

Self-harm in Ireland: Trends, risk factors and implications for intervention and prevention

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Systematic Review of the Efficacy of Psychosocial and pharmacological Treatments in Preventing Repetition. *British Medical Journal*.

Hawton K, Arensman E, Townsend E, Bremner S, Feldman E, Goldney R, et al.(1998).

Papers

The difference may be partly accounted for by the factors that influence infectivity of the two viruses. Hepatitis B is much more likely to be transmitted from mother to infant if there is a high concentration of the virus in the mother's blood. This explains the ethnic differences that are observed—for example, the transmission rate is over 70% in Chinese women but less than 10% in white women. This ethnic difference does not seem to apply to hepatitis C infection.

Alcohol intake and obesity are both thought to be associated with more severe hepatitis C, although the exact interaction is unknown. Advanced liver disease,

for example, is far worse in people infected with hepatitis C who also have a high alcohol intake than in those with a low intake. About half of patients with hepatitis B infections respond to interferon compared with 15% with hepatitis C. Ongoing trials of interferon and antivirals together may prove more fruitful. Although infection with hepatitis C virus does not necessarily cause abnormal liver function, precirrhotic damage confirmed by biopsy is one reason for starting treatment with interferon.

Abi Berger. *Science editor, BMJ*

Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition

Keith Hawton, Ella Arensman, Ellen Townsend, Sandy Bremner, Eleanor Feldman, Robert Goldney, David Gunnell, Philip Hazell, Kees van Heeringen, Allan House, David Owens, Isaac Sakinofsky, Lil Trakman-Bendz

Abstract

Objective: To identify and synthesise the findings from all randomised controlled trials that have examined the effectiveness of treatments of patients who have deliberately harmed themselves.

Design: Systematic review of randomised controlled trials of psychosocial and physical treatments. Studies categorised according to type of treatment. When there was more than one investigation in a particular category a summary odds ratio was estimated with the Mantel-Haenszel method.

Setting: Randomised trials available in electronic databases in 1996, in the Cochrane Controlled Trials Register in 1997, and from hand searching of journals to 1997.

Subjects: Patients who had deliberately harmed themselves shortly before entry into the trials with information on repetition of behaviour. The included trials comprised 2452 randomised participants with outcome data.

Main outcome measures: Repetition of self harm.

Results: 20 trials reported repetition of self harm as an outcome variable, classified into 10 categories.

Summary odds ratio (all for comparison with standard aftercare) indicated reduced repetition for problem solving therapy (0.73; 95% confidence interval 0.45 to 1.18) and for provision of an emergency contact card in addition to standard care (0.45; 0.19 to 1.07). The summary odds ratios were 0.83 (0.61 to 1.14) for trials of intensive aftercare plus outreach and 1.19 (0.53 to 2.67) for antidepressant treatment compared with placebo. Significantly reduced rates of further self harm were observed for depot flupenthixol versus placebo in multiple repeaters (0.09; 0.02 to 0.50) and for dialectical behaviour therapy versus standard aftercare (0.24; 0.06 to 0.93).

Conclusion: There remains considerable uncertainty about which forms of psychosocial and physical treatments of patients who harm themselves are most effective. Further larger trials of treatments are needed.

Introduction

Prevention of suicide is now included in health policy initiatives in several countries, and reduction in suicidal behaviour, both fatal and non-fatal, is part of the Health for All targets of the World Health Organisation.¹ In the United Kingdom, reduction in the number of suicides is a central theme in the government's Health of the Nation strategy for England.² There is, however, a considerable lack of information as to which preventive strategies are effective.³ Improvement of outcome after deliberate self harm is an important focus because at least 1% of patients presenting to general hospitals in the United Kingdom after deliberate self harm kill themselves within a year and 3–5% do so within 5–10 years. A history of multiple episodes of deliberate self harm is a particular risk factor.⁴ Higher rates of suicide after deliberate self harm have been reported from other countries.^{5–7} About half of all people who kill themselves have a history of deliberate self harm, an episode having occurred within the year before death in 20–25%.^{8–10}

It would be difficult to investigate the effectiveness of intervention strategies after deliberate self harm in terms of subsequent actual suicides because extremely large populations of patients would be required. Repetition of deliberate self harm is, however, a reasonable proxy measure because of its strong associations with suicide. It is also in itself an important outcome because it occurs frequently,^{11–13} indicates persistent distress, and results in considerable healthcare costs. Deliberate self harm is common in Europe¹⁴ and in other parts of the world,^{15–18} especially in young people. Recent marked increases in rates of deliberate self harm in the United Kingdom,^{19–21} with a currently estimated 140 000 hospital referrals in England and Wales,²² have highlighted the need for effective aftercare strategies.

Descriptive reviews of treatment outcomes in patients who deliberately harm themselves have been

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BMJ 1998;317:441–7

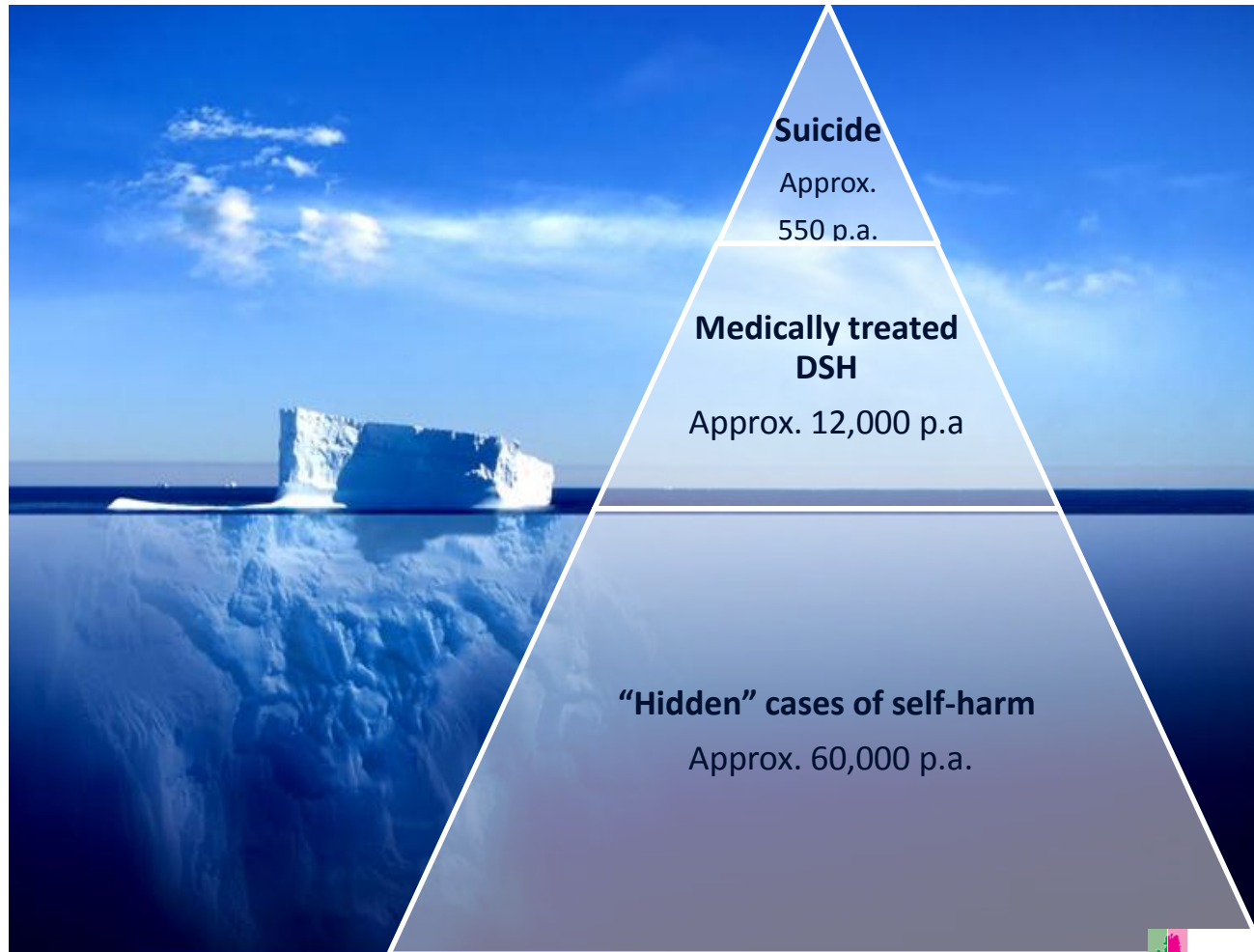
Dialectical Behaviour Therapy was the only psychotherapeutic treatment showing a significant reduction in self-harm.

Target group: People with a history of multiple acts of self-harm who met the diagnostic criteria for Borderline Personality Disorder

Overview

- The National Registry of Deliberate Self-Harm
- Trends in self-harm in Ireland and associated risk factors
- Evidence based interventions for self-harm
- Evidence informed implementation of DBT in Ireland

Suicide and medically treated deliberate self harm in Ireland: the tip of the iceberg

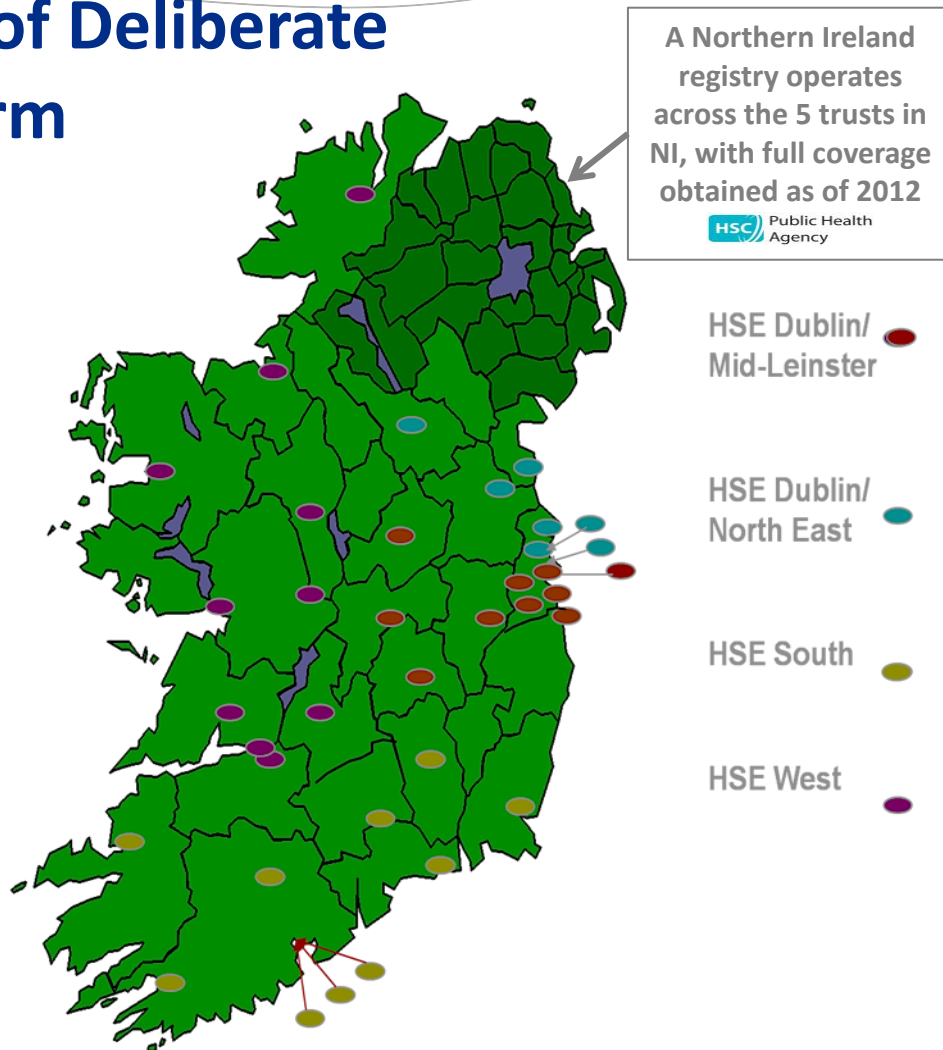




National Registry of Deliberate Self-Harm

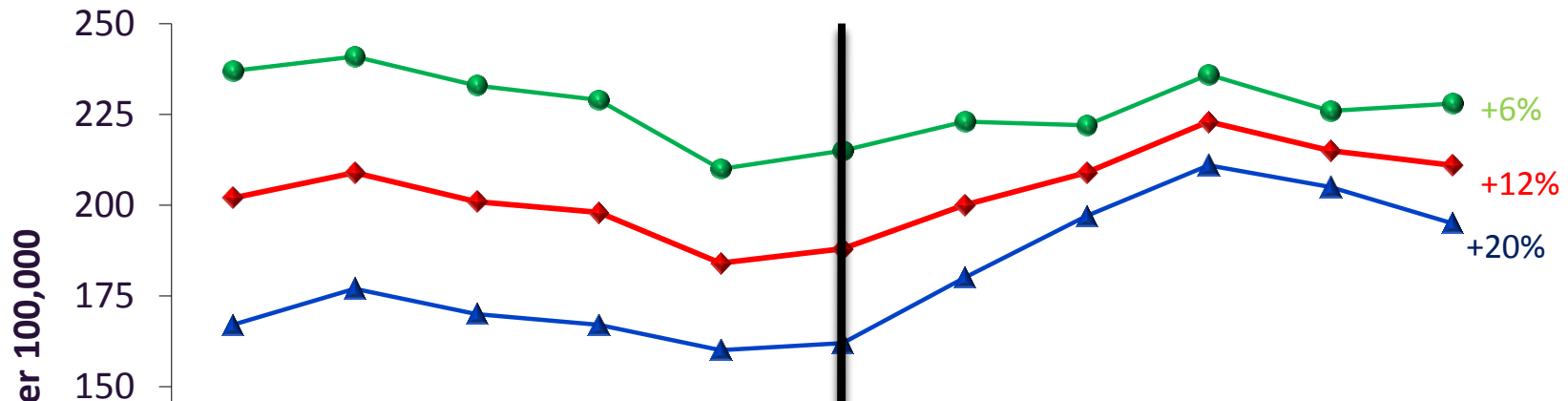
Identification of deliberate self harm presentations in accordance with an internationally recognised definition (*Schmidtke et al, 1996*)

- Non-fatal outcome
- Deliberately initiated self-harming behaviour
- Varying behaviours (e.g. self cutting, overdose etc.)
- Varying intentions (e.g. wish to die, self-punishment, relief from state of mind)

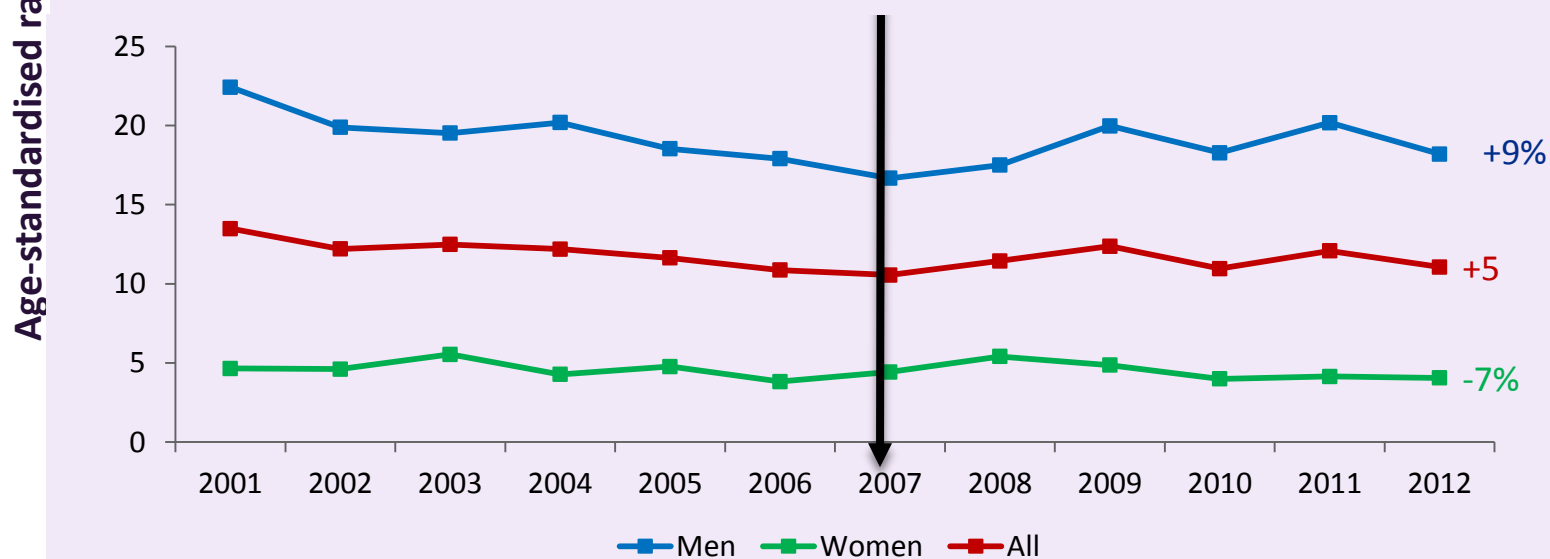


**In 2012, there were 12,010 presentations made by 9,483 individuals:
Since 2003 there have been 111,682 presentations
of self-harm recorded by the Registry**

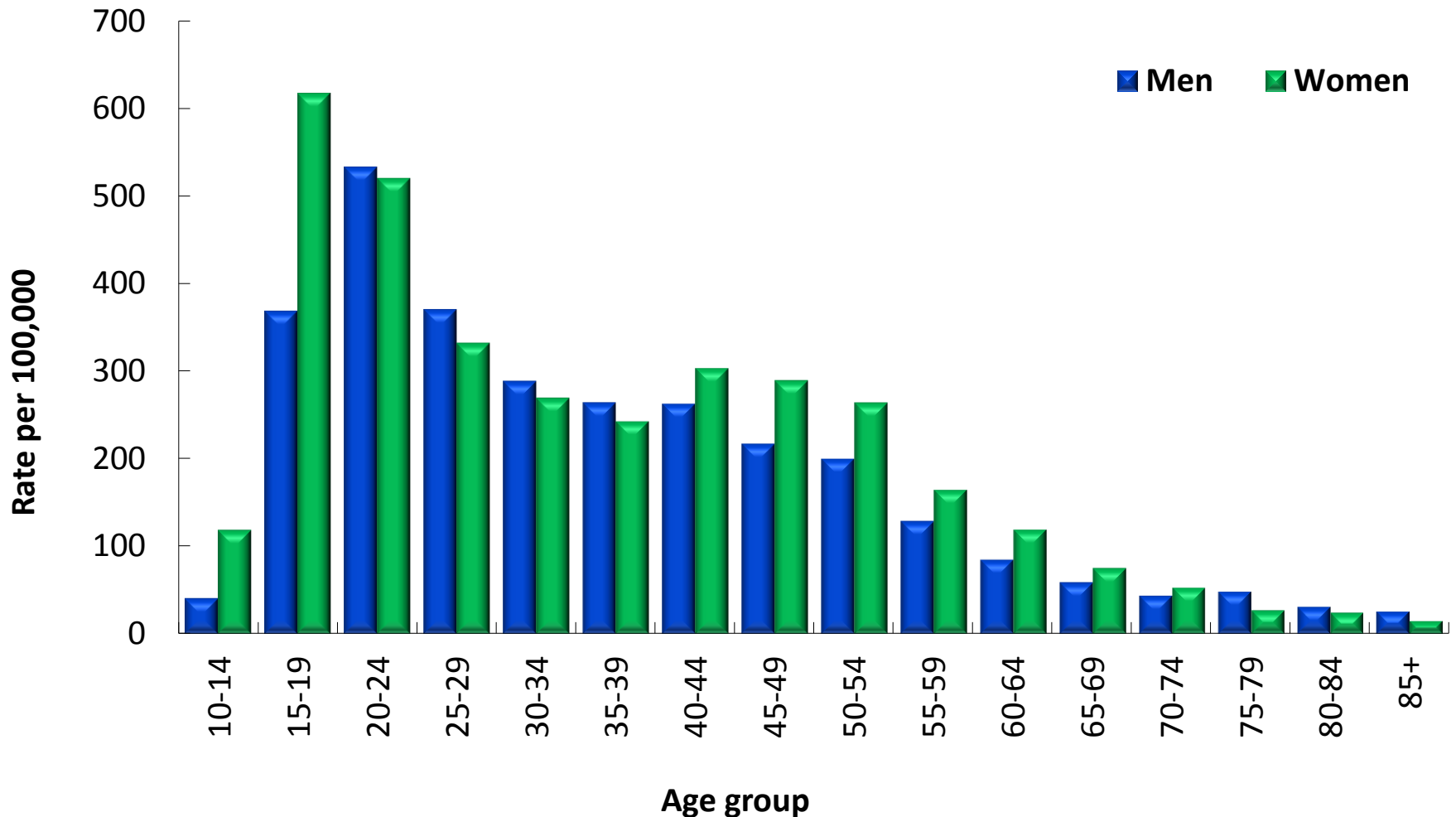
Trends in rates of self-harm and suicide in Ireland



Trends in rate of suicide

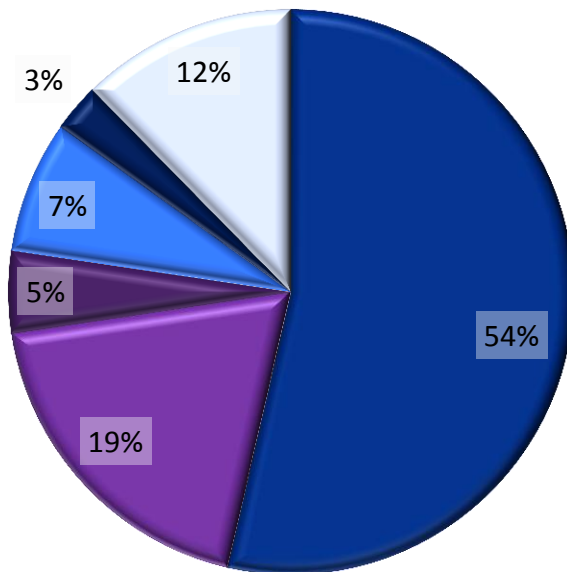


Rates of self-harm per 100,000 by age and gender

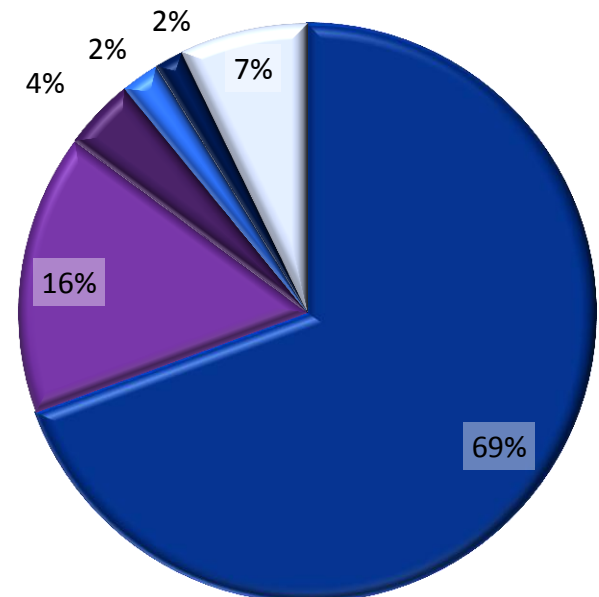


Methods of self-harm by gender

Men



Women



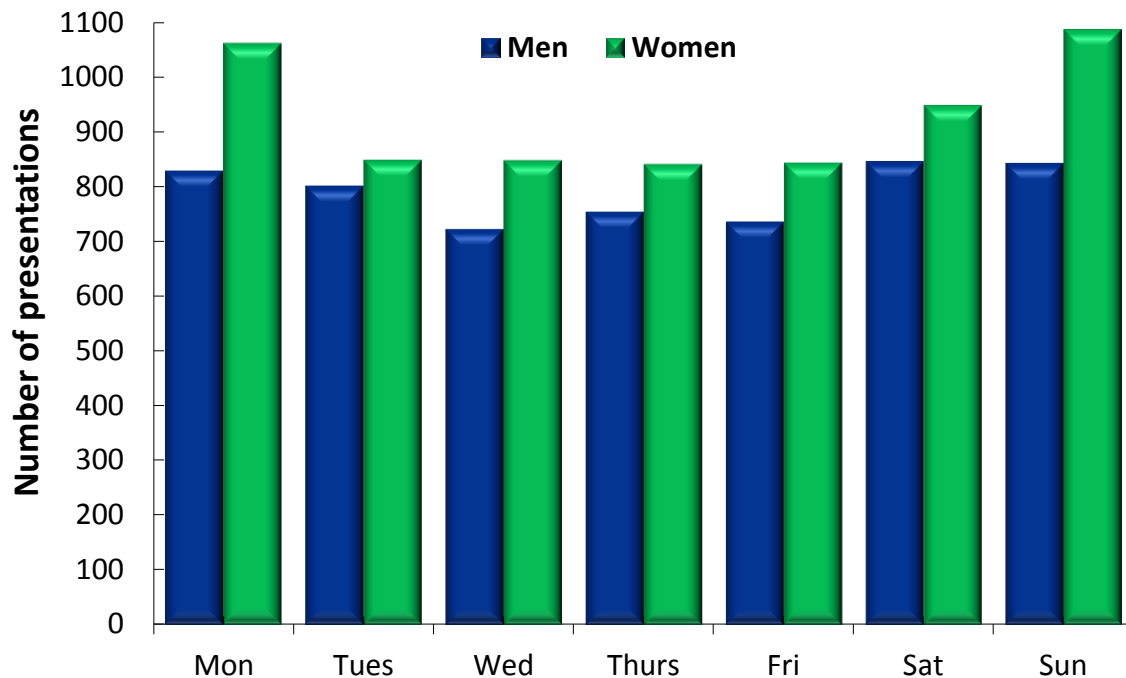
- Drug overdose only
- Self-cutting only
- Overdose & self-cutting
- Attempted hanging only
- Attempted drowning only

Alcohol was involved in 38% of all cases (42% in men, 36% in women)

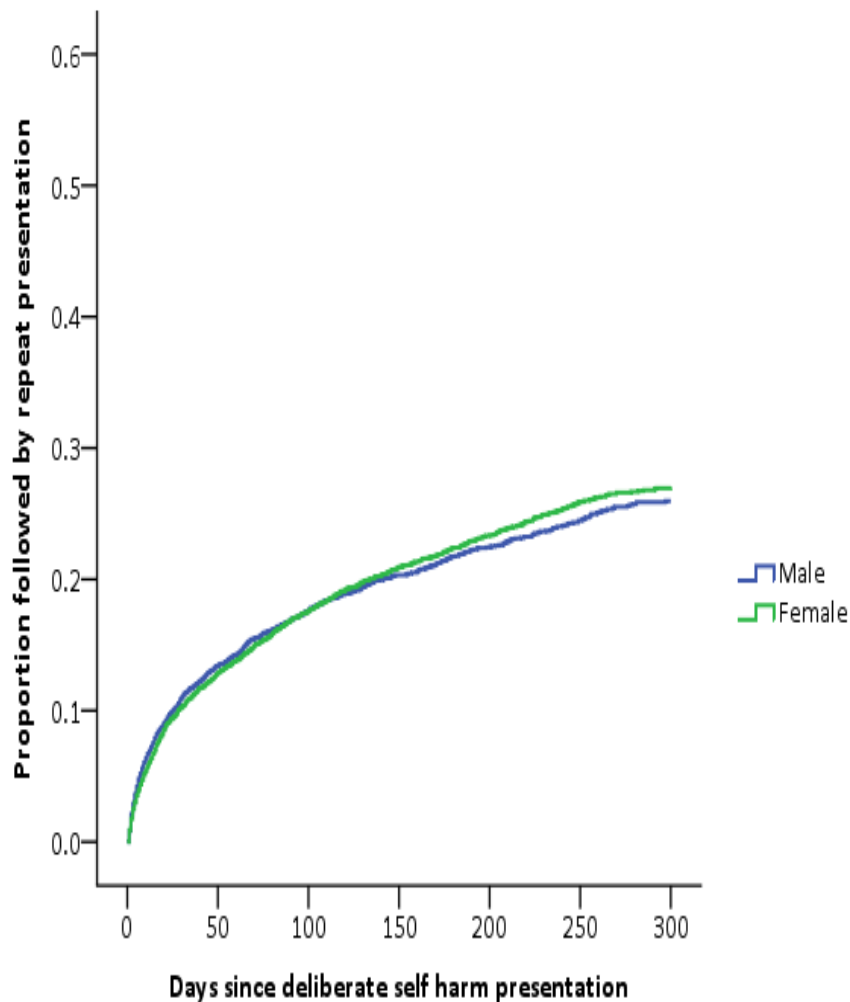
Consistent peaks of self-harm during the year and week

- Average number of self-harm presentations to hospital per day: n=33
- Dates in the year on which 50 or more self-harm presentations occurred were mostly public holidays or the day after, e.g in 2012:
 - January 1st
 - March 17th and 18th
 - June 5th

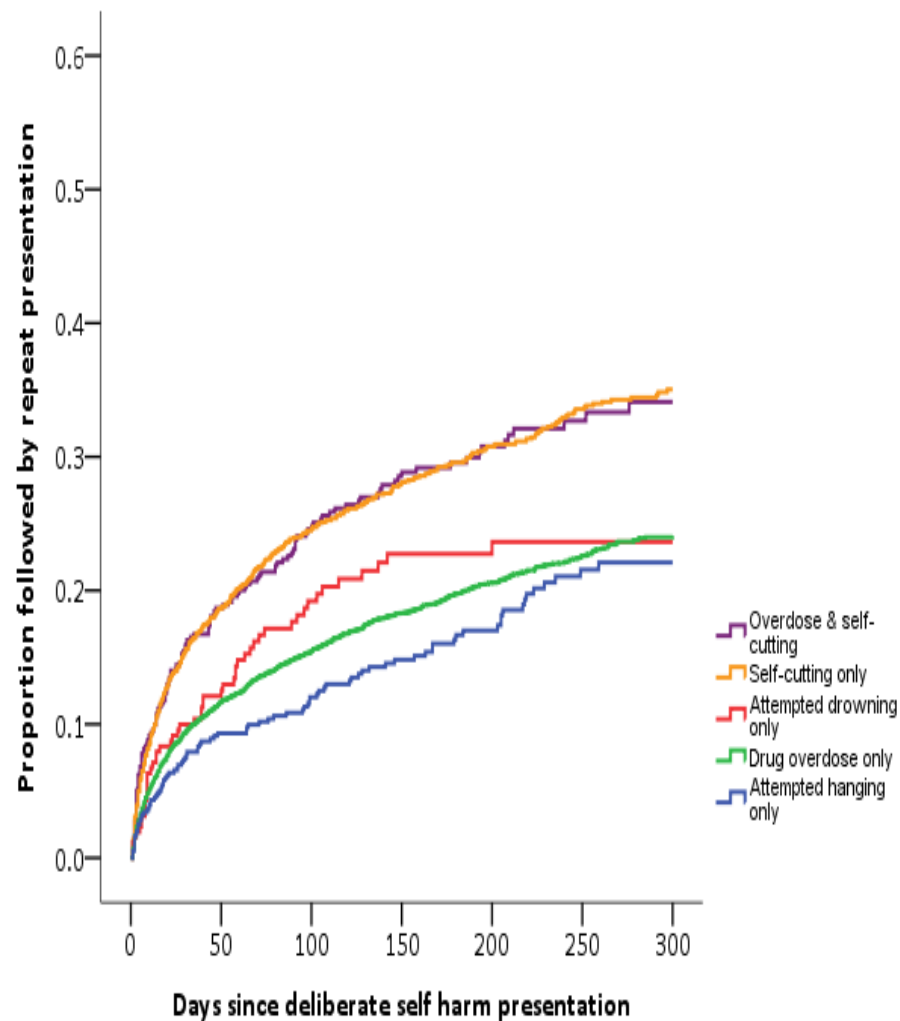
Self-harm by day of the week and gender



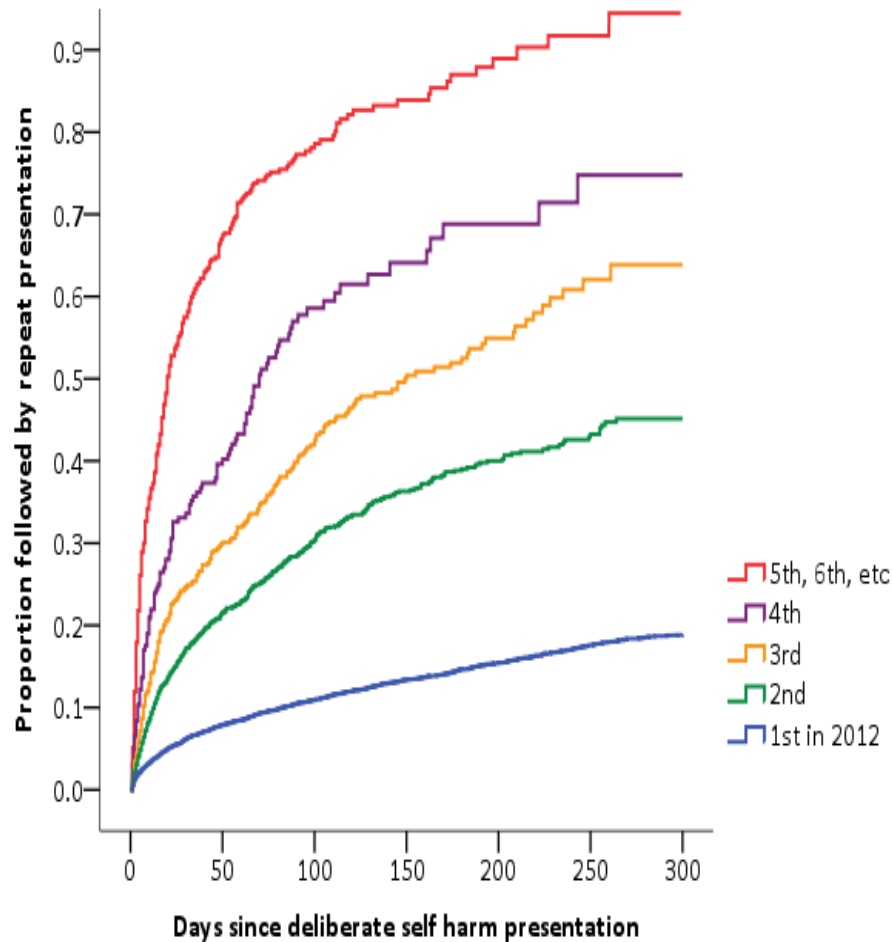
Repetition of self-harm by gender



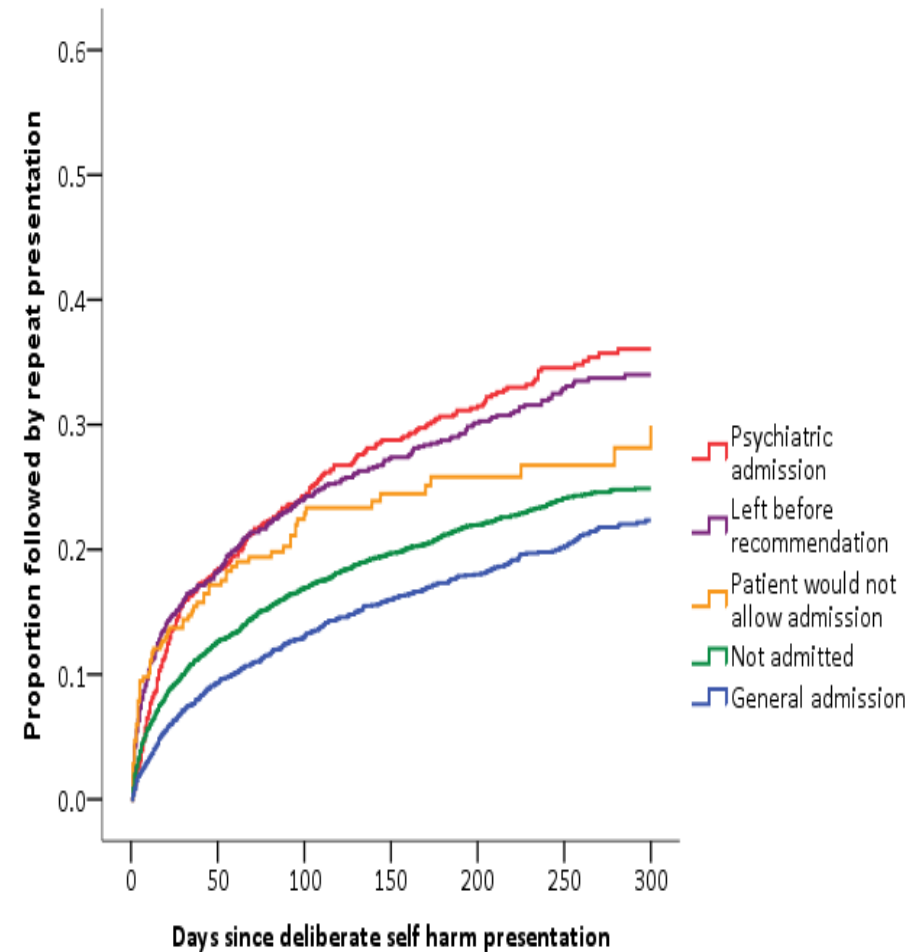
Repetition of self-harm by method



Repetition by number of self-harm presentations



Repetition of self-harm by recommended next care

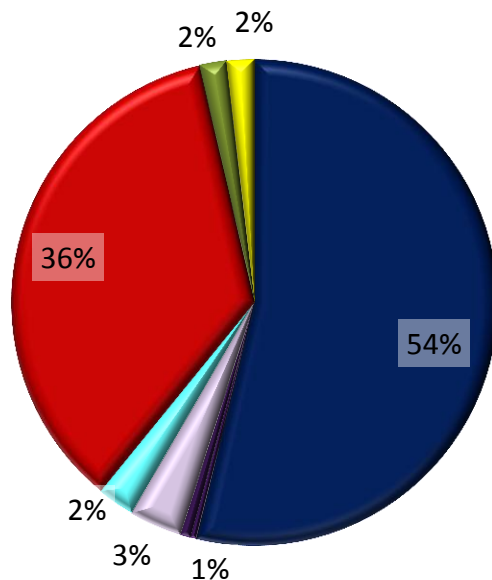


The extent of repeated self-harm presentations

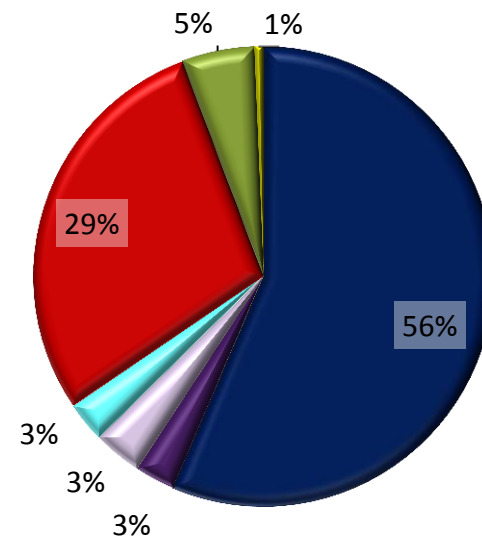
Number of DSH acts in 2003-2011	Persons		Presentations	
	Number	(%)	Number	(%)
One	48,066	77.1%	48,066	48.2%
Two	7,899	12.7%	1,5798	15.8%
Three	2,709	4.3%	8,127	8.2%
Four	1,297	2.1%	5,188	5.2%
Five - Nine	1,713	2.8%	11,010	11%
10 or more	635	1.0%	11,483	11.5%

Methods of self-harm among those who repeat 10 times or more (women: 55%, men: 45%)

Men

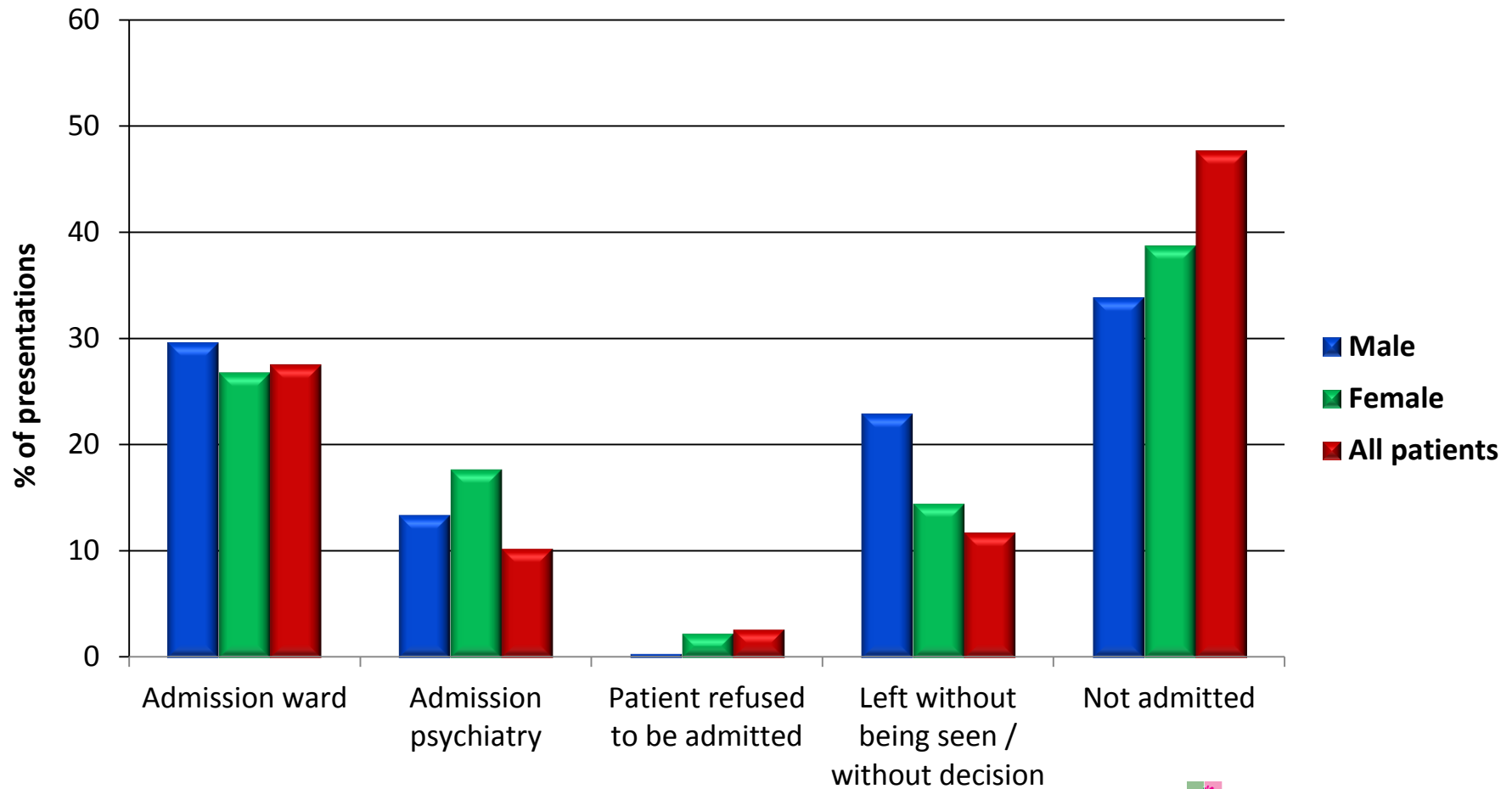


Women



- Overdose
- Alcohol
- Poisoning
- Hanging
- Drowning
- Cutting
- Other
- Unknown

Recommended aftercare among those who repeat 10 times or more



Evidence based interventions taking into account differences among people who self-harm

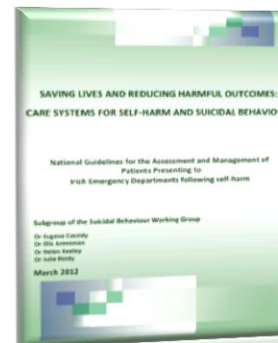
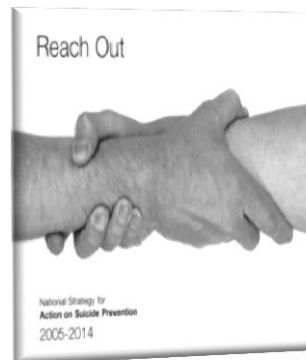
- Dialectical Behaviour Therapy –
Individuals with a history of multiple self-harm acts, often associated with Borderline Personality Disorder and co-morbid mental health problems
- Cognitive Behaviour Therapy, Mindfulness based Cognitive Therapy -
Individuals with single/infrequent self-harm acts, often associated with mood, anxiety disorders, and alcohol/drug abuse
- Problem-solving interventions –
Individuals with single self-harm acts, not primarily associated with mental health problems

National Clinical Programme for Mental Health

- A programme for the management of self-harm among people presenting to hospital emergency departments

Key objectives:

- Enhance assessment and management of self-harm for people presenting to EDs at national level and ensure continuity of care, e.g. referral to indicated treatment, and follow-up
- Standardisation of evidence based treatment options nationally for people who have engaged in self-harm based on best available evidence



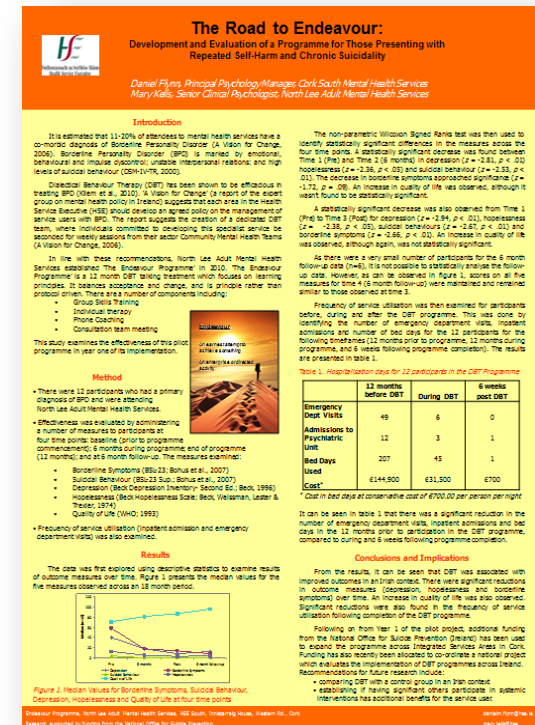
Evidence informed implementation of Dialectical Behaviour Therapy in Ireland



Outcomes initial DBT programme implemented in the North Lee Adult Mental Health Services – Endeavour Programme

(Flynn and Kells, 2013)

- Following 12 month DBT, reductions in most outcomes:
 - Self-harm repetition rates
 - Symptoms of Borderline Personality Disorder
 - Depression
 - Hopelessness
- Cost-effectiveness – Comparing use of service in the 12 months prior to DBT and in the 3 months after completion of the programme: Significant reductions in:
 - ED visits (from 49 to 0)
 - In-patient admissions (from 12 to 1)
 - Bed days (from 207 to 1)



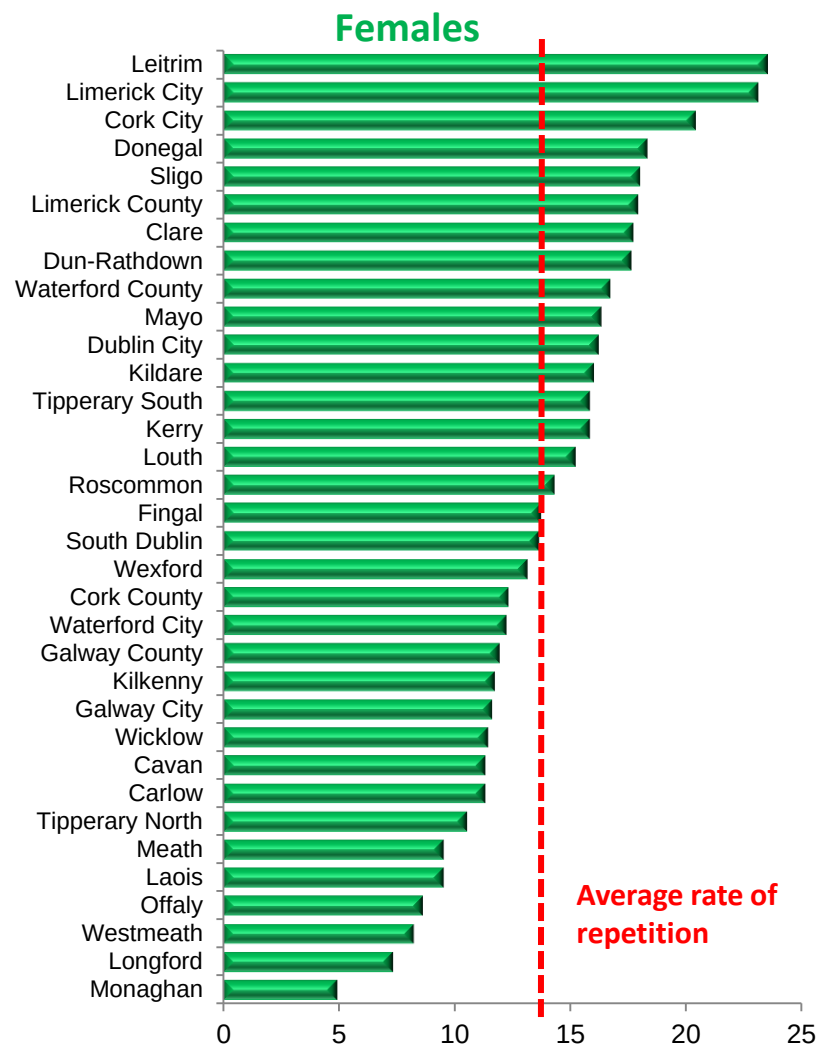
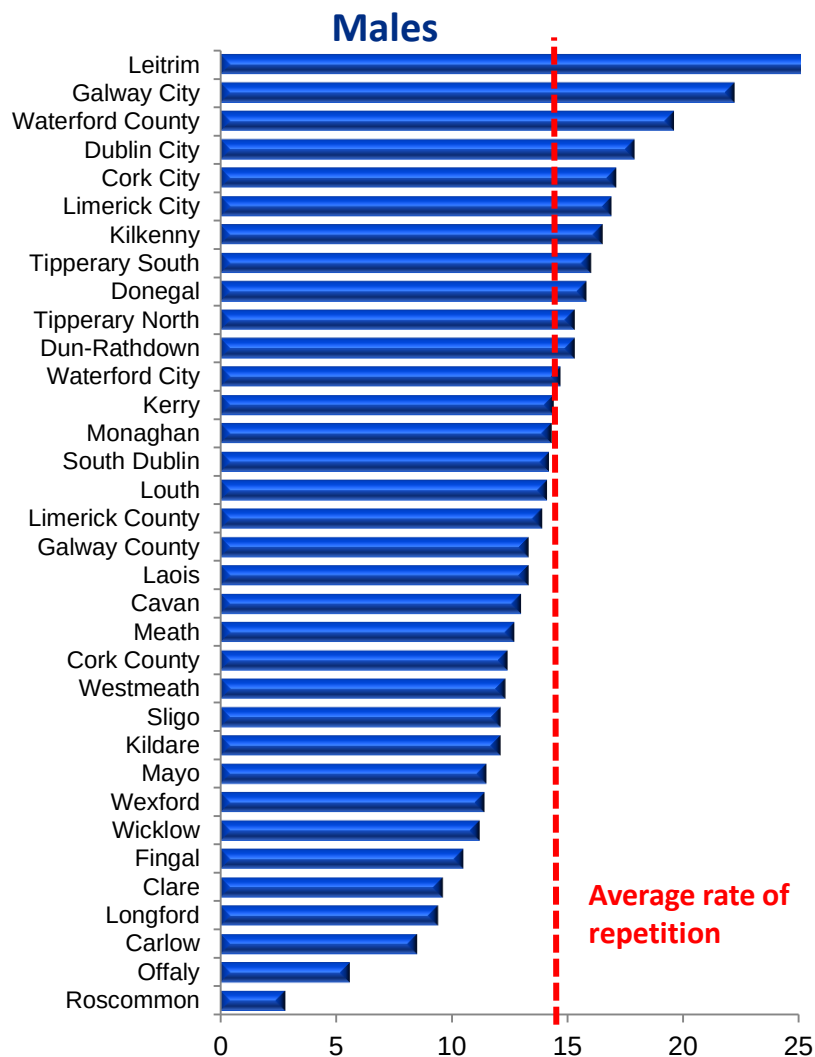
Wider implementation of DBT in Ireland

- After the initial project, DBT was expanded to 3 other adult mental health sites in Cork, funded by the National Office for Suicide Prevention (NOSP)
- Additional funding has been provided by NOSP to further implement DBT in Ireland over the period 2013-2015 – Key objectives:
 - Establishment of National DBT Project Office in Cork, June 2013
 - Support the administration of the national roll out of DBT and allied interventions
 - Ensure continued independent evaluation focussing on effectiveness and cost/benefit of training
 - Ensure meaningful involvement in DBT and allied intervention programmes

Action plan National DBT project

- Training 16 teams nationwide over a period of 2 years
- Teams selected on the basis of their area's incidence of repeated self-harm and local commitment to the implementation of DBT
- Teams selected in year 1:
 - 4 adult (AMHS) and 4 adolescent (CAMHS)
 - Teams trained in December 2013
 - Delivery of DBT to start in March 2014
 - Training of further 8 teams in September 2014

Consideration of variation in self-harm repetition rates when implementing DBT at national level



DBT recommended as part of a comprehensive treatment programme for persons with Borderline Personality Disorder

NHS
National Institute for
Health and Clinical Excellence

Issue date: January 2009

Borderline personality disorder

Borderline personality disorder:
treatment and management

PRACTICE GUIDELINE FOR THE Treatment of Patients With Borderline Personality Disorder

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Originally published in October 2001. This guideline is more than 5 years old and has not been updated to ensure that it reflects current knowledge and practice. In accordance with national standards, including those of the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse (<http://www.guideline.gov>), this guideline can no longer be assumed to be current. The March 2005 Guideline Watch associated with this guideline provides additional information that has become available since publication of the guideline, but it is not a formal update of the guideline.

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Reach Out



National Strategy for
Action on Suicide Prevention
2005-2014



Challenges

- The high levels of self-cutting and repeated self-harm among Irish men may pose challenges for the implementation of DBT as most DBT trials included women
-
- How can DBT be sustained in the long term, and integrated in the mental health services as one of the options of a menu of evidence based treatments offered to people with multiple self-harm acts
- Linking the implementation of guidelines of the national clinical programme to the national roll out of DBT

“People who attempt suicide never want to die, what they want is a different life”

(R. Wieg, 2003)



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- **Department of Health**

Thank you!

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