



**GIG**  
CYMRU  
**NHS**  
WALES

Arsyllfa Iechyd  
Cyhoeddus Cymru  
Public Health  
Wales Observatory

# **Research evidence review report for the Child Death Review Programme's thematic review of deaths of children and young people through probable suicide (2013-2017)**

**Dr Chukwudi Okolie, Research Officer**

**2019**

Title: Research evidence review report for the Child Death Review Programme's thematic review of deaths of children and young people through probable suicide (2013-2017).

Publisher: Public Health Wales NHS Trust

Date: December 2019

ISBN 978-1-78986-154-60

© 2019 Public Health Wales NHS Trust.

Material contained in this document may be reproduced under the terms of the Open Government Licence (OGL)

[www.nationalarchives.gov.uk/doc/open-government-licence/version/3/](http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/)

provided it is done so accurately and is not used in a misleading context.

Acknowledgement to Public Health Wales NHS Trust to be stated.

Copyright in the typographical arrangement, design and layout belongs to Public Health Wales NHS Trust.

## **Research evidence review question**

The review addressed the question:

*What interventions might be effective in reducing rates of suicide, self-harm and suicide ideation in children and young people in Wales?*

### **1. Research evidence review question**

This research evidence review followed systematic review methodology which was detailed in an a priori protocol for addressing an explicit question. Full methodological details are contained within a protocol and search technical document which are available on request. Systematic reviews aim to provide an objective, reliable synthesis of the evidence base through following explicit methodology which is transparent, repeatable and which aims to minimise bias. In brief, evidence sources (Clinical guidelines and well-designed systematic reviews from organisations known to use robust and transparent methods) located by the systematic search strategy (in July 2018) were filtered for relevance and type of source based first on their titles and in a second filtering stage, on details contained in abstracts. The full-text of sources which were retained following this filtering process were then examined. Relevant data were then extracted from included sources, into an Evidence Summary Table and conclusions drawn about the quality, strength and direction of the evidence of effectiveness relating to different categories of intervention.

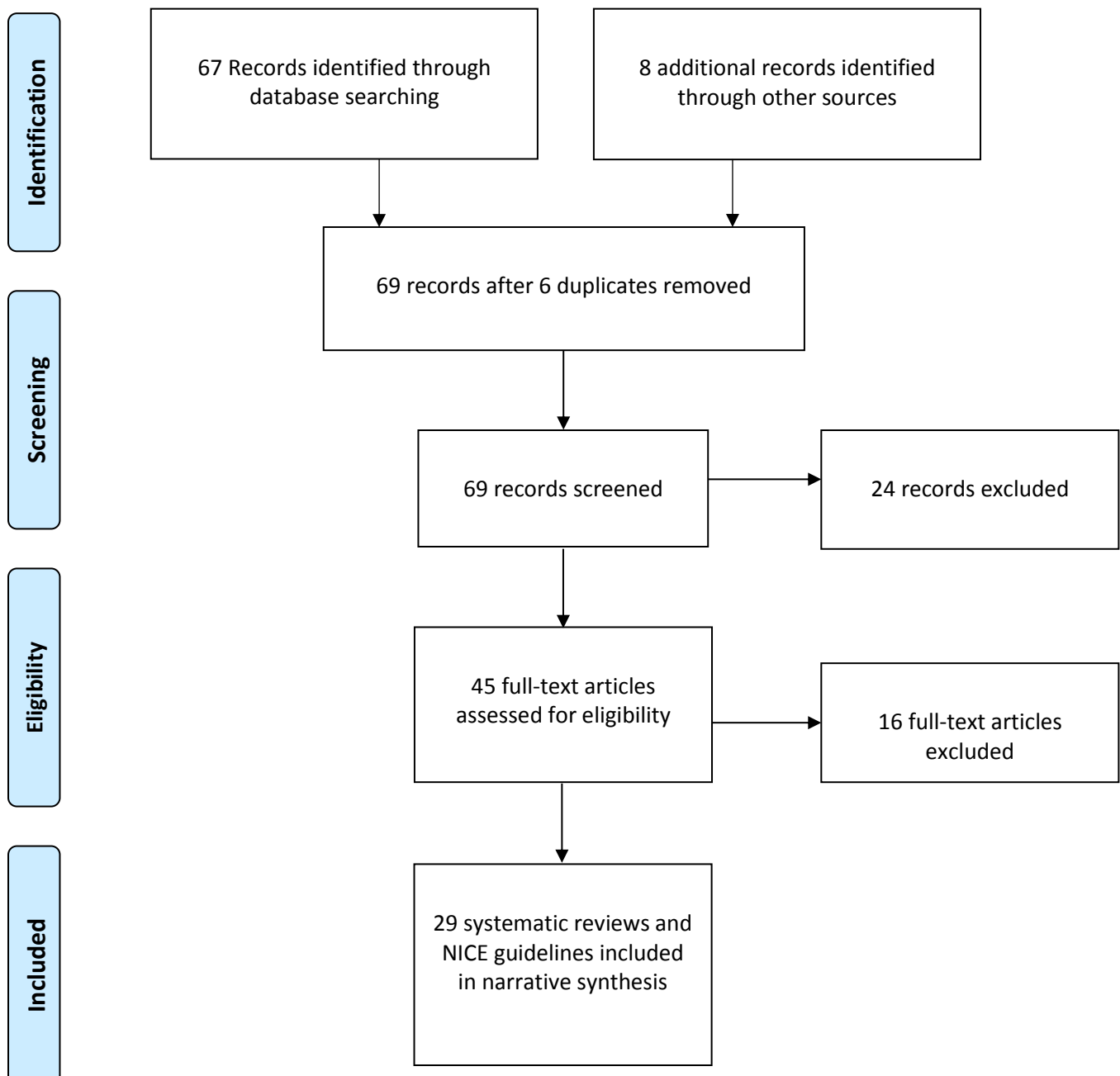
### **2. Review findings**

Twenty nine articles were included in this review: twenty NICE guidelines and nine systematic reviews (including five Cochrane reviews).

The findings of this evidence review are presented in three sections organised using a population-based approach. These are:

- Universal interventions which aim to eliminate or attenuate risk factors and strengthen protective factors
- Selective/targeted interventions aimed at individuals at risk, such as those with a mental disorder
- Indicated interventions which aim to reduce reoccurrence in children and young people with known suicide ideation and self-harm

**Figure 1: PRISMA Flow Diagram of information through the evidence review**



A 'headline' statement on the overall state of the evidence base has been given at the beginning of each section. These are followed by separate statements for each included source relevant to that section. An evidence grading colour scheme has been applied to indicate the extent to which the potential effectiveness of the intervention is supported by the research evidence synthesised by the source. In brief:

- Green indicates moderate or good evidence of effectiveness
- Yellow/amber indicates inconsistent/inconclusive evidence
- Red indicates evidence of ineffectiveness.
- Blue indicates NICE good practice recommendations

## **A. UNIVERSAL INTERVENTIONS**

### **School-based programmes**

#### **School-based programmes to prevent bullying and victimisation**

There is evidence that school-based programmes are effective in preventing and reducing traditional bullying, cyberbullying and cybervictimisation.

An evidence update (Access [here](#)) identified new evidence that could have an impact on the recommendations for NICE guidelines on social and emotional wellbeing in primary education [PH12]. One RCT evaluating the effectiveness of a school-based anti-bullying programme found that the programme was effective in preventing cyberbullying and cyber-victimisation and that this continued after 6 months.

An evidence update (Access [here](#)) identified new evidence that could have an impact on the recommendations for NICE guidelines on social and emotional wellbeing in secondary education [PH20]. Four RCTs looked at interventions to reduce bullying in schools and it was found that these were effective at reducing involvement, bullying, victimisation, aggression and improving attitudes, empathy and knowledge.

Update and amalgamation of NICE guidelines PH12 and PH20 is currently being planned. Topic experts have provided advice. A number of ongoing research trials were found that related to reducing bullying, anxiety and depression, and improving resilience, health behaviours and mental health.

## **Prevention of substance misuse**

**Intervention:** Motivational interviewing for the prevention of alcohol misuse

**Outcomes:** Alcohol use, misuse and problems

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect

Foxcroft DR, et al. Motivational interviewing for the prevention of alcohol misuse in young adults. Cochrane Database of Systematic Reviews 2016, Issue 7. Access [here](#)

**Intervention:** Primary care behavioural interventions

**Outcomes:** Drug use

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

Patnode et al (2014) Primary care behavioral interventions to prevent or reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: a systematic evidence review for the U.S. Preventive Services Task Force. Rockville, MD:Agency for Healthcare Research and Quality. Access [here](#)

## **Prevention of child sexual abuse**

**Intervention:** School-based education programmes

**Outcomes:** Protective behaviours; knowledge of sexual abuse or knowledge of sexual abuse prevention concepts, or both; retention of protective behaviours over time; retention of knowledge over time; harm, manifest as parental or child anxiety or fear; and disclosure of sexual abuse by child or adolescent during or after programmes

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

Walsh K et al. School-based education programmes for the prevention of child sexual abuse. Cochrane Database of Systematic Reviews 2015, Issue 4. Access [here](#)

## **Prevention of mental disorders**

**Intervention:** Psychological depression prevention and/or treatment interventions

**Outcomes:** Reduction in suicide-related behaviour

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect

Devenish et al. The treatment of suicidality in adolescents by psychosocial interventions for depression: A systematic literature review. Australian & New Zealand Journal of Psychiatry 2016, Vol. 50(8) 726–740. Access [here](#)

## **Prevention of suicide in community and custodial settings**

**Intervention:** Multi-agency partnerships

**Outcomes:** Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public (service experience)

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 1 for multi-agency partnerships. NICE guideline NG105. London: NICE. Access [here](#)

**Intervention:** Multi-component suicide prevention plans

**Outcomes:** Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Improved surveillance-data and local intelligence, Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 2 for local suicide plans. NICE guideline NG105. London: NICE. Access [here](#)

**Intervention:** Interventions to respond to suicide clusters

**Outcomes:** Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Improved surveillance-data and local intelligence

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

**Intervention:** Interventions that provide information, advice, education for staff or public

**Outcomes:** Suicide rates amongst target population, Suicide attempts, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, beliefs, skills and behaviour of practitioners, public and peers, Staff/public training completed/refreshed

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence report 4 for information, advice, education and training. NICE guideline NG105. London: NICE. Access [here](#)

## Means restriction interventions

**Intervention:** Physical barriers at high frequency jump sites

**Outcomes:** Suicide rates, Suicide attempts, Number of people hospitalised after suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines).

**Evidence statement:** This intervention is supported by moderate to good quality evidence of its effectiveness

**Intervention:** Blue light-emitting-diode lights on railway platforms

**Outcomes:** Suicide rates, Suicide attempts, Number of people hospitalised after suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines).

**Evidence statement:** There is good evidence to suggest that this intervention has a sound theoretical basis or that work in this area is likely to have an impact but this has not been demonstrated in trials (this would apply particularly to pilot or novel interventions)

**Intervention:** Encouraging help-seeking

**Outcomes:** Suicide rates, Suicide attempts, Number of people hospitalised after suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines).

**Evidence statement:** There is some evidence suggesting that this intervention is ineffective but it is not conclusive

**Intervention:** Surveillance (CCTV camera or police patrol)



**Outcomes:** Suicide rates, Suicide attempts, Number of people hospitalised after suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines).

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 6 for reducing access to means. NICE guideline NG105. London: NICE. Access [here](#)

**Intervention:** Media guidelines

**Outcomes:** Suicide rates, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Changes in attitude, acceptance, intentions, beliefs and behaviour of people exposed to the reporting.

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 7 for local media reporting of suicides. NICE guideline NG105. London: NICE. Access [here](#)

**Intervention:** Suicide awareness campaigns

**Outcomes:** Suicide rates among target/participant communities, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 8 for suicide awareness Campaigns. London: NICE. Access [here](#)

## **B. SELECTIVE/TARGETED INTERVENTIONS**

### **Gatekeeper training**

**Intervention:** School-based gatekeeper training

**Outcomes:** Outcomes related to suicide prevention such as knowledge, skills, attitudes towards suicide, self-efficacy

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

Mo et al. School-based gatekeeper training programmes in enhancing gatekeepers' cognitions and behaviours for adolescent suicide prevention: a systematic review. Child Adolesc Psychiatry Ment Health (2018) 12:29. Access [here](#)

## **Postvention**

**Intervention:** Local interventions to support those bereaved or affected by suicide

**Outcomes:** Suicide rates among target/participant communities, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence review 5 for interventions to support people bereaved or affected by a suspected suicide. NICE guideline NG105. London: NICE. Access [here](#)

## **Identification and management of a mental disorder**

### **Identification and management of depression**

Two evidence updates (Access [here](#) and [here](#)) for NICE guideline on Depression in children and young people [CG28] Access [here](#), provided new evidence relevant to depression in children and young people.

**Intervention:** Newer generation antidepressants

**Outcome:** Diagnosis of depressive disorder, suicide completion, depression symptom severity, remission or response, functioning, suicide related outcomes

**Evidence statement:** This review provides some evidence that the intervention is effective but it is not conclusive

**Intervention:** Psychological therapy and/or antidepressant medication

**Outcome:** Remission, treatment dropout, suicide related behaviours

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect

**Intervention:** Psychological therapy and/or medication to prevent relapse or reoccurrence of depressive disorder

**Outcome:** Prevention of second or next episode; suicide-related behaviours

**Evidence statement:** There is some evidence supporting the use of these interventions but it is not conclusive

**Intervention:** Group based CBT for depression in young offenders

**Outcome:** Symptoms of depression

**Evidence statement:** There is some evidence that this intervention is effective but it is not conclusive

**Intervention:** Psychological therapy and/or antidepressant medication

**Outcome:** Remission, treatment dropout, suicide related behaviours

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect

Cox GR, et al. Psychological therapies versus antidepressant medication, alone and in combination for depression in children and adolescents. Cochrane Database of Systematic Reviews 2014, Issue 11. Access [here](#)

## **Management of post-traumatic stress disorder**

**Intervention:** Psychological therapies

**Outcomes:** Diagnosis of PTSD, symptoms of PTSD, severity or incidence of anxiety symptoms, depressive symptoms, behavioural problems, function, quality of life, adverse events, loss to follow-up

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

Gillies D et al. Psychological therapies for children and adolescents exposed to trauma. Cochrane Database of Systematic Reviews 2016, Issue 10. Access [here](#)

## **Childhood maltreatment**

### **NICE GUIDANCE - Child maltreatment: when to suspect maltreatment in under 18s**

This guideline covers the signs of possible child maltreatment in children and young people aged under 18 years. It aims to raise awareness and help health professionals who are not child protection specialists to identify the

features of physical, sexual and emotional abuse, neglect and fabricated or induced illness. Access [here](#)

## **NICE GUIDANCE child abuse and neglect**

This guideline covers recognising and responding to abuse and neglect in children and young people aged under 18. It covers physical, sexual and emotional abuse, and neglect. The guideline aims to help anyone whose work brings them into contact with children and young people to spot signs of abuse and neglect and to know how to respond. It also supports practitioners who carry out assessments and provide early help and interventions to children, young people, parents and carers. Access [here](#)

### **Management of children who have been sexually abused**

**Intervention:** Psychoanalytic/psychodynamic psychotherapy for sequelae of sexual abuse

**Outcomes:** PTSD, depression, aggression, sexualised behaviour, suicide and self-harm

**Evidence statement:** Evidence about the effectiveness of the intervention is lacking

### **Preventing suicides in residential custodial and detention settings**

**Intervention:** Peer support

**Outcomes:** Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public (service experience).

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

**Intervention:** Risk management training for prison staff

**Outcomes:** Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public (service experience).

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings. Evidence review 9 for preventing suicides in residential custodial and detention settings. NICE guideline NG105. London: NICE. Access [here](#)

## **Interventions to prevent substance misuse**

**Intervention:** Skills training for children and young people at risk of drug misuse

**Evidence statement:** Recommended good practice based on clinical experience of the Guideline Development Group

National Institute for Health and Care Excellence (2017) Drug misuse prevention: targeted interventions [NG64]. London: NICE. Access [here](#)

## **C. INDICATED INTERVENTIONS**

### **Management of self-harm**

Two evidence updates did not identify any new evidence relevant to the NICE guidelines for Self-harm in over 8s: longer-term management [CG133] and Self-harm in over 8s: short-term management and prevention of recurrence [CG16].

### **Longer term management of self-harm**

This guideline covers the longer-term psychological treatment and management of self-harm in people aged 8 and over. It aims to improve the quality of care and support for people who self-harm and covers both single and recurrent episodes of self-harm. This guidance is for health and social care professionals.

National Institute for Health and Care Excellence (2011) Self-harm in over 8s: long-term management [CG133]. Access [here](#)

**Intervention:** Access to services

Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS)

Ensure that children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate

**Evidence statement:** There is good evidence from qualitative studies to support this recommendation

**Intervention:** Training and supervision for health and social care professionals

Health and social care professionals who work with people who self-harm (including children and young people) should be:

- Trained in the assessment, treatment and management of self-harm and
- Educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes

**Evidence statement:** There is some evidence supporting this intervention but it is not conclusive

**Interventions:** Consent and confidentiality

Health and social care professionals who have contact with children and young people who self-harm should be trained to:

- Understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm
- Understand how issues of capacity and consent apply to different age groups
- Assess mental capacity in children and young people of different ages.

They should also have access at all times to specialist advice about capacity and consent

**Evidence statement:** NICE good practice recommendation

**Intervention:** Safeguarding

CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures

If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:

- Use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
- Consider using the Common Assessment Framework; advice on this can be sought from the local named lead for safeguarding children

If serious concerns are identified, develop a child protection plan

When working with people who self-harm, consider the risk of domestic or other violence or exploitation and consider local safeguarding procedures for vulnerable adults and children in their care. Advice on this can be obtained from the local named lead on safeguarding adults

**Evidence statement:** NICE good practice recommendation

**Intervention:** Families carers and significant others  
CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with perceived risks and the responsibilities and views of parents or carers.

**Evidence statement:** NICE good practice recommendation

**Intervention:** Managing endings and supporting transitions  
CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services.

- Time the transfer to suit the young person, even if it takes place after they reach the age of 18 years.
- Continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.

Mental health trusts should work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services, as described in this guideline.

**Evidence statement:** NICE good practice recommendation

**Intervention:** Primary care

If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:

- Levels of distress are rising, high or sustained
- The risk of self-harm is increasing or unresponsive to attempts to help
- The person requests further help from specialist services
- Levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help.

**Evidence statement:** NICE good practice recommendation

**Intervention:** Psychosocial assessment in mental health settings  
Follow the same principles as for adults when assessing children and young people who self-harm but also include a full assessment of the person's family, social situation, and child protection issues.

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

**Intervention:** Risk assessment

In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person

**Evidence statement:** NICE good practice recommendation

**Intervention:** Risk assessment tools and scales to predict future suicide or repetition of self-harm

**Evidence statement.** There moderate to good evidence of ineffectiveness. NICE specifically recommends that this intervention should not be adopted

**Intervention:** Risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged

**Evidence statement.** There is moderate to good evidence of ineffectiveness. NICE specifically recommends that this intervention should not be adopted

**Intervention:** Provision of care

Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS

**Evidence statement:** This is a NICE good practice recommendation

**Intervention:** 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.

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

**Intervention:** Drug treatment as a specific intervention for self-harm



**Evidence statement:** NICE recommends that this intervention should not be offered. The evidence is inconsistent and it is not possible to draw conclusions but it tends towards no effect

**Effect size:** Repetition of self-harm

Repetition during first six months – antidepressant vs placebo risk ratio 1.60 95% CI 0.63 to 4.04

Repetition in first six months after trial entry Flupenthixol vs placebo risk ratio 0.29 95% CI 0.10 to 0.81

**Intervention:** Harm reduction

If stopping self-harm is unrealistic in the short term:

- Consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible
- Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team
- Advise the service user that there is no safe way to self-poison.

**Evidence statement:** There is good evidence to suggest that this intervention is likely to have an impact but this has not been demonstrated in trials

**Intervention:** Individual CBT-based psychotherapy

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but it tends towards no effect

**Intervention:** Dialectical behavioural therapy for adolescents

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

**Intervention:** Mentalisation

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence supporting the use of this intervention but it is not conclusive

**Intervention:** Group-based psychotherapy

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence suggesting that this intervention is ineffective but it is not conclusive

**Intervention:** Therapeutic assessment

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** The evidence is inconsistent and it is not possible to draw a conclusion but it tends towards no effect

**Intervention:** Compliance enhancement

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence suggesting that this intervention is ineffective but it is not conclusive

**Intervention:** Home-based family intervention

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence suggesting that this intervention is ineffective but it is not conclusive

**Intervention:** Remote contact interventions

**Outcomes:** Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide

**Evidence statement:** There is some evidence suggesting that this intervention is ineffective but it is not conclusive

Hawton K et al. Interventions for self-harm in children and adolescents. Cochrane Database of Systematic Reviews 2015, Issue 12. Access [here](#)

## Short term management of self-harm

This guideline covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm.

**Intervention:** Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's nurses and doctors in a separate children's area of the emergency department.

**Evidence statement:** NICE good practice recommendation

**Intervention:** Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed

**Evidence statement:** NICE good practice recommendation

**Intervention:** Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues

**Evidence statement:** NICE good practice recommendation

**Intervention:** All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary

**Evidence statement:** NICE grade C recommendation

**Intervention:** For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person

**Evidence statement:** NICE grade C recommendation

**Intervention:** A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm

**Evidence statement:** NICE grade C recommendation

**Intervention:** Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person

**Evidence statement:** NICE grade C recommendation

**Intervention:** In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act

**Evidence statement:** NICE good practice recommendation

**Intervention:** During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team and social services and education staff as appropriate.

**Evidence statement:** NICE grade C recommendation

**Intervention:** All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues

**Evidence statement:** NICE good practice recommendation

**Intervention:** Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should:

- be trained specifically to work with children and young people, and their families, after self-harm
- be skilled in the assessment of risk
- have regular supervision
- have access to consultation with senior colleagues

**Evidence statement:** NICE grade C recommendation

**Intervention:** Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed

**Evidence statement:** NICE good practice recommendation

## Evidence Summary Table

Study details	Summary of main recommendations	Main findings and evidence grading
<b>UNIVERSAL INTERVENTIONS</b>		
<b>School-based programmes to prevent bullying and victimisation</b>		
<p>National Institute for Health and Care Excellence (2017)  <b>Surveillance report 2017 - Social and emotional wellbeing in primary education (2008) NICE guideline PH12 and Social and emotional wellbeing in secondary education (2009) NICE guideline PH20 - Appendix: Evidence summary for NICE guideline PH12.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Children aged 4 to 11 years in primary education</p> <p><b>Interventions:</b> Approaches to promoting social and emotional wellbeing in children</p> <p><b>Studies were included up to:</b> Evidence reviewed in December 2017 – new evidence identified requiring updating of guidelines</p>	<p>This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Social and emotional wellbeing in primary education. Public health guideline [PH12] (2008). This guideline covers approaches to promoting social and emotional wellbeing in children aged 4 to 11 years in primary education. It includes planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing. It also covers identifying signs of anxiety or social and emotional problems in children and how to address them.</p> <p>The evidence was reviewed in December 2017 and new evidence was identified that could have an impact on the recommendations. A decision was made to update and amalgamate the guidelines on social and emotional wellbeing in primary education [PH12] and social and emotional wellbeing in secondary education [PH20]. It was considered that the guidelines should be amalgamated so that commonalities and differences between interventions for children at different ages and life stages (for example at puberty) can be addressed, to provide recommendations around transition between primary and secondary education, and to reflect the evidence base, which includes populations that are of both primary and secondary school age.</p> <p>There is a lack of discussion around the issues of cyberbullying within these recommendations which may need to be updated in order to acknowledge increasing social media issues.</p> <p><b>Evidence that may affect the recommendations</b>  <b>Bullying</b>  One RCT (Petra et al 2016) looked at tackling cyber bullying and was effective at prevention. This RCT involved 2042 students from 18 schools. The intervention was the anti-bullying programme ViSC. This programme is a school development task and usually lasts for one year.</p>	<p><b>Intervention:</b> School-based programmes to prevent bullying and victimisation</p> <p><b>Evidence statement:</b></p> <p>Update and amalgamation of guidelines PH12 and PH20 planned. Topic experts have provided advice. A number of ongoing research trials were found that related to reducing bullying, anxiety and depression, and improving resilience, health behaviours and mental health.</p>

	<p>It was noted that the ViSC programme was effective in preventing cyberbullying and cyber-victimisation and that this continued after 6 months.</p> <p>Ongoing research is currently looking at school-based interventions to reduce bullying in UK primary and secondary schools. The intervention was found to be effective in Finland, however the results from this trial have yet to be published.</p>	
--	---	--

Study details	Summary of main recommendations	Main findings and evidence grading
<p>National Institute for Health and Care Excellence (2017)  <b>Surveillance report 2017 - Social and emotional wellbeing in primary education (2008) NICE guideline PH12 and Social and emotional wellbeing in secondary education (2009) NICE guideline PH20 - Appendix: Evidence summary for NICE guideline PH20.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Young people aged 11–19 years who are in full-time education</p> <p><b>Interventions:</b> Interventions to support social and emotional wellbeing</p> <p><b>Studies were included up to:</b> Evidence reviewed in December 2017 – new evidence identified requiring updating of guidelines</p>	<p>This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Social and emotional wellbeing in secondary education. Public health guideline [PH20] (2009). This guideline covers interventions to support social and emotional wellbeing among young people aged 11–19 years who are in full-time education. It aims to promote good social, emotional and psychological health to protect young people against behavioural and health problems.</p> <p>The evidence was reviewed in December 2017 and new evidence was identified that could have an impact on the recommendations. A decision was made to update and amalgamate the guidelines on social and emotional wellbeing in primary education [PH12] and social and emotional wellbeing in secondary education [PH20]. It was considered that the guidelines should be amalgamated so that commonalities and differences between interventions for children at different ages and life stages (for example at puberty) can be addressed, to provide recommendations around transition between primary and secondary education, and to reflect the evidence base, which includes populations that are of both primary and secondary school age.</p> <p><b>Evidence that may affect the recommendations</b>  <b>Bullying</b>  Four RCTs looked at interventions to reduce bullying in schools and it was found that these were effective at reducing involvement, bullying, victimisation, aggression and improving attitudes, empathy and knowledge.  One RCT considered a whole-school approach to preventing cyberbullying. 35 schools were randomised to either the intervention or the control. The intervention group showed significant declines in involvement in cybervictimisation and perpetration but there were no other significant differences.</p>	<p><b>Intervention:</b> School-based programmes to prevent bullying and victimisation</p> <p><b>Evidence statement:</b></p> <p>Update and amalgamation of guidelines PH12 and PH20 planned. Topic experts have provided advice. A number of ongoing research trials were found that related to reducing bullying, anxiety and depression, and improving resilience, health behaviours and mental health.</p>

	<p>One RCT involved a cyberbullying video program and 167 college students were randomly assigned to the intervention group or the control. Follow up occurred both immediately and after one month. It was noted that the intervention group had significantly improved attitudes, descriptive norms, empathy and knowledge both in the short and long term.</p> <p>One RCT involved an intervention entitled Take the Lead and consisted of a 16 session curriculum in order to build social competencies. The 323 participants who took part in the intervention noted significant reductions in bullying (<math>p=0.001</math>) and victimisation (<math>p=0.001</math>) compared to the controls.</p> <p>One RCT involved 18 schools randomised to the intervention and 18 randomised to the control. This intervention was entitled the Second Step: Student Success Through Prevention and focused on reducing youth violence. It consisted of 15 weekly lessons in the curriculum on social emotional learning skills including empathy, communication, bully prevention and problem-solving. There were significant effects in the intervention group in regard to physical aggression and this continued after 1 year follow up. Students were randomly assigned to the intervention or a delayed treatment group. Those in the intervention took part in the Second Step programme and cultural lessons. Those in the delayed treatment group received Second Step after the intervention group were completed. Those who were in the intervention group had a decrease in the amount of bullying perpetration (<math>p=0.05</math>). There was also an increase in perceived self-control (<math>p=0.05</math>).</p> <p>There was an increase in valuing others' cultures (<math>p=0.05</math>) and acceptance of others' cultures (<math>p=0.05</math>) and perceived self-control (<math>p=0.01</math>). There were also lower levels of physical aggression (<math>p=0.01</math>).</p> <p><b><u>Resilience</u></b></p> <p>There was one systematic review and two RCTs that looked at improving resilience in high school pupils. The systematic review and one RCT showed that interventions can be effective at increasing coping, resilience, social behaviour and self-esteem.</p> <p><b><u>Depression, stress, anxiety</u></b></p> <p>There were three RCTs that looked at interventions to prevent depression, stress and anxiety symptoms. Two of the RCTs showed that interventions could be effective at preventing stress, depression, anxiety and negative thoughts and emotions.</p>	
--	---	--



Study details	Results of the review	Main findings and evidence grading
<b>Interventions to prevent substance misuse</b>		
<p>Foxcroft DR, et al. <b>Motivational interviewing for the prevention of alcohol misuse in young adults</b>. Cochrane Database of Systematic Reviews 2016, Issue 7.</p> <p><b>Type of source:</b> Cochrane Systematic Review</p> <p><b>Study Population:</b> Young adults aged up to 25 years</p> <p><b>Interventions:</b> Motivational interviewing</p> <p><b>Relevant outcomes:</b> Alcohol use, misuse and problems</p> <p><b>Studies were included up to:</b> April 2016</p> <p><b>Included study types:</b> RCTs and cluster RCTs</p>	<p><b>Description of included studies:</b> Eighty four trials (80 RCTs and 4 cluster RCTs) with 22,872 participants were included in the review. Sixty-six trials took place in USA, six in Switzerland, four in the UK, two in Brazil, and one apiece in Australia, Spain, France, Thailand, and Holland. One trial took place in both Canada and the USA. Study participants' average age ranged from 15 to 24 years. Ethnicity of participants was mixed, with the majority (n = 52) of studies in largely (&gt; 60%) white participants. Most trials (70/84) reported that participants were assessed as being at higher risk for alcohol use or misuse because they were over a screening test threshold score, presented with evidence of alcohol misuse or had an associated risk factor. Fifty eight of the 84 studies took place in college (mainly university but also four vocational) settings. The remaining trials took place in healthcare locations, a youth centre, local companies, a job-related training centre, an army recruitment setting, UK drug agencies and youth prisons.</p> <p><b>Quality of included studies:</b> The quality of included studies was assessed using the Cochrane Risk of Bias tool. Thirty-five trials reported an adequate method of randomisation, and 13 described proper allocation concealment. No study adequately blinded study participants and therapists. The attrition rate (at final follow-up) in 54 trials was acceptable (20% or less), and for 25 trials it was not acceptable (&gt; 20%). Most trials (73/84) were free of selective outcome reporting. Studies with follow-up periods of at least four months were less susceptible to short-term reporting or publication bias.</p> <p><b>Synthesis:</b> Meta-analysis</p> <p><b>Findings:</b> At four or more months follow-up, the results showed effects in favour of MI for the quantity of alcohol consumed (SMD -0.11, 95% CI -0.15 to -0.06 or a reduction from 13.7 drinks/week to 12.5 drinks/week; moderate quality evidence); frequency of alcohol consumption (SMD -0.14, 95% CI -0.21 to -0.07 or a reduction in the number of days/week alcohol was consumed from 2.74 days to 2.52 days; moderate quality evidence); and peak blood alcohol concentration, or BAC (SMD -0.12, 95% CI -0.20 to 0.05, or a reduction from 0.144% to 0.131%; moderate quality evidence).</p>	<p><b>Intervention:</b> Motivational interviewing for the prevention of alcohol misuse</p> <p><b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p> <p><b>Author's conclusions:</b> The results of this review indicate that there are no substantive, meaningful benefits of MI interventions for preventing alcohol use, misuse or alcohol-related problems. Although we found some statistically significant effects, the effect sizes were too small, given the measurement scales used in the included studies, to be of relevance to policy or practice. Moreover, the statistically significant effects are not consistent for all misuse measures, and the quality of evidence is not strong, implying that any effects could be inflated by risk of bias.</p>

	<p>The results show a marginal effect in favour of MI for alcohol problems (SMD -0.08, 95% CI -0.17 to 0.00 or a reduction in an alcohol problems scale score from 8.91 to 8.18; low quality evidence) and no effects for binge drinking (SMD -0.04, 95% CI -0.09 to 0.02, moderate quality evidence) or for average BAC (SMD -0.05, 95% CI -0.18 to 0.08; moderate quality evidence). The study authors also considered other alcohol-related behavioural outcomes, and at four or more months follow-up, they found no effects on drink-driving (SMD -0.13, 95% CI -0.36 to 0.10; moderate quality of evidence) or other alcohol-related risky behaviour (SMD -0.15, 95% CI -0.31 to 0.01; moderate quality evidence).</p> <p>Further analyses showed that there was no clear relationship between the duration of the MI intervention (in minutes) and effect size. Subgroup analyses revealed no clear subgroup effects for longer-term outcomes (four or more months) for assessment only versus alternative intervention controls; for university/college vs other settings; or for higher risk vs all/low risk participants.</p> <p>None of the studies reported harms related to MI.</p>	
--	--	--

Study details	Results of the review	Main findings and evidence grading
<p>Patnode et al (2014) <b>Primary care behavioral interventions to prevent or reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: a systematic evidence review for the U.S. Preventive Services Task Force.</b> Rockville, MD: Agency for Healthcare Research and Quality</p> <p><b>Type of source:</b> Systematic Review</p> <p><b>Study Population:</b> Children and adolescents aged &lt; 18 years who were not diagnosed with a substance use disorder or seeking treatment for substance misuse</p>	<p><b>Description of included studies:</b> Six trials (reporting seven publications) met the inclusion criteria for the review. Three of the six studies were conducted in or recruited patients from primary care. The other three RCTs evaluated the effectiveness of a computer-based prevention programme for reducing substance use among adolescent girls.</p> <p><b>Quality of included studies:</b> The Quality of included studies was rated as 'good', 'fair', or 'poor' according to USPSTF standards.</p> <p><b>Synthesis:</b> Narrative synthesis</p> <p><b>Findings:</b> Six trials were included, four of which examined the effect of the intervention on a health or social outcome. One trial found no effect of the intervention on marijuana-related consequences or driving under the influence of marijuana; 3 trials generally found no reduction in depressed mood at 12 or 24 months. Four of the 5 trials assessing self-reported marijuana use found statistically significant differences favouring the intervention group</p>	<p><b>Intervention:</b> Primary care behavioural interventions</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Author's conclusions:</b> Evidence is inadequate on the benefits of primary care-relevant behavioural interventions in reducing self-reported illicit and pharmaceutical drug use among adolescents.</p>

<p><b>Interventions:</b> Interventions judged feasible for conduct in primary care that had a link to a health care setting or system, with or without referral to specialty treatment services.</p> <p><b>Relevant outcomes:</b> Drug use</p> <p><b>Studies were included up to:</b> August 2013</p> <p><b>Included study types:</b> RCTs or controlled clinical trials</p>	<p>participants (such as a between-group difference of 0.10 to 0.17 use occasions in the past month). Three trials also reported positive outcomes in nonmedical prescription drug use occasions.</p>	
--	---	--

Study details	Results of the review	Main findings and evidence grading
<b>Prevention of child sexual abuse</b>		
<p>Walsh K et al. <b>School-based education programmes for the prevention of child sexual abuse.</b> Cochrane Database of Systematic Reviews 2015, Issue 4.</p> <p><b>Type of source:</b> Cochrane systematic Review</p> <p><b>Study Population:</b> Children (aged 5 to 12 years) and adolescents (aged 13 to 18 years) attending primary (elementary) or secondary (high) schools.</p> <p><b>Interventions:</b> School-based education programmes focusing on knowledge of sexual abuse and sexual abuse prevention concepts,</p>	<p><b>Description of included studies:</b> Twenty four studies (from 29 reports) where included in the review. Seven studies were RCTs, 11 were cluster RCTs, and six were quasi-RCTs. Sixteen studies were conducted in the USA, there in Canada, and one study apiece in China, Germany, Spain, Taiwan, and Turkey. All studies were conducted in school settings: 23 in primary schools and one in a special school for adolescents with intellectual disabilities. A total of 5802 school-aged participants were included in the 24 trials. Study participants' mean ages at baseline in the included studies ranged from 5.8 years to 13.44 years. In all 24 trials, interventions focused specifically on child sexual abuse prevention. The targets of the interventions were school-aged children who were taught knowledge of sexual abuse, sexual abuse prevention concepts, and/or skill acquisition in self-protective behaviours.</p> <p><b>Quality of included studies:</b> Quality was assessed using the Cochrane risk of bias tool. Twenty studies stated that individuals or groups were "randomised", "randomly allocated", or "randomly assigned" to groups, but provided no detail about how the random sequence was generated. No studies provided information on methods used to conceal allocation. The school-based nature of the interventions made blinding of</p>	<p><b>Intervention:</b> School-based education programmes</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Author's conclusions:</b> The studies included in this review show evidence of improvements in protective behaviours and knowledge among children exposed to school-based programmes, regardless of the type of programme. The results might have differed had the true ICCs or cluster-adjusted results been available. There is evidence that children's knowledge does not deteriorate over time, although this requires further research with longer-term follow-up. Programme participation does not generate increased or decreased child anxiety or fear, however there is a need for on-going monitoring of both positive and negative short- and long-term effects. The results show that programme participation may increase the odds of disclosure,</p>

<p>or skill acquisition in protective behaviours, or both.</p> <p><b>Relevant outcomes:</b> Protective behaviours; knowledge of sexual abuse or knowledge of sexual abuse prevention concepts, or both; retention of protective behaviours over time; retention of knowledge over time; harm, manifest as parental or child anxiety or fear; and disclosure of sexual abuse by child or adolescent during or after programmes</p> <p><b>Studies were included up to:</b> September 2014</p> <p><b>Included study types:</b> Randomised controlled trials (RCTs), cluster-RCTs, or quasi-RCTs</p>	<p>participants receiving the intervention and personnel delivering the intervention impossible. Most studies reported complete outcome data that matched the stated aims or hypothesis of the study, and reported on pre-specified outcomes of interest. More than half of the trials in each meta-analysis contained unit of analysis errors.</p> <p><b>Synthesis:</b> Meta-analysis</p> <p><b>Findings:</b></p> <ol style="list-style-type: none"> <li>1. Meta-analysis of two trials evaluating protective behaviours favoured intervention (OR 5.71, 95% CI 1.98 to 16.51), with borderline low to moderate heterogeneity (<math>I^2 = 27\%</math>). The results did not change after adjustments were made using intra class correlation coefficients to correct errors made in studies where data were analysed without accounting for the clustering of students in classes or schools.</li> <li>2. Meta-analysis of 18 trials evaluating questionnaire-based knowledge favoured intervention (SMD 0.61, 95% CI 0.45 to 0.78), but there was substantial heterogeneity (<math>I^2 = 84\%</math>). The results did not change when adjusted for clustering.</li> <li>3. Meta-analysis of 11 trials evaluating vignette-based knowledge favoured intervention (SMD 0.45, 95% CI 0.24 to 0.65), but there was substantial heterogeneity (<math>I^2 = 71\%</math>). The results did not change when adjusted for clustering.</li> <li>4. Meta-analysis of four trials evaluating retention of knowledge over time showed an effect of the intervention that seemed to persist beyond the immediate assessment (SMD 0.78, 95% CI 0.38 to 1.17; <math>I^2 = 84\%</math>) to six months (SMD 0.69, 95% CI 0.51 to 0.87; <math>I^2 = 25\%</math>). The results did not change when adjustments were made using ICCs.</li> <li>5. The meta-analysis for adverse effects manifesting as child anxiety or fear showed no increase or decrease in anxiety or fear in intervention participants (SMD -0.08, 95% CI -0.22 to 0.07; <math>n = 795</math>) and there was no heterogeneity (<math>I^2 = 0\%</math>). The results did not change when adjustments were made using ICCs.</li> <li>6. Three studies were included in the meta-analysis for disclosure of previous or current sexual abuse. The results favoured intervention (OR 3.56, 95% CI 1.13 to 11.24), with no heterogeneity (<math>I^2 = 0\%</math>). However, adjusting for the effect of clustering had the effect of widening the confidence intervals around the OR (ICC: 0.1 OR 3.04, 95% CI 0.75 to 12.33; ICC: 0.2 OR 2.95, 95% CI 0.69 to 12.61).</li> </ol>	<p>however there is a need for more programme evaluations to routinely collect such data. Further investigation of the moderators of programme effects is required along with longitudinal or data linkage studies that can assess actual prevention of child sexual abuse.</p>
--	--	---

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Prevention of mental disorders</b>		
<p>Devenish et al. <b>The treatment of suicidality in adolescents by psychosocial interventions for depression: A systematic literature review.</b> Australian &amp; New Zealand Journal of Psychiatry 2016, Vol. 50(8) 726–740</p> <p><b>Type of source:</b> Systematic review</p> <p><b>Study Population:</b> adolescents aged 11 to 19 years</p> <p><b>Interventions:</b> Psychological depression prevention and/or treatment interventions</p> <p><b>Relevant outcomes:</b> Reduction in suicide-related behaviour</p> <p><b>Studies were included up to:</b> April 2015</p> <p><b>Included study types:</b> Trials</p>	<p><b>Description of included studies:</b> A total of 35 articles pertaining to 12 treatment trials met inclusion criteria. Twelve studies were treatment studies and four were designed to be preventative. Nine studies evaluated the efficacy of CBT, and seven studies evaluated the efficacy of other psychological treatments, which included systemic family therapy, attachment-based family therapy (ABFT) and interpersonal therapy.</p> <p><b>Quality of included studies:</b> The quality of included studies was assessed using the Cochrane Collaboration's tool for assessing risk of bias. Six studies had a low risk of bias for more than half of the criteria. All remaining studies had an unclear or high risk of bias. The larger and higher quality studies were RCTs examining CBT in comparison to medication.</p> <p><b>Synthesis:</b> Narrative</p> <p><b>Findings:</b> In both intervention and active control groups, suicidality decreased over time; however, most structured psychological depression treatment interventions did not outperform pharmaceutical or treatment as usual control groups. Depression prevention studies demonstrated small but statistically significant reductions in suicidality. Four studies examined the efficacy of school-based suicide prevention programmes for adolescents which aimed to reduce suicidal ideation as a risk factor for suicide, with three of these finding suicidality reduced between baseline and post-intervention</p>	<p><b>Intervention:</b> Psychological depression prevention and/or treatment interventions</p> <p><b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p> <p><b>Author's conclusions:</b> It is unclear whether psychological treatments are more effective than no treatment since no study has used a no-treatment control group. There is evidence to suggest that Cognitive Behavioural Therapy interventions produce pre-post reductions in suicidality with moderate effect sizes and are at least as efficacious as pharmacotherapy in reducing suicidality; however, it is unclear whether these effects are sustained. There are several trials showing promising evidence for family-based and interpersonal therapies, with large pre-post effect sizes, and further evaluation with improved methodology is required. Depression prevention interventions show promising short-term effects.</p>

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Prevention of suicide in community and custodial settings</b>		
<b>Multi-agency partnerships</b>		
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence review 1 for multi-agency partnerships. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole populations or subgroups</p> <p><b>Interventions:</b> Multi-agency partnerships for suicide prevention, including but not limited to:</p> <ul style="list-style-type: none"> <li>Managing skills mix and team composition</li> <li>Identifying and linking partners</li> <li>Shared resources and intelligence</li> </ul> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public (service experience).</p>	<p>This review provides evidence from recent studies of suicide prevention on the topic of multiagency partnerships for preventing suicide. The aim of this review was to determine the arrangements local partners can make for multi-agency teams to ensure they support partnership working and are cost-effective and effective in reducing suicide. Twelve references reporting on 11 studies were included: seven were quantitative studies; two were qualitative studies and two were health economic studies</p> <p><b>Quantitative evidence</b>  <b>Suicide rate</b>  Evidence from five quasi-experimental studies showed a reduction in suicide rates after the implementation of multi-component suicide prevention programmes (pooled relative risk=0.76, [95%CI 0.65 to 0.90], absolute differences range from 3.6 23 to 5.4 per 100,000 fewer suicides). One quasi-experimental study showed that the suicide rate among youth aged between 10 and 24 years in counties which implemented the suicide prevention programme was 1.33 fewer suicides per 100,000 than similar counties that did not implement the programme. The committee's confidence in the evidence was moderate.</p> <p><b>Suicide attempts</b>  Evidence from one quasi-experimental study showed a statistically significant reduction in the rate of suicide attempts (4.9 fewer per 1000) among young people and adults aged between 10 and 24 years from counties that implemented the programme compared to those that had not. The committee's confidence in the evidence was very low.</p> <p>Evidence from one experimental study showed a reduction in the rate of suicide attempts after the introduction of a multimodal community intervention programme. The rate of suicide attempts decreased from 11.0 per 100,000 to 9.3 per 100,000 37 annually among community residents. This reduction was not statistically significant (relative risk=0.84, [95%CI 0.59 to 1.21]; absolute difference=1.7 fewer per 100,000). The committee's confidence in the evidence was very low.</p> <p><b>Qualitative evidence</b>  <b>The impact of multi-agency partnerships</b>  Evidence from two qualitative studies showed benefits of engaging professionals such as GPs, the public, community facilitators and support groups as collaborators for implementation activities relating to</p>	<p><b>Intervention:</b> Multi-agency partnerships</p> <p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p>

	<p>suicide prevention (Harris et al 2016). In a prison setting, a multi-agency approach was considered crucial to integrate diverse partners inside and outside the prison, enabling effective communication for suicide prevention (Slade and Forrester 2015).</p> <p><b>Expert testimony</b>  <b><u>Multi-agency partnership approach for suicide 10 prevention</u></b>  The expert witness presented a multi-agency-partnership approach aimed at preventing suicide. This partnership was introduced to implement the 'NO MORE' action plan- A Zero Suicide Strategy for Cheshire, Merseyside 2015-2020.</p> <p><b>Quality of the evidence</b>  The committee acknowledged that the evidence on the multi-agency partnerships approach for suicide prevention was limited, and, as expected, there were no randomised controlled trials in this area. All studies were quasi-experimental study designs and all were carried out in non-UK countries. Evidence showed a reduction of rates of suicide and suicide attempts following the implementation of multi-component interventions. Overall, the committee discussed that evidence indicated a beneficial effect of multi-component interventions with the context of a wider intervention, showing a reduction in both suicides and suicide attempts. This was supported by expert testimony and the experience of the topic experts. As such the committee recommended the use of multi-agency partnerships. The committee considered that a research recommendation would be needed to examine the effectiveness of individual aspects within multi-component intervention to identify the most effective components of preventing suicides.</p>	
--	---	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Local suicide plans</b>		
National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence review 2 for local suicide plans. NICE guideline NG105.</b> London: NICE	This review provides evidence from studies of suicide prevention on the topic of local suicide plans. The aim of this review is to determine whether these plans are effective and cost effective at preventing suicide, and to examine what components are present in effective plans. Five studies (with 6 references) were included: two quantitative studies and three qualitative studies	<b>Intervention:</b> Multi-component suicide prevention plans <b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group

<p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole population or subgroups</p> <p><b>Interventions:</b> Multi-component suicide prevention plans (including suicide audits)</p> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Improved surveillance-data and local intelligence, Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public</p>	<p><b>Quantitative evidence</b></p> <p><b><u>Suicide rate</u></b></p> <p>Evidence from one observational study showed a reduction in the suicide rate after the introduction of suicide surveillance and prevention programme. The suicide rate decreased from 45.5 per 100,000 to 30.3 per 100,000 among people who were part of the White Mountain Apache Tribe (relative risk=0.57, [95%CI 0.17 to 1.95]; absolute difference=15.2 fewer per 100,000). This reduction was not statistically significant. The committee's confidence in the evidence was low.</p> <p><b><u>Suicide attempts</u></b></p> <p>Evidence from one observational study showed a reduction in the suicide attempt rate after the introduction of suicide surveillance and prevention programme. The rates decreased from 13.5 per 1,000 to 7.7 per 1,000 annually among people who were part of the White Mountain Apache Tribe (relative risk=0.57, [95%CI 0.46 to 16 0.70]; absolute difference=5.8 fewer per 1,000). This reduction was statistically significant. The committee's confidence in the evidence was moderate</p> <p><b><u>Suicide data recording</u></b></p> <p>Evidence from an audit study showed differences in reported numbers of suicide and open verdicts by the Coroner and the Office of National Statistics (ONS). The number of suicides reported for each year between 2000 and 2002 by the Coroners in Cornwall were 44, 36 and 41 and 41, 35 and 41 by the ONS respectively. The number of open verdicts reported by the Coroners in Cornwall for the same years were 21, 33 and 43 in year and were 11, 24 and 26 by the ONS respectively. The committee's confidence in the evidence was very low.</p> <p><b>Qualitative evidence</b></p> <p><b><u>Suicide data collection and audit</u></b></p> <p>Evidence from one qualitative study and one mixed-method study reported that there were barriers to data collection, including problems when collecting data from coroners, general practitioners and local healthcare trusts. Coroners were identified as key sources of information and data but there were concerns about engagement and access allowed to local partners, the quality of the data and the lack of standardised approach to collection and reporting. Furthermore, protocols for information sharing were reported to be under-developed or absent by some participants. Participants in the studies highlighted the difficulty of making sense of local data and assessing trends, due to small numbers and lack of meaningful comparators. Where data collection was undertaken to implement change it was considered to be of principal value to support the identification of groups who are high risk of suicide, to identify measures to restrict access to means and to clarify the need for local services and support. The committee's confidence in the evidence was low.</p> <p><b><u>Suicide prevention plans</u></b></p>	
---	--	--



	<p>Evidence from one qualitative study reported that having plans with explicit procedures and protocols could improve the implementation of school-based suicide prevention (Stein et al 2010). This study also reported that a lack of resources for audit and implementation could hinder the process of suicide prevention planning but over a third of audited PCTs could not identify any actions taken on the basis of audit findings (Owens et al 2014).</p> <p>Evidence indicated that a combination of national, regional and local data was appropriate, and local data were seen as “information for action” as they allowed local agencies to be more responsive to specific local issues and neighbours (McElroy and Chappel 2006). The committee’s confidence in the evidence was low.</p> <p><b>Quality of the evidence</b></p> <p>The committee noted that all studies were observational studies with only one UK study. The certainty of evidence was considered as ‘moderate’ to ‘low’, with concerns around the accuracy of data recording/reporting on suicide and suicide attempts and the indirectness of populations targeted in the studies (such as Native American population) which had limited generalisability to the UK general population.</p> <p>There were 3 qualitative studies (2 from the UK) exploring the views and experiences of Directors of Public Health in England and from people involved in using local suicide data to inform suicide prevention plans. Overall, the confidence of evidence for themes reported in these studies was low. Moderate concerns regarding study methodology including poor sampling strategies, poor reporting of the method and finally of the methods used for data analysis. Nevertheless, the committee noted that evidence from these qualitative studies was applicable to the context of the review and provided an overview of current suicide prevention plans in the UK.</p> <p>The committee highlighted that the included studies focused on the use of data collected by surveillance system or audit, but there was limited evidence on the effectiveness of local suicide plans. Therefore, based on personal experience members of the committee acknowledged the benefits of using local data in suicide prevention.</p>	
--	---	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Local approaches to suicide clusters</b>		
National Institute for Health and Care Excellence (2018) <b>Preventing</b>	This review provides evidence from recent studies of local approaches that respond to “suicide clusters” and to determine whether approaches	<b>Intervention:</b> Interventions to respond to suicide clusters

<p><b>suicide in community and custodial settings: Evidence report 3 for local approaches to suicide clusters. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole population or subgroups</p> <p><b>Interventions:</b> Interventions to respond to suicide clusters (in time or place)</p> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Improved surveillance-data and local intelligence</p>	<p>to proactively respond to suicide clusters are effective and cost effective at preventing suicide. Three studies were identified that provided evidence in relation to local approaches to suicide clusters. All three were quantitative studies.</p> <p><b>Evidence Suicide</b> Evidence from an experimental study showed that, following 5 reports of suicide attempts amongst 12-15 year-old students in a school during a 2-month period, a community-based intervention including educational debriefings, individual screening for referral and crisis evaluation developed and implemented in the school (Askland et al 2003) identified no further suicides and suicide attempts coming to the attention of school personnel. Also in a school setting, early crisis intervention and using of first talk-thoughts and psychological debriefing within 2 days following suicide could prevent suicide contagion (Pojula et al 2001). In line with these results, Hacker et al (2008) reported fewer cases of suicide attempts amongst young people aged 10-24 after the development a surveillance system. The committee's confidence in the evidence was low.</p> <p><b>Suicide attempts</b> Evidence from an observational study (Hacker et al 2008] indicated that timely community or school-based interventions resulted in a reduction in cases of further suicidal behaviour including suicides and suicide attempts although estimated effects were not statistically significant. The committee's confidence in the evidence was very low.</p> <p><b>Expert testimony</b> Responding to suicide cluster: The expert witness presented the epidemiology of suicide clusters in the UK and provided a background to the Public Health England report "Suicide prevention: identifying and responding to suicide clusters". The expert noted that suicide clusters historically occurred within a defined geographical area however there has been an increase in the number of clusters developing through social media platforms. The expert outlined the importance of community suicide action plan which included suicide surveillance measure to monitor and review the occurrence of suicides together with responding measures to prevent the contagion. In addition, support should be provided to people who were affected by suicide clusters including first responders.</p> <p><b>Quality of the evidence</b> The committee noted the paucity of evidence in this area and the poor quality of the evidence that was available. Only 3 studies met the inclusion criteria for this review. The committee agreed that evidence on interventions to prevent suicide clusters was limited as the</p>	<p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p>
--	--	---

	<p>occurrence of clusters tends to be circumstantial and sporadic, and as such it is hard to perform research in this area.</p> <p>The evidence on the effectiveness of interventions responding to suicide clusters was considered to be very weak despite the findings being consistent across studies. All 3 studies found that suicidal events reduced after intervention, however the certainty in results was low as by their nature suicide clusters are spikes in suicide rates and as such there is uncertainty if any reduction in suicides or suicides attempts after the intervention is a demonstration of the effectiveness of the intervention rather than a return to the 'normal' rates of suicide or suicide attempts. The committee also suggested that there is a possibility of publication bias as authors may only submit studies for publication if the intervention demonstrated a positive effect.</p> <p>With this in mind, the committee agreed to accept expert testimony on the recognition of clusters and best practice points in managing the response to clusters. The committee also made reference to the Public Health England report in 2015 "Identifying and responding to suicide clusters and contagion A practice resource". This report is based on evidence and expert advice on best practice from four countries</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Increasing public and professional awareness</b>		
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence report 4 for information, advice, education and training. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b></p> <ul style="list-style-type: none"> <li>Staff and practitioners</li> <li>People at risk of suicidal acts in the community or custodial settings</li> <li>People recently discharged from custody or about to enter prison</li> </ul>	<p>The review aims to determine the effectiveness and cost-effectiveness of non-clinical interventions to help staff and members of the public recognise and respond to signs of distress or crisis that may indicate someone is contemplating suicide, and to determine the effectiveness of non-clinical interventions to support people who are at risk of suicidal acts.</p> <p>In all, 43 studies (18 RCTs, 18 non-RCTs and 7 economic studies) were included in the review: 35 quantitative studies (18 RCTs, 17 non-RCTs); 1 qualitative study; and 7 health economic studies.</p> <p><b>Quality of the evidence</b></p> <p>Evidence from both RCT and non-RCT studies reported on the effectiveness of included interventions. However, the committee suggested a lack of RCT evidence on suicide rates. Nine non-RCT studies which reported suicide rates, had a low to moderate certainty in results as random fluctuations of suicide events and the nature of study design (non-controlled study) with confounding factors and regression to the mean after study selection due to initial high rates might have an impact on the estimated effect. The committee also indicated that none of these</p>	<p><b>Intervention:</b> Interventions that provide information, advice, education for staff or public</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p>

<p><b>Interventions:</b> Any interventions that provide information, advice, education for staff or public</p> <p><b>Relevant outcomes:</b> Suicide rates amongst target population, Suicide attempts, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, beliefs, skills and behaviour of practitioners, public and peers, Staff/public training completed/refreshed</p>	<p>studies were based on UK populations, and populations in some studies were unique (e.g. having access to firearms).Therefore, the findings might not be generalisable to UK populations or communities.</p> <p>Evidence on the effectiveness of interventions on suicide attempts and suicidal ideation were largely from RCT studies. The committee noted that the certainty in results ranged from very low to moderate due to risk of bias including self-selected participants (Gould et al 2013), interventions not being masked (Schilling et al 2014, Schilling et al 2016, Wyman et al 2010), and no true control (Sareen et al 2013, Wasserman et al 2015). In addition, the committee discussed that data on both outcomes were collected through surveys, and as such should be treated with caution when interpreting the results, because self-reported data may not reflect the true effect of the intervention. The committee also raised a question regarding how suicide attempt and suicidal ideation were defined in included studies, and this could affect the accuracy of outcomes reported.</p> <p>Results of changes in knowledge, attitudes, behaviours, beliefs and skills were reported in 12 RCT studies and 8 non-RCT studies. The committee noted that the overall certainty in the evidence from RCT studies ranged from very low to moderate, and results of the impact of training or education on self-reported changes were mixed across studies. Of non-RCT studies, the certainty in the results were very low but all interventions showed a positive effect on changes in these outcomes. The committee suggested that, similar to suicide attempts and suicidal ideation, these outcomes were measured based on self-reported data, which did not provide a strong evidence base for making strong recommendations.</p> <p>The committee agreed that all interventions had a beneficent effect on suicide rates, showing a reduction in suicide events after the implementation of suicide prevention interventions. However the impact of interventions on suicide attempts and suicidal ideation were not consistent. The committee were inclined to seek expert testimony to facilitate their understanding of the evidence base and the interventions used in the UK</p>	
---	---	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Restricting access to the means of suicide</b>		
National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and</b>	This review focuses on local interventions to restrict or change access to the means of suicide and the aim is to determine whether these interventions are effective and cost effective at preventing suicide.	<b>Intervention:</b> Physical barriers at high frequency jump sites

<p><b>custodial settings: Evidence review 6 for reducing access to means. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole populations or subgroups</p> <p><b>Interventions:</b> Local interventions to change or reduce access to the means of suicide</p> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Number of people hospitalised after suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines).</p>	<p><b>Quality of the evidence</b></p> <p>Nineteen quantitative studies met the inclusion criteria for this review. All studies used a before-after study design to examine the effectiveness of the interventions. The committee noted that the overall certainty in the evidence on physical barriers or blue lights in this review was moderate to high, and evidence on encouraging help-seeking combined with surveillance was very low to low. There was also a paucity of evidence on restrictions to access to means in custodial settings such as removal of ligature points or timed surveillance. Amongst the included studies, evidence was provided on the effectiveness of the following interventions:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Physical barriers at jump sites</li> <li><input type="checkbox"/> Restrictions on road access to high frequency sites</li> <li><input type="checkbox"/> Safety nets</li> <li><input type="checkbox"/> Guard rails on windows</li> <li><input type="checkbox"/> Platform screen doors in railway or subway stations</li> <li><input type="checkbox"/> Crisis telephone (or telephone hotline)</li> <li><input type="checkbox"/> Signpost</li> <li><input type="checkbox"/> Blue light-emitting-diode lights</li> <li><input type="checkbox"/> Surveillance (CCTV camera or police patrol)</li> </ul> <p>Most of the interventions were delivered in isolation, and 4 studies reported a combination of interventions for preventing suicide. Overall pooled results of the effectiveness of restriction on accessing to suicide means including physical barriers, road blockage, and platform screen doors were consistent across studies, reporting a statically significant reduction in suicide events after intervention. The certainty in results was moderate to high as the number of suicides observed/reported and the length of follow-up time before and after study interventions varied widely amongst included studies. There was also a possibility of incomplete suicide cases being reported but this had little impact on the estimated effect on preventing suicide.</p> <p>Two included studies accessed the impact of restriction on road access to high frequency suicide sites. The committee agreed that such studies were natural experiments and present issues with repeatability.</p> <p><b>Physical barriers</b> - the committee agreed that an overall positive effect on suicide prevention after the introduction of physical barriers at sites where suicide frequently occurred was substantial, with a statistically significant reduction in the number of suicides at these sites. However further research may be needed to warrant the use of platform screen doors at railway or subway stations for preventing suicides. In addition, there is a lack of evidence on interventions to restrict access to means in prison settings.</p> <p><b>Encouraging help-seeking</b> - The committee noted four studies that examined the effectiveness of interventions related to help-seeking,</p>	<p><b>Evidence statement:</b> This intervention is supported by moderate to good quality evidence of its effectiveness</p> <p><b>Intervention:</b> Blue light-emitting-diode lights on railway platforms</p> <p><b>Evidence statement:</b> There is good evidence to suggest that this intervention has a sound theoretical basis or that work in this area is likely to have an impact but this has not been demonstrated in trials (this would apply particularly to pilot or novel interventions)</p> <p><b>Intervention:</b> Encouraging help-seeking</p> <p><b>Evidence statement:</b> There is some evidence suggesting that this intervention is ineffective but it is not conclusive</p> <p><b>Intervention:</b> Surveillance</p> <p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p>
--	--	---

	<p>however pooled results did not show any benefit effect of this type of intervention in preventing suicide. The committee suggested that the encouragement of help-seeking at high frequency sites such as the use of signposts and crisis telephones may be an area where further research is needed.</p> <p><b>Blue-lights</b> - The committee found it difficult to evaluate the effectiveness of blue lights on preventing suicide as the evidence base was very uncertain due to only one study being included. The committee noted that blue lights are being introduced in the UK but only as a combined intervention of signposting, crisis telephones and gate-keeping training. Committee members also raised concerns over how blue lights would work as a calming measure and further noted that these lights would only be useful at night time.</p> <p><b>Surveillance (CCTV camera or police patrol)</b> - It was agreed that interventions involving surveillance such as the installation of CCTV and the presence of staff at high frequency suicide sites, led to a reduction in the number of suicides.</p> <p>The committee agreed that the evidence base on preventing access to the means of other suicide methods were limited in the review. There was a gap in the evidence on restriction of access to means in custodial settings and settings where specific occupational groups have access to means for suicide such as doctors, nurses, veterinary workers, and farmers. The committee based on their experience in practice, described several other common forms of suicide methods such as hanging, self-poisoning by prescription medications (in particular, medications prescribed to individuals with terminal conditions that are unused if the individual dies), fire-arms and GP access to information on fire-arm ownership and burning.</p>	
--	---	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Media reporting of suicides</b>		
National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence review 7 for local media</b>	<p>The aim of this review is to determine whether the print, internet, broadcast and digital media reports of suicide or suicidal behaviour have an effect on suicide rates.</p> <p><b>Quality of the evidence</b></p>	<p><b>Intervention:</b> Media guidelines</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p>

<p><b>reporting of suicides. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole populations or subgroups</p> <p><b>Interventions:</b> Local reporting for suicide and suicidal behaviour in local print, internet and digital media</p> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Changes in attitude, acceptance, intentions, beliefs and behaviour of people exposed to the reporting. Unintended consequences and effects: Disapproval, Contagion or copycat behaviour.</p>	<p>The quantitative studies identified were considered to have a high risk of bias, due to lack of information on the number of suicides before and after a media report. The evidence specific to local (not national) media reporting of suicides was limited, and the evidence base was further hampered by the poor quality of data reporting and the different types of analysis methods used in the included studies. For this reason the committee found it difficult to interpret the evidence and to ascertain the true impact of media reporting.</p> <p>There were 5 qualitative studies exploring the experiences of journalists and people bereaved by suicide concerning media reports of suicide, to consider what approaches were acceptable when reporting suicide and/or suicidal behaviour. Overall, the confidence of evidence for themes reported in these studies was low to moderate due to concerns regarding study methodology including poor sampling strategies, poor reporting of the methods and data analysis. There were two UK studies and both were considered to be applicable in terms of context. The committee, however, had concerns over one study (Jempson 2007) as it was conducted before the national suicide prevention strategy which may reduce the applicability of the evidence because of changes in practice in recent years.</p> <p>The committee agreed that evidence showing that media reporting of suicide and/or suicidal behaviour was associated with a change in the number of suicides post report. The benefit of a media reporting guideline was demonstrated with a reduction in the number of suicides. This evidence base was weak with just a single study investigating the impact of a media reporting guideline on suicide numbers (Niederkrötenhaler and Sonneck 2007). Media reporting of the methods used did appear to have a harmful effect with an increase in the number of suicides following media reports of an unusual method used in three deaths (Hagihara and Abe 2012). Evidence also found an increased number of newspaper articles related to suicides and/or suicidal behaviours in high frequency areas (cluster areas) when compared to matched control areas (Gould et al 2014), which suggests that newspaper coverage of suicide may be associated with the initiation of a suicide cluster. The committee agreed any association between media reports and an increase in suicides and/or imitator or so called 'copycat' suicides was a huge concern. Furthermore, the committee agreed that inaccurate media reporting, for example by misquoting or speculation, causes distress among people bereaved by suicide and increased dissatisfaction with the media in general (Chapple et al 2013).</p>	
---	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Suicide awareness campaigns</b>		
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence review 8 for suicide awareness Campaigns.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Whole population or subgroups</p> <p><b>Interventions:</b> Local suicide awareness campaigns and interventions including: Social media, Face-to-face approaches (individual or group), Instructor or peer approaches, Posters and leaflets</p> <p><b>Relevant outcomes:</b> Suicide rates among target/participant communities, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.</p>	<p>This review provides evidence from studies of suicide prevention on the topic: local media campaigns for suicide awareness. The aim of this review is to determine the effectiveness and cost-effectiveness of awareness campaigns to help people reduce stigma associated with suicidality, enable people to talk about suicidal thoughts and emotional distress and increase their help-seeking behaviours.</p> <p><b>Quality of the evidence</b> 12 references reporting on 10 studies were included in the review: 9 were quantitative studies; and 1 qualitative study.</p> <p>The committee noted that 3 non-UK studies reported on suicide-related outcomes, and the certainty of evidence was considered as 'very low'. The committee noted that the evidence base was limited, with concerns around the accuracy of data recording/reporting on these outcomes. The committee also agreed that there are no standardised and validated scales for suicidal ideation so only self-reported information was available further reducing the certainty in the findings for this outcome. Information on service uptake was reported in 4 uncontrolled observational studies. The evidence base was at high risk of bias due to including selection bias, misclassification bias and variations in the delivery of the campaign across targeted areas. Additionally, the committee noted short observation or follow-up periods were used when comparing some outcomes; for example, call rates to emergency telephone services 3 months before and after the awareness campaign (Oliver et al 2008; Till et al 2013).</p> <p>One RCT study reported changes in normative beliefs about suicide and attitudes towards help-seeking. The certainty of evidence varied by outcome from very low to moderate with some concerns over generalisability as participants were recruited from a single university (Klimes-Dougan et al 2010, 2016). Such university populations may not be applicable to the target population of this review. Likewise, one included qualitative study was specifically targeted at middle age men in a region of Scotland, which also limited the generalisability of findings to populations of interest in this review.</p> <p>The committee agreed that limited evidence showed a direct beneficial effect of suicide awareness campaigns. Although the evidence presented to the committee suggested a reduction in rates of suicides, suicide</p>	<p><b>Intervention:</b> Suicide awareness campaigns</p> <p><b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p>



	<p>attempts, and suicidal ideation in the follow-up periods, these reductions were not statistically significant.</p> <p>Despite the fact that there was little evidence of direct benefits of awareness campaigns, indirect evidence showed that the suicide media campaigns had the potential to improve people's attitude towards seeking help.</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings. NICE guideline [NG105]</b>. London: NICE</p> <p><b>Type of source:</b> NICE guidance</p>	<p>This guideline covers ways to reduce deaths by suicide and help people bereaved or affected by suicides. It aims to:</p> <ul style="list-style-type: none"> <li>• Help local services work more effectively together to prevent suicide</li> <li>• Identify and help people at risk</li> <li>• Prevent suicide in places where it is currently more likely.</li> </ul> <p>It does not cover national strategies, general mental wellbeing, or areas covered by other NICE guidance such as self-harm or mental health conditions.</p> <p>This guideline includes recommendations on:</p> <ul style="list-style-type: none"> <li>• Suicide prevention partnerships, strategies and action plans</li> <li>• Gathering and analysing suicide-related information</li> <li>• Awareness raising by suicide prevention partnerships</li> <li>• How suicide prevention partnerships can reduce access to methods of suicide</li> <li>• Training by suicide prevention partnerships</li> <li>• How suicide prevention partnerships can support people bereaved or affected by a suspected suicide</li> <li>• Reducing the potential harmful effects of media reporting of a suspected suicide</li> </ul>	<p>Evidence reviews covered above</p>

Study details	Results of the review	Main findings and evidence grading
<b>SELECTIVE/TARGETED INTERVENTIONS</b>		
<b>Gatekeeper training</b>		
<p>Mo et al. <b>School-based gatekeeper training programmes in enhancing gatekeepers' cognitions and behaviours for adolescent suicide prevention: a systematic review.</b> Child Adolesc Psychiatry Ment Health (2018) 12:29</p> <p><b>Type of source:</b> Systematic Review</p> <p><b>Study Population:</b> Based in middle or high school</p> <p><b>Interventions:</b> School-based gatekeeper intervention</p> <p><b>Relevant outcomes:</b> Outcomes related to suicide prevention</p> <p><b>Studies were included up to:</b> December 2017</p> <p><b>Included study types:</b> Randomised and quasi-randomised controlled trials</p>	<p><b>Description of included studies:</b> Fourteen studies describing 15 programmes met all the inclusion criteria for this review. Approximately 3050 gatekeeper participants were covered in these programmes, only one of which solely involved female participants. Participants included teachers, counsellors, social workers, and psychologists. Nine studies were conducted in the United States. Five out of the ten included studies used the QPR approach. Five other studies performed diverse interactive trainings. Two other programmes focused on the management of self-harm.</p> <p><b>Quality of included studies:</b> An assessment of the quality of studies with comparison groups was conducted. This included their use of randomised assignment, concealment methods, use of an intent-to-treat analysis, and whether the intervention deliverer was blinded to the study. Only two studies employed a random assignment of participants and only one study employed intent-to-treat analyses. None of the included studies concealed allocation, or kept deliverers blind during the interventions</p> <p><b>Synthesis:</b> Narrative synthesis</p> <p><b>Findings:</b>  <b>Knowledge:</b> Thirteen studies assessed the outcome of gatekeepers' knowledge; all of which showed benefits in increasing knowledge. Despite significant increases in knowledge at immediate post-test found for all gatekeeper training conditions in these four studies, one study further showed that such a positive effect was not maintained at a 3 month follow-up.  <b>Gatekeeper skills:</b> Three studies assessed the outcome of gatekeeper skills and all of them showed significant positive effect.  <b>Attitude towards adolescent suicide:</b> A positive effect of gatekeeper trainings was observed in two controlled trials; one found a higher score on attitudes about suicide in the training group compared to one of the control groups; while the other observed a significant increase only in</p>	<p><b>Intervention:</b> School-based gatekeeper training</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Author's conclusions:</b> Findings suggest that school-based gatekeeper training is effective in improving participants' knowledge, skills, self-efficacy and likelihood to intervene, while mixed evidence exists in changing participants' attitudes and gatekeeper behaviour. Methodological issues, such as lack of RCT and the inability to use validated measures, jeopardize the conclusions that can be drawn from the studies. More high-quality studies with longer follow-up periods are warranted to ascertain the effect of school-based gatekeeper training in improving participants' knowledge, skills, attitudes towards adolescent suicide and gatekeeper behaviour. Such studies should also seek to include long term outcomes such as suicide attempts or behaviour.</p>

	<p>one ("suicide is preventable") of the three attitudes items at post-test and 3 month follow-up.</p> <p><b>Self-efficacy:</b> All nine studies that assessed change in self-efficacy reported positive effects.</p> <p><b>Likelihood to intervene:</b> Two studies adapted items from previous research to evaluate the outcome of self-reported likelihood to intervene; both revealed a positive effect.</p> <p><b>Gatekeeper behaviour:</b> Three controlled trials evaluated the effects on gatekeeper behaviour with self-developed items, and two of them found positive effects on specific behaviours.</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Postvention</b>		
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings: Evidence review 5 for interventions to support people bereaved or affected by a suspected suicide. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> People who are bereaved by suicide (populations may include people in workplaces, schools/colleges and prisons)</p> <p><b>Interventions:</b> Local interventions to support those bereaved or affected by suicide (postvention)</p>	<p>The aim of this review is to examine interventions that can be delivered in community and custodial settings to provide support for people bereaved by suicide and to encourage them to seek help. This may include:</p> <ul style="list-style-type: none"> <li>providing information about grief and bereavement by suicide (leaflets, verbal info, social media)</li> <li>giving information about bereavement support services (sign-posting)</li> <li>community or peer support.</li> </ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>Use rapid intelligence gathering and data from other sources, such as coroners to identify anyone who may be affected by a suspected suicide or may benefit from bereavement support.</li> <li>Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This</li> </ul>	<p><b>Intervention:</b> Local interventions to support those bereaved or affected by suicide</p> <p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p>

<p><b>Relevant outcomes:</b> Suicide rates among target/participant communities, Suicide attempts, Changes in mental health state, Reporting of suicide ideation, Service uptake, Changes in knowledge, attitude, acceptance, intentions, beliefs and behaviour of people who are bereaved by suicide.</p>	<p>also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.</p> <ul style="list-style-type: none"> <li>Consider: <ul style="list-style-type: none"> <li>providing support from trained peers who have been bereaved or affected by a suicide or suspected suicide</li> <li>whether any adjustments are needed to working patterns or the regime in residential custodial and detention settings.</li> </ul> </li> </ul> <p><b>Quality of the evidence</b></p> <p>The committee discussed the relative importance of the outcomes and agreed that suicide rates among people bereaved by suicide was the most important outcome for this review. Rates of suicide attempts and/or suicidal ideation for the target population were regarded as important as another measure of suicidality.</p> <p><b>Suicide:</b> Evidence from an experimental study found a reduction in suicide amongst students by 1.0%, from 1.1% to 0.1% following 2-hours of psychological debriefing sessions (relative risk=0.14, [95%CI 0.01 to 2.75]), absolute difference=10 fewer per 1000, [95%CI 11 fewer to 19 more]). This reduction was not significant. The committee's confidence in the evidence was low.</p> <p><b>Suicidal behaviour:</b> Evidence from a RCT study found a non-significant difference in suicidal ideation among people bereaved by suicide who received family-based cognitive behaviour therapy compared with those who received usual care, 13 months after suicide (relative risk=1.06, [95%CI 0.48 to 2.33], absolute difference=10 more per 10000). The committee's confidence in the evidence was low.</p> <p>Evidence from an observational study found a significant difference in the number of people considered to be at high risk for suicidality between people bereaved by suicide who had contacted a suicide bereavement support service and those who had not (relative risk=0.75, [95%CI 0.59 to 0.94], absolute difference=160 fewer per 1000, [95%CI 38 fewer to 262 fewer]). The committee's confidence in the evidence was very low.</p> <p>The committee noted that the evidence base in this topic area is hampered by the difficulty of recruiting people bereaved by suicide into studies. The committee agreed that those who agreed to participate in these studies were largely self-selected and most of them were already in contact with services. Both of these considerations negatively impact on the generalisability of the evidence to the population of interest.</p>	
--	--	--

	<p>Overall, the certainty of evidence for outcomes of the interest reported in quantitative studies was defined as 'low' or 'very low'. The committee noted that none of the studies reported on the impact of postvention on suicide rates, and just one RCT examined suicidal ideation as an outcome.</p> <p>Results of changes in mental health state were reported in 2 RCTs and 3 non-RCTs. The included studies suffered from the presence of risk of bias such as selection bias and differences in baseline characteristics between study participants in the intervention and control groups.</p> <p>Overall, the quality of the qualitative studies for themes reported in qualitative studies was defined as 'moderate'. The committee had minor concerns regarding study methodology including poor sampling strategies, poor reporting of the method and data analysis. Two of the studies and the expert testimony were based on a UK context as were directly applicable to UK services.</p> <p>Despite the lack of effectiveness evidence from the UK, the committee agreed that overall postvention support appeared to have a beneficial effect on people bereaved by suicide, showing that people who contacted and received support were less likely to be at high risk for suicidality, had lower depression scores and anxiety. This evidence was supported by the experiences of the committee. The qualitative studies reported that the postvention support helped people bereaved by suicide improve their awareness of the impact of suicide and to combat the stigma around suicide. Therefore, the committee considered postvention would be helpful and should be recommended to support people bereaved by suicide and help them seek help.</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Identification and management of a mental disorder</b>		
<b>Identification and management of depression</b>		

<p>National Institute for Health and Care Excellence (2018) <b>Depression in children and young people: Evidence Update June 2013. A summary of selected new evidence relevant to NICE clinical guideline 28 'depression in children and young people: identification and management in primary, community and secondary care' (2005).</b> Manchester: National Institute for Health and Care Excellence</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Children and young people aged between 5 and 18 years</p> <p><b>Interventions:</b> Identification and management of depression</p>	<p>This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Depression in children and young people. NICE clinical guideline 28 (2005).</p> <p>A search was conducted for new evidence from 17 August 2010 to 14 January 2013. Evidence was again reviewed in August 2017 – an update of the recommendations on psychological therapy for treatment of depression in children and young people is currently being planned.</p> <p>The current guideline covers identifying and managing depression in children and young people aged between 5 and 18 years. Based on the stepped care model, it aims to improve recognition and assessment and promote effective treatments for mild, moderate and severe depression.</p> <p>This evidence update includes recommendations on:</p> <ol style="list-style-type: none"> <li>1. Care of all children and young people with depression</li> </ol> <p><b>Impact on treatment response of parental marital discord, abuse and other factors</b> - NICE CG28 recommends that when a child or young person has been diagnosed with depression, consideration should be given to the possibility of parental depression, parental substance misuse, or other mental health problems and associated problems of living, as these may have a negative impact on the success of treatment.</p> <p>This evidence update found two studies (Amaya 2011; Shamseddeen 2011) - Taken together, and within their individual limitations, findings from these studies suggest that a range of individual characteristics and family contextual issues may moderate the effects of treatment, consistent with NICE CG28 guidance.</p> <p><b>Modular approach to psychotherapeutic interventions</b> - NICE CG28 recommends that comorbid diagnoses and developmental, social and educational problems should be assessed and managed, either in sequence or in parallel, with the treatment for depression. One RCT (Weisz 2012) involving 10 US outpatient clinical centres assessed standard treatment versus the 'Modular Approach to Therapy for Children with Anxiety, Depression or Conduct Problems' (MATCH). Limitations of the study included the sample size, which imposed constraints on the level of analysis. The authors concluded that the modular approach may be a promising way to build on the strengths of evidence-based treatments, which is consistent with the current recommendations of NICE CG28. However, if the findings are supported in studies in a European or UK setting, the resource and client</p>	<p><b>Intervention:</b> Newer generation antidepressants</p> <p><b>Evidence statement:</b> This review provides some evidence that the intervention is effective but it is not conclusive</p> <p><b>Intervention:</b> Psychological therapy and/or antidepressant medication</p> <p><b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p> <p><b>Intervention:</b> Psychological therapy and/or medication to prevent relapse or reoccurrence of depressive disorder</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of these interventions but it is not conclusive</p> <p><b>Intervention:</b> Group based CBT for depression in young offenders</p> <p><b>Evidence statement:</b> There is some evidence that this intervention is effective but it is not conclusive</p>
---	--	--

	<p>implications arising from the more rapid response with a modular approach may have an impact on service design.</p> <p>2. Stepped care – no new key evidence was found for this section</p> <p>3. Step 1: detection, risk profiling and referral - no new key evidence was found for this section</p> <p>4. Step 2: recognition – no new key evidence was found for this section</p> <p>5. Step 3: Mild depression</p> <p><b>Classroom-based CBT in young people at high risk of depression</b>  NICE CG28 recommends that after up to 4 weeks of watchful waiting, children and young people with mild depression should be offered a course of non-directive supportive therapy, group CBT or guided self-help. It is recommended that these interventions are delivered by appropriately trained professionals in tier 1 (which includes teachers and primary care services). However, the guideline does not currently specify, or advise against, any particular types of group CBT for young people with mild depression.</p> <p>Stallard et al. (2012) conducted a pragmatic cluster RCT to assess reduction in depressive symptoms following a classroom-based CBT depression prevention programme in young people at high risk of depression. The evidence suggests that a group CBT programme for preventing depression, delivered universally in a school setting, may not reduce symptoms of depression in young people at high risk of depression, and could increase reporting of symptoms. The study authors therefore suggest that this approach is not pursued without further research and evaluation. NICE CG28 does not currently recommend, or advise against, any specific types of group CBT for young people with mild depression. However these data suggest that there may be potential harms associated with universal group CBT provision in schools. This evidence may, therefore, have a potential impact on NICE CG28, although the details of any impact are outside the scope the Evidence Update. Decisions on how the new evidence may impact guidance will not be possible until the guidance is reviewed by NICE following its published processes and methods.</p> <p><b>Computerised CBT for young people with depressive symptoms</b>  The interventions recommended by NICE CG28 for mild depression do not include computer-based therapies, although a research recommendation was made on computerised CBT. Among trials conducted on computerised CBT since publication of NICE CG28 is a study by Merry et al. (2012). This non-inferiority study compared the effectiveness of SPARX (Smart, Positive, Active, Realistic, X-factor thoughts) with usual care for young people seeking help for depressive symptoms. SPARX was not inferior to usual care in the primary, per protocol analysis (participants completing at least 4 of the SPARX</p>	
--	---	--

	<p>modules), as shown by the difference in mean reduction in CDRS-R score (2.73, 95% CI -0.31 to 5.77, p=0.079). Similar findings for SPARX versus usual care were reported in the intention-to-treat population (1.60, 95% CI -1.21 to 4.41, p=0.264). There was also no significant difference in the rate of response to treatment (defined as a 30% decrease in symptoms on the CDRS-R) with SPARX and usual care in the primary analysis (66.2% versus 58.3%; difference=7.9%, 95% CI -7.9 to 24%, p=0.332). However, there was a significantly higher remission rate (score less than 30 on the CDRS-R) with SPARX than usual care (43.7% versus 26.4%; difference=17.3%, 95% CI 1.6 to 31.8%, p=0.03). Limitations included missing data on adherence to treatment in the usual care group (not all clinicians supplied complete records to the study), and that some young people expressed dislike of computers. Nevertheless, as exemplified by this study, computerised CBT may be a valid treatment option for young people with mild depression. Consequently, this study (and others published prior to the search period for this Evidence Update) may have a potential impact on NICE CG28, although the details of any impact are outside the scope of the Evidence Update. Decisions on how the new evidence may impact guidance will not be possible until the guidance is reviewed by NICE following its published processes and methods</p> <p>6. Steps 4 and 5: moderate to severe depression</p> <p><b>Prescribing antidepressants for children and young people</b></p> <p>At the time NICE CG28 was published, there were no antidepressant treatments licensed in the UK for use in children or young people. Since publication of the guideline, fluoxetine has been licensed for use in children and young people aged 8 years and older to treat moderate to severe major depression that is unresponsive to psychological therapy after 4–6 sessions, only in combination with a concurrent psychological therapy. NICE CG28 notes that unlicensed medicines may be legally prescribed where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion. NICE CG28 also notes particular cautions when considering the use of antidepressants for children and young people. In particular the Committee on Human Medicinal Products (CHMP) of the European Medicines Agency has advised that SSRIs and serotonin noradrenaline reuptake inhibitors (SNRIs) should not be used in children and adolescents except within their approved indications – not usually depression – because of the risk of suicide-related behaviour and hostility.</p> <p><b>Treatment with psychological or antidepressant therapy, alone or in combination</b> - NICE CG28 recommends that children and young people with moderate to severe depression should be assessed by healthcare professionals in Child and Adolescent Mental Health Services and offered, as a first-line treatment, a specific psychological therapy</p>	
--	---	--



	<p>(individual CBT, interpersonal therapy or shorter-term family therapy) of at least 3 months duration. If there is no response after 4 to 6 sessions, the child or young person should be reviewed by a multidisciplinary team and considered for alternative or additional psychological therapy or combined psychological therapy and fluoxetine (cautiously in younger children). NICE CG28 also advises that antidepressant medication should not be offered to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Two reviews were identified - A Cochrane review by Cox et al. (2012) evaluating the use of psychological therapies compared with antidepressant medication, alone and in combination, for the treatment of depression in children and young people, and Calati et al. (2011) a meta-analysis comparing 12 weeks of treatment with combined CBT and antidepressant medication with the same antidepressant alone.</p> <p>Overall, these meta-analyses suggest that there may be little difference in efficacy between monotherapy with psychological or antidepressant treatment for moderate or severe depression in the populations of young people studied (although there was some evidence to suggest a greater effect with antidepressant monotherapy as measured by clinician-defined remission). There is an increased risk of suicidal ideation from antidepressant monotherapy compared with psychological treatment alone. Combining CBT with antidepressants may be beneficial with regard to some measures of global functioning, although benefits in other measures are less clear. Combining CBT with antidepressants has not been convincingly shown to mitigate the risk of suicidal ideation from antidepressants.</p> <p>Evidence from these reviews may have a potential impact on NICE CG28, although the details of any impact are outside the scope the Evidence Update. Decisions on how the new evidence may impact guidance will not be possible until the guidance is reviewed by NICE following its published processes and methods.</p> <p><b>Choice of antidepressant medication</b></p> <p>NICE CG28 recommends that when an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks. If treatment with fluoxetine is unsuccessful or is not tolerated because of side effects, consideration should be given to the use of another antidepressant. Sertraline or citalopram are the recommended second-line treatments. NICE CG28 also states that paroxetine and venlafaxine should not be used for the treatment of depression in children and young people.</p> <p>A Cochrane review by Hetrick et al. (2012) evaluated newer generation antidepressants for depressive disorders in children and young people aged 6–18 years. Overall, the evidence from this review is consistent with the recommendation of NICE CG28 that fluoxetine is the</p>	
--	---	--

	antidepressant of choice, when medication is used. There remains little evidence to inform views on the relative value of other antidepressants in children and young people. 7. Transfer to adult services – no new key evidence	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<p>National Collaborating Centre for Mental Health (2017) <b>Depression in Children and Young People: Identification and management in primary, community and secondary care (partially updated)</b>. London: The British Psychological Society</p> <p><b>Type of source:</b> Clinical practice guidelines (commissioned by NICE)</p> <p><b>Study Population:</b> Children and young people aged between 5 and 18 years who have experience of depression</p> <p><b>Interventions:</b> Identification, treatment and management of depression</p> <p><b>Studies were included up to:</b> A search was conducted for new evidence from 17 August 2010 to 14 January 2013. (Partially updated in March 2015. Evidence for psychological therapies and for treatment of depression in children and young people)</p>	Same as for NICE (2018) above	Same as for NICE (2018) above

Study details	Summary of main recommendations	Main findings and evidence grading
<p>National Institute for Health and Care Excellence (2017) <b>Appendix A: Summary of evidence from surveillance (2017) - Depression in children and young people: identification and management (2005) NICE guideline CG28.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> Children and young people aged between 5 and 18 years</p> <p><b>Interventions:</b> Identification and management of depression</p>	<p>This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Depression in children and young people: identification and management Clinical guideline [CG28].</p> <p>The evidence was reviewed in August 2017 – an update of the recommendations on psychological therapy for treatment of depression in children and young people is currently being planned</p> <p>The current guideline covers identifying and managing depression in children and young people aged between 5 and 18 years. Based on the stepped care model, it aims to improve recognition and assessment and promote effective treatments for mild, moderate and severe depression.</p> <p>This guideline includes recommendations on:</p> <ul style="list-style-type: none"> <li>Care of all children and young people with depression</li> <li>Stepped care</li> <li>step 1: detection, risk profiling and referral</li> <li>step 2: recognition</li> <li>step 3: mild depression</li> <li>steps 4 and 5: moderate to severe depression</li> <li>transfer to adult services</li> </ul>	<p><b>Intervention:</b> Newer generation antidepressants <b>Evidence statement:</b> This review provides some evidence that the intervention is effective but it is not conclusive</p> <p><b>Intervention:</b> Psychological therapy and/or antidepressant medication <b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p> <p><b>Intervention:</b> Psychological therapy and/or medication to prevent relapse or reoccurrence of depressive disorder <b>Evidence statement:</b> There is some evidence supporting the use of these interventions but it is not conclusive</p> <p><b>Intervention:</b> Group based CBT for depression in young offenders <b>Evidence statement:</b> There is some evidence that this intervention is effective but it is not conclusive</p>

Study details	Results of the review	Main findings and evidence grading
<p>Cox, et al. (2014) <b>Psychological therapies versus antidepressant medication, alone and in combination for depression in children and adolescents.</b> Cochrane Database of Systematic Reviews.</p> <p><b>Type of source:</b> Cochrane Systematic Review</p> <p><b>Study Population:</b> Children (six to 12 years) and adolescents (13 to 18)</p>	<p><b>Description of included studies:</b> Eleven RCTs involving 1307 participants were included in the review. Eight of the 11 trials were undertaken in the USA, while one each were undertaken in the UK, Australia, and South Korea. There were eight trials of selective serotonin reuptake inhibitors (SSRIs), one of a tricyclic antidepressant (TCA), one of a serotonin-norepinephrine reuptake inhibitor (SNRI) and one of a norepinephrine-dopamine reuptake inhibitors (NDRI). Five trials compared combination therapy to psychological therapies with placebo medication; five trials compared combination therapies to antidepressant medication alone; one trial compared combination therapy to a placebo condition and one compared combination therapy to 'treatment as usual', involving routine medication of SSRIs.</p>	<p><b>Intervention:</b> Psychological therapy and/or antidepressant medication <b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but there is some evidence of effect</p> <p><b>Author's conclusions:</b> There is very limited evidence upon which to base conclusions about the relative effectiveness of psychological interventions, antidepressant medication and a combination of these interventions. On the basis of the available evidence, it was not possible to draw robust conclusions, nor to</p>

<p>years) with a primary diagnosis of depressive disorder</p> <p><b>Interventions:</b> Psychological therapy and/or antidepressant medication.</p> <p><b>Relevant outcomes:</b> Suicide-related behaviours</p> <p><b>Studies were included up to:</b> June 2014</p> <p><b>Included study types:</b> Published and unpublished RCTs</p>	<p>Treatment programmes ranged from six weeks to 24 weeks in length, and participants received between six and 24 sessions of psychological therapy. All psychological therapies contained core elements of CBT, or behavioural therapy (BT), or both.</p> <p><b>Quality of included studies:</b> The quality of included studies was assessed using the Cochrane Risk of Bias tool. Around 50% of the studies had adequate sequence generation and allocation concealment. Outcome assessors were blind to the participants' intervention in six studies, and in general, studies reported on incomplete data analysis methods, mainly using intention-to-treat (ITT) analyses.</p> <p><b>Synthesis:</b> Meta-analyses were conducted for suicide-related outcomes</p> <p><b>Findings:</b></p> <p><b><u>Psychological therapy vs. antidepressant medications</u></b> Two trials reported outcomes related to suicidal behaviour. In one trial, there were significantly fewer participants experiencing suicidal ideation in the psychological therapy group than in the medication group post-intervention (OR 0.26, 95% CI 0.09 to 0.72). This effect was still evident at six to nine months (OR 0.26, 95% CI 0.07 to 0.98). Two trials reported continuous suicidal ideation data. At post-intervention, there was a small effect favouring psychological therapy compared with medication (MD -3.12, 95% CI -5.91 to -0.33). This effect remained at six to nine months follow-up (MD -2.89, 95% CI -5.49 to -0.28). Only one trial provided data at 12 months follow-up. The reduction in suicidal ideation experienced by those receiving psychological therapy did not reach statistical significance (MD -2.50, 95% CI -5.09 to 0.09).</p> <p><b><u>Combination therapy versus antidepressant medication</u></b> Two trials reported suicidal-related outcomes. At post-intervention, the effect of combination therapy compared with medication alone was unclear (OR 0.75, 95% CI 0.26 to 2.16). There was significant heterogeneity (I<sup>2</sup> = 68%, P = 0.08). At six to nine months follow-up, the effect of the two intervention approaches remained unclear (OR 0.53, 95% CI 0.06 to 4.58). There was significant heterogeneity (I<sup>2</sup> = 83%; P = 0.08). Only one trial provided data at 12 months follow-up. This favoured combination therapy, with fewer individuals reporting suicidal ideation, compared with those treated with medication alone; however this did not reach significance (OR 0.16, 95% CI 0.03 to 0.77). Two trials provided continuous suicidal ideation data. There were no differences in treatment approaches post-intervention (MD -2.57, 95% CI -5.53 to 0.40), at six to nine months (MD -1.89, 95% CI -4.50 to 0.72); or at 12 months follow-up (MD -1.60, 95% CI -4.18 to 0.98).</p>	<p>establish which intervention strategy was most effective.</p> <p>Further appropriately powered RCTs are required in which measures of suicidal-related behaviours are measured robustly and consistently.</p>
--	--	--

	<p><b><u>Combination therapy versus psychological therapy</u></b> Only one trial provided dichotomous suicidal ideation data. At post-intervention, there was little evidence of any difference between treatment approaches (OR 1.68, 95% CI 0.53 to 5.34). The effect was unclear at six to nine months follow-up (OR 0.63, 95% CI 0.10 to 3.89). Two trials provided continuous suicidal ideation data. There appeared to be little effect of either intervention in level of suicidal ideation at post-intervention (MD 0.60, 95% CI -2.25 to 3.45), six to nine months follow-up (MD 1.78, 95% CI -2.29 to 5.85) or 12 months follow-up (MD 0.90, 95% CI -1.37 to 3.17).</p> <p><b><u>Combination therapy versus psychological therapy plus placebo</u></b> One trial containing 126 participants reported data based on question 13 of the CDRS-R about suicidal ideation. At post-intervention, the effect of combination treatment compared with psychological therapy plus placebo was unclear (MD -0.06, 95% CI -0.36 to 0.24).</p>	
--	---	--

Study details	Results of the review	Main findings and evidence grading
<b>Management of post-traumatic stress disorder</b>		
<p>Gillies D et al. <b>Psychological therapies for children and adolescents exposed to trauma.</b> Cochrane Database of Systematic Reviews 2016, Issue 10. Art. No.: CD012371. DOI: 10.1002/14651858.CD012371.</p> <p><b>Type of source:</b> Cochrane Systematic Review</p> <p><b>Study Population:</b> Children or adolescents, boys and girls, up to and including 18 years of age, who had been exposed to a traumatic event.</p> <p><b>Interventions:</b> Psychological therapies</p>	<p><b>Description of included studies:</b> Fifty one studies with a total of 6201 participants were included in the review. Ten studies were cluster-randomised controlled trials while other included studies randomised participants to interventions. Most (27) included trials were done in the United States, three in the Democratic Republic of Congo; two each were carried out in Australia, Israel, the Netherlands, Palestine, Sri Lanka and the UK. One study each was done in Bosnia, Burundi, Canada, Indonesia, Iran, Jordan, Peru, Sierra Leone and Switzerland.</p> <p><b>Quality of included studies:</b> The quality of included studies was assessed using the Cochrane Risk of Bias tool. The generation of a randomisation sequence was described and was considered to lead to low risk of bias in 25 trials and to unclear risk in the remainder. Allocation concealment was not described in 42 trials, which therefore were rated as having unclear risk. Eight studies were considered to have low risk, while one study was considered at high risk. Thirty two trials were rated as having a high risk of performance bias because participants were likely to be aware of whether they had been assigned to an intervention group or a control group. Thirty trials were rated as having high risk of detection bias.</p>	<p><b>Intervention:</b> Psychological therapies</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Author's conclusions:</b> The meta-analyses in this review provide some evidence for the effectiveness of psychological therapies in prevention of PTSD and reduction of symptoms in children and adolescents exposed to trauma for up to a month. However, our confidence in these findings is limited by the quality of the included studies (very low to moderate) and by substantial heterogeneity between studies.</p> <p>More evidence is needed to evaluate the effectiveness of psychological therapies longer than one month after treatment. Much more evidence is needed to demonstrate the relative effectiveness of psychological therapies for children and adolescents exposed to</p>

<p><b>Relevant outcomes:</b> Diagnosis of PTSD, symptoms of PTSD, severity or incidence of anxiety symptoms, depressive symptoms, behavioural problems, function, quality of life, adverse events, loss to follow-up</p> <p><b>Studies were included up to:</b> May 2015</p> <p><b>Included study types:</b> Randomised and quasi-randomised controlled trials.</p>	<p>Risk of attrition bias was low in 10 studies and high in 18 studies, with the remainder having unclear risk. Four studies were rated as having high risk of reporting bias, 14 studies unclear risk, and the remainder low risk of reporting bias. Eight studies were rated as having high risk of other bias.</p> <p><b>Synthesis:</b> Meta-analysis</p> <p><b>Findings:</b> The likelihood of being diagnosed with PTSD in children and adolescents who received a psychological therapy was significantly reduced compared to those who received no treatment, treatment as usual or were on a waiting list for up to a month following treatment (OR) 0.51, 95% confidence interval (CI) 0.34 to 0.77; number needed to treat for an additional beneficial outcome (NNTB) 6.25, 95% CI 3.70 to 16.67; five studies; 874 participants). However the overall quality of evidence for the diagnosis of PTSD was rated as very low. PTSD symptoms were also significantly reduced for a month after therapy (SMD) - 0.42, 95% CI -0.61 to -0.24; 15 studies; 2051 participants) and the quality of evidence was rated as low. These effects of psychological therapies were not apparent over the longer term. CBT was found to be no more or less effective than EMDR and supportive therapy in reducing diagnosis of PTSD in the short term (OR 0.74, 95% CI 0.29 to 1.91; 2 studies; 160 participants), however this was considered very low quality evidence. For reduction of PTSD symptoms in the short term, there was a small effect favouring CBT over EMDR, play therapy and supportive therapies (SMD -0.24, 95% CI -0.42 to -0.05; 7 studies; 466 participants). The quality of evidence for this outcome was rated as moderate.</p>	<p>trauma. High-quality studies should be conducted to compare these therapies.</p>
---	---	---

Study details	Results of the review	Main findings and evidence grading
<b>Management of children who have been sexually abused</b>		
<p>Parker B, Turner W. (2014)</p> <p><b>Psychoanalytic/Psychodynamic Psychotherapy for Sexually Abused Children and Adolescents: A Systematic</b></p>	<p><b>Description of included studies:</b> No randomised and quasi-randomised trials that compared psychoanalytic/psychodynamic therapy with treatment as usual, no treatment or waiting list control for children and adolescents who have been sexually abused were identified.</p>	<p><b>Intervention:</b> Psychoanalytic/psychodynamic psychotherapy for sequelae of sexual abuse</p> <p><b>Evidence statement:</b> Evidence about the effectiveness of the intervention is lacking</p>

<p><b>Review.</b> Research on Social Work Practice, 24, 389-399</p> <p><b>Type of source:</b> Systematic review</p> <p><b>Interventions:</b> Psychoanalytic/psychodynamic psychotherapy</p> <p><b>Relevant Outcomes:</b> PTSD, depression, aggression, sexualised behaviour, suicide and self-harm.</p> <p><b>Study Population:</b> Children and adolescents up to 18 years who have experienced sexual abuse</p> <p><b>Studies were included up to:</b> May 2013</p> <p><b>Included study types:</b> Randomised and quasi randomised trials</p>	<p><b>Quality of included studies:</b> NA</p> <p><b>Synthesis:</b> NA</p> <p><b>Findings:</b> NA</p>	<p><b>Author's conclusions:</b> Conclusions as to the effectiveness of psychoanalytic/psychodynamic psychotherapy for this population cannot be drawn. This important gap emphasises the need for further research into the effectiveness of psychoanalytic/psychodynamic psychotherapy in this population. Such research should ideally be in the form of methodologically high-quality, large-scale randomised controlled trials. If these are not conducted, future systematic reviews on this subject may need to consider including other lower quality evidence in order to avoid overlooking important research.</p>
--	--	---

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Preventing suicides in residential custodial and detention settings</b>		
<p>National Institute for Health and Care Excellence (2018) <b>Preventing suicide in community and custodial settings. Evidence review 9 for preventing suicides in residential custodial and detention settings. NICE guideline NG105.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p>	<p>This review provides evidence from recent studies on the topic of preventing suicides in custodial settings. The aim of this review is to determine the effective interventions that may have an impact on preventing suicide in custodial setting.</p> <p><b>Quality of the evidence</b> The committee acknowledged that evidence on preventing suicide in custodial settings was scant, and limited only to 4 studies. There was no randomised controlled trial. The committee noted that research in custodial settings was complex and posed particular ethical challenges. Evidence from observational data examined the effectiveness of peer support on suicide rates, and the certainty of evidence was considered</p>	<p><b>Intervention:</b> Peer support</p> <p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p> <p><b>Intervention:</b> Risk management training for prison staff</p> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p>

<p><b>Study Population:</b> Adults, young people and children in custodial settings; Adults, young people and children who are in contact with the criminal justice system.</p> <p><b>Interventions:</b></p> <ul style="list-style-type: none"> <li>Local approaches to preventing suicide in custodial settings</li> <li>Interventions to support people in custodial settings, or who are transferring between settings</li> </ul> <p><b>Relevant outcomes:</b> Suicide rates, Suicide attempts, Reporting of suicide ideation, Service uptake (such as mental health services, helplines, GPs), Changes in knowledge, attitude and behaviour of practitioners and partners, Views and experiences of professionals and the public (service experience).</p>	<p>'low' as data was only from one prison in Canada, which had limited generalisability to the UK prison setting. Results of change in knowledge and attitudes among prison staff was reported in Hayes et al (2008)'s study, and the certainty of evidence was considered to be 'very low' due to the nature of self-reported data and variations in the implementation of the intervention.</p> <p>Evidence from one study showed a reduction in the number of suicides in a prison after the implementation of peer support service. The reduction was not statistically significant and low certainty of evidence did not provide a robust evidence base for strong recommendations. However, the committee based on their experience, suggested that peer support could have a potential beneficial effect on prisoners such as a reduction in a feeling of distress and an improvement in their help-seeking.</p> <p>As included studies provided limited evidence on preventing suicides in custodial or detention settings, the committee agreed testimonies by experts who were working in this field were useful to inform the evidence base for recommendations for this guideline.</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>Interventions to prevent substance misuse</b>		
<p>National Institute for Health and Care Excellence (2017) <b>Drug misuse prevention: targeted interventions [NG64]</b>. London: NICE</p> <p><b>Type of source:</b> NICE guideline</p> <p><b>Study Population:</b> Children, young people and adults who are most</p>	<p>This guideline covers targeted interventions to prevent misuse of drugs, including illegal drugs, 'legal highs' and prescription-only medicines. It aims to prevent or delay harmful use of drugs in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally. This guideline updates and replaces NICE guideline PH4 (March 2007).</p> <p>Recommendations are made on:</p>	<p><b>Intervention:</b> Skills training for children and young people at risk of drug misuse</p> <p><b>Evidence statement:</b> Recommended good practice based on clinical experience of the Guideline Development Group</p>



likely to start using drugs or who are already experimenting or using drugs occasionally  <b>Interventions:</b> Targeted interventions to prevent misuse of drugs, including illegal drugs, 'legal highs' and prescription-only medicines	<ul style="list-style-type: none"> <li>• Delivering drug misuse prevention activities as part of existing services</li> <li>• Assessing whether someone is vulnerable to drug misuse</li> <li>• Providing skills training for children and young people who are vulnerable to drug misuse</li> <li>• Providing information to adults who are vulnerable to drug misuse</li> <li>• Providing information about drug use in settings that people who use drugs or are at risk of using drugs may attend</li> </ul>	
---	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
<b>INDICATED INTERVENTIONS</b>		
<b>Management of self-harm</b>		
<p>National Institute for Health and Care Excellence (2013) <b>Self-harm: longer term management. Evidence Update April 2013. A summary of selected new evidence relevant to NICE clinical guideline 133 'self-harm: longer term management' (2011).</b> Manchester: National Institute for health and Care Excellence</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> People aged eight years and older who self-harm</p> <p><b>Interventions:</b> Longer-term psychological treatments for self-harm</p>	<p>This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Self-harm: longer-term management. NICE clinical guideline 133 (2011).</p> <p>The evidence was reviewed in September 2016. No major studies were identified affecting existing recommendations.</p> <p>This guideline covers the longer-term psychological treatment and management of self-harm in people aged 8 and over. It aims to improve the quality of care and support for people who self-harm and covers both single and recurrent episodes of self-harm. This guidance is for health and social care professionals.</p> <p>Recommendations are made on:</p> <ol style="list-style-type: none"> <li>1. General principles of care – no new key evidence found</li> <li>2. Primary care</li> </ol> <p><b>Impact of asking questions about suicide</b> - NICE CG 133 recommends that when assessing the risk of repetition of self-harm or risk of suicide, the specific risks for the person who self-harms should</p>	<p><b>Intervention:</b> Access to services <b>Evidence statement:</b> There is good evidence from qualitative studies to support this recommendation</p> <p><b>Intervention:</b> Training and supervision for health and social care professionals <b>Evidence statement:</b> There is some evidence supporting this intervention but it is not conclusive</p> <p><b>Interventions:</b> Consent and confidentiality <b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Safeguarding <b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Families carers and significant others <b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Managing endings and supporting transitions <b>Evidence statement:</b> NICE good practice recommendation</p>

<p><b>Studies were included up to:</b> 24 October 2012 (evidence reviewed in September 2016 – no new evidence)</p>	<p>be identified and agreed, taking into account factors including current and past suicidal intent. The findings from a multicentre, single-blind, RCT (n = 443) suggest that questions about suicidal ideation in people who have signs of depression do not appear to increase feelings that life is not worth living. The evidence appears to be consistent with NICE CG133 and suggests that asking about suicidal ideas is not harmful.</p> <p>3. Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks.</p> <p><b>Risk assessment by psychiatrists versus mental health nurses following self-harm</b> - NICE CG133 defines a risk assessment as a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm. It does not however make any specific distinction about the type of healthcare professionals who should perform the assessment. Evidence from a prospective cohort study suggests that there appears to be consistency in the predictive value of risk assessments for self-harm between junior psychiatrists and mental health nurses (although psychiatrists may be more likely to make inpatient admissions). However, study limitations (particularly regarding the specialism of the nurses, and lack of randomisation to assessment groups) mean that findings may need wider corroboration in other settings. This evidence is unlikely to have implications for NICE CG133.</p> <p><b>Prediction of suicide</b> - NICE CG133 recommends taking into account current and past suicidal intent within a detailed clinical assessment. The results from a retrospective cohort study suggest that there may be factors predictive of death by suicide, particularly that taking precautions against the discovery of a suicide attempt may be a predictor of eventual suicide (which was also noted as a potential predictive factor in the full version of NICE CG133). However, limitations of the evidence mean that it is unlikely to have any additional impact on the recommendations in NICE CG133 that current and past suicidal intent should be assessed.</p> <p><b>Risk assessment tools</b> - NICE CG133 recommends that risk assessment tools and scales to predict future suicide or repetition of self-harm should not be used. Although methodologically limited, the evidence from a prospective cohort study (n = 4019) that evaluated the ability of the SAD PERSONS scale and the modified SAD PERSONS scale to predict suicide attempts, suggests that both scales have poor predictive ability for future suicide attempts. This appears to be consistent with recommendations in NICE</p>	<div data-bbox="1417 220 2027 300"> <p><b>Intervention:</b> Primary care  <b>Evidence statement:</b> NICE good practice recommendation</p> </div> <div data-bbox="1417 323 2027 403"> <p><b>Intervention:</b> Psychosocial assessment  <b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> </div> <div data-bbox="1417 403 2027 483"> <p><b>Intervention:</b> Risk assessment  <b>Evidence statement:</b> NICE good practice recommendation</p> </div> <div data-bbox="1417 483 2027 746"> <p><b>Intervention:</b> Prediction of suicide  <b>Evidence statement:</b> There moderate to good evidence of ineffectiveness. NICE specifically recommends that this intervention should not be adopted</p> <p><b>Intervention:</b> Risk assessment tools  <b>Evidence statement:</b> There moderate to good evidence of ineffectiveness. NICE specifically recommends that this intervention should not be adopted</p> </div> <div data-bbox="1417 770 2027 1161"> <p><b>Intervention:</b> 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:</p> <ul style="list-style-type: none"> <li>• The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.</li> <li>• Therapists should be trained and supervised in the therapy they are offering to people who self-harm.</li> <li>• Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</li> </ul> <p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> </div> <div data-bbox="1417 1185 2027 1345"> <p><b>Intervention:</b> General interventions for self-harm and suicide  <b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Intervention:</b> Mentalisation-based treatment</p> </div>
--	--	---

	<p>CG133 that risk assessment scales should not be used to predict future suicide.</p> <p>4. Longer-term treatment and management of self-harm</p> <p><b><u>Interventions for self-harm</u></b></p> <p>NICE CG133 recommends considering 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:</p> <ul style="list-style-type: none"> <li>• The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.</li> <li>• Therapists should be trained and supervised in the therapy they are offering to people who self-harm.</li> <li>• Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</li> </ul> <p><b>Assertive outreach</b> - The evidence from a parallel group superiority RCT (n = 243) suggests that an assertive outreach intervention does not appear to reduce the frequency of subsequent suicide attempts when compared with standard treatment. It is therefore unlikely to have an impact on NICE CG133.</p> <p><b>Problem-solving therapy</b> - Data from one RCT suggest that although problem-solving therapy appeared to be no more effective than usual care in preventing repetition of self-harm among people presenting with self-harm for the first time, for those presenting with recurrent self-harm it may be more effective than standard care. These benefits are broadly consistent with the recommendation in NICE CG133 that potential interventions to be considered for self-harm could include problem solving.</p> <p><b>An outreach, problem solving, adherence, and continuity intervention</b> - In addition to the psychological interventions recommended by NICE CG133, the guideline also recommends that health and social care professionals should maintain continuity of therapeutic relationships wherever possible, and should receive support from senior colleagues in consideration of the emotional impact of self-harm on the professional. Data from a single-blind RCT suggest that an OPAC intervention may potentially reduce repeated suicide attempts after 12 months. The nature of the intervention is consistent with some recommendations in NICE CG133 (such as the focus on continuity of care and psychological supervision of professionals) but differed from the guideline in that the main effects were observed after 6 months and the intervention had a strong focus on continuing personalised contact over a period of time (whereas current recommendations state only 3 to 12 sessions should be offered). However, limitations of the evidence mean that further research is needed (for example, to validate results in a UK setting against usual treatment) and therefore this evidence is currently unlikely to have an impact on NICE CG133.</p>	<p><b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p>
--	---	---

	<p><b>Postcard intervention</b> - NICE CG133 does not make any recommendations for interventions involving the use of postcards to communicate with people who self-harm. Although the data from one RCT (n = 2300) suggest that a postcard intervention may reduce suicidal ideation and suicide attempts compared with TAU, the limitations of the study (particularly differences between the Iranian setting and the UK) mean that the evidence is unlikely to have an impact on NICE CG133. It should be noted that studies of postcard interventions from Australia and New Zealand were examined in the full version of NICE CG133, which concluded that there was insufficient evidence to determine clinical effects between interventions and routine care.</p> <p><b>Self-harm in adolescents</b> NICE CG133 does not make any specific recommendations about treatment interventions for self-harm in adolescents, but does recommend that children and young people who self-harm should have access to the full range of treatments and services recommended in the guideline within child and adolescent mental health services.</p> <p><b>General interventions for self-harm and suicide</b> - Two reviews (Ougrin 2012; Robinson 2011) examined interventions for self-harm and suicide among adolescents. Despite identifying studies in adolescents additional to those examined during the development of NICE CG133, the authors of both reviews concluded that there was a general insufficiency of evidence for the effectiveness of interventions for self-harm and suicide among adolescents and further research is needed. There is therefore unlikely to be an impact of this evidence on current guidance.</p> <p><b>Mentalisation-based treatment</b> - Evidence from a double-blind RCT (n = 80) (Rossouw 2012) suggests that a year-long MBT-A programme may be more effective than TAU in reducing self-harm among adolescents at 12 months, but further research is needed to confirm findings (particularly cost-effectiveness analysis, because the length and intensive nature of the intervention may involve high costs). The results are currently unlikely to have an impact on NICE CG133</p> <p>5. Treating associated mental health conditions - search for new evidence was not performed for this section</p>	
--	--	--

Study details	Summary of main recommendations	Main findings and evidence grading
National Institute for Health and Care Excellence (2016) <b>12-year surveillance audit document.</b>	This evidence update identifies new evidence that is relevant to, and may have a potential impact, on the reference guidance: Self-harm in	<b>Intervention:</b> Children and young people under 16 years of age who have self-harmed should be triaged, assessed and treated by appropriately trained children's

<p><b>Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16. Appendix A.1: Summary of new evidence from surveillance.</b> London: NICE</p> <p><b>Type of source:</b> NICE guidance</p> <p><b>Study Population:</b> People aged eight years and older who have self-harmed</p> <p><b>Interventions:</b> Short-term physical and psychological management for self-harm</p>	<p>over 8s: short-term management and prevention of recurrence Clinical guideline [CG16]</p> <p>This guideline covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm (this is covered in guideline CG133).</p> <p>The guideline includes recommendations on:</p> <ul style="list-style-type: none"> <li>• Issues for all services and healthcare professionals</li> <li>• Care in primary care, by ambulance services, in emergency departments and the medical and surgical management of self-harm</li> <li>• Support and advice for people who repeatedly self-harm</li> <li>• Psychosocial assessment</li> <li>• Referral, admission and discharge</li> <li>• Special issues for people under 16 years and older than 65 years</li> <li>• Psychological, psychosocial and pharmacological interventions</li> </ul> <p>This guideline was published in 2004, but the evidence was reviewed in September 2016. No major studies were identified effecting existing recommendations.</p>	<p>nurses and doctors in a separate children's area of the emergency department.</p> <p><b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed</p> <p><b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues</p> <p><b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending upon the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary</p> <p><b>Evidence statement:</b> NICE grade C recommendation</p> <p><b>Intervention:</b> For young people of 14 years and older who have self-harmed, admission to a ward for adolescents may be considered if this is available and preferred by the young person</p> <p><b>Evidence statement:</b> NICE grade C recommendation</p> <p><b>Intervention:</b> A paediatrician should normally have overall responsibility for the treatment and care of children and young people who have been admitted following an act of self-harm</p> <p><b>Evidence statement:</b> NICE grade C recommendation</p>
---	--	--

		<p><b>Intervention:</b> Following admission of a child or young person who has self-harmed, the admitting team should obtain parental (or other legally responsible adult) consent for mental health assessment of the child or young person</p> <p><b>Evidence statement:</b> NICE grade C recommendation</p> <p><b>Intervention:</b> In the assessment and treatment of self-harm in children and young people, special attention should be paid to the issues of confidentiality, the young person's consent (including Gillick competence), parental consent, child protection, the use of the Mental Health Act in young people and the Children Act</p> <p><b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> During admission to a paediatric ward following self-harm, the Child and Adolescent Mental Health Team should undertake assessment and provide consultation for the young person, his or her family, the paediatric team and social services and education staff as appropriate.</p> <p><b>Evidence statement:</b> NICE grade C recommendation</p> <p><b>Intervention:</b> All children and young people who have self-harmed should be assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm. Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues</p> <p><b>Evidence statement:</b> NICE good practice recommendation</p> <p><b>Intervention:</b> Child and adolescent mental health service practitioners involved in the assessment and treatment of children and young people who have self-harmed should:</p> <ul style="list-style-type: none"> <li>• be trained specifically to work with children and young people, and their families, after self-harm</li> <li>• be skilled in the assessment of risk</li> <li>• have regular supervision</li> <li>• have access to consultation with senior colleagues</li> </ul> <p><b>Evidence statement:</b> NICE grade C recommendation</p>
--	--	--

		<b>Intervention:</b> Initial management should include advising carers of the need to remove all medications or other means of self-harm available to the child or young person who has self-harmed <b>Evidence statement:</b> NICE good practice recommendation
--	--	---

Study details	Results of the review	Main findings and evidence grading
<p>Hawton K et al. <b>Interventions for self-harm in children and adolescents.</b> Cochrane Database of Systematic Reviews 2015, Issue 12. Art. No.: CD012013. DOI: 10.1002/14651858.CD012013.</p> <p><b>Type of source:</b> Cochrane Systematic Review</p> <p><b>Study Population:</b> Males and females up to 18 years of age of all ethnicities who had engaged in any type of non-fatal intentional self-poisoning or self-injury resulting in presentation to child and adolescent mental health services in the six months prior to trial entry</p> <p><b>Interventions:</b> Psychosocial or pharmacological interventions for self-harm</p> <p><b>Relevant outcomes:</b> Occurrence of repeated self-harm, treatment adherence, depression, hopelessness, suicidal ideation, problem-solving, suicide</p> <p><b>Studies were included up to:</b> January 2015</p>	<p><b>Description of included studies:</b> Eleven RCTs involving 1126 participants were included in the review. Five trials were conducted in the UK, three were from the USA, and one each was from Australia, New Zealand, and Norway. All 11 trials included in the review investigated the effectiveness of various forms of psychosocial therapy, there were no trials of pharmacological treatments.</p> <p><b>Quality of included studies:</b> The quality of included studies was assessed using the Cochrane Risk of Bias tool. The majority of studies were rated as having a low risk of bias for sequence generation (k = 9; 81.8%) and allocation concealment (k = 8; 72.7%). The study authors classified blinding of participants (k = 9; 81.8%) and clinical personnel (k = 10; 90.9%) as resulting in a high risk of bias. Outcome assessors were blind to treatment allocation in eight trials (72.7%) and were therefore rated as having a low risk of bias. Four trials conducted analyses on an intention-to-treat basis and were therefore rated as having a low risk of bias. All 11 trials were rated as having an unclear risk of bias for selective reporting. Most trials were classified as having a low risk of bias for other potential sources of bias (k = 9; 81.8%).</p> <p><b>Synthesis:</b> Meta-analysis and narrative</p> <p><b>Findings:</b>  <u><b>Individual CBT-based psychotherapy</b></u>  There was no evidence of a significant treatment effect for brief psychological therapy on repetition of SH during the six month follow-up period (4/21 versus 2/18; OR 1.88, 95% CI 0.30 to 11.73; k = 1; N = 39; GRADE: moderate quality). Likewise there was no evidence of a significant treatment effect on treatment adherence, depression, and suicidal ideation at 6 or 12 months. There was no clear evidence of a significant treatment effect on problem-solving at 6 months, however by 12 months, there was evidence of a significant treatment effect of psychological therapy according to scores on the SPSI (mean 139.00,</p>	<p><b>Intervention:</b> Individual CBT-based psychotherapy  <b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but it tends towards no effect</p> <p><b>Intervention:</b> Dialectical behavioural therapy for adolescents  <b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Intervention:</b> Mentalisation  <b>Evidence statement:</b> There is some evidence supporting the use of this intervention but it is not conclusive</p> <p><b>Intervention:</b> Group-based psychotherapy  <b>Evidence statement:</b> There is some evidence suggesting that this intervention is ineffective but it is not conclusive</p> <p><b>Intervention:</b> Therapeutic assessment  <b>Evidence statement:</b> The evidence is inconsistent and it is not possible to draw a conclusion but it tends towards no effect</p> <p><b>Intervention:</b> Compliance enhancement  <b>Evidence statement:</b> There is some evidence suggesting that this intervention is ineffective but it is not conclusive</p> <p><b>Intervention:</b> Home-based family intervention  <b>Evidence statement:</b> There is some evidence suggesting that this intervention is ineffective but it is not conclusive</p> <p><b>Intervention:</b> Remote contact interventions  <b>Evidence statement:</b> There is some evidence suggesting that this intervention is ineffective but it is not conclusive</p>

<p><b>Included study types:</b> RCTs including cluster randomised and cross-over trials</p>	<p>SD 31.39, n = 15 versus mean 105.00, SD 29.48, n = 15; MD 34.00, 95% CI 12.21 to 55.79; k = 1; N = 30) but not on the MEPS (mean 9.44, SD 4.72, n = 15 versus mean 9.89, SD 2.47, n = 15; MD -0.45, 95% CI -3.15 to 2.25; k = 1; N = 30).</p> <p><b><u>Interventions for patients with multiple episodes of SH or emerging personality problems versus TAU or other routine management</u></b></p> <p>DBT-A was not associated with a reduction in the proportion of adolescents repeating SH when compared to either TAU or enhanced usual care (n = 104; k = 2 trials; OR 0.72, 95% CI 0.12 to 4.40; GRADE: low quality). In one trial however, the authors reported a significantly greater reduction over time in frequency of repeated SH in adolescents in the DBT condition, in whom there were also significantly greater reductions in depression, hopelessness, and suicidal ideation</p> <p>Mentalisation therapy was associated with fewer adolescents scoring above the cut-off for repetition of SH based on the Risk-Taking and Self-Harm Inventory 12 months post-intervention (n = 71; k = 1 trial; OR = 0.26, 95% CI 0.09 to 0.78; GRADE: moderate quality).</p> <p><b><u>Group-based psychotherapy</u></b></p> <p>We found no significant treatment effects for group-based therapy on repetition of SH for individuals with multiple episodes of SH at either the six (n = 430; k = 2; OR 1.72, 95% CI 0.56 to 5.24; GRADE: low quality) or 12 month (n = 490; k = 3; OR 0.80, 95% CI 0.22 to 2.97; GRADE: low quality) assessments, although considerable heterogeneity was associated with both (I<sup>2</sup> = 65% and 77% respectively). There was no clear evidence of a difference in treatment effect for either depression or suicidal ideation at either the six month or 12 month assessments.</p> <p><b><u>Therapeutic assessment</u></b></p> <p>Therapeutic assessment appeared to increase adherence with subsequent treatment compared with TAU (i.e., standard assessment; n = 70; k = 1; OR = 5.12, 95% CI 1.70 to 15.39), but this had no apparent impact on repetition of SH at either 12 (n = 69; k = 1; OR 0.75, 95%CI 0.18 to 3.06; GRADE: low quality) or 24 months (n = 69; k = 1; OR = 0.69, 95% CI 0.23 to 2.14; GRADE: low quality evidence). These results are based on a single cluster randomised trial, which may overestimate the effectiveness of the intervention.</p> <p><b><u>Compliance enhancement</u></b></p> <p>There was no clear evidence of a difference in treatment effect for repetition of SH by the six month follow-up assessment (3/29 versus</p>	<p><b>Author's conclusions:</b> There have been relatively few investigations into interventions for children and adolescents who engage in self-harm. Thus there is not much evidence on which to draw conclusions on effects of interventions for SH in this population. While there were some very limited positive findings regarding DBT-A, mentalisation, and therapeutic assessment, these approaches require further evaluation before any definitive conclusions about their use in clinical practice can be made.</p>
---	--	---



	<p>5/34; OR 0.67, 95%CI 0.15 to 3.08; k = 1;N= 63; GRADE: very low quality).</p> <p><b><u>Home-based family intervention</u></b></p> <p>There was no evidence of a difference in treatment effect for repetition of SH (six month follow-up assessment: n = 149; k = 1; OR = 1.02, 95% CI 0.41 to 2.51; GRADE: low quality), treatment adherence, hopelessness, suicidal ideation, problem-solving and suicide.</p> <p><b><u>Remote contact interventions</u></b></p> <p>There was no clear evidence of a difference in treatment effect for emergency cards on repetition of SH (12 month follow-up assessment: n = 105, k = 1; OR = 0.50, 95% CI 0.12 to 2.04; GRADE: very low quality).</p>	
--	--	--

