

Frequent repeaters of self-harm: Findings from the Irish National Registry of Deliberate Self-Harm

E Griffin¹, E Arensman^{1,2}, P Corcoran^{1,2}, IJ Perry²

¹NATIONAL SUICIDE RESEARCH FOUNDATION, CORK

²DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH, UNIVERSITY COLLEGE CORK



ESSSB 15,

15th European Symposium on Suicide and Suicidal Behaviour,

27-30 August, Tallinn



Background

- Hospital-treated self-harm is a significant health issue
 - In Ireland, approx. 12,000 cases per annum (Griffin et al, 2013)
 - In England 220,000 estimated attendances per annum (Hawton et al, 2007)
- Estimated median risk of non-fatal repetition of 16% within 1 year (Owens et al, 2002; Carroll et al, 2014)
- Risk of repetition greatest in the short-term (Cedereke et al 2005; Kapur, 2006)
- Repetition varies by age, method of self-harm and number of previous presentations as well as psychosocial vulnerabilities (Perry et al, 2012; Larkin et al, 2014)

Factors associated with repeated self-harm

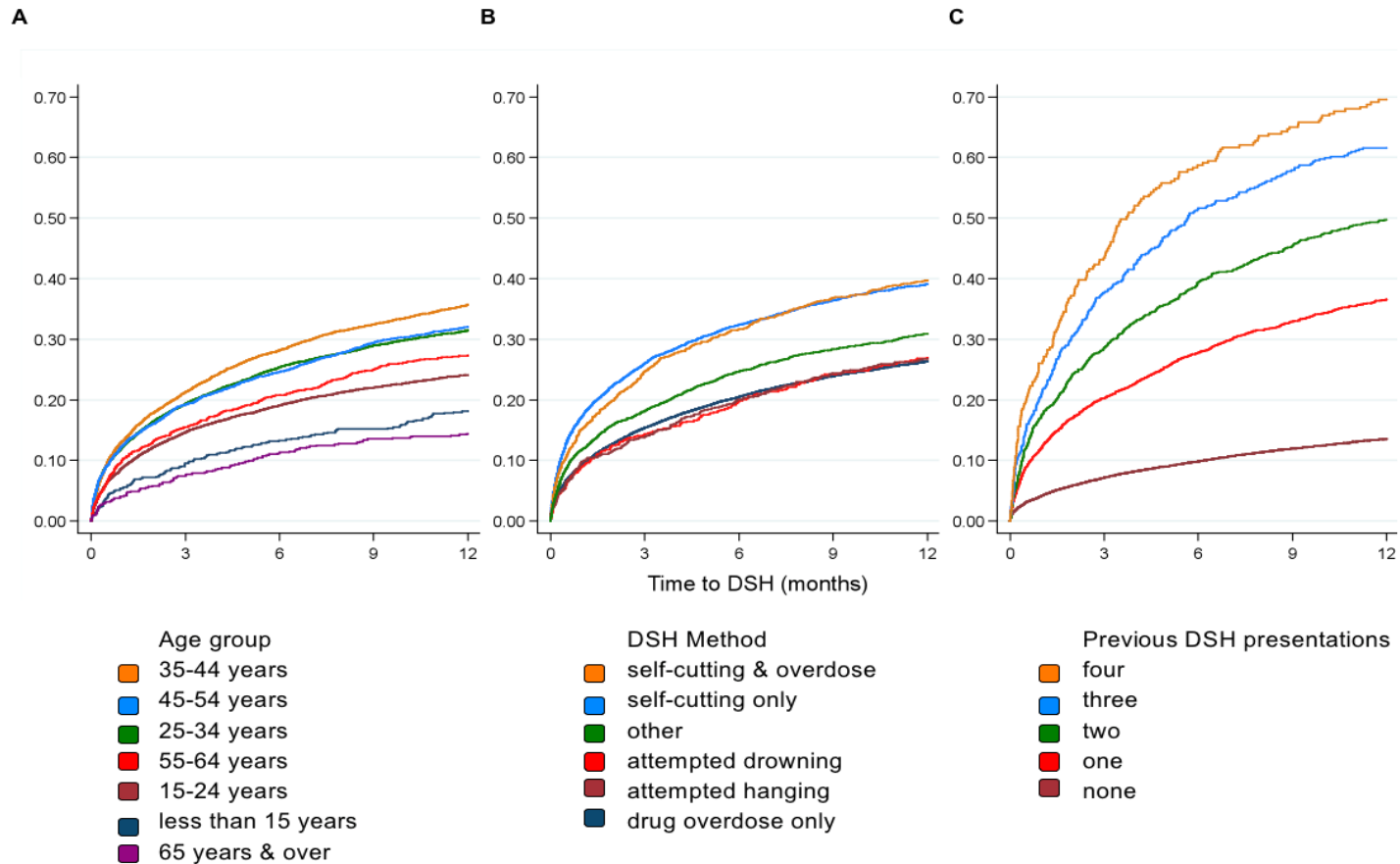


Figure 3: Kaplan-Meier failure curves showing the cumulative probability of a repeated deliberate self harm (DSH) presentation

Background

- Major / grand repeaters (5+ acts) (Kreitman & Casey, 1988; Kerkhof et al, 1998; Bergen et al, 2010)
- Frequent repeaters are a minority, but have a major impact on services and their environment (resource, concerns and economic) (Rodger & Scott, 1995; Haw et al, 2007)
- Sign of persistent distress
 - 60-80% of those with Borderline Personality Disorder engage in suicidal behaviour (Linehan et al, 2006)
 - Personality disorder as a risk factor for repetition (Mehlum et al, 1994; Haw et al, 2007; Larkin et al, 2014)
- Effectiveness of psychosocial assessment and person-based therapies (Hawton et al, 1998; Linehan et al, 2006; Bergen et al, 2010; Kapur et al, 2013)

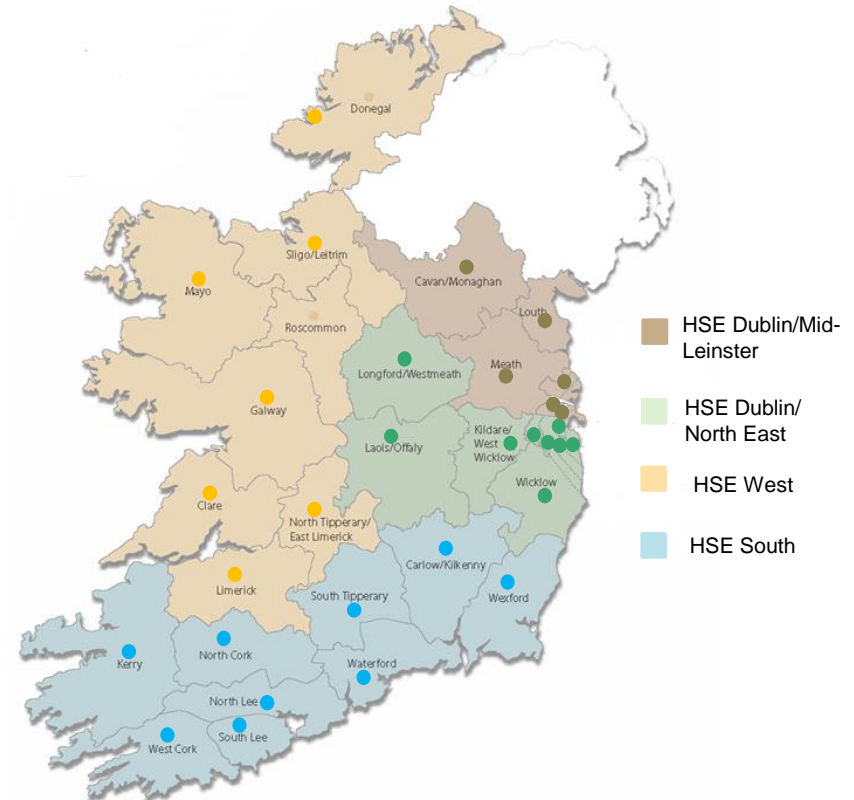


Aims of research

1. Quantify impact of frequent repeaters
2. Explore how patterns of self-harm change according to chronicity
3. Highlight a national health service response to issue of frequent repeaters

Setting: National Registry of Deliberate Self-Harm

- Republic of Ireland
- 4 Health Service Executive (HSE) regions
- 37-40 general hospital emergency departments operating 2004-2012
- Approximately 1.2m presentations annually (2012) (self-harm represents approx. 1%)
- Population: 4,593,300 (2012)



Definition of self-harm

‘an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences’.

(Platt et al, 1992)

- Non-fatal outcome
- Deliberately-initiated behavior (e.g. self-cutting; drug overdose)
- Varying degrees of suicidal intent
- Varying intentions (e.g. wish to die; relief from a state of mind; self-punishment)

Repetition: Any repeat presentation to an emergency department following an index episode of self-harm (Perry et al, 2012)

Results

- Over the 8-year period 2004-2012 there were 101,904 presentations made to hospital recorded by the Registry, involving 63,457 individuals
- 55% (n=55,538) were female
- Drug overdose was the most common method of self-harm (72%, followed by self-cutting (22%))
- 14,755 (23%) individuals repeated at least once

The extent of repeated self-harm presentations

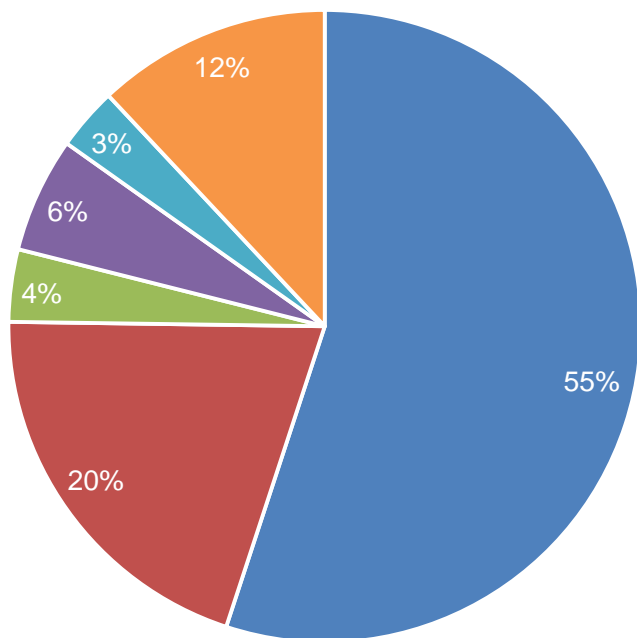
No. of self-harm acts in 2004-2012	Persons (n=63,457)		Presentations (n=101,904)	
	Number	(%)	Number	(%)
One	48,702	76.7	48,702	47.8
Two	8,159	12.9	16,318	16.0
Three	2,809	4.4	8,427	8.3
Four	1,305	2.1	5,220	5.1
Five - Nine	1,854	2.9	11,620	11.4
10 or more	628	1.0	11,617	11.4

628 people made 11,617 self-harm presentations to hospital

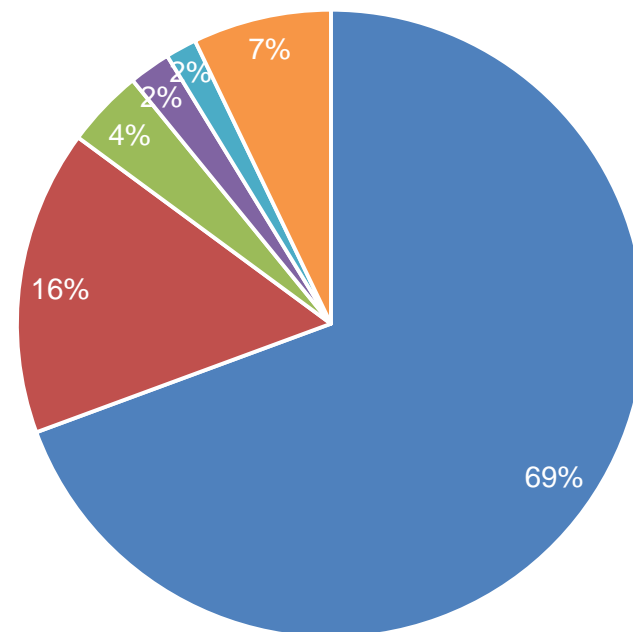
Method of self-harm

(n=101,904)

Men



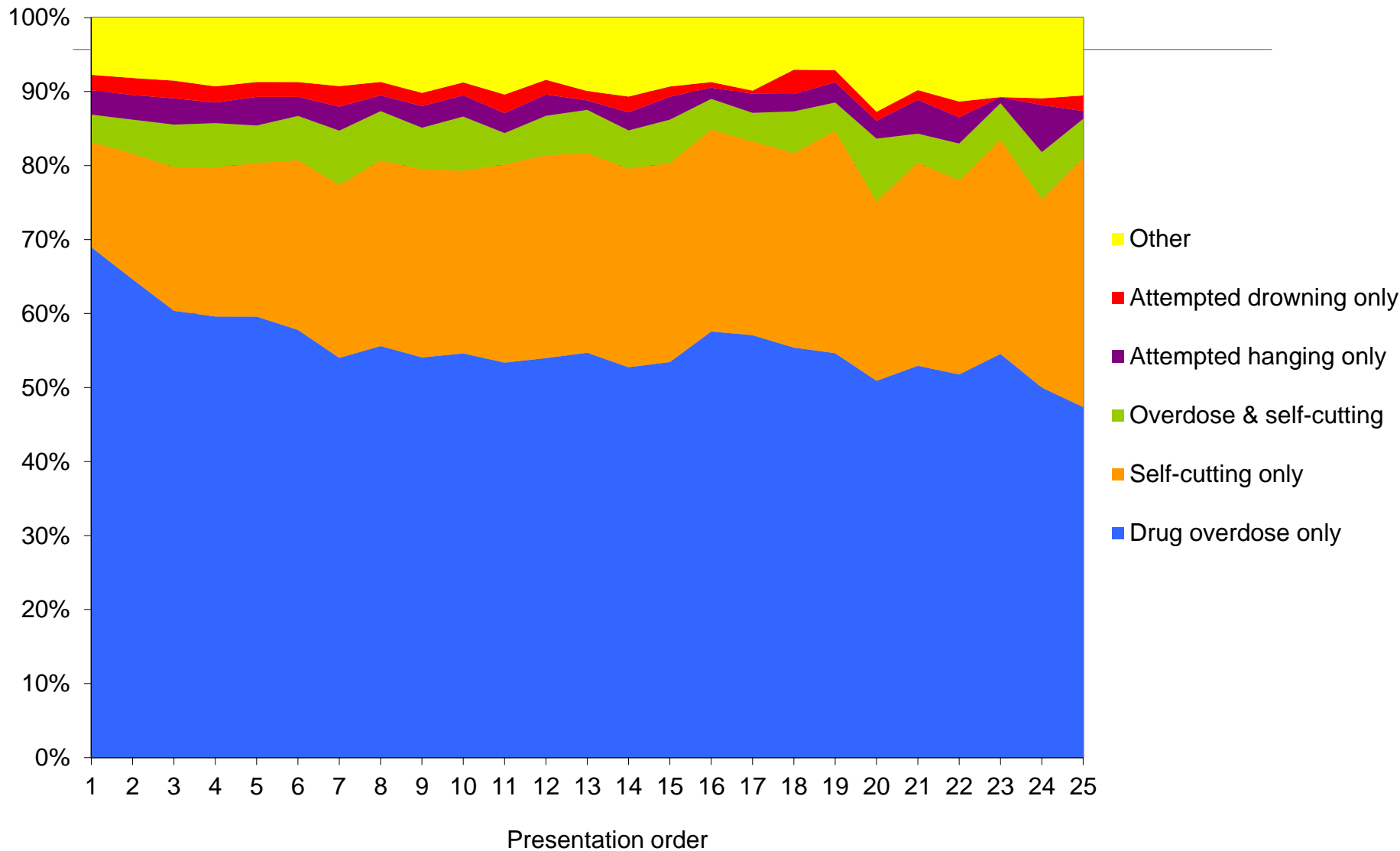
Women



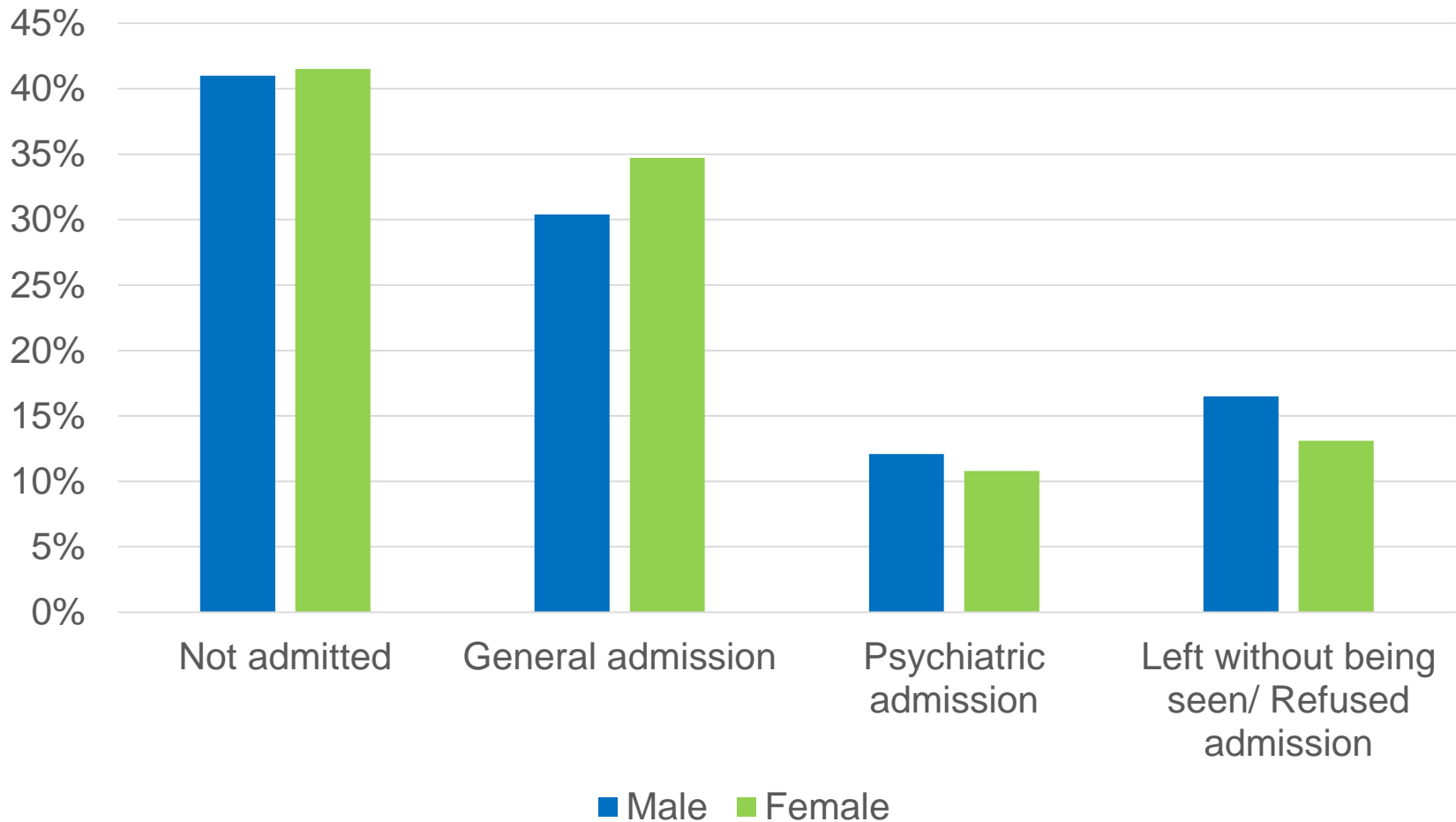
- Drug overdose only
- Self-cutting only
- Overdose & self-cutting
- Attempted hanging only
- Attempted drowning only
- Other

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

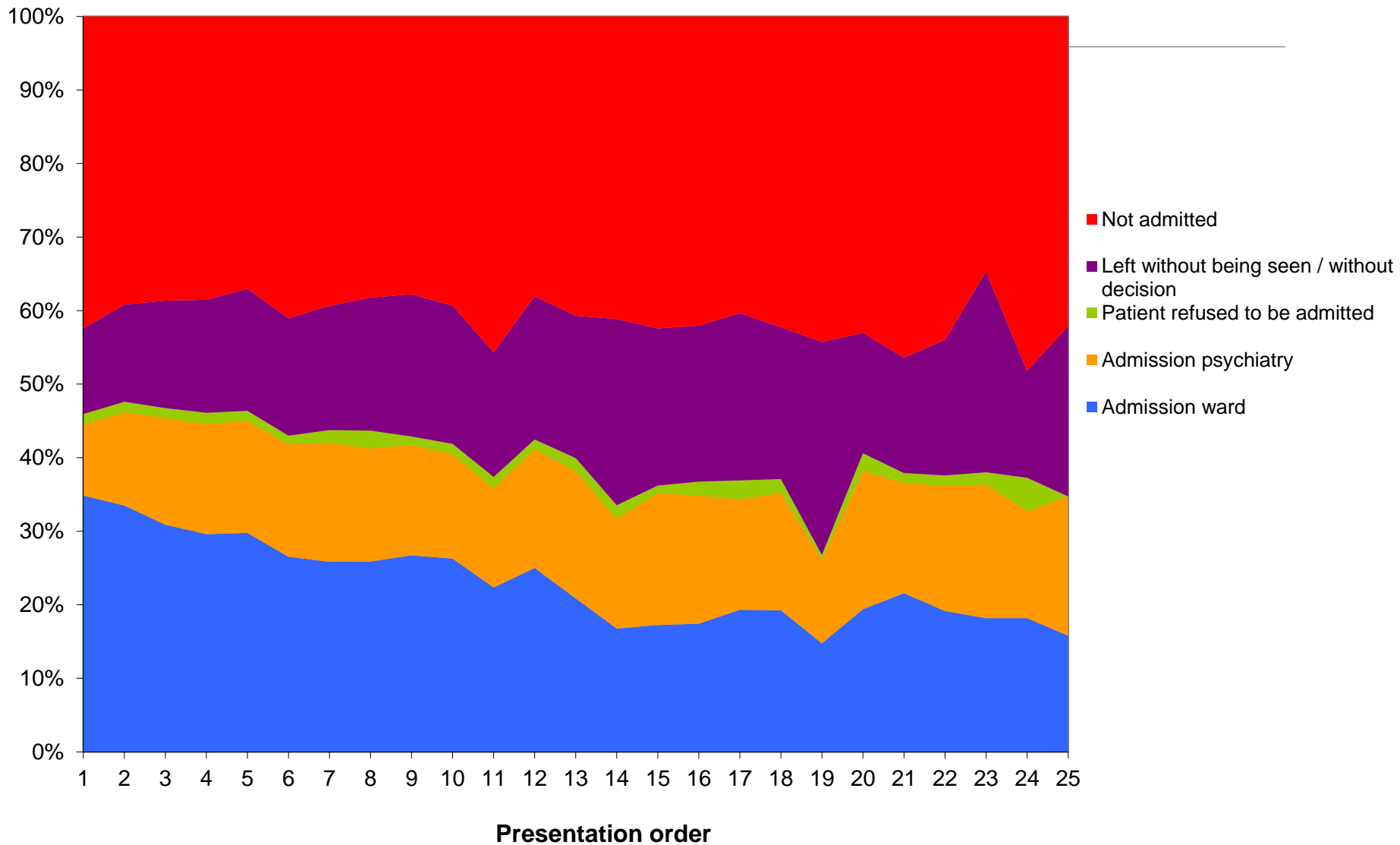
How method of self-harm changes with repeated presentation (N=101,904)



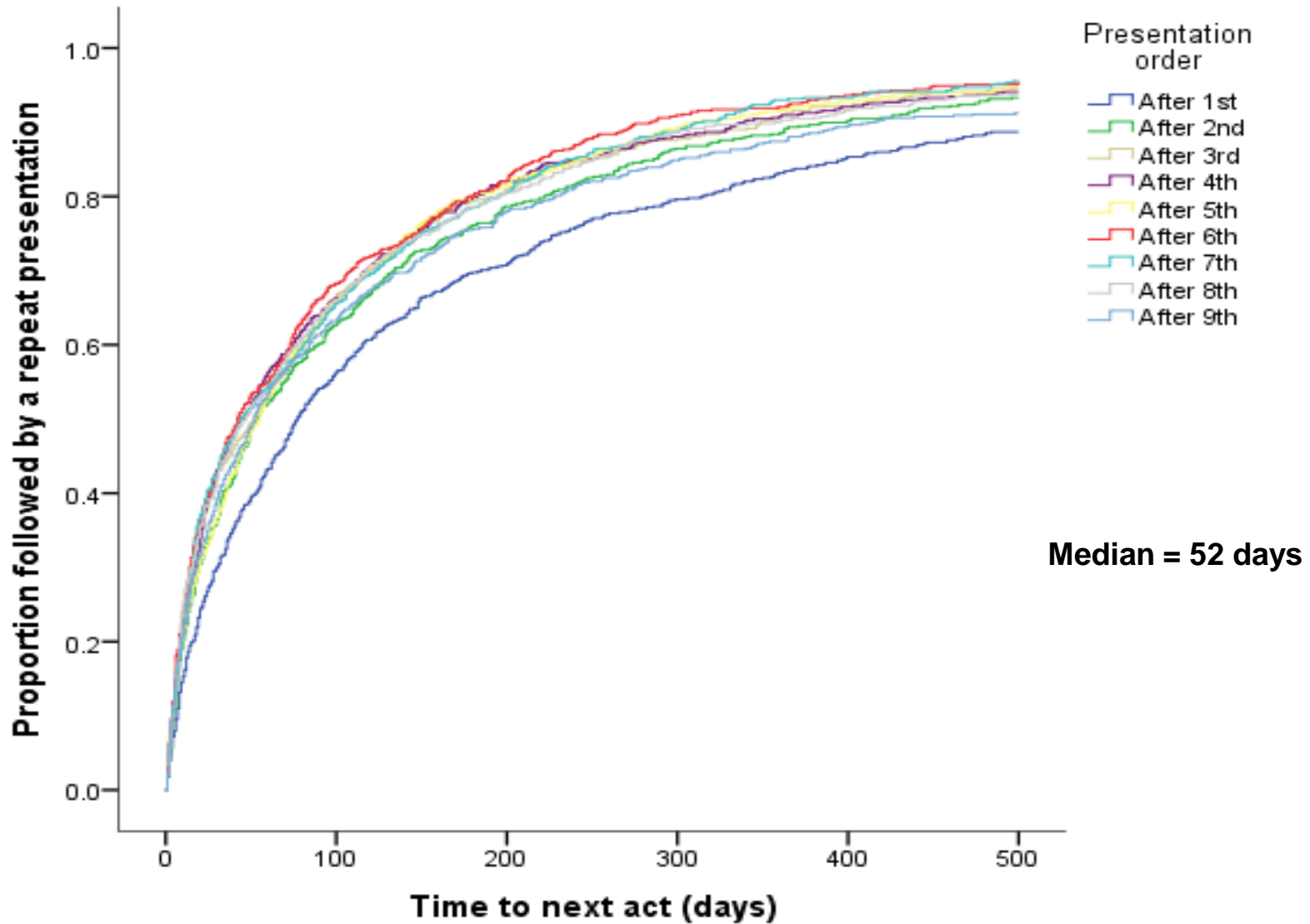
Aftercare of self-harm (N=101,904)



How aftercare of self-harm changes with repeated presentation



How time to next self-harm act changes with repetition (n=628)



Summary

- In an eight-year period, 628 people made over 11,000 presentations to hospital involving self-harm
- There was an association with self-cutting and repetition
- Frequent repeaters were less often admitted to hospital wards, and more likely to leave without a recommendation
- Time to next act was considerably short, with most repeating within 5 months
- The findings suggest that self-harmers are not a homogenous group

Dialectical behavioural therapy and suicidal behaviour

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 Goldacre, David Gunnell, Philip Hazell, Kees van Heeringen, Allan House, David Owens, Isaac Sakinofsky, Lil Traskman-Benzel

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 measure: Repetition of self harm.

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

Summary odds ratios (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 (0.55 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. 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.³ Higher rates of suicide after deliberate self harm have been reported from other countries.⁴ 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%.⁵

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,⁶⁻¹⁰ indicates persistent distress, and results in considerable healthcare costs. Deliberate self harm is common in Europe¹¹ and in other parts of the world,¹²⁻¹⁵ especially in young people. Recent marked increases in rates of deliberate self harm in the United Kingdom,¹⁶⁻¹⁸ with a currently estimated 140 000 hospital referrals in England and Wales,¹⁹ have highlighted the need for effective aftercare strategies.

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

Department of Psychiatry, Otago University, Waikaraiti Hospital, Otago CNZ 725
Keith Hawton, professor of psychiatry
Ella Arensman, postdoctoral research psychologist
Ellen Townsend, postdoctoral research psychologist
Psychological Medicine, Siripon Hospital, PO Box 15, Pwafu, NSW 2750, Australia
Sandy Bremner, consultant psychiatrist

Department of Psychiatry, Jules Kiefflich Hospital, Otago CNZ 924
Eleanor Feldman, consultant liaison psychiatrist
Department of Psychiatry, University of Adelaide, Adelaide, SA 5053, Australia
Robert Goldacre, professor of psychiatry

Department of Social Medicine, University of Bristol, Bristol BS8 2PR
David Gunnell, senior lecturer in epidemiology and public health
correspondence

BMJ 1998;317:441-7

- Systematic Review of the Efficacy of Psychosocial and pharmacological Treatments in Preventing Repetition (Hawton et al, 1998; BMJ).

- DBT 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

Consistency of positive outcomes in applying DBT in different countries and settings

Efficacy of Dialectical Behavior Therapy in Women Veterans With Borderline Personality Disorder

CEDAR R. KOONS
Durham VA Medical Center

CLIVE J. ROBINS
Duke University Medical Center
and Duke University

J. LINDSEY TWEED
THOMAS R. LYNCH

ALICIA M. GONZALEZ
Duke University Medical Center

JENNIFER Q. MOESE
Duke University

G. KAY BISHOP
Durham VA Medical Center

MARJAN I. BUTTERFIELD
LORI A. BASTIAN
Durham VA Medical Center
and Duke University Medical Center

Support for this study was provided by a VA Research Advisory Group grant to the first author. The authors would also like to acknowledge the significant contributions of the following individuals: Theresa Vachok and Lawrence Davis, VA staff psychiatrists providing medication management; Habib Chantazian and Dhanita Jagla-Schudel, skills training group co-leaders, and Jean Beckham, VA staff psychologist and consultant. Address correspondence to Cedar R. Koons, P.O. Box 4952, Santa Fe, NM 87505; e-mail: kreench@comlink.net.

371 001-7894/05/3203-0371\$06.00/0
Copyright © 2005 by Association for Advancement of Behavior Therapy
All rights for reproduction in any form reserved.

REGULAR ARTICLES

Dialectical Behavior Therapy for Patients with Borderline Personality Disorder and Drug-Dependence

Marsha M. Linehan, Ph.D.,¹ Henry Schmidt III, M.A.,²
Linda A. Dimeff, Ph.D.,³ Christopher Craft, B.S.,⁴
Jonathan Kanter, M.A.,⁴ Katherine A. Comtois, Ph.D.

Abstract: A randomized clinical trial was conducted to evaluate whether Dialectical Behavior Therapy (DBT), an effective cognitive-behavioral treatment for suicidal individuals with borderline personality disorder (BPD), would also be effective for drug-dependent women with BPD when compared with treatment-as-usual (TAU) in the community. Subjects were randomly assigned to either DBT or TAU for a year of treatment. Subjects were assessed at 4, 8, and 12 months, and at a 16-month follow-up. Subjects assigned to DBT had significantly greater reductions in drug abuse measured both by structured interview and urinalyses throughout the treatment year and at follow-up than did subjects assigned to TAU. DBT also maintained subjects in treatment better than did TAU, and subjects assigned to DBT had significantly greater gains in alcohol and social adjustment at follow-up than did those assigned to TAU. DBT had been shown to be more effective for reducing drug abuse in treating drug abuse in this study, providing more support for DBT as an effective treatment for severely dysfunctional BPD patients across a range of presenting problems (Am J Addict 1999;8:279-292).

Substance abuse is a common and frequently grave problem for individuals with borderline personality disorder (BPD).

Specifically, individuals meeting criteria for BPD are more likely to also meet criteria for current substance abuse than individuals

Received November 9, 1998; revised May 24, 1999; accepted July 19, 1999.
From the Behavioral Science Program, Department of Psychology, University of Washington, Seattle, WA (M.M.L.); Department of Psychology, University of Washington, Seattle, WA (H.S.); Department of Psychology, University of Washington, Seattle, WA (L.A.D.); Department of Psychology, University of Washington, Seattle, WA (C.C.); Department of Psychology, University of Washington, Seattle, WA (J.K.); Department of Psychology, University of Washington, Seattle, WA (K.A.C.).

Regular Article

Psychotherapy 2002;16:356-365
DOI: 10.1023/A:1015702300027

Received January 20, 2002
Accepted after revision April 11, 2002
Published online September 1, 2002

Psychotherapy and Psychosomatics

Effectiveness and Cost-Effectiveness of Dialectical Behaviour Therapy for Self-Harming Patients with Personality Disorder: A Pragmatic Randomised Controlled Trial

Stefan Friebel^a, Nyla Bhatt^b, Kirsten Bamicot^b, Stephen Bremner^a, Amy Gaglio^a, Christina Katsakou^{a,b}, His-Molsan-Kwek^a, Paul McCrone^a, Martin Ziniker^a

^aQueen Mary University of London, East London NHS Foundation Trust, and ^bInstitute of Psychiatry, King's College London, London, UK

Key Words: Dialectical behaviour therapy · borderline personality disorder · self-harm · cost-effectiveness

Abstract

Background: A primary goal of dialectical behaviour therapy (DBT) is to reduce self-harm, but findings from empirical studies are inconclusive. The aim of this study was to assess the effectiveness and cost-effectiveness of DBT in reducing self-harm in patients with personality disorder. **Methods:** Participants with a personality disorder and at least 5 days of self-harm in the previous year were randomised to receive 12 months of either DBT or treatment as usual (TAU). The primary outcome was the frequency of days with self-harm. Secondary outcomes included borderline personality disorder symptoms, general psychiatric symptoms, subjective quality of life, and costs of care. **Results:** Forty patients each were randomised to DBT and TAU. In an intention-to-treat analysis, there was a statistically significant treatment by time interaction for self-harm (incidence rate ratio 0.93, 95% CI 0.83-0.92, p < 0.001). For every 20 months spent in DBT the risk of self-harm decreased by 9% relative to TAU. There was no evidence of difference on any secondary outcomes. The

economic analysis revealed a total cost of a mean of 5,685 GBP (£,786 EUR) in DBT compared to a mean of 3,754 GBP (£,481 EUR) in TAU, but the difference was not significant (95% CI -603 to 1,599 GBP, forty-eight per cent of patients completed DBT). They had a greater reduction in self-harm compared to disposition (incidence rate ratio 0.78, 95% CI 0.76-0.80, p < 0.001). **Conclusions:** DBT can be effective in reducing self-harm in patients with personality disorder, possibly incurring higher total treatment costs. The effect is stronger in those who complete treatment and whose research should explore how to improve treatment adherence.
Copyright © 2005 John Wiley & Sons, Ltd

Background

Dialectical behaviour therapy (DBT) [1] was developed [1, 2] for the treatment of patients with borderline personality disorder (BPD), with a primary focus on self-harm reduction. Since its development, it has gained increasing popularity as an effective treatment for people with BPD who regularly self-harm [3, 4]. In the UK, DBT is the only psychosocial treatment recommended by a National Institute for Health and Clinical Excellence as a treat-

Dialectical behaviour therapy for women with borderline personality disorder

12-month, randomised clinical trial in The Netherlands
ROEL VERHEIJ, LOUISE M. C. VAN DEN BOSCH, HAARTEN W. J. KOETTER, MARIA A. DE RIDDER, THEO STIJNEN and WIM VAN DEN BRINK

Background: Dialectical behaviour therapy (DBT) is widely considered to be a promising treatment for borderline personality disorder (BPD). However, the evidence for its efficacy published thus far should be regarded as preliminary.

Aims: To compare the effectiveness of DBT with treatment as usual for patients with BPD and to examine the impact of baseline severity on effectiveness.

Method: Fifty-eight women with BPD were randomly assigned to either 12 months of DBT or usual treatment in a randomised controlled study. The patients were recruited through clinical referrals from both addiction treatment and psychiatric services. Outcome measures included treatment retention and the course of suicidal, self-mutilating and self-damaging impulsive behaviours.

Results: Dialectical behaviour therapy resulted in better retention rates and greater reductions of self-mutilating and self-damaging impulsive behaviours, compared with usual treatment, especially among those with a history of frequent self-mutilation.

Conclusions: Dialectical behaviour therapy is superior to usual treatment in reducing high-risk behaviours in patients with BPD.

Declaration of interest: None. This work was supported by ZAO (Health Insurance Company, Amsterdam).

According to the American Psychiatric Association's practice guidelines, the first major treatment for borderline personality disorder is psychotherapy, supplemented by symptom-targeted pharmacotherapy if necessary (American Psychiatric Association, 2001). It is stated in this guideline that two psychosocial approaches to the treatment of personality-psychosomatic therapy and dialectical behaviour therapy. The guideline has been criticised because it primarily based upon evidence from clinical trials of single case studies and uncontrolled studies (e.g. Tyrer, 2002). Only few methodologically rigorous efficacy studies have been conducted. With respect to dialectical behaviour therapy, two randomised clinical trials of small to moderate size have been conducted (Linehan et al., 1991, 1999). In addition, several other unpublished or uncontrolled studies have been reported by Koerner & Linehan (2000). In a randomised controlled trial, we compared the effectiveness of dialectical behaviour therapy with treatment as usual in terms of the therapy's primary targets (Linehan et al., 1999): five treatment retention and reduced, high-risk behaviours, including suicidal, self-mutilating and self-damaging impulsive behaviours. A further aim was to examine whether the efficacy of dialectical behaviour therapy is modified by baseline severity of personality. This report describes the first 12 months of the trial.

METHOD

Sample recruitment: Women with borderline personality disorder aged 18-70 years residing within a 60-km radius around Amsterdam, who were referred by a psychiatrist or psychologist willing to sign an agreement exposing the participant to follow 12 months of treatment or usual, were contacted for recruitment. No restriction was

made in terms of the referral source. Referrals originated from addiction treatment services, psychiatric hospitals, centers for mental health care, independently working psychologists and psychiatrists, and even from general practitioners and self-referrals. Women in the latter two categories were allowed to participate in the study only when they were able to locate a psychiatrist or psychologist willing to provide treatment as usual. The inclusion criteria were a DSM-IV diagnosis of bipolar disorder or chronic psychotic disorder (American Psychiatric Association, 1994), insufficient control of the Dutch language, and severe psychiatric symptoms (American Psychiatric Association, 2001). It is stated in this guideline that two psychosocial approaches to the treatment of personality-psychosomatic therapy and dialectical behaviour therapy. The guideline has been criticised because it primarily based upon evidence from clinical trials of single case studies and uncontrolled studies (e.g. Tyrer, 2002). Only few methodologically rigorous efficacy studies have been conducted. With respect to dialectical behaviour therapy, two randomised clinical trials of small to moderate size have been conducted (Linehan et al., 1991, 1999). In addition, several other unpublished or uncontrolled studies have been reported by Koerner & Linehan (2000). In a randomised controlled trial, we compared the effectiveness of dialectical behaviour therapy with treatment as usual in terms of the therapy's primary targets (Linehan et al., 1999): five treatment retention and reduced, high-risk behaviours, including suicidal, self-mutilating and self-damaging impulsive behaviours. A further aim was to examine whether the efficacy of dialectical behaviour therapy is modified by baseline severity of personality. This report describes the first 12 months of the trial.

Randomisation procedure: Following the completion of the intake assessment, patients were randomly assigned to treatment conditions. A minimisation method was used to ensure comparability of the two treatment conditions on age, gender, psychiatric diagnoses, and comorbidity (as measured by the European profile of the Addiction Severity Index (Kukavetz & Manning, 1993)).

Treatments: Patients assigned to dialectical behaviour therapy received 12 months of treatment as specified in the manual (Linehan, 1993). The treatment combines weekly individual cognitive-behavioral psychotherapy sessions with the primary therapy, weekly skills-training groups (lasting 2-3 h per session), and weekly supervision and consultation meetings for 60-90 min (Linehan, 1993). Individual therapy focuses primarily on motivational enhancement to sign an agreement exposing the participant to follow 12 months of treatment or usual, were contacted for recruitment. No restriction was

made in terms of the referral source. Referrals originated from addiction treatment services, psychiatric hospitals, centers for mental health care, independently working psychologists and psychiatrists, and even from general practitioners and self-referrals. Women in the latter two categories were allowed to participate in the study only when they were able to locate a psychiatrist or psychologist willing to provide treatment as usual. The inclusion criteria were a DSM-IV diagnosis of bipolar disorder or chronic psychotic disorder (American Psychiatric Association, 1994), insufficient control of the Dutch language, and severe psychiatric symptoms (American Psychiatric Association, 2001). It is stated in this guideline that two psychosocial approaches to the treatment of personality-psychosomatic therapy and dialectical behaviour therapy. The guideline has been criticised because it primarily based upon evidence from clinical trials of single case studies and uncontrolled studies (e.g. Tyrer, 2002). Only few methodologically rigorous efficacy studies have been conducted. With respect to dialectical behaviour therapy, two randomised clinical trials of small to moderate size have been conducted (Linehan et al., 1991, 1999). In addition, several other unpublished or uncontrolled studies have been reported by Koerner & Linehan (2000). In a randomised controlled trial, we compared the effectiveness of dialectical behaviour therapy with treatment as usual in terms of the therapy's primary targets (Linehan et al., 1999): five treatment retention and reduced, high-risk behaviours, including suicidal, self-mutilating and self-damaging impulsive behaviours. A further aim was to examine whether the efficacy of dialectical behaviour therapy is modified by baseline severity of personality. This report describes the first 12 months of the trial.

ORIGINAL ARTICLE

Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder

Marsha M. Linehan, PhD, Katherine Ann Comtois, PhD, Angela M. Murray, MS, MDR, Heidi D. Brown, PhD, Robert J. Gallup, PhD, Hsi-Li Hsiang, PhD, Freda M. Lynch, PhD, Richard F. Day, PhD, Daniel A. Cook, MS, Sarah K. Reynolds, PhD, Susan Lendinier, MS

Context: Dialectical behavior therapy (DBT) is a treatment for suicidal behavior and/or borderline personality disorder with well-documented efficacy.

Objective: To evaluate the hypothesis that unique aspects of DBT are more efficacious compared with treatment offered by non-behavioral psychotherapy experts.

Design: One-year randomized controlled trial, plus 1 year of posttreatment follow-up.

Setting: University outpatient clinic and community practice.

Participants: One hundred one clinically referred women with recent suicidal and self-inflicted behaviors meeting DSM-IV criteria, matched for conditions on age, suicide attempt history, negative prognostic indication, and number of lifetime inpatient self-harm and psychiatric hospitalizations.

Interventions: One year of DBT or 1 year of community treatment by experts (developed to maximize treatment fidelity by controlling for therapist age, availability, expertise, allegiance, training and experience, consultation availability, and institutional pressure).

Main Outcome Measures: Trained assessors of suicidal behaviors, emergency services use, and general psychological functioning. Measures were selected based on precision outcome studies of DBT. Outcome measures were evaluated by blinded assessors.

Results: Dialectical behavior therapy was associated with better outcomes in the intent-to-treat analysis than community treatment by experts in most target areas during the 2-year treatment and follow-up period. Subjects receiving DBT were half as likely to make a suicide attempt (hazard ratio = 2.66, P < .005), required less hospitalization for suicide ideation (F_{1,97} = 7.3, P < .004) and had lower medical risk (F_{1,97} = 3.2, P < .01) across all suicide attempts and self-inflictions as combined. Subjects receiving DBT were half as likely to drop out of treatment (hazard ratio = 3.2, P < .001) and had fewer psychiatric hospitalizations (F_{1,97} = 6.0, P < .007) and psychiatric emergency department visits (F_{1,97} = 2.9, P < .01).

Conclusions: Our findings place these two procedures side-by-side and suggest that the effectiveness of DBT can reasonably be attributed to general factors associated with expert psychotherapy. Dialectical behavior therapy appears to be uniquely effective in reducing suicide attempts.

Arch Gen Psychiatry 2006;63:375-386

SUCIDAL BEHAVIOUR IS A RECURRENT phenomenon that includes death by suicide and suicidal ideation. In a meta-analysis of 10 studies, 54% of patients with BPD used psychiatric services over a 2-year period (Linehan et al., 1999). In a 10-year follow-up study, 47% of patients with BPD were hospitalized at least once (Linehan et al., 2002). In a 10-year follow-up study, 47% of patients with BPD were hospitalized at least once (Linehan et al., 2002). In a 10-year follow-up study, 47% of patients with BPD were hospitalized at least once (Linehan et al., 2002).

Washington, on July 3, 2006
at 18:00, 8/1/2006

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

(Flynn and Kells, 2013)

- Following 12 months DBT intervention:
 - Reductions in self-harm repetition, symptoms of BPD, depression and hopelessness
 - Reductions in ED visits (49 to 0), in-patient admissions (12 to 1) and bed days (207 to 1)
- Project expanded to 16 community mental health teams over 2 years

The Road to Endeavour:
Development and Evaluation of a Programme for Those Presenting with Repeated Self-Harm and Chronic Suicidality

Daniel Flynn, Principal Psychologist, Coish South Mental Health Service
Mary Kells, Senior Clinical Psychologist, North Lee Adult Mental Health Service

Introduction

The non-emergent, voluntary, 12-week, 10-session, manual-based, group-based, cognitive-behavioural programme for those presenting with repeated self-harm and chronic suicidality was developed and implemented in the North Lee Adult Mental Health Services (NLMS) in 2011. The programme was developed and implemented in the NLMS in 2011. The programme was developed and implemented in the NLMS in 2011.

Method

The study was a non-randomised, controlled, before-and-after study. The study was a non-randomised, controlled, before-and-after study. The study was a non-randomised, controlled, before-and-after study.

	12 months before DBT	During DBT	6 weeks post DBT
Emergency Dept Visits	49	6	0
Admissions to Psychiatric Unit	12	3	1
Bed Days (total)	207	45	1
DBT	1474 (100%)	1474 (100%)	4700 (100%)

Conclusions and Implications

The study was a non-randomised, controlled, before-and-after study. The study was a non-randomised, controlled, before-and-after study. The study was a non-randomised, controlled, before-and-after study.

Discussion

- Non-fatal repetition of self-harm remains a real clinical challenge
 - Impact on both services and environment
- Patterns of aftercare and timing of acts suggest 'a gap' in services for frequent repeaters
- All self-harm patients presenting to the ED should receive a comprehensive assessment and tailored treatment
 - Screening for suicide risk

Thank You!

evegriffin@ucc.ie

+353 21 420 5551

4.35 Western Gateway Building,
University College Cork



National Suicide
Research Foundation