher (0.26 lower to 0.83 higher)		

[1] not statistically significant

[2] total sample size smaller than 300

7.1.4g

Question: Should Compliance enhance versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Compliance enhance	TAU	Relative (95% CI)	Absolute		
Repetition at 12 months												
1	randomised trials	no serious limitations			serious[1]	none	21/196 (10.7%)	34/195 (17.4%)	RR 0.61 (0.37 to 1.02)	68 fewer per 1000 (from 110 fewer to 3 more)		
								17.4%		68 fewer per 1000 (from 110 fewer to 3 more)		
suicides												
1	randomised trials	no serious limitations				none	6/196 (3.1%)	7/195 (3.6%)	not pooled	not pooled		
								3.6%		not pooled		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

[1] Not statistically significant

7.1.4h

Question: Should Case management versus Routine care be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Case management	Routine care	Relative (95% CI)	Absolute		
Readmission for repetition DSH												
1	randomised trials	no serious limitations			serious[1]	none	19/220 (8.6%)	25/247 (10.1%)	RR 0.85 (0.48 to 1.51)	15 fewer per 1000 (from 53 fewer to 52 more)		
								10.1%		15 fewer per 1000 (from 53 fewer to 52 more)		
Multiple Readmission for repetition DSH												
1	randomised trials	no serious limitations			serious[1]	none	9/220 (4.1%)	2/247 (0.8%)	RR 5.05 (1.1 to 23.13)	33 more per 1000 (from 1 more to 179 more)		
								0.8%		32 more per 1000 (from 1 more to 177 more)		
Suicides at 36 mths follow up												
1	randomised trials	no serious limitations				none	1/220 (0.45%)	1/247 (0.4%)	not pooled	not pooled		
								0.4%		not pooled		

[1] Not statistically significant

7.1.4i

Question: Should Supportive contact versus TAU be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Supportive contact	TAU	Relative (95% CI)	Absolute		
Repetition of DSH at 18 months												
1	randomised trials	no serious limitations			serious[1]	none	60/800 (7.5%)	66/863 (7.6%)	RR 0.98 (0.7 to 1.37)	2 fewer per 1000 (from 23 fewer to 28 more)		
								7.7%		2 fewer per 1000 (from 23		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

										fewer to 28 more)		
Suicides at 18 months												
1	randomised trials	no serious limitations				none	2/872 (0.23%)	18/827 (2.2%)	not pooled	not pooled		
								2.2%		not pooled		

[1] Not statistically significant

7.1.4j

Question: Should GP's letter to patient versus Routine care be used for people who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**GP's letter to patient**	**Routine care**	**Relative (95% CI)**	**Absolute**		
Repetition of DSH during first 12 months												
1	randomised trials	no serious limitations			serious[1]	none	211/964 (21.9%)	189/968 (19.5%)	RR 1.12 (0.94 to 1.34)	23 more per 1000 (from 12 fewer to 66 more)		
								19.5%		23 more per 1000 (from 12 fewer to 66 more)		
Contact with services during first 6 weeks												
1	randomised trials	no serious limitations			serious[1]	none	351/599 (58.6%)	387/681 (56.8%)	RR 1.03 (0.94 to 1.13)	17 more per 1000 (from 34 fewer to 74 more)		
								56.8%		17 more per 1000 (from 34 fewer to 74 more)		

[1] Not statistically significant

7.1.4k

Question: Should Intensive intervention and community treatment versus routine care be used for self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Intensive intervention and community treatment**	**Routine care**	**Relative (95% CI)**	**Absolute**		
Per protocol repetition of DSH at last follow up												
1	randomised trials	no serious limitations			serious[1,2]	none	119/140 (85%)	64/143 (44.8%)	RR 1.9 (1.56 to 2.31)	403 more per 1000 (from 251 more to 586		CRITICAL

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

										more)		
								15.8%		142 more per 1000 (from 88 more to 207 more)		
Attendance at treatment at 12 months												
1	randomised trials					none	119/140 (85%)	64/143 (44.8%)	not pooled	not pooled		
								44.8%		not pooled		
Attendance (Better indicated by lower values)												
1	randomised trials					none	140	134	-	not pooled		
Depression (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	94	50	-	SMD 0.31 lower (0.66 lower to 0.03 higher)		
Hopelessness (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	94	50	-	SMD 0.26 lower (0.61 lower to 0.08 higher)		

[1] Not statistically significant

[2] Total sample size is lower than 400 participants

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

7.1.7a

Question: Should Group therapy versus TAU be used for adolescents who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Group therapy	TAU for adolescents	Relative (95% CI)	Absolute		
Per protocol repetition of DSH during first 12 months												
3	randomised trials	no serious limitations	serious[1]	no serious indirectness	serious[2]	none	136/249 (54.6%)	144/248 (58.1%)	RR 0.95 (0.63 to 1.45)	29 fewer per 1000 (from 215 fewer to 261 more)	⊕⊕OO LOW	
								60.1%		30 fewer per 1000 (from 222 fewer to 270 more)		
Per protocol suicidal ideation at last follow up (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	231	240	-	SMD 0.03 lower (0.21 lower to 0.15 higher)	⊕⊕⊕O MODERATE	
Per protocol depression at last follow up (Better indicated by lower values)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2,3]	none	63	66	-	SMD 0.17 lower (0.52 lower to 0.18 higher)		

[1] Moderate heterogeneity (50-79%)

[2] Not statistically significant

[3] Total sample size smaller than 300

7.1.7b

Question: Should Psychological therapy versus Usual care be used for adolescents who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Psychological therapy	Usual care for adolescents	Relative (95% CI)	Absolute		
Repetition at 6 months after trial entry												
1	randomised trials	no serious limitations			serious[1,2]	none	4/21 (19%)	2/18 (11.1%)	RR 1.71 (0.35 to 8.29)	79 more per 1000 (from 72 fewer to 810 more)		
								11.1%		79 more per 1000 (from 72 fewer to 809 more)		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

Depression at 6 months after trial entry (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	15	16	-	SMD 0.38 lower (1.09 lower to 0.33 higher)		
Adherence-Treatment completion												
1	randomised trials	no serious limitations			serious[1,2]	none	13/21 (61.9%)	13/18 (72.2%)	RR 0.86 (0.55 to 1.33)	101 fewer per 1000 (from 325 fewer to 238 more)		
								72.2%		101 fewer per 1000 (from 325 fewer to 238 more)		
Suicidal ideation at 6 months after trial entry (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	15	15	-	SMD 0.14 lower (0.86 lower to 0.58 higher)		

[1] Not statistically significant

[2] Total sample size is lower than 300

7.1.7c

Question: Should Home based family intervention versus TAU be used for adolescents who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Home based family intverntion**	**TAU for adolescents**	**Relative (95% CI)**	**Absolute**		
Repetition in 6 months												
1	randomised trials	no serious limitations			serious[1,2]	none	11/74 (14.9%)	11/75 (14.7%)	RR 1.01 (0.47 to 2.19)	1 more per 1000 (from 78 fewer to 175 more)		
								14.7%		1 more per 1000 (from 78 fewer to 175 more)		
Attendance												
1	randomised trials	no serious limitations				none	39/84 (46.4%)	28/77 (36.4%)	not pooled	not pooled		
								36.4%		not pooled		
Suicide ideation at 6 months (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	74	75	-	SMD 0.13 lower (0.45 lower to 0.19 higher)		
Problem solving scores at 6 months (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1,2]	none	73	74	-	SMD 0.04 lower (0.36 lower to 0.28 higher)		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

Suicide													
1	randomised trials	no serious limitations				none	1/74 (1.4%) 	0/75 (0%) 0%	not pooled	not pooled not pooled		
Hopelessness scores at 6 months (Better indicated by lower values)													
1	randomised trials	no serious limitations			serious[1,2]	none	74	74	-	SMD 0.06 higher (0.26 lower to 0.38 higher)		

[1] Not statistically significant

[2] Total sample size smaller than 300

7.1.7d

Question: Should Standard disposition planning with added compliance enhancement versus without planning be used for adolescents who self-harm?

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Standard disposition planning with added compliance enhancement**	**Without for DSH adolescents**	**Relative (95% CI)**	**Absolute**		
Repetition at 3 months from trial entry												
1	randomised trials	no serious limitations			serious[1]	none	3/29 (10.3%) 	5/34 (14.7%) 14.7%	RR 0.7 (0.18 to 2.69)	44 fewer per 1000 (from 121 fewer to 249 more) 44 fewer per 1000 (from 121 fewer to 248 more)		
No. of treatment sessions (Better indicated by lower values)												
1	randomised trials	no serious limitations			serious[1]	none	29	34	-	SMD 0.25 higher (0.25 lower to 0.75 higher)		
Attendance												
1	randomised trials	no serious limitations				none	44/58 (75.9%) 	47/68 (69.1%) 69.1%	not pooled	not pooled not pooled		
Attendance - Attended at least 1 treatment session												
1	randomised trials	no serious limitations				none	27/29 (93.1%) 	31/34 (91.2%) 91.2%	not pooled	not pooled not pooled		

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study

Attendance - Completed treatment												
1	randomised trials	no serious limitations				none	17/29 (58.6%)	16/34 (47.1%)	not pooled	not pooled		
								47.1%		not pooled		

[1] Not statistically significant

Please take note that inconsistency and indirectness were not rated in comparisons that contain only one study