



Surveillance report 2016 – Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16 and Self-harm in over 8s: long term management (2011) NICE guideline CG133

Surveillance report

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Surveillance decision

We will not update NICE guidelines CG16 or CG133.

NICE guideline CG16 Self-harm in over 8s: short-term management and prevention of recurrence will remain on the static list because:

- No evidence was identified that would impact on the current guidance and no major ongoing studies or research have been identified as due to be published in the near future (that is, within the next 3–5 years).

Reason for the decision

Self-harm in over 8s: short-term management and prevention of recurrence NICE guideline CG16

We found 50 new studies through surveillance of this guideline.

This included new evidence that supports current recommendations on:

- Issues for all services and healthcare professionals (users' experience of services, staff training and service planning)
- Medical and surgical management of self-harm (general treatment for ingestion, management of paracetamol overdose, flumazenil in benzodiazepine overdose, treatment of opioid overdose)
- Support and advice for people who repeatedly self-harm
- Psychosocial assessment
- Special issues for children and young people (under 16 years)
- Psychological, psychosocial and pharmacological interventions

We asked topic experts whether this new evidence would affect current recommendations in NICE guideline CG16. Generally, the topic experts thought that an update was not needed. However, the majority of topic experts felt that the current distinction between short and long term management of self-harm is rather artificial and suggested considering combining NICE guidelines CG16 and CG133 when an update of the guidelines is decided.

None of the new evidence considered in surveillance of this guideline was thought to have an effect on current recommendations.

We did not find any new evidence on:

- Issues for all services and healthcare professionals (consent to care, activated charcoal)
- The management of self-harm in primary care
- The assessment and initial management of self-harm by ambulance services
- The treatment and management of self-harm in emergency departments
- Medical and surgical management of self-harm (paracetamol screening, treatment and management of poisoning with salicylates, general treatment for self-injury)
- Referral, admission and discharge following self-harm
- Special issues for older people (older than 65 years)

In addition, no major ongoing studies or research due to be published in the next 3–5 years was identified. Topic experts highlighted an ongoing randomised controlled trial (Self-Harm Intervention Family Therapy [SHIFT]) comparing family therapy against treatment as usual in young people with subsequent episodes of self-harm. However, the SHIFT trial was considered to be relevant for NICE guideline CG133 and will be assessed during the next surveillance review of NICE guideline CG133.

Self-harm in over 8s: long term management NICE guideline CG133

We found 34 new studies through surveillance of this guideline.

This included new evidence that supports current recommendations on:

- General principles of care (training and supervision for health and social care professionals)
- Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks
- Longer-term treatment and management of self-harm (interventions for self-harm)

We asked topic experts whether this new evidence would affect current recommendations in NICE guideline CG133. Generally, the topic experts thought that an update was not needed.

None of the new evidence considered in surveillance of this guideline was thought to have an effect on current recommendations.

We did not find any new evidence on:

- General principles of care (working with people who self-harm, access to services, self-harm and learning disabilities, consent and confidentiality, safeguarding, families, carers and significant others, managing endings and supporting transitions)
- Primary care
- Longer-term treatment and management of self-harm (provision of care, care plans, risk management plans, provision of information about the treatment and management of self-harm, harm reduction)
- Treating associated mental health conditions

Equalities

No equalities issues were identified for either NICE guideline CG16 or CG133 during the surveillance process.

Overall decision

After considering all the new evidence and views of topic experts, we decided not to update NICE guidelines CG16 and CG133, and leave NICE guideline CG16 on the static list.

Consideration will be given to combining both NICE guidelines CG16 and CG133 during a future update.

See [how we made the decision](#) for further information.

Commentary on selected new evidence

With advice from topic experts we selected 3 studies for further commentary.

Longer-term treatment and management of self-harm – Interventions for self-harm

Three Cochrane reviews were selected for this area ([Hawton 2015a](#); [Hawton 2016](#); [Hawton 2015b](#)) because these Cochrane reviews were used during the development of NICE guideline CG133. These reviews update and replace the original Cochrane review which addressed psychosocial and pharmacological treatments for self-harm in children, adolescents and adults in a single review ([Hawton et al. 2000](#)).

What the guideline recommends

NICE guideline CG133 recommends the following for managing self-harm in the long-term:

1.4.8 Consider 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. In addition:

- The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
- Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
- Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

1.4.9 Do not offer drug treatment as a specific intervention to reduce self-harm.

Psychosocial interventions for self-harm in children and adolescents

Methods

The Cochrane review by [Hawton et al. \(2015a\)](#) focuses on psychosocial and pharmacological interventions for self-harm in children and adolescents. Hawton et al. (2015) conducted a Cochrane review of 11 randomised controlled trials (n=1,126 participants) assessing the effects of psychosocial interventions for self-harm in children and adolescents. Pharmacological

interventions were also considered but no relevant trials were found. Participants were included if they were 18 years and younger, had at least one episode of self-harm in the 6 months prior to trial entry, and had presented to clinical services as a result of self-harm.

Psychosocial interventions included:

- Individual cognitive behavioural therapy (CBT) based therapy
- Group-based psychotherapy
- Therapeutic assessment approaches
- Compliance enhancement approaches
- Home-based family interventions
- Remote contact interventions.
- Interventions for patients with multiple episodes of self-harm or emerging personality problems

Comparator interventions included treatment as usual (TAU) and other routine management. TAU was defined as provision of routine clinical service while other routine management included no specific treatment or enhanced usual care.

The primary outcome measure was occurrence of repeated self-harm which was reported as the proportion of participants repeating self-harm or the frequency of repeat episodes. Secondary outcomes included depression, hopelessness, suicidal ideation, and suicide.

Meta-analyses were undertaken for interventions evaluated in more than one independent trial. Only two interventions were reported in more than one trial (dialectical behaviour therapy for adolescents and group-based psychotherapy).

Results

Participants were 15.3 years old on average (age was reported by 9 studies). Most of the participants were female (80.6%, gender was reported by 10 studies). The most common co-morbidities were depression, behavioural disorders, and emerging borderline personality disorder. The following findings were reported by the included studies:

Individual CBT-based psychotherapy compared to TAU

One study evaluated a brief skill-based psychological therapy which was classified as a CBT-based psychotherapy. The results showed no significant treatment effect with wide confidence intervals on repetition of self-harm at 6-month follow-up.

Interventions for patients with multiple episodes of self-harm or emerging personality problems compared to TAU or other routine management

Two studies evaluated the effectiveness of dialectical behaviour therapy for adolescents (DBT-A) showing no significant treatment effect post-intervention on either repetition of self-harm (odds ratio [OR] 0.72, 95% confidence interval [CI] 0.12 to 4.44; 2 studies, n=105) or frequency of self-harm (mean difference [MD] -0.79, 95% CI -2.78 to 1.20; 2 studies, n=104) or on depression (MD -2.39, 95% CI -5.02 to 0.24; 1 study, n=77) or on hopelessness (standard mean difference [SMD] -0.13, 95% CI -0.93 to 0.67; 2 studies, n=101) compared to TAU (1 study) or enhanced usual care (1 study). There was evidence of a statistically significant treatment effect post-intervention on hopelessness with DBT-A compared to enhanced usual care (SMD -0.47, 95% CI -0.93 to -0.02; 1 study, n=77). There was evidence of a significant treatment effect post-intervention on suicidal ideation with DBT-A compared to TAU or enhanced usual care (SMD -0.62, 95% CI -1.07 to -0.16; 2 studies, n=100).

One study evaluated a mentalisation-based therapy in adolescents diagnosed with comorbid depression. The results showed significant treatment effect on repetition of self-harm post-intervention compared to TAU (OR 0.26, 95% CI 0.09 to 0.78; 1 study, n=71) and on depression (MD -2.28, 95% CI -2.81 to -0.75; 1 study, n=80).

Group-based psychotherapy compared to TAU

Three studies compared group therapy against TAU using techniques such as CBT, problem-solving therapy, dialectical behaviour therapy (DBT), and group psychodynamic psychotherapy. The results showed no significant treatment effect on repetition of self-harm at 6-month follow-up (OR 1.72, 95% CI 0.56 to 5.24; 2 studies, n=430) or at 12-month follow-up (OR 0.80, 95% CI 0.22 to 2.97; 3 studies, n=490) or on depression at 6-month follow-up (MD 0.40, 95% CI -2.76 to 3.55; 2 studies, n=420) or at 12-month follow-up (MD -0.93, 95% CI -4.03 to 2.17; 3 studies, n=473) or on suicidal ideation at 6-month follow-up (MD 1.27, 95% CI -7.74 to 10.28; 2 studies, n=421) or at 12-month follow-up (MD -1.51, 95% CI -9.62 to 6.59; 3 studies, n=471).

Therapeutic assessment compared to TAU

One study evaluated the effectiveness of therapeutic assessment showing no significant treatment effect on repetition of self-harm at 12-month follow-up (OR 0.75, 95% CI 0.18 to 3.06; 1 study, n=69) or at 24-month follow-up (OR 0.69, 95% CI 0.23 to 2.14; 1 study, n=69).

Compliance enhancement plus standard disposition planning compared to TAU

One study evaluated the effectiveness of compliance enhancement plus standard disposition planning. There was no evidence of a significant treatment effect on repetition of self-harm at 6-month follow-up (OR 0.67, 95% CI 0.15 to 3.08; 1 study, n=63).

Home-based family intervention compared to TAU

One study evaluated the effectiveness of a home-based family intervention showing no evidence of a significant treatment effect on repetition of self-harm at 6-month follow-up (OR 1.02, 95% CI 0.41 to 2.51; 1 study, n=149) or on hopelessness (MD 0.20, 95% CI -0.91 to 1.31; 1 study, n=148) or on suicidal ideation (MD -5.10, 95% CI -17.37 to 7.17; 1 study, n=149). There was a person who died by suicide in the home-based family intervention compared to none in the TAU group.

Remote contact interventions plus TAU compared to TAU

One study evaluated an emergency card as a remote contact intervention enabling adolescents to re-admit themselves to the local hospital on demand if they felt suicidal. The results showed no significant treatment effect on repetition of self-harm at 12-month follow-up (OR 0.50, 95% CI 0.12 to 2.04; 1 study, n=105).

Strengths and limitations

Strengths

The main strength was that the study used the Cochrane methodology. The authors judged that more than 70% of included studies had low risk of selection bias, detection bias, and other potential sources of bias.

Limitations

This Cochrane review included a limited number of studies for each type of intervention. Therefore, only 2 meta-analyses could be undertaken and each meta-analysis included 2 or 3 studies. The authors judged that more than 80% of studies had high risk of performance bias.

Reporting bias was rated as unclear because the trial protocols were not available. Furthermore, the quality of the evidence was assessed as being low or very low using the GRADE approach.

Psychosocial interventions for self-harm in adults

Methods

The Cochrane review by [Hawton et al. \(2016\)](#) focuses on psychosocial interventions for self-harm in adults. Hawton et al. (2016) conducted a review of 55 randomised controlled trials (n=17,699 participants) assessing the effects of psychosocial interventions for self-harm in adults. Participants were included if they were 18 years and older, had engaged in any type of self-harm in the 6 months prior to trial entry, and had presented to clinical services as a result of self-harm. Trials with <15% of adolescents were also included.

Psychosocial interventions included:

- CBT-based psychotherapy
- Interventions for multiple repetition of self-harm/probable personality disorder
- Case management
- Treatment adherence enhancement approaches
- Mixed multimodal interventions
- Remote contact interventions
- Other mixed interventions

Comparator interventions included TAU, enhanced usual care (EUC), treatment by an expert, discharge with no aftercare and other alternative forms of psychotherapy including brief or short-term psychotherapy, standard case management, and standard dialectical behaviour therapy.

The primary outcome measure was occurrence of repeated self-harm which was reported as the proportion of participants repeating self-harm and the frequency of repeat episodes. Secondary outcomes included depression, hopelessness, suicidal ideation, and suicide.

Random-effects meta-analyses were undertaken to estimate the effect of each intervention if possible.

Results

Participants were, on average, 30.9 years old (age was reported by 39 studies). Small numbers of adolescents were included in 20 trials. More than half of participants were women (69.2%, gender was reported by 46 studies). Thirteen studies focused on participants with specific disorders: borderline personality disorder (8 studies), any personality disorder (3 studies), alcohol use (1 study), and comorbid post-traumatic stress disorder with borderline personality disorder (1 study). The following findings were reported by the included studies:

CBT-based psychotherapy compared to TAU

CBT-based therapy including cognitive behavioural therapy or problem-solving therapy was evaluated in 18 studies. Most studies included individual CBT-based therapy apart from 1 study which focused on group CBT-based psychotherapy. This was defined as an intervention helping people to identify and evaluate their interpretation of disturbing emotional experiences and events with the final aim to change how they deal with problems.

At 6-month follow-up:

- Individual CBT-based psychotherapy significantly reduced repetition of self-harm (OR 0.52, 95% CI 0.36 to 0.75; 11 studies, n=1,083), depression (SMD -0.33, 95% CI -0.56 to -0.11; 11 studies, n=1,434), hopelessness (SMD -0.48, 95% CI -0.63 to -0.33; 3 studies, n=734), suicidal ideation (SMD -0.41, 95% CI -0.55 to -0.27; 5 studies, n=777).
- Group-based psychotherapy was not found to have an effect on self-harm repetition (OR 1.35, 95% CI 0.75 to 2.41; 1 study, n=234) or depression (SMD -0.13, 95% CI -0.39 to 0.13; 1 study, n=234) or hopelessness (SMD -0.05, 95% CI -0.31 to 0.21; 1 study, n=234) or suicidal ideation (SMD -0.02, 95% CI -0.28 to 0.24; 1 study, n=234).
 - The difference between individual and group-based psychotherapy was significant for repetition of self-harm ($\text{Chi}^2=7.32$, degrees of freedom [DF]=1, $p=0.007$, $I^2=86.3\%$), for hopelessness ($\text{Chi}^2=8.11$, DF=1, $p=0.004$, $I^2=87.7\%$) and for suicidal ideation ($\text{Chi}^2=6.69$, DF=1, $p=0.010$, $I^2=85.1\%$).

At 12-month follow-up:

- There was a significant treatment effect on repetition of self-harm with individual CBT-based psychotherapy (OR 0.74, 95% CI 0.59 to 0.94; 10 studies, n=1,799) as well as on depression (SMD -0.36, 95% CI -0.64 to -0.07; 7 studies, n=1,130) and hopelessness (SMD -1.89, 95% CI -2.97 to -0.81; 3 studies, n=539) but not with group-based psychotherapy for repetition of self-

harm (OR 1.04, 95% CI 0.67 to 1.61; 1 study, n=433). There was no significant treatment effect on suicidal ideation with individual CBT-based psychotherapy (MD -1.10, 95% CI -2.45 to 0.25; 1 study, n=418).

- The difference between individual and group-based psychotherapy was not significant for repetition of self-harm ($\text{Chi}^2=1.68$, $\text{DF}=1$, $p=0.19$, $I^2=40.6\%$).

At 24-month follow-up:

There was a significant treatment effect on repetition of self-harm with individual CBT-based psychotherapy (OR 0.31, 95% CI 0.14 to 0.69; 2 studies, n=105) but not on depression (SMD -0.22, 95% CI -0.48 to -0.05; 2 studies, n=225).

Final follow-up assessment:

- There was a significant treatment effect on repetition of self-harm with individual CBT-based psychotherapy (OR 0.66, 95% CI 0.53 to 0.84; 16 studies, n=2,232) as well as on depression (SMD -0.35, 95% CI -0.54 to -0.16; 13 studies, n=1,625), hopelessness (SMD -0.38, 95% CI -0.60 to -0.16; 6 studies, n=783), and suicidal ideation (SMD -0.35, 95% CI -0.55 to -0.15; 7 studies, n=818) but not with group-based psychotherapy on repetition of self-harm (OR 1.04, 95% CI 0.67 to 1.61; 1 study, n=433) or depression (SMD -0.13, 95% CI -0.39 to 0.13; 1 study, n=234) or hopelessness (SMD -0.05, 95% CI -0.31 to 0.21; 1 study, n=234) or suicidal ideation (SMD -0.02, 95% CI -0.24 to 0.20; 1 study, n=313).
 - The difference between individual and group-based psychotherapy was not significant for repetition of self-harm ($\text{Chi}^2=3.08$, $\text{DF}=1$, $p=0.08$, $I^2=67.5\%$) or for hopelessness ($\text{Chi}^2=3.65$, $\text{DF}=1$, $p=0.06$, $I^2=72.6\%$) but it was significant for suicidal ideation ($\text{Chi}^2=4.61$, $\text{DF}=1$, $p=0.03$, $I^2=78.3\%$).
- There was no significant treatment effect on frequency of repetition of self-harm with individual CBT-based psychotherapy (MD -0.66, 95% CI -1.71 to 0.40; 5 studies, n=161) or with group-based psychotherapy (MD -0.06, 95% CI -0.32 to 0.20; 1 study, n=433).
 - The difference between individual and group-based psychotherapy was not significant ($\text{Chi}^2=1.17$, $\text{DF}=1$, $p=0.28$, $I^2=14.2\%$).
- There was no significant treatment effect on suicides with individual or group-based CBT-based psychotherapy (MD 0.66, 95% CI 0.29 to 1.51; 15 studies, n=2,354).

Interventions for multiple repetition of self-harm or probable personality disorder compared to TAU or other alternative forms of psychotherapy

Nine studies evaluated the effectiveness of 5 different interventions on multiple repetition of self-harm in people with personality disorders. These results are applicable to people with personality disorders and may not be applicable to treatment of self-harm in people without personality disorders.

- Group-based emotion regulation psychotherapy showed a significant treatment effect on repetition of self-harm with fewer people repeating self-harm (OR 0.34, 95% CI 0.13 to 0.88; 2 studies, n=83) and depression (MD -9.59, 95% CI -13.43 to -5.75; 2 studies, n=83) but not on frequency of repetition of self-harm meaning that the number of episodes were not reduced (MD -12.76, 95% CI -34.92 to 9.40; 2 studies, n=83) compared to TAU. Therefore, group-based emotion regulation psychotherapy reduced the number of people repeating self-harm but not the number of episodes per person.
- Mentalisation-based therapy showed a significant treatment effect on repetition of self-harm (OR 0.35, 95% CI 0.17 to 0.73; 1 study, n=134), on frequency of repetition of self-harm (MD -1.28, 95% CI -2.01 to -0.55; 1 study, n=134), and on depression (MD -3.88, 95% CI -6.82 to -0.94; 1 study, n=134) compared to TAU.
- Dialectical behaviour-oriented psychotherapy showed a significant treatment effect on repetition of self-harm (OR 0.05, 95% CI 0.00 to 0.49; 1 study, n=24), on frequency of self-harm post-intervention (MD -4.83, 95% CI -7.90 to -1.76; 1 study, n=24), on depression (MD -9.16, 95% CI -14.79 to -3.53; 1 study, n=24), and on suicidal ideation (MD -7.75, 95% CI -14.66 to -0.84; 1 study, n=24) compared to client-oriented therapy.
- Three studies evaluated the effectiveness of dialectical behaviour therapy on repetition of self-harm compared to TAU. A significant treatment effect on frequency of repetition of self-harm was evident post-intervention (MD -18.82, 95% CI -36.68 to -0.95; 3 studies, n=292). The results showed no significant treatment effect for the following outcomes:
 - Repetition of self-harm
 - ◇ post-intervention (OR 0.59, 95% CI 0.16 to 2.15; 3 studies, n=267)
 - ◇ at 12-month follow-up (OR 0.36, 95% CI 0.05 to 2.47; 2 studies, n=172)
 - ◇ or at final assessment (OR 0.57, 95% CI 0.21 to 1.59; 3 studies, n=247)

- ◇ Dialectical behaviour therapy reduced the number of episodes of self-harm per person but not the number of people repeating self-harm.

- Depression

- ◇ post-intervention (MD -2.37, 95% CI -6.52 to 1.78; 2 studies, n=198)
 - ◇ at 24-month follow-up (MD 0.57, 95% CI -4.00 to 5.14; 1 study, n=180).

- Hopelessness

- ◇ at 24-month follow-up (MD 0.17, 95% CI -5.61 to 5.95; 1 study, n=18).

- Suicidal ideation

- ◇ post-intervention (MD -7.91, 95% CI -18.47 to 2.65; 1 study, n=81).

- Suicide

- ◇ post-intervention (OR 3.00, 95% CI 0.12 to 76.49; 3 studies, n=317).

- One study evaluated the effectiveness of dialectical behaviour therapy prolonged exposure compared to standard dialectical behaviour therapy in women with comorbid borderline personality disorder and post-traumatic stress disorder. Frequency of repetition of self-harm did not change post-intervention (MD -0.25, 95% CI -2.47 to 1.97; 1 study, n=18) or at 3-month follow-up (MD -0.34, 95% CI -0.61 to 1.29; 1 study, n=18). In addition, no significant treatment effect was found for repetition of self-harm, depression and suicide:

- at post-intervention for repetition of self-harm (OR 0.67, 95% CI 0.08 to 5.68; 1 study, n=18) and depression (MD -3.70, 95% CI -10.59 to 3.19; 1 study, n=18)
 - 3-month follow-up for repetition of self-harm (OR 0.67, 95% CI 0.08 to 5.68; 1 study, n=18) and depression (MD -4.30, 95% CI -9.68 to 1.08; 1 study, n=18)
 - 6-month follow-up for suicide (OR 0.16, 95% CI 0.01 to 4.41; 1 study, n=26).

Case management compared to TAU

Four RCTs evaluated the effectiveness of case management to prevent self-harm compared to TAU or enhancement usual care. No significant treatment effect was found for repetition of self-harm post-intervention (OR 0.78, 95% CI 0.47 to 1.30; 4 studies, n=1,608) or for suicide (OR 0.95, 95% CI 0.57 to 1.57; 4 studies, n=1,757).

Treatment adherence enhancement approaches compared to TAU or other alternative forms of psychotherapy

One study evaluated the effectiveness of treatment adherence enhancement compared to TAU. No significant treatment effect was observed for repetition of self-harm at 12-month follow-up (OR 0.57, 95% CI 0.32 to 1.02; 1 study, n=516) or for suicide (OR 0.85, 95% CI 0.28 to 2.57; 1 study, n=391). Another study evaluated the effectiveness of continuing aftercare with the same therapist compared to changing to a different therapist showing no significant treatment effect on repetition of self-harm at 12-month follow-up (OR 0.28, 95% CI 0.07 to 1.10; 1 study, n=136) or on suicide (OR 0.62, 95% CI 0.10 to 3.82; 1 study, n=136).

Mixed multimodal interventions compared to TAU

Two studies evaluated the effectiveness of mixed multimodal interventions (a package including problem-solving psychotherapy, postcards, and a voucher to one free visit to their general practitioner). Both studies used a Zelen design which involves post-randomisation consent. One study compared the mixed multimodal intervention with TAU showing no significant treatment effect on repetition of self-harm at post-intervention (OR 0.98, 95% CI 0.68 to 1.43; 1 study, n=684), depression (MD 0.30, 95% CI -0.63 to 1.23; 1 study, n=445), hopelessness (MD -0.10, 95% CI -1.28 to 1.08; 1 study, n=443), and suicide (OR 0.54, 95% CI 0.05 to 6.03; 1 study, n=684). Another study compared a culturally-adapted mixed multimodal intervention with TAU showing no significant treatment effect on repetition of self-harm at 12-month follow-up (OR 0.83, 95% CI 0.44 to 1.55; 1 study, n=167), depression (MD -0.50, 95% CI -2.13 to 1.13; 1 study, n=114), hopelessness (MD -0.70, 95% CI -2.43 to 1.03; 1 study, n=113), and suicide (OR 0.43, 95% CI 0.02 to 10.82; 1 study, n=167).

Remote contact interventions compared to TAU

Eleven studies evaluated the effectiveness of 5 different interventions to prevent repetition of self-harm.

- Sending postcards to patients in a regular basis showed no significant treatment effect on repetition of self-harm:
 - at post-intervention (OR 0.87, 95% CI 0.62 to 1.23; 4 studies, n=3,277)
 - at 12-month follow-up (OR 0.76, 95% CI 0.57 to 1.02; 2 studies, n=2,885)
 - at final follow-up assessment (OR 0.88, 95% CI 0.62 to 1.25; 4 studies, n=3,277)

- or on frequency of repetition of self-harm at post-intervention (MD -0.07, 95% CI -0.32 to 0.18; 3 studies, n=1,097) or at 12-month follow-up (MD -0.19, 95% CI -0.58 to 0.20; 2 studies, n=984) or at 24-month follow-up (MD -0.03, 95% CI -0.16 to 0.10; 1 study, n=472)
- a significant effect on suicidal ideation at post-intervention (OR 0.57, 95% CI 0.48 to 0.68; 1 study, n=2,213) and at 12-month follow-up (OR 0.62, 95% CI 0.52 to 0.74; 1 study, n=2,001)
- no significant effect on suicide at post-intervention (OR 1.86, 95% CI 0.61 to 5.72; 4 studies, n=1816) and at 12-month follow-up (OR 0.41, 95% CI 0.08 to 2.15; 1 study, n=772)
- Sensitivity analyses (using fixed-effect model instead of random-effect model) showed a significant treatment effect on repetition of self-harm at 12-month follow-up (OR 0.75, 95% CI 0.61 to 0.91; 2 studies, n=2,885) and at final follow-up assessment (OR 0.79, 95% CI 0.66 to 0.95; 4 studies, n=3,277).
- Providing an emergency contact card (24-hour access to psychiatric advice) showed no significant treatment effect on repetition of self-harm compared with TAU:
 - at post-intervention (OR 0.82, 95% CI 0.31 to 2.14; 2 studies, n=1,039)
 - or at 12-month follow-up (OR 1.19, 95% CI 0.85 to 1.67; 1 study, n=827)
 - or on frequency of repetition of self-harm reported as no episodes (OR 0.83, 95% CI 0.57 to 1.21; 1 study, n=827), a single episode (OR 1.46, 95% CI 0.91 to 2.35; 1 study, n=827), or 2 or more episodes at follow-up (OR 0.87, 95% CI 0.49 to 1.53; 1 study, n=827)
 - or on suicide at 6-month follow-up (OR 1.97, 95% CI 0.18 to 21.82; 1 study, n=827).
- General practitioner's letter offering appointment and advice showed no significant treatment effect on repetition of self-harm at 12-month follow-up compared with TAU (OR 1.15, 95% CI 0.93 to 1.44; 1 study, n=1,932).
- Telephone contact showed no significant treatment effect on repetition of self-harm at 6-month follow-up (OR 0.23, 95% CI 0.02 to 2.11; 1 study, n=81), at 12-month follow-up (OR 1.00, 95% CI 0.45 to 2.23; 1 study, n=172), at 24-month follow-up (OR 0.76, 95% CI 0.49 to 1.16; 1 study, n=605), or at final follow-up (OR 0.74, 95% CI 0.42 to 1.32; 3 studies, n=840) or on depression at 6-month follow-up (MD 0.16, 95% CI -3.55 to 3.87; 1 study, n=81) and at 12-month follow-up (MD -0.11, 95% CI -4.32 to 4.10; 1 study, n=63), or on suicidal ideation at

12-month follow-up (MD 1.80, 95% CI -6.27 to 9.87; 1 study, n=13), or on suicide at final follow-up (OR 0.70, 95% CI 0.11 to 4.33; 2 studies, n=821).

- Participants did not repeat self-harm over a 6-month follow-up with either mobile telephone-based psychotherapy (including problem-solving therapy, meditation and social support) or TAU in an RCT of 68 participants. Therefore, it was not possible to calculate the odds ratio or confidence interval for this comparison. There was a significant treatment effect at post-intervention on depression (MD -7.60, 95% CI -11.48 to -3.72; 1 study, n=68), suicidal ideation (MD -3.70, 95% CI -5.63 to -1.77; 1 study, n=68) but not on suicide (OR 3.09, 95% CI 0.12 to 78.55; 1 study, n=68).

Other mixed interventions compared to TAU or other alternative forms of psychotherapy

Ten studies evaluated the effectiveness of 9 different interventions on repetition of self-harm.

- Interpersonal problem-solving skills training showed no significant treatment effect on repetition of self-harm at 12-month follow-up compared to a brief problem-oriented therapy (OR 0.40, 95% CI 0.06 to 2.57; 1 study, n=33) or on hopelessness (MD 1.77, 95% CI -1.06 to 4.60; 1 study, n=39).
- Behaviour therapy showed no significant treatment effect on repetition of self-harm at 12-month follow-up compared to insight-oriented therapy (OR 0.60, 95% CI 0.08 to 4.45; 1 study, n=24) or on suicidal ideation (OR 0.24, 95% CI 0.04 to 1.36; 1 study, n=24). There was a significant treatment effect on depression at post-treatment with two measures Beck Depression Inventory (MD -10.00, 95% CI -17.16 to -2.84; 1 study, n=24) and Zung Self-Rating Depression Scale (MD -11.00, 95% CI -20.12 to -1.88; 1 study, n=24) and 6-month follow-up with Beck Depression Inventory (MD -7.00, 95% CI -15.64 to 1.64; 1 study, n=24) but not with Zung Self-Rating Depression Scale (MD -9.00, 95% CI -16.09 to -1.91; 1 study, n=24).
- Provision of information and support showed no significant treatment effect on repetition of self-harm at 18-month follow-up (OR 1.02, 95% CI 0.71 to 1.47; 1 study, n=1,663) and a significant increase in frequency of repetition of self-harm at 6-month follow-up (MD 0.46, 95% CI 0.32 to 0.60; 1 study, n=629) compared to TAU. There was a significant effect at 18-month follow-up on depression (MD -3.09, 95% CI -5.70 to -0.48; 1 study, n=111) and suicide (OR 0.10, 95% CI 0.02 to 0.45; 1 study, n=1,699).
- A brief intervention for alcohol misuse showed no significant treatment effect on repetition of self-harm at 6-month follow-up compared to TAU (OR 0.57, 95% CI 0.20 to 1.60; 1 study, n=103).

- Home-based problem solving therapy showed no significant treatment effect on repetition of self-harm at 12-month follow-up compared to outpatient clinic-based problem-solving therapy (OR 0.68, 95% CI 0.20 to 2.32; 1 study, n=96).
- Intensive inpatient and community treatment showed no significant treatment effect compared to TAU on repetition of self-harm (OR 1.18, 95% CI 0.62 to 2.25; 1 study, n=274) or in frequency of repetition of self-harm at 12-month follow-up (MD 0.00, 95% CI -0.17 to 0.17; 1 study, n=274) or on depression (MD -5.00, 95% CI -10.52 to 0.52; 1 study, n=144) or on hopelessness (MD -1.40, 95% CI -3.32 to 0.52; 1 study, n=144) or on suicide (OR 0.47, 95% CI 0.04 to 5.30; 1 study, n=274).
- General hospital admission showed no significant treatment effect compared to non-admission on repetition of self-harm at post-intervention (OR 1.03, 95% CI 0.14 to 7.69; 1 study, n=77) or at 6-month follow-up (OR 0.75, 95% CI 0.16 to 3.60; 1 study, n=77) or on suicidal ideation at 4-month follow-up (MD 0.18, 95% CI -0.15 to 0.51; 1 study, n=52).
- Intensive outreach interventions showed no significant treatment effect compared to TAU on repetition of self-harm at post-intervention (OR 0.27, 95% CI 0.07 to 1.06; 1 study, n=119), at 24-month follow-up (OR 1.24, 95% CI 0.59 to 2.62; 1 study, n=126), at final follow-up (OR 0.65, 95% CI 0.15 to 2.85; 2 studies, n=245) or on suicide at 24-month follow-up (OR 3.00, 95% CI 0.30 to 29.52; 1 study, n=150).
- Long-term psychotherapy showed no significant treatment effect on repetition of self-harm at 12-month follow-up compared to short-term psychotherapy (OR 1.00, 95% CI 0.35 to 2.86; 1 study, n=80).

Strengths and limitations

Strengths

The main strength was that the study used the Cochrane methodology. The authors judged that more than 70% of studies had low risk of sequence generation bias and other potential sources of bias.

Limitations

Although this Cochrane review included a large number of studies and different psychosocial interventions, pooled meta-analyses combining all studies related to a specific intervention was done only for 2 interventions: CBT-based psychotherapy and case management both compared to TAU. The authors judged that more than 90% of studies had high risk of performance bias. Reporting bias was rated as unclear in 94.5% of studies because the trial protocols were not

available. Furthermore, the quality of the evidence was assessed as being low or very low using the GRADE approach.

Pharmacological interventions for self-harm in adults

Methods

[Hawton et al. \(2015b\)](#) conducted a Cochrane review of 7 randomised controlled trials (n=546 participants) assessing the effects of pharmacological interventions for self-harm in adults. Participants were included if they were 18 years and older, had engaged in any type of self-harm in the 6 months prior to trial entry, and had presented to clinical services as a result of self-harm.

Pharmacological interventions included:

- Tricyclic antidepressants
- Newer generation antidepressants (mianserin, nomifensine, paroxetine)
- Any other antidepressants such as irreversible mono-amine oxidase inhibitors
- Antipsychotics
- Mood stabilisers (including antiepileptics and lithium)
- Other pharmacological agents
- Natural products (omega-3 essential fatty acid [n-3EFA])

Placebo, another pharmacological intervention or lower doses of the intervention drugs were the comparators.

The primary outcome measure was occurrence of repeated self-harm which was reported as the proportion of participants repeating self-harm and the frequency of repeat episodes. Secondary outcomes included depression, hopelessness, suicidal ideation, and suicide.

Meta-analysis was undertaken only for newer generation antidepressants because the rest of interventions were reported by one study each or the comparator was different when 2 studies evaluated the same intervention.

Results

Participants were 35.3 years old on average (age was reported in 5 studies). More than half of participants were women (63.5%, gender was reported by 6 studies). The most common co-morbidities were: personality disorders and major depression. The following findings were reported by the included studies:

Newer generation antidepressants (mianserin, nomifensine, paroxetine) compared to placebo

Three studies evaluated the effectiveness of newer generation antidepressants on repetition of self-harm. There was no significant treatment effect at 12-week follow-up with mianserin or nomifensine (OR 1.31, 95% CI 0.46 to 3.71; 1 study, n=114), at 6-month follow-up with mianserin (OR 0.67, 95% CI 0.18 to 2.41; 1 study, n=38), at 12-month follow-up with paroxetine (OR 0.55, 95% CI 0.24 to 1.29; 1 study, n=91), or at last follow-up combining all three studies (OR 0.76, 95% CI 0.42 to 1.36; 3 studies, n=243) or on suicide at 12-month follow-up with paroxetine (OR 0.32, 95% CI 0.01 to 8.04; 1 study, n=91).

Antipsychotics compared to placebo or a lower dose

A study evaluated the effectiveness of flupenthixol ('prophylactic' injections) on repetition of self-harm at 6-month follow-up. The results showed a significant treatment effect compared to placebo (OR 0.09, 95% CI 0.02 to 0.50; 1 study, n=30). Another study evaluated the effectiveness of fluphenazine (12 mg) on repetition of self-harm showing no significant treatment effect at 6-month follow-up compared to an ultra-low dose (1.5 mg) fluphenazine (OR 1.51, 95% CI 0.50 to 4.58; 1 study, n=53).

Mood stabilisers (lithium) compared to placebo

One study failed to show an effect of lithium compared to placebo on:

- Repetition of self-harm at 12-month follow-up (OR 0.99, 95% CI 0.33 to 2.95; 1 study, n=167).
- Depression
 - 3-month follow-up (MD -0.34, 95% CI -2.92 to 2.24; 1 study, n=110)
 - 6-month follow-up (MD 0.54, 95% CI -2.91 to 3.99; 1 study, n=85)
 - 12-month follow-up (MD -0.39, 95% CI -4.21 to 3.43; 1 study, n=64).

- **Hopelessness**

- 3-month follow-up (MD -0.56, 95% CI -2.86 to 1.74; 1 study, n=98)
- 6-month follow-up (MD -0.84, 95% CI -4.51 to 2.83; 1 study, n=52)
- 12-month follow-up (MD -0.16, 95% CI -3.33 to 3.01; 1 study, n=51).

- **Suicidal ideation**

- 3-month follow-up (OR 1.15, 95% CI 0.52 to 2.57; 1 study, n=109)
- 6-month follow-up (OR 1.18, 95% CI 0.46 to 3.02; 1 study, n=82)
- 12-month follow-up (OR 0.66, 95% CI 0.22 to 1.97; 1 study, n=63).

- **Suicides** (OR 0.14, 95% CI 0.01 to 2.68; 1 study, n=167).

Natural products (omega-3 essential fatty acid [n-3EFA]) compared to placebo

A study evaluated the effectiveness of dietary supplementation (n-3EFA) on repetition of self-harm showing no significant treatment effect at 12-week follow-up compared to placebo (OR 1.33, 95% CI 0.38 to 4.62; 1 study, n=49) but a significant effect on suicidal ideation at 12-week follow-up (OR 0.24, 95% CI 0.07 to 0.80; 1 study, n=49).

Strengths and limitations

Strengths

The main strength was that the study used the Cochrane methodology. The authors judged that more than 85% of studies had low risk of performance bias (relating to blinding of participants) and other potential sources of bias.

Limitations

The authors rated more than 70% of studies unclear risk of selection (allocation concealment) and reporting bias. The quality of the evidence was assessed as being low or very low using the GRADE approach. Meta-analysis was undertaken only for one intervention because the rest of interventions were reported by one study each. Therefore, it is difficult to conclude which pharmacological interventions are effective to treat self-harm in adults.

Impact on guideline

Psychosocial interventions for self-harm in children and adolescents

The findings of this Cochrane review showed that individual CBT-based psychotherapy, DBT-A, group-based psychotherapy, therapeutic assessment, compliance enhancement, home-based family intervention and emergency cards resulted in no significant treatment effect on repetition or frequency of self-harm in children and adolescents. Mentalisation-based therapy (MBT) had a significant treatment effect on repetition of self-harm. These findings are unlikely to affect current recommendations in NICE guideline CG133 which recommends consideration of psychological interventions that could include cognitive-behavioural, psychodynamic or problem-solving elements.

Topic experts noted that another systematic review of randomised controlled trials ([Ougrin et al. 2015](#)) included similar studies as Hawton et al. (2015a) but reported different results. Ougrin et al. (2015) included 19 randomised controlled trials (n=2,176 youths) and reported that there was a significantly lower proportion of adolescents who self-harmed for three intervention groups DBT, CBT and MBT. Topic experts also highlighted that DBT had a much larger effect size than MBT in the systematic review by Ougrin et al. (2015) which was the converse of the results reported by Hawton et al. (2015a). It might be possible that sample size had an impact on the differences in results between Ougrin et al. (2015, 19 RCTs [n=2,176]) and Hawton et al. (2015a, 11 RCTs [n=1,126]). Topic experts also noted that the problems with group-based therapy found by Hawton et al. (2015a) were highlighted by NICE guideline CG16 during the surveillance review in 2012 (see [Appendix 1 – Short-term recommendation 1.9.1.13](#)).

Psychosocial interventions for self-harm in adults

The findings of this Cochrane review showed that some psychosocial interventions were effective in reducing repetition of self-harm such as CBT-based psychotherapy and group-based emotion-regulation psychotherapy but not at reducing the frequency of self-harm. Other psychosocial interventions did not reduce repetition of self-harm such as case management, treatment adherence enhancement, continuing aftercare with the same therapist, mixed multimodal interventions, remote contact interventions, and other mixed interventions. There were inconsistent results for dialectical behaviour therapy showing reduced repetition and frequency of self-harm in some studies but no reduction in others. The frequency of self-harm was increased with the provision of information and support.

The findings of this Cochrane review are unlikely to affect current recommendations in NICE guideline CG133 which recommends considering to offer psychological interventions that could include cognitive-behavioural, psychodynamic or problem-solving elements.

Topic experts noted that a Cochrane review of randomised controlled trials of psychological therapies for people with borderline personality disorder ([Stoffers et al. 2012](#)) included more studies evaluating dialectical behaviour therapy compared to Hawton et al. (2016) and reported an impact on self-harm with a medium effect size. Topic experts highlighted that the difference in number of included RCTs in both Stoffers et al. (2012) and Hawton et al. (2016) might be due to different inclusion criteria in each Cochrane review. Topic experts concluded that the differences between the Cochrane reviews by Hawton et al. (2016) and Stoffers et al. (2012) could account for the variation in the findings. Topic experts mentioned that it seems safe to use dialectical behaviour therapy prolonged exposure in the treatment of post-traumatic stress disorder (PTSD) in suicidal people with borderline personality disorder (BPD). This was highlighted because there had been reluctance to treat PTSD in this specific population in the past. It was also highlighted that one of the included studies ([Guthrie et al. 2001](#)) in the review by Hawton et al. (2016) may have been incorrectly classified as CBT-based psychotherapy as topic experts considered this study to cover psychodynamic therapy. Topic experts clarified that this study was included during the development of NICE guideline CG133 and it was correctly categorised.

Pharmacological interventions for self-harm in adults

The findings of this Cochrane review (Hawton 2015b) showed that there was no evidence of a significant treatment effect on repetition of self-harm for most of the included interventions such as newer generation antidepressants, mood stabilisers, and natural products. Antipsychotics had a significant treatment effect on repetition of self-harm when compared to placebo but not compared to lower dose of the same antipsychotic. However, the significant effect was reported by a small trial (n=30 participants) which was rated as very low quality with GRADE. Therefore, these findings are unlikely to affect current recommendation of NICE guideline CG133 which recommends not offering drug treatment as a specific intervention to reduce self-harm.

How we made the decision

We check our guidelines regularly to ensure they remain up to date. We based the decision on surveillance 12 years after the publication of [Self-harm in over 8s: short-term management and prevention of recurrence](#) (2004) NICE guideline CG16 and surveillance 4 years after the publication of [Self-harm in over 8s: long term management](#) (2011) NICE guideline CG133.

For details of the process and update decisions that are available, see [ensuring that published guidelines are current and accurate](#) in developing NICE guidelines: the manual.

Previous surveillance update decisions for NICE guidelines [CG16](#) and [CG133](#) are on our website.

New evidence

Self-harm in over 8s: short-term management and prevention of recurrence NICE guideline CG16

We found 11 new studies in a search for systematic reviews and randomised controlled trials published between 19 September 2011 and 26 April 2016. We also considered 3 additional studies identified by members of the guideline committee who originally worked on this guideline.

Evidence identified in previous surveillance 7 years after publication of the guideline was also considered. This included 36 studies identified by search.

From all sources, 50 studies were considered to be relevant to the guideline.

We also checked for relevant ongoing research, which will be evaluated again at the next surveillance review of the guideline.

See [Appendix A1: summary of new evidence from surveillance](#) and references for all new evidence considered.

Self-harm in over 8s: long term management NICE guideline CG133

We found 15 new studies in a search for systematic reviews and randomised controlled trials published between 25 October 2012 and 26 April 2016. We also considered 6 additional studies identified by members of the guideline committee who originally worked on this guideline.

Evidence identified in previous surveillance 2 years after publication of the guideline was also considered. This included 13 studies identified by search.

From all sources, 34 studies were considered to be relevant to the guideline.

We also checked for relevant ongoing research, which will be evaluated again at the next surveillance review of the guideline.

See [Appendix A2: summary of new evidence from surveillance](#) and references for all new evidence considered.

Views of topic experts

We considered the views of topic experts, including those who helped to develop the guideline and other correspondence we have received since the publication of the guideline.

Views of stakeholders

Stakeholders commented on the decision not to update NICE guidelines CG16 and CG133. See [Appendix B](#) for stakeholders' comments and our responses.

Four stakeholders commented on the proposal to not update NICE guideline CG16: 2 agreed with the decision and 2 disagreed with the decision. Consultees mentioned that the guideline does not separate self-harm in terms of its nature. However, it was noted that the guideline adopted a broad definition of self-harm to cover all its variants. Consultees also referred to a case study as part of the Implementation Plan of the Mental Health Taskforce which highlights that NHS England is testing and evaluating models of crisis resolution for children and young people during 2016/2017. Therefore, we will add this to our guideline issues log and consider the results of this evaluation when available.

Three stakeholders commented on the proposal to not update NICE guideline CG133: 1 stakeholder agreed with the decision and 2 disagreed with the decision. Consultees mentioned that the guideline makes an emphasis on self-harm as a diagnosis but not about the psychological causes. The consultees referred to recommendations 1.4.2 and 1.4.4 regarding the lack of reference to the psychological causes. However, there was no new evidence during this surveillance review relevant to recommendations 1.4.2 and 1.4.4.

Two stakeholders commented on the proposal to leave NICE guideline CG16 on the static list: 1 agreed with the decision and 1 disagreed with the decision. No new ongoing or published studies were identified by the consultees related to NICE guideline CG16. A consultee highlighted a case study relevant to NICE guideline CG16 which is part of an evaluation of models of crisis resolution for children and young people during 2016/2017 by NHS England within the [Implementation Plan of the Mental Health Taskforce](#). However, NHS England is testing and evaluating models of crisis resolution for children and young people during 2016/2017. Therefore, we will add this to our guideline issues log and consider the results of this evaluation when available.

This surveillance review also proposed to remove four research recommendations from the NICE version of NICE guideline CG133 and the NICE research recommendations database. Four consultees answered the proposal. Consultees disagreed with the proposal of removing three research recommendations. It was decided to retain these research recommendations based on the feedback on their importance. Consultees agreed with the proposal of removing the fourth research recommendation.

See [ensuring that published guidelines are current and accurate](#) in developing NICE guidelines: the manual for more details on our consultation processes.

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