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PSYCHOLOGICAL AND PSYCHOSOCIAL INTERVENTIONS

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Should psychological interventions versus treatment as usual (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 interventions	TAU	Relative risk (95% CI)	Absolute		
Per protocol repetition of self-harm – 0 to 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 self-harm – 6 to 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 self-harm – 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 self-harm – last follow-up (follow-up 0 to 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 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	⊕⊕OO LOW	IMPORTANT

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

										higher)		
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 to 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
Number 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)		
Number 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 to 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 trials	-	-	-	-	None	2/532 (0.38%)	7/511 (1.4%)	Not pooled	Not pooled	-	-
							-	0%		Not pooled		

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

Appendix 17a

[1] Treatment conducted in different settings (home or outpatient); number of sessions varies.
[2] Treatment modalities differ across studies (problem-solving, psychodynamic interpersonal and cognitive behavioural therapies).
[3] Total sample size is lower than 300 participants.
[4] Majority outpatient-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.

Should intensive multi-modal intervention versus treatment as usual 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 multi-modal intervention	TAU	Relative risk (95% CI)	Absolute		
Per protocol repetition of self-harm – 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 follow-up												
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 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[2,3]	None	94	50	-	SMD 0.31 lower (0.66 lower to 0.03 higher)	-	-

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

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 to 79%).
[2] Not statistically significant.
[3] Total sample size is lower than 400 participants.

Should emergency card versus treatment as usual (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 risk (95% CI)**	**Absolute**		
Repetition of self-harm – 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 to 79%).
[2] Not statistically significant.

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

Should telephone contact versus treatment as usual (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 risk (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 self-harm – between 3 and 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 self-harm – between 1 and 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 note that inconsistency and indirectness were not rated in comparisons that contain only one study.

Should postcard interventions plus treatment as usual (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	Postcard plus TAU	TAU	Relative risk (95% CI)	Absolute		
Repetition of self-harm – 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 self-harm – 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 months 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 months 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 note that inconsistency and indirectness were not rated in comparisons that contain only one study.

Should interpersonal problem-solving skills training (IPSST) versus brief problem-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	IPSST	Brief problem-oriented therapy	Relative risk (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.

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

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 risk (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)												
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.

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 risk (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.

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

Should same therapist 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 therapist	Different therapist	Relative risk (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 months (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 (t least once)												
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.

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

Should home versus outpatient problem-solving 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	Home	Outpatient	Relative risk (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 smaller than 300.

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

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 risk (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 months (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.

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

Should compliance enhancement versus treatment as usual (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 enhancement	TAU	Relative risk (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		
[1] Not statistically significant.												

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

Should case management versus treatment as usual 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	TAU	Relative risk (95% CI)	Absolute		
Readmission for repetition self-harm												
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 self-harm												
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 months' 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.

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

Should supportive contact versus treatment as usual (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 risk (95% CI)	Absolute		
Repetition of self-harm – 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 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.												

Should GP letter to patient/enhanced care versus treatment as usual (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	GP letter to patient	TAU	Relative risk (95% CI)	Absolute		
Repetition of self-harm – 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.												

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

Should intensive inpatient and community treatment versus treatment as usual (TAU) be used for self-harm?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Intensive inpatient and community treatment	TAU	Relative risk (95% CI)	Absolute		
Per protocol repetition of self-harm – 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 more)	-	CRITICAL
							-	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 note that inconsistency and indirectness were not rated in comparisons that contain only one study.

Should group psychotherapy versus treatment as usual (TAU) be used for young people who self-harm?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Group psychotherapy	TAU	Relative risk (95% CI)	Absolute		
Per protocol repetition of self-harm – 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 to 79%).
[2] Not statistically significant.
[3] Total sample size smaller than 300.

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

Should CBT versus treatment as usual (TAU) be used for young people who self-harm?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	CBT	TAU	Relative risk (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)		
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)		
Suicide 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.

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

Should home-based family intervention versus treatment as usual (TAU) be used for young people who self-harm?

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Home-based family intervention	TAU	Relative risk (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)	-	-
Suicide												
1	Randomised trials	No serious limitations	-	-	-	None	1/74 (1.4%)	0/75 (0%)	Not pooled	Not pooled	-	-
							-	0%		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.

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

Should standard disposition planning with and without added compliance enhancement be used for young people 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	Relative risk (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%)	RR 0.7 (0.18 to 2.69)	44 fewer per 1000 (from 121 fewer to 249 more)	-	-
							-	14.7%		44 fewer per 1000 (from 121 fewer to 248 more)		
Number 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%)	Not pooled	Not pooled	-	-
							-	69.1%		Not pooled		
Attendance – attended at least one treatment session												
1	Randomised trials	No serious limitations	-	-	-	None	27/29 (93.1%)	31/34 (91.2%)	Not pooled	Not pooled	-	-
							-	91.2%		Not pooled		
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 note that inconsistency and indirectness were not rated in comparisons that contain only one study.

Health economic evidence for manual-assisted cognitive behavioural therapy (MACT) versus treatment as usual (TAU)

Study and country	Limitations	Applicability	Other comments	Incremental cost (£)	Incremental effect (QALYs)	ICER (£/QALY)	Uncertainty
BYFORD 2003 UK	Minor limitations[1]	Directly applicable[2]	Primary outcome used in economic analysis was proportion of patients experiencing a repeat episode of self-harm during 12-month follow-up. QALYs were also estimated from EQ-5D utility scores	-£1188[3]	-0.0118	ICER per QALY gained was £100658 using TAU	CEACs showed >90% probability that MACT was more cost-effective than TAU
BYFORD 1999 UK	Minor limitations[4]	Partially applicable[5]	Array of outcome measures used rather single measure, including: suicide ideation, hopelessness scale, family assessment device	-£458[6]	NA	NA	One-way sensitivity analyses around key resource-use and cost variables, with no overall effect on the base-case results
GREEN2011 UK	Minor limitations[7]	Partially applicable[8]	Time horizon limited to 12 months; cost reported in 2005/06 price year	£6408	3%	£2020/1% of young people not self-harming at 12 months	Probability of group therapy compared with routine care being cost effective ranges from 12 to 28%

[1] Unclear whether deaths by suicide were included in QALY calculations; no costs to patients' family/carers included.
[2] Voluntary sector, community accommodation, criminal justice system and patient productivity costs included; unclear whether utility scores obtained from UK population sample.
[3] Inflated from 1999/2000 to 2008/09 prices using Hospital and Community Health Services Pay and Prices inflation indices (Curtis, 2009).
[4] Short time horizon (6 months); educational sector costs included;one way deterministic sensitivity analyses conducted.
[5] No synthesis of costs and outcomes performed by authors.
[6] Inflated from 1997/1998 to 2008/09 prices using Hospital and Community Health Services Pay and Prices inflation indices (Curtis, 2009).
[7] Efficacy data derived from one RCT and most results were not statistically significant.
[8] Final outcome measure reported in natural units.
Please note that inconsistency and indirectness were not rated in comparisons that contain only one study.