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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
Completed

Last Edited
30/10/2026

Condition category
Mental and Behavioural Disorders

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

Plain English summary of protocol

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 and a follow-up within 7 days of discharge, as per current guidelines. Psychosocial assessment includes an evaluation of risk and needs, and this is reviewed during the 7-day follow-up. Many young people do not experience these contacts 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 care after discharge from the ED, to see if it can help reduce self-harm and future crisis.

Who can participate?
We are recruiting mental health practitioners to deliver the new approach to care, and young people aged 12-18 who visit recruiting emergency departments with self-harm or suicidal ideation with recent self-harm (within the past month), parents/carers are also invited to participate and consent on behalf of young people under the age of 16.

What does the study involve?
Researchers will aim to contact young people who are identified as eligible for the study for consent within 48-72 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 up to six sessions, the first of which will ideally happen within one week of discharge from ED. These sessions will include: a therapeutic assessment, enhanced safety planning and up to five solution-focused follow-up appointments with the same practitioner over an 8 week period, as well as two letters including details of the contacts. According to young person preference, parents/carers may also be invited to be involved in joint or individual sessions. Participants in the treatment-as-usual arm 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 2026

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

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

Contact information

Type(s)
Public

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Additional identifiers

Integrated Research Application System (IRAS)
312523

Central Portfolio Management System (CPMS)

53021

Study information

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

Acronym
SASH

Study objectives
Current study hypothesis as of 11/07/2025:
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 or suicidal ideation (with recent self-harm) in an Emergency Department (ED).

Further research questions:
1. Does the intervention improve secondary outcomes, i.e. symptoms of depression and anxiety, repeat ED attendance for self-harm, death by suicide, school attendance, mental wellbeing, separate domains relating to suicidal thoughts and self-harm behaviour, health-related quality of life, parent/carer health-related quality of life?
2. How is the intervention experienced by minority ethnic, non-heterosexual 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 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

Primary study design
Interventional

Study design
Multicentre interventional assessor-blind randomized controlled trial

Study type(s)
Treatment

Health condition(s) or problem(s) studied
Self-harm in adolescents

Interventions
Current interventions as of 11/07/2025:
Consenting participants are randomly allocated to one of two groups.

Control group: Participants receive treatment as usual based on recommended NICE care which consists of a 7-day follow-up in the community, including review of needs, risk assessment and review of the integrated care and risk management plan developed in the ED; and relevant aftercare if there are ongoing safety concerns.

Intervention group: Participants receive up to six sessions in total, which includes an initial session comprising of a therapeutic assessment, enhanced and personalised safety planning and up to five 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, and improving understanding of the SASH intervention. Standard care is received concurrently. At 2 and 5 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 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(s)
Current primary outcome measure as of 11/07/2025:
Self-reported episodes of self-harm within the past month, assessed 6 months post-randomisation. This is a count outcome based on summing the number of episodes of self-harm reported from a single item (“How many times in the past month?”) across the three behavioural domains (suicide attempt, self-harmed without intent to end life, self-harm with ambiguous intent) from the modified version of the Short Form of the Self Injurious Thoughts and Behaviour Interview (SITBI, Nock et al., 2007).

Previous 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

Key secondary outcome(s)
Current secondary outcome measures as of 11/07/2025:
1. Depressive symptoms, measured by the short version of the Moods and Feelings Questionnaire (MFQ) at baseline and 6 months
2. Anxiety symptoms 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, identified in NHS records, captured at 6 months
5. School attendance, obtained from the Client Service Receipt Inventory (CSRI), obtained at

baseline and 6 months
6. General wellbeing measured by the Warwick-Edinburgh Mental Wellbeing 14-item scale at baseline and 6 months
7. Three separate domains of self-harm behaviour assessed by the modified SITBI Short Form: number of reported episodes of self-harm with suicidal intent, self-harm without suicidal intent, and self-harm where intent is ambiguous, in the past month, at baseline and 6 months
8. Three separate domains of self-harm related suicidal ideation assessed by the SITBI Short Form: number of reported episodes of suicidal ideation, suicide plans, and thoughts of non-suicidal self-injury in the past month, measured at baseline and 6 months
9. Dichotomized self-harm (any self-harm in the past month) assessed by the SITBI short form, at baseline and 6 months
10. Number of young person reported self-harm episodes obtained every two weeks for the duration of 6-month follow-up via text message survey where provided
11. Parent/carer self-reported health-related quality of life assessed by the ED-5D-5L at baseline and 6 months
12. Children's self-reported health-related quality of life data collected using Child Health Utility 9D (or CHU9D) at baseline and 6 months

Other variables:
1. Experiences of care in the ED assessed by a version of the Negative Effects Questionnaire, developed for a similar trial in adults, the ASSURED trial, captured at baseline
2. Parental/carer involvement in care received as part of the Intervention or Treatment as Usual (binary variable), captured as part of a bespoke form designed specifically for the SASH trial

Other data that will be extracted from records:
1. Co-occurring mental disorders
2. Young people and carer participants' sociodemographic and clinical baseline data from medical records will be complemented with interviews.

Resource use will also be assessed:
1. Resources to train SASH Practitioners and resources involved in delivering SASH and TAU will be collected using two Health Economics Inventory forms designed for the SASH trial
2. Health and social care service use and school support services use by young people will be assessed using the CSRI
3. Productivity loss and family resource use due to the mental health difficulties of young people will be assessed using the CSRI

Previous 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-of-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

Completion date
30/09/2026

Eligibility

Key inclusion criteria
Current inclusion criteria as of 11/07/2025:
Practitioner participants:
NHS practitioners working or allied with CAMHS crisis/urgent care/community teams delivering follow-up care to young people after presenting to ED with self-harm (e.g. mental health nurses, social workers, assistant psychologists, clinical associate psychologists).

Adolescent participants:
1. 12-18 years old
2. Presenting in crisis to the ED with self-harm or suicidal ideation with recent self-harm (defined as within one month)

Previous inclusion criteria as of 25/06/2025:
1. 12-19 years old
2. Presenting in crisis to the ED with self-harm or suicidal ideation with recent self-harm (within one month)

Previous inclusion criteria as of 13/06/2023:
Children and adolescents aged 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 aged 12-19 years

Participant type(s)
Health professional, Patient

Healthy volunteers allowed
No

Age group
Mixed

Lower age limit
12 Years

Upper age limit
18 Years

Sex
All

Total final enrolment
154

Key exclusion criteria
Current exclusion criteria as of 11/07/2025:
Practitioner participants:
No exclusion criteria

Adolescent participants:
1. Possible Learning Disability, judged by a clinician
2. Need for more intensive treatment than the intervention offers, e.g. inpatient treatment (tier 4) or intensive/outreach care in the community (Tier 3.5)
3. Current psychotic episode
4. Registered with a GP outside of the mental health NHS Trust catchment area
5. Receiving individual one-to-one psychological therapy for more than one hour per week
6. Interpreter required to complete research procedures

Previous exclusion criteria as of 25/06/2025:
1. Possible Learning Disability, judged by clinician
2. Need for intensive treatment (i.e. more intensive treatment than the intervention offers e.g. Tier 3.5 or an inpatient psychiatric admission)

3. Current psychotic episode
4. Registered with a GP outside of the mental health NHS trust catchment area
5. Receiving individual one-to-one psychological therapy for more than one hour per week
6. Interpreter required to complete research procedures

Previous 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)

Date of first enrolment
10/05/2023

Date of final enrolment
31/03/2025

Locations

Countries of recruitment
United Kingdom

England

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

Study participating centre
Homerton Hospital
Homerton Row
London
England
E9 6SR

Study participating centre

Newham General Hospital
Glen Road
London
England
E13 8SL

Study participating centre
Royal London Hospital
Whitechapel
London
England
E1 1BB

Study participating centre
The Hillingdon Hospital
Pield Heath Road
Uxbridge
England
UB8 3NN

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

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

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

Sponsor information

Organisation
City St George's, University of London

ROR
https://ror.org/047ybhc09

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

Individual participant data (IPD) sharing plan
The datasets generated and/or analysed during the current study will be available on request – where relevant consent is in place - from Prof. Rose McCabe (rose.mccabe@citystgeorges.ac.uk). Individual-level patient data will not be made publicly available due to data privacy/GDPR. Additional access to the final study dataset will be considered with an appropriate data-sharing agreement in place.

IPD sharing plan summary
Available on request

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?

Protocol article	14/09/2025	17/09/2025	Yes	No
Other publications	14/10/2026	30/10/2026	Yes	No
Study website	11/11/2025	11/11/2025	No	Yes