ISRCTN81846131 https://doi.org/10.1186/ISRCTN81846131

Supporting adolescents with self-harm: a brief psychological intervention to reduce self-harm in adolescence

Submission date
13/12/2022

Recruitment status
No longer recruiting

Registration date
13/12/2022

Overall study status
Ongoing

Last Edited
15/04/2025

Condition category
Mental and Behavioural Disorders

[X] Prospectively registered
[ ] Protocol
[ ] Statistical analysis plan
[ ] Results
[ ] Individual participant data
[X] Record updated in last year

Plain English Summary

Background and aims
Suicide is a leading cause of death in young people, and previous self-harm is the strongest predictor of suicide. Rates of self-harm in adolescents range from 6.9% to 15.9% and every year young people in crisis visit emergency departments (ED) having self-harmed. Most EDs have a paediatric psychiatric liaison team of mental health practitioners who conduct a comprehensive psychosocial assessment as per current guidelines. Psychosocial assessment includes an evaluation of risk and needs, but many young people do not experience this as therapeutic and do not engage in follow-up. The period after discharge from ED is associated with the highest risks of repeat self-harm and suicide, suggesting that this period in the care pathway presents a unique opportunity to intervene quickly so that young people can be supported to find alternative ways of coping. This study is testing the effects of a new approach to assessment along with a brief psychological therapy delivered in the community to see if it can help reduce self-harm and future crisis.

Who can participate?
Mental health practitioners, carers and young people aged 12-19 years who visit recruiting emergency departments with self-harm or suicidal ideation with recent self-harm

What does the study involve?
Participants who are identified as eligible for the study will be contacted for consent by a researcher within 48 hours of their visit to the emergency department. A computer will randomly allocate them to either the SASH approach or treatment as usual. Young people who are allocated to the SASH approach will be offered a therapeutic assessment and up to six follow-up appointments with the same practitioner over an 8-week period, as well as two letters including details of the contacts. Carers may be invited to join sessions according to the young person's preference and the carer's need, and/or be invited to one or two standalone sessions, inclusive of the six sessions delivered overall. Participants in the treatment as usual group will receive a standard psychosocial assessment and care. All participants will be asked to complete a research interview at 6 months and those with a mobile phone will be sent a brief electronic questionnaire to complete every 2 weeks within the 6-month period.

What are the possible benefits and risks of participating?
Participating in a study whilst young people are in distress may present a risk of further distress. If the practitioners or the researchers feel that the research is too overwhelming, they will stop the process immediately. Some young people may value talking about their experiences and being listened to, as well as contributing to research aiming to help other young people who self-harm.

Where is the study run from?
City, University of London (UK)

When is the study starting and how long is it expected to run for?
May 2022 to September 2025

Who is funding the study?
The Kavli Trust (Norway)

Who is the main contact?
Maria Long, maria.long@city.ac.uk

Study website
https://sashstudy.co.uk/

Contact information

Type(s)
Public

Contact name
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Additional identifiers

EudraCT/CTIS number
Nil known

IRAS number
312523

ClinicalTrials.gov number
Nil known

Secondary identifying numbers
IRAS 312523, CPMS 53021

Study information

Scientific Title
A brief psychological intervention to reduce self-harm in adolescence

Acronym
SASH

Study hypothesis
Current study hypothesis as of 13/06/2023:
Main hypothesis: a brief psychological intervention of therapeutic assessment and solution-focused follow-up contacts will reduce repeat self-harm in adolescents presenting with self-harm in an Emergency Department (ED).

Further research questions:
1. Does the intervention improve secondary outcomes, i.e. repeat ED attendance for self-harm, wellbeing, symptoms of depression and anxiety, and negative experiences of care?
2. How is the intervention experienced by minority ethnic, same-sex attracted and gender-diverse adolescents and how should it be adapted to address ethnicity, sexuality and gender?
3. Is the intervention cost-effective?

Previous study hypothesis:
Main hypothesis: a brief psychological intervention of therapeutic assessment and solution-focused follow-up contacts will reduce repeat self-harm in adolescents presenting with self-harm in an Emergency Department (ED).

Further research questions:
1. Does the intervention improve secondary outcomes, i.e. repeat ED attendance for self-harm, social functioning, emotional and behavioural difficulties, and negative experiences of care?
2. How is the intervention experienced by minority ethnic, same-sex attracted and gender-diverse adolescents and how should it be adapted to address ethnicity, sexuality and gender?
3. Is the intervention cost-effective?

Ethics approval required
Old ethics approval format

Ethics approval(s)
Approved 23/08/2022, London - Riverside Research Ethics Committee (Ground Floor, Temple Quay House, 2 The Square, Bristol, BS1 6PN, UK; +44 (0)207 104 8150, +44 (0)207 104 8013; riverside.rec@hra.nhs.uk), ref: 22/LO/0400

Study design
Multicentre interventional assessor-blind randomized controlled trial

Primary study design
Interventional

Secondary study design
Randomised controlled trial

Study setting(s)
Hospital

Study type(s)
Treatment

Participant information sheet
Not available in web format, please use the contact details to request a patient information sheet

Condition
Self-harm in adolescents

Interventions
Current interventions as of 13/06/2023:
Consenting participants are randomly allocated to one of two groups. Participants will be randomised to the intervention or control arm with a 1:1 ratio. The researchers will use randomized permuted blocks stratified by clinical site and whether the young person has presented to the emergency department more than once.

Control group: Participants receive treatment as usual based on recommended NICE care which consists of a comprehensive psychosocial assessment, including assessment of needs, risk assessment and development of an integrated care and risk management plan; and relevant aftercare if there are ongoing safety concerns.

Intervention group: Participants receive an initial session comprising of a therapeutic assessment, enhanced and personalised safety planning and up to six solution-focused rapid follow-up contacts. Carers may be invited to participate in joint sessions with the young person or offered one or two standalone sessions, organised around some or all of the following elements, according to need: signposting, psychoeducation around self-harm, emotional support, improving understanding of the SASH intervention. At 3 and 6 months after the ED presentation, adolescents will receive personalised letters from the practitioner to remind them of the safety plan and support networks. Therapeutic assessment and rapid solution-focused follow-up contacts after self-harm presentations are manualised.

Previous interventions:
Consenting participants are randomly allocated to one of two groups. Participants will be randomised to the intervention or control arm with a 1:1 ratio. The researchers will use randomized permuted blocks stratified by clinical site.

Control group: Participants receive treatment as usual based on recommended NICE care which consists of a comprehensive psychosocial assessment, including assessment of needs, risk assessment and development of an integrated care and risk management plan; and relevant aftercare if there are ongoing safety concerns.

Intervention group: Participants receive an initial session comprising of a therapeutic assessment, enhanced and personalised safety planning and three solution-focused rapid follow-up contacts. At 3 and 6 months after the ED presentation, adolescents will receive personalised letters from the practitioner to remind them of the safety plan and support networks. Therapeutic assessment and rapid solution-focused follow-up contacts after self-harm presentations are manualised.

Intervention Type
Behavioural

Primary outcome measure
Number of self-harm episodes during the past month measured using a modified version of the Self-Injurious Thoughts and Behaviours Interview Short Form at baseline and 6 months

Secondary outcome measures
1. Depression measured by the short version of the Moods and Feelings Questionnaire (MFQ) at baseline and 6 months
2. Anxiety measured by the Generalised Anxiety Disorder Assessment (GAD-7) at baseline and 6 months
3. Repeat ED attendance due to self-harm: identified in ED medical records, measured by count at baseline and 6 months
4. Death by suicide, i.e., cause of death is intentional self-harm or undetermined intent: NHS /local authority/coroner records, captured at 6 months
5. School attendance, obtained from the adolescent's school, measured by count at baseline and 6 months
6. General wellbeing measured by the Warwick-Edinburgh Mental Wellbeing 14-item scale at baseline and 6 months
7. Experiences of care in A&E measured by the adapted Negative Effects Questionnaire (NEQ) at baseline
8. Separate dimensions of self-harm measured by the Self-Injurious Thoughts and Behaviors Interview (SITBI) Short Form): Number of reported episodes, in the past month, of the below, measured at baseline and 6 months:
8.1. Self-injury without suicidal intent
8.2. Suicide attempts
8.3. Self-injury with unclear or ambiguous intent
9. Dichotomized self-harm (any self-harm in the last month) measured by the SITBI Short Form at baseline and 6 months
10. Additional dimensions of self-harm measured by the SITBI Short Form: Number of reported episodes, in the last month, of the below, measured at 6 months:
10.1. Suicidal ideation
10.2. Suicide plan
10.3. Thoughts of non-suicidal self-injury
11. Number of self-harm episodes reported via text message survey (Ecological Momentary Assessment) every 2 weeks

Resource use:
1. Health and quality-adjusted life-years (QALYs) measured and calculated using the Child Health Utility 9D (CHUD9) at baseline and 6 months
2. Cost of health and social care services use for children measured by the Client Service Receipt Inventory adapted for young people, collected by either the young person or parent/guardian (if applicable) according to participant preference, measured at baseline and 6 months

3. Costs of productivity lost and out-out-pocket service for guardians measured by the Client Service Receipt Inventory at baseline and 6 months

Parent-reported data:
1. Guardians' self-reported health-related quality of life measured using EQ-5D-5L at baseline and 6 months
2. Cost of health and social care services use for children as measured by Client Service Receipt as detailed above, at baseline and 6 months

Overall study start date
05/05/2022

Overall study end date
30/09/2025

Eligibility

Participant inclusion criteria
Current inclusion criteria as of 13/06/2023:
Children and adolescents age 12-19 years who present to recruiting emergency departments with self-harm OR suicidal ideation with recent (in the past month) self-harm

Previous inclusion criteria:
Children and adolescents age 12-19 years

Participant type(s)
Patient

Age group
Mixed

Lower age limit
12 Years

Upper age limit
19 Years

Sex
Both

Target number of participants
144

Participant exclusion criteria
Current exclusion criteria as of 13/06/2023:
1. Intellectual disability as judged by a clinician
2. Currently experiencing an episode of psychosis
3. Registered with a GP outside of the mental health Trust catchment area
4. Need for more intensive care (e.g. tier 3.5 or an inpatient admission)

Previous exclusion criteria:
1. Intellectual disability (IQ less than 70)
2. Diagnosis of psychosis
3. Registered with a GP outside of the mental health Trust catchment area
4. Need for more intensive care (e.g. tier 3.5 or an inpatient admission)

Recruitment start date
11/05/2023

Recruitment end date
28/02/2025

Locations

Countries of recruitment
England

United Kingdom

Study participating centre
West Middlesex University Hospital
Twickenham Road
Isleworth
United Kingdom
TW7 6AF

Study participating centre
Homerton Hospital
Homerton Row
London
United Kingdom
E9 6SR

Study participating centre
Newham General Hospital
Glen Road
London
United Kingdom
E13 8SL

Study participating centre
Royal London Hospital
Whitechapel

London
United Kingdom
E1 1BB

Study participating centre
The Hillingdon Hospital
Pield Heath Road
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United Kingdom
UB8 3NN

Study participating centre
Northwick Park Hospital
Watford Road
Harrow
United Kingdom
HA1 3UJ

Study participating centre
Chelsea & Westminster Hospital
369 Fulham Road
London
United Kingdom
SW10 9NH

Study participating centre
St Mary's Hospital
Praed Street
London
United Kingdom
W2 1NY

Sponsor information

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City, University of London

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Sponsor type
University/education

Website
https://www.city.ac.uk/

ROR
https://ror.org/04489at23

Funder(s)

Funder type
Charity

Funder Name
Kavlifondet

Alternative Name(s)
The Kavli Trust, Kavli Trust, O. Kavli og Knut Kavlis Almennyttige Fond

Funding Body Type
Private sector organisation

Funding Body Subtype
Trusts, charities, foundations (both public and private)

Location
Norway

Results and Publications

Publication and dissemination plan
Planned publication in a high-impact peer-reviewed journal.

Intention to publish date
30/04/2026

Individual participant data (IPD) sharing plan

The data-sharing plans for the current study are unknown and will be made available at a later date

IPD sharing plan summary

Data sharing statement to be made available at a later date