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PLEASE RESPOND WITHIN 48 HOURS
Trial of therapeutic assessment in London: randomised controlled trial of therapeutic assessment versus standard psychosocial assessment in adolescents presenting with self-harm

Dennis Ougrin,1 Tobias Zundel,2 Audrey Ng,3 Ricky Banarsee,4 Alex Bottle,4 Eric Taylor1

ABSTRACT
Objective To determine whether therapeutic assessment (TA) versus assessment as usual (AAU) improves engagement with follow-up in adolescents presenting with self-harm.
Design Randomised controlled trial with 3 months naturalistic follow-up.
Setting Child and adolescent mental health services in two London National Health Service Trusts.
Participants 26 clinicians randomised into TA and AAU groups recruited 70 newly referred adolescents with self-harm.
Interventions TA, a manualised procedure including a basic psychosocial assessment and a 30 min therapeutic intervention; AAU, standard psychosocial assessment.
Main outcome measures Attendance at the first follow-up session; number of the follow-up sessions attended and changes in Strengths and Difficulties Questionnaire and Children’s Global Assessment Scale scores. All measures were adjusted for clustering, social class, changes of therapist and previous contact with services.
Results Using the data on all participants (n=70), those in the TA group were significantly more likely to attend the first follow-up appointment: 29 (83%) versus 17 (49%), OR 5.12, 95% CI (1.49 to 17.55) and more likely to attend four or more treatment sessions: 14 (40%) versus 4 (11%), OR 5.19, 95% CI (2.22 to 12.10). Three months after the initial assessment there were no statistically significant differences between the groups on Strengths and Difficulties Questionnaire scores: 15.6 versus 16.0, mean difference −0.37, 95% CI (−3.28 to 2.53) or Children’s Global Assessment Scale scores: 64.6 versus 60.1, mean difference 4.49, 95% CI (−0.98 to 9.96).
Conclusions TA was associated with statistically significant improvement in engagement. TA could be usefully applied at the point of initial assessment for adolescents with self-harm.

Trial registration ISRCTN 81605131 http://www.controlled-trials.com/ISRCTN81605131/

INTRODUCTION
Suicide is the third or the second leading cause of death in adolescents in most Western countries.1–5 Self-harm is the strongest predictor of eventual death by suicide in adolescence, increasing the risk up to 10-fold.4
A range of intervention and prevention studies have shown effects in reducing self-harm ideation

What is already known on this topic
▶ Self-harm is the strongest predictor of suicide in adolescents.
▶ Adolescents with self-harm engage poorly with treatment.
▶ Brief interventions in emergency departments have had a modest impact on engagement.

What this study adds
▶ Therapeutic assessment is a feasible intervention during self-harm assessment.
▶ Therapeutic assessment leads to improved engagement with treatment.
▶ Effective psychotherapeutic interventions need to be developed to capitalise on the improved engagement.
the encouraging results of a pilot, the purpose of the present study was to determine whether therapeutic assessment (TA), a brief intervention based on cognitive analytic therapy, is more effective than assessment as usual (AAU) at improving engagement 3 months after the initial assessment.

METHODS
Eligibility criteria for participants
Adolescents aged 12–18 years not currently engaged with psychiatric services who had self-harmed and been referred for a psychosocial assessment were eligible for participation in the trial. Self-harm was defined as self-injury or self-poisoning irrespective of the underlying intent. in British national guidelines. Exclusion criteria were gross reality distortion (eg, owing to psychotic illness or intoxication), known history of moderate or severe learning disability, lack of fluent English, immediate risk of violence or suicide and the need for in-patient psychiatric admission.

The settings and locations where the data were collected
The referral for psychosocial assessment was made either following a screening at the emergency departments of four inner-London hospitals or following an urgent general practitioner’s referral to the child and adolescent mental health services (CAMHS) in two London NHS Trusts. Both the referring practitioner and the emergency department staff were blind to the allocation of the adolescents to either TA or AAU.

Interventions
Eligible participants were approached about participating in the trial after they had received medical clearance following an episode of self-harm. After parents (and 16 or 17-year-old participants) signed an informed consent document and adolescents younger than 16 years assented to participate, the participants received either a standard psychosocial evaluation and standard disposition planning (AAU) or standard psychosocial evaluation, standard disposition planning plus a brief therapeutic intervention (TA). All participants and their guardians, if present, completed the Strength and Difficulties Questionnaire (SDQ) and were assigned a Children’s Global Assessment Scale (CGAS) score.

Control group: assessment as usual
AAU included a standard psychosocial history and risk assessment, and followed the recommendations set out in the National Institute for Health and Clinical Excellence (NICE) guidelines. The assessment letter was sent to the relevant community team and a copy was sent to the family in accordance with the trusts’ policies. A random sample of 10 (29%) audiotaped assessments was assessed by two independent raters and adequate adherence to the model was documented.

Intervention group: therapeutic assessment
The major components of TA are as follows:
1. Standard psychosocial history and risk assessment (approximately 1 h).
2. A 10 min break to review the information gathered and to prepare for the rest of the session, followed by a 30 min intervention covering the next four steps.
3. Joint construction of a diagram (based on the cognitive analytic therapy paradigm) that consists of three elements: reciprocal roles, core pain and maladaptive procedures.
4. Identifying a target problem.
5. Considering and enhancing motivation for change.
6. Exploring potential ‘exits’ (ie, ways of breaking the vicious cycles identified).
7. Describing the diagram and the exits in an ‘understanding letter’. In addition to the ‘understanding letter’ the family also received the usual assessment letter.

The assessment process was manualised, although assessing clinicians used clinical judgement when deciding on the best approach to ‘exits’. Family members were involved in all stages of TA whenever possible. Clinicians received five half-day training in TA accompanied by weekly homework and a video assessment before and after training with independent fidelity assessment. A random sample of 10 (29%) audiotaped assessments was assessed by two independent raters and adequate adherence to the model was documented.

Study hypothesis
TA versus AAU will lead to improved attendance at the first follow-up appointment. Offering an appointment within 7 days of a self-harm assessment is a recommendation outlined by NICE guidelines.

Outcomes
Primary
Data on the participants’ attendance at the individual outpatient treatment sessions were obtained using an electronic patient journey system (ePJS) for 64 (91%) of the participants. For the remainder of the sample, the CAMHS responsible for the provision of follow-up was contacted in writing and the number of sessions attended was obtained from either the care co-ordinator or the manager of the service, both of whom were blind to the treatment allocation.

Secondary
(1) Attendance at four or more sessions during the 3-month follow-up period, (2) total number of sessions attended, (3) SDQ and (4) CGAS.

Follow-up interview
Three months after the initial assessment three higher specialist trainees in psychiatry, blind to the patients’ allocation, conducted face-to-face interviews with the participants and their guardians if available. If a face-to-face interview was not possible a telephone follow-up interview was conducted. Participants and their guardians, whenever available, also completed the follow-up version of the SDQ.

Other variables
Clinical diagnosis
Clinical diagnosis was recorded using International Classification of Diseases, 10th edition criteria. In order to aid clinicians with the diagnostic process the ePJS was used in 66 of the 70 assessments. Primary clinical diagnoses were collapsed to form these four groups: (1) no diagnosis, (2) emotional disorders, (3) disruptive disorders and (4) other.

Socioeconomic status
Socioeconomic status (SES) was assigned by the assessing clinician on the basis of the occupation of the main breadwinner in the family.

Randomisation
Randomisation occurred at the assessor level. Randomisation was conducted by a senior psychiatrist independent of the study clinicians. The randomisation was stratified by centre, and two...
blocks (block lengths 22 and 4) were created using a permuted block design to ensure equal numbers of clinicians from each centre being allocated to either intervention or control groups. The randomisation scheme was generated using web-based randomisation software (http://www.randomization.com). The clinicians were informed of their allocation by email.

Power calculation
Using the results of a pilot study,26 it was assumed that 75% of the participants in the intervention group and 40% of the participants in the control group would attend the first community follow-up session. nQuery Advisor V.4.0 was used to establish that 35 participants in each group (70 in total) were required for there to be an 85% chance of significantly detecting this difference between the two groups (at the two sided 5% level).

Blinding
It was not possible to blind the clinicians to the intervention they were delivering. Participants were unaware as to what type of assessment they were receiving. The study statistician and the researchers conducting follow-up assessments were unaware of the participants’ allocation.

Statistical analyses
Generalised estimating equations were created to account for the two-level data structure (patients ‘clustered’ within assessing clinician), first with just group (TA vs AAU) in the model and second with the following two predetermined additional independent variables: whether there was a change of clinician from assessment to follow-up and whether there was previous contact with mental health services. In addition, following univariate analysis, SES was entered into the final model.

Intention-to-treat analysis
All 70 recruited participants were analysed on the primary and secondary outcome measures. Whenever the data were missing we used the last observation available. Parent-rated SDQ scores were excluded due to poor completion.

RESULTS

Clinicians’ flow
There were 73 adolescents assessed by the study clinicians that met inclusion criteria, and 70 (95.9%) of those agreed to participate in the study. Two adolescents (one in each arm) did not give a reason for refusing to participate. Another adolescent (in the control arm) agreed but her mother disagreed, again not providing a reason. There was an average of five adolescents assessed by each clinician in the TA group (range 1 to 12) and an average of 4.4 (range 1 to 14) in the AAU group. See figures 1 and 2.

Dates of recruitment and follow-up
Participants were recruited from November 2007 to May 2009. Participants were followed up 3 months after the initial assessment (mean 3.48 months, SD=0.79, range 2.30 to 6.97).

Baseline characteristics
The initial sample of 26 clinicians had a mean age of 35.9 (SD=5.35) with a mean of 7.38 (SD=5.15) years of mental health experience. Eleven (42%) of the clinicians were doctors, seven (27%) nurses, five (19%) psychologists and six (23%) social workers. Seventeen (65%) clinicians were white, five (19%) Asian and four (15%) black. See table 1 for participant characteristics.

Summary of results
Primary outcome—attending the first follow-up session
Primary outcome data were available for all participants, 35 in the AAU group (28 female) and 35 in the TA group (28 female).

On discharge, all participants apart from one (in the TA group) were offered community follow-up. Since the young

The consort flowchart: participants

Assessed for eligibility (n=26)

Enrolment

Randomised (n=28)

Allocated to TA (n=13)

Allocated to AAU (n=13)

Excluded (n=0)

Discontinued participation

Left or changed employment (n=4)

Did not complete TA training (n=1)

Centredropped out (n=1)

Recruited at least one patient (n=7)

Recruited patients

Excluded from analysis (n=0)

Left or changed employment (n=4)

Centredropped out (n=1)

Recruited at least one patient (n=8)

Excluded from analysis (n=0)
Figure 2

A person should have been offered a follow-up appointment according to the national guidelines he was considered a treatment failure. Following the first follow-up appointment all but two (one in each arm) were offered further appointments.

**Unadjusted analysis**

We first analysed the impact of TA versus AAU for patients clustered within assessor against the outcome. Significantly more participants in the TA group than the AAU group attended the first follow-up session (table 2). The number needed to treat was three (95% CI 1.8 to 7.4). Two participants (one in each arm) did not attend their first follow-up appointment but subsequently attended at least one appointment. Significantly more participants in the TA group versus AAU group attended at least one follow-up appointment: 30/35 (86%) versus 18/35 (51%), difference of proportions 0.35 (95% CI 0.24 to 0.46, p=0.002).

**Multivariate analyses**

To account for the clustered nature of the data (patients were nested within assessors), we used generalised estimating equations. These provide correct inference and often yield wider CIs than standard regression.

The model included the following four variables: condition with patients clustered around assessing clinicians, previous contact with CAMHS, whether the follow-up clinician was the same as the assessing clinician and SES. SES was not a predetermined variable, however it was included due to its nearly significant impact in univariate analysis.

Adding the three variables—SES, previous contact with CAMHS and the follow-up clinician—the difference between the groups remained significant (p=0.044, table 3). Having had a previous contact with CAMHS was also associated with significantly higher odds of attending the follow-up appointment at the 5% level (table 3).

**Naturalistic follow-up**

Participants in the TA group were more likely to attend four or more sessions of routine community treatment over the 3 months of naturalistic follow-up (number needed to treat=4, 95% CI 2.1 to 10.8). In addition participants in the TA group attended significantly more sessions overall (median 2 sessions (minimum 0, maximum 20, IQR 4) vs 0 sessions (minimum 0, maximum 6, IQR 2, p<0.001)). There was a statistically significant difference in the proportion of the young people who had at least one session of a structured psychotherapy (cognitive–behavioural therapy, family therapy, motivational interview based therapy or mentalisation based psychotherapy) versus non-specific case management alone: TA group 19 (54%), AAU 8 (23%), χ²=7.295, df=1, difference of proportions 0.31, 95% CI (0.2 to 0.42), p=0.007 (table 4).

**Change of SDQ and CGAS scores from baseline**

Both groups improved significantly between the initial assessment and the follow-up on the measures of general psychopathology and function: CGAS: mean 54.34 versus 62.36, difference of means −8.02, 95% CI (−10.44 to −5.59), p<0.001; SDQ(S): mean 18.77 versus 15.79, difference of means 2.98, 95% CI (1.83 to 4.14), p<0.001. There were no statistically significant differences in the SDQ and the CGAS scores between the groups.

**DISCUSSION**

**Main findings**

In this study TA was associated with a statistically significant increase in the proportion of participants attending the first follow-up appointment and in the subsequent engagement with treatment. This study adds to the growing evidence of efficacy of brief interventions in adolescents presenting in crisis. TA might have lead to improved engagement by addressing the participants’ hopes and expectations from self-harm assessment, through an unusual reminder (sending a TA understanding letter) or through improving adolescents’ experience of self-harm assessment. Alternatively, it is possible that spending more time with adolescents, and clinicians’ enthusiasm may both have contributed to the increased engagement.

In comparison with similar studies the improved engagement was greater yet the study was embedded into routine clinical practice and the intervention was delivered by frontline clinicians with no prior experience of research.
### Table 1 Participants’ baseline characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>TA (n=35)</th>
<th>AAU (n=35)</th>
<th>χ²</th>
<th>p Value</th>
</tr>
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<tbody>
<tr>
<td>Mean age (SD)</td>
<td>15.6 (1.5)</td>
<td>15.5 (1.2)</td>
<td>0.26*</td>
<td>0.79</td>
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<tr>
<td>Female</td>
<td>28 (80)</td>
<td>28 (80)</td>
<td>0</td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>White</td>
<td>17 (49)</td>
<td>20 (57)</td>
<td>2.87</td>
<td>0.58</td>
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<tr>
<td>Black</td>
<td>7 (20)</td>
<td>7 (20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>7 (20)</td>
<td>1 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>3 (9)</td>
<td>6 (17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (3)</td>
<td>1 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Self poisoning</td>
<td>9 (26)</td>
<td>19 (54)</td>
<td>3.35</td>
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<td></td>
<td>Self injury</td>
<td>22 (63)</td>
<td>15 (43)</td>
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<tr>
<td></td>
<td>Both</td>
<td>4 (11)</td>
<td>1 (3)</td>
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<td>Assessment setting</td>
<td>Outpatient department</td>
<td>28 (80)</td>
<td>18 (51)</td>
<td>3.17</td>
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<td></td>
<td>Emergency department</td>
<td>7 (20)</td>
<td>17 (49)</td>
<td></td>
</tr>
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<td></td>
<td>Previous self harm</td>
<td>25 (71)</td>
<td>16 (54)</td>
<td>2.38</td>
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<td></td>
<td>Previous contact with mental health services</td>
<td>25 (71)</td>
<td>28 (80)</td>
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<td></td>
<td>Family SES</td>
<td>High professional</td>
<td>4 (11)</td>
<td>2 (6)</td>
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<td></td>
<td>Intermediate professional</td>
<td>10 (29)</td>
<td>6 (17)</td>
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<td></td>
<td></td>
<td>Junior supervisory/skilled</td>
<td>5 (14)</td>
<td>7 (20)</td>
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<td></td>
<td>Semi-skilled/Unskilled</td>
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<td>8 (23)</td>
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<td></td>
<td>No regular employment</td>
<td>9 (26)</td>
<td>12 (34)</td>
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<td>Disruptive disorder</td>
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<td>5 (14)</td>
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<td>No mental illness</td>
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<td>8 (23)</td>
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<td></td>
<td></td>
<td>Other</td>
<td>0 (0)</td>
<td>2 (6)</td>
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*All figures in brackets are percentages unless otherwise specified.

*Spirito et al found that a compliance enhancement intervention did not significantly increase the number of sessions attended (mean 7.7 vs 6.4 sessions) although the findings reached statistical significance when adjusted for barriers to services (mean 8.4 vs 5.2). In a study by Rotherham-Borus et al the corresponding findings were 5.73 versus 4.67. The participants were also more likely to attend their first follow-up appointment in that study (95.4% vs 82.7% p=0.018). The reasons for these differences are unclear but the following factors might play a role. Both previous studies reported a higher baseline of sessions attended. This may be due to the fact that psychiatric hospitalisation following a self-harm episode was more common in the US studies (over 50%), as was the rate of prescribing psychotropic medication (also over 50%), both factors are positively associated with treatment attendance. TA or a similar intervention may well influence engagement in the psychiatrically hospitalised adolescents; however, the differences in the population with high hospitalisation rate could be harder to demonstrate.

One of the most important predictors of engagement in the US studies appears to be family barriers to services, including lack of insurance coverage and inability to afford transportation. These barriers are less important in countries with universal healthcare coverage and with policies of reimbursing patients’ transport. There were no differences in the outcomes measuring participants’ psychopathology and functioning 3 months after the initial assessment for self-harm. The study was not powered to detect a difference in any of the secondary outcome measures. Nevertheless, the sample size is comparable to most other studies in the field and therefore this lack of difference appears important. There are several possible explanations for this. First, the follow-up period may have been too short to detect differences. Second, the secondary outcome measures may not have been sensitive enough to the group differences in the context of the overall improvement in the scores. Third, it is possible that the interventions offered to adolescents with self-harm in routine clinical practice are not effective.

**Table 2 Attendance at the first follow-up session, participants nested within assessors (GEE, OR, unadjusted)**

<table>
<thead>
<tr>
<th>End point</th>
<th>TA (n=35)</th>
<th>AAU (n=35)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended first follow-up session</td>
<td>29 (83)</td>
<td>17 (49)</td>
<td>5.12 (1.49 to 17.55)</td>
</tr>
</tbody>
</table>

*AAU, assessment as usual; GEE, generalised estimating equation; TA, therapeutic assessment.

**Table 3 Attendance at the first follow-up session, participants nested within assessors (GEE, adjusted)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR</th>
<th>95% CI</th>
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<tr>
<td>TA vs AAU</td>
<td>5.73*</td>
<td>1.05 to 31.41</td>
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<tr>
<td>SES I, II and III</td>
<td>3.63</td>
<td>0.72 to 18.40</td>
</tr>
<tr>
<td>Previous contact with services</td>
<td>3.30</td>
<td>1.05 to 10.35</td>
</tr>
<tr>
<td>Same clinician at follow-up</td>
<td>2.50</td>
<td>0.63 to 8.89</td>
</tr>
</tbody>
</table>

*Adjusted for SES, previous contact with services and change of clinician offering follow-up. AAU, assessment as usual; GEE, generalised estimating equation; SES, socioeconomic status; TA, therapeutic assessment.

**Limitations**

Beyond the design limitations of the sample size, exclusion of clinically relevant subgroups and short follow-up period, all of which limits the power to detect differences in outcome and the generalisability of the findings, we included adolescents with suicidal as well as non-suicidal self-harm in this study. Although many researchers in the UK and Europe consider self-harm to be a broad range of behaviour irrespective of the underlying intent, many American researchers study adolescents with suicidal and non-suicidal self-harm separately. It is indeed possible that suicidal adolescents might differ in some respects from non-suicidal self-harmers, however there is no evidence of differential engagement or response to treatment in these two groups. Our findings therefore may not be applicable to strictly defined suicidal or non-suicidal samples.

A further limitation of this study is not assessing several potential predictors of engagement including barriers to services, engagement with other (non-statutory) agencies and the family expectations regarding future therapy. In addition the power calculation did not take the impact of clustering into account. Clustering was, however, appropriately handled in the analysis.

Main strengths of the study include pragmatic design and using an intervention with minimal training requirements delivered by front line clinicians.

**Clinical implications**

TA, a brief therapeutic intervention at the point of the initial psychosocial assessment of adolescents presenting with...
Table 4 Secondary end points: engagement, psychopathology and function at 3 months naturalistic follow-up (GEE OR/t test, unadjusted)

<table>
<thead>
<tr>
<th>End point</th>
<th>AAU (n=35)</th>
<th>AUA (n=35)</th>
<th>OR/mean difference</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended four or more follow-up sessions</td>
<td>14 (40)</td>
<td>4 (11)</td>
<td>5.19</td>
<td>2.22 to 12.10</td>
</tr>
<tr>
<td>CGAS score (follow-up)</td>
<td>64.6 (SD 12.9)</td>
<td>60.1 (SD 9.9)</td>
<td>4.49</td>
<td>-0.98 to 9.96</td>
</tr>
<tr>
<td>SDD score (follow-up)</td>
<td>15.6 (SD 6.2)</td>
<td>18.0 (SD 8.0)</td>
<td>-0.37</td>
<td>-3.28 to 2.53</td>
</tr>
</tbody>
</table>

AAU, assessment as usual; CGAS, Children’s Global Assessment Scale; GEE, generalised estimating equation; SDD, Strengths and Difficulties Questionnaire; SES, socioeconomic status; TA, therapeutic assessment.

self-harm, is likely to improve engagement with follow-up services. Engagement with treatment is a necessary first step in achieving treatment goals. Clinicians should consider including a therapeutic element into their self-harm assessments to improve engagement with aftercare. The efficacy of TA at improving engagement may not be parallelled by improvement in the severity of psychopathology thus highlighting the need to develop effective community interventions for adolescents presenting with self-harm.

Contributors DO, TZ, AN and ET designed the study. DO, TZ and AN devised Therapeutic Assessment. RB and AB provided help with statistical analysis and interpretation of the results. All contributors reviewed and edited the manuscript. DO is the guarantor.

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