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

Prof. Ella Arensman
National Suicide Research Foundation
Department of Epidemiology and Public Health, UCC

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NSRF
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
ucc
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

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 Träskman-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 measure: 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 6] 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%.[7 8]

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,[9 10] indicates persistent distress, and results in considerable healthcare costs. Deliberate self harm is common in Europe[11] and in other parts of the world,[12 13] especially in young people. Recent marked increases in rates of deliberate self harm in the United Kingdom,[14 15] with a currently estimated 140 000 hospital referrals in England and Wales,[16] have highlighted the need for effective aftercare strategies.

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

Department of Psychiatry, Oxford University, Warneford Hospital, Oxford OX3 7JX
Keith Hawton, *professor of psychiatry*
Ella Arensman, *postdoctoral research psychologist*
Ellen Townsend, *postdoctoral research psychologist*
Psychological Medicine, Nepean Hospital, PO Box 63, Penrith, NSW 2750, Australia
Sandy Bremner, *consultant psychiatrist*
Department of Psychological Medicine, John Radcliffe Hospital, Oxford OX3 9DU
Eleanor Feldman, *consultant liaison psychiatrist*
Department of Psychiatry, University of Adelaide, Adelaide, SA 5005, Australia
Robert Goldney, *professor of psychiatry*
Department of Social Medicine, University of Bristol, Bristol BS8 2PR
David Gunnell, *senior lecturer in epidemiology and public health*

continued over

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

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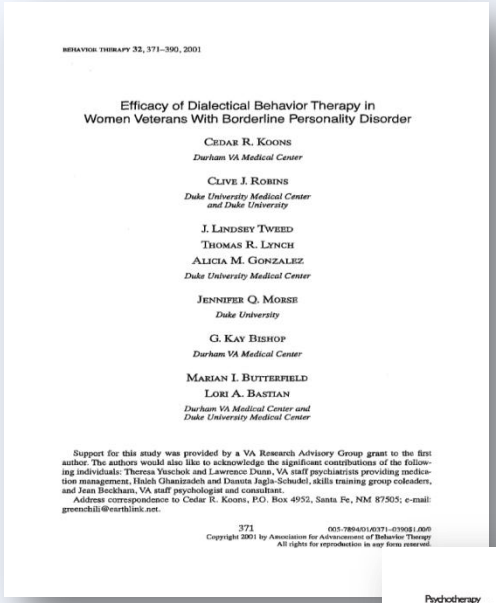
Consistency of positive outcomes in applying Dialectical Behaviour Therapy in different countries and settings



BEHAVIOR THERAPY 32, 371–390, 2001

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. MORSE
Duke University
G. KAY BISHOP
Durham VA Medical Center
MARIAN I. BUTTERFIELD
LORI A. BASTIAN
Durham VA Medical Center and Duke University Medical Center

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Address correspondence to Cedar R. Koons, P.O. Box 4952, Santa Fe, NM 87505; e-mail: greenchili@earthlink.net.

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REGULAR ARTICLES

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

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

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 interviews 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 global and social adjustment at follow-up than did those assigned to TAU. DBT has been shown to be more effective than treatment-as-usual 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)

Linehan, M.M., Schmidt, H., Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. The American Journal on Addictions, 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 individu-

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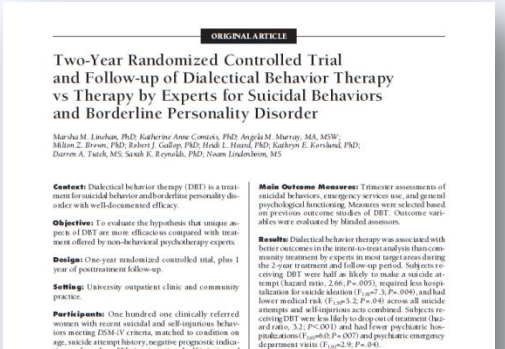
From the Behavioral Research and Therapy Clinics, Department of Psychology, University of Washington, Seattle. Address correspondence to Dr. Linehan, Department of Psychology, University of Washington, Box 351525, Seattle, WA 98195–1525. E-mail: linehan@u.washington.edu.



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 Anne Comtois, PhD; Angela M. Murray, MA, MSW; Milton Z. Brown, PhD; Robert J. Gallop, PhD; Heidi L. Heard, PhD; Kathryn E. Korslund, PhD; Darren A. Tutek, MS; Sarah K. Reynolds, PhD; Noam Lindenboim, MS

Context: Dialectical behavior therapy (DBT) is a treatment for suicidal behavior and 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-injurious behaviors meeting *DSM-IV* criteria, matched to condition on age, suicide attempt history, negative prognostic indication, and number of lifetime intentional self-injuries and psychiatric hospitalizations.

Intervention: One year of DBT or 1 year of community treatment by experts (developed to maximize internal validity by controlling for therapist sex, availability, expertise, allegiance, training and experience, consultation availability, and institutional prestige).

Main Outcome Measures: Trimester assessments of suicidal behaviors, emergency services use, and general psychological functioning. Measures were selected based on previous outcome studies of DBT. Outcome variables 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 1-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 ($F_{1,98} = 7.3$; $P = .008$), and had lower medical risk ($F_{1,98} = 3.2$; $P = .04$) across all suicide attempts and self-injurious acts combined. Subjects receiving DBT were less likely to drop out of treatment (hazard ratio, 3.2; $P < .001$) and had fewer psychiatric hospitalizations ($F_{1,98} = 6.9$; $P = .007$) and psychiatric emergency department visits ($F_{1,98} = 2.9$; $P = .04$).

Conclusions: Our findings replicate those of previous studies of DBT and suggest that the effectiveness of DBT cannot 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;63:757-766

SUICIDAL BEHAVIOR IS A BROAD term that includes death by suicide and intentional, nonfatal, self-injurious acts committed with or without intent to die. It is associated with several mental disorders, including depression, substance dependence, and schizophrenia. Borderline personality disorder (BPD) is 1 of only 2 *DSM-IV* diagnoses for which suicidal behavior is a hallmark criterion.[1–3] Borderline personality disorder is severe and chronic, with a suicide rate of up to 9%.[4–6] Forty percent of the highest users of inpatient psychiatric services receive a diagnosis of BPD.[7–12] Patients with BPD use more services than those with major depression[13] and other personality disorders.[14] Among patients with BPD seen for treatment, 7.2% have had at least 1 psychiatric hospitalization and 97% have received outpatient treatment from a mean of 6.1 previous therapists.[15,16] Despite this high-use pattern, patients with BPD have high rates of treatment failure.[17,18]

Outpatient dialectical behavior therapy (DBT)[19,20] and mentalization-based treatment provided in a partial hospital pro-

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Regular Article

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

Stefan Priebe[a] Nyla Bhatti[b] Kirsten Barnicot[a] Stephen Bremner[a] Amy Gaglia[b] Christina Katsakou[a, b] Iris Molosankwe[c] Paul McCrone[c] Martin Zinkler[a]

[a]Queen Mary University of London, [b]East London NHS Foundation Trust, and [c]Institute 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 0.91, 95% CI 0.89–0.92, p < 0.001). For every 2 months spent in DBT, the risk of self-harm decreased by 9% relative to TAU. There was no evidence of differences on any secondary outcomes. The economic analysis revealed a total cost of a mean of 5,685 GBP (6,786 EUR) in DBT compared to a mean of 3,754 GBP (4,481 EUR) in TAU, but the difference was not significant (95% CI −603 to 4,599 GBP). Forty-eight per cent of patients completed DBT. They had a greater reduction in self-harm compared to dropouts (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. Future research should explore how to improve treatment adherence.

Background

Dialectical behaviour therapy (DBT) 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 the National Institute for Health and Clinical Excellence as a treat-

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E-Mail karger@karger.ch
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Stefan Priebe
Unit for Social and Community Psychiatry, Queen Mary University of London
Barts and the London School of Medicine and Dentistry
Newham Centre for Mental Health, London E13 8SP (UK)
E-Mail s.priebe@qmul.ac.uk

BRITISH JOURNAL OF PSYCHIATRY (2002), 181, 133–140

Dialectical behaviour therapy for women with borderline personality disorder

12-month, randomised clinical trial in The Netherlands

ROEL VERHEUL, LOUISE M. C. VAN DEN BOSCH, MAARTEN W. J. KOETER, MARIA A. J. 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. Participants 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. A further aim was to examine whether the efficacy of dialectical behaviour therapy is modified by baseline severity of parasuicide. This report describes the first 12 months of the trial.

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 guideline, the primary treatment for borderline personality disorder is psychotherapy, complemented by symptom-targeted pharmacotherapy if necessary (American Psychiatric Association, 2001). It is stated in this guideline that two psychotherapeutic approaches have been shown in randomised trials to have efficacy: psychoanalytic/psychodynamic therapy and dialectical behaviour therapy. The guideline has been criticised because it is primarily based upon evidence from uncontrolled or single-case studies and clinical consensus (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*a*). In addition, several other unpublished or uncontrolled studies have been summarised 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*b*): first, treatment retention and second, 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 parasuicide. 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 40-km circle centred on Amsterdam, who were referred by a psychologist or psychiatrist willing to sign an agreement expressing the commitment to deliver 12 months of treatment as usual, were considered for recruitment. No restriction was made in terms of the referral source. Referrals originated from addiction treatment services, psychiatric hospitals, centres for mental health care, independently working psychologists and psychiatrists, and even from general practitioners and self-referral. Women in the latter two categories were allowed to participate in the study only when they were able to locate a psychologist or psychiatrist willing to provide treatment as usual. The exclusion criteria were a DSM-IV diagnosis of bipolar disorder or (chronic) psychotic disorder (American Psychiatric Association, 1994), insufficient command of the Dutch language, and severe cognitive impairments. The diagnosis of borderline personality disorder was established using both the Personality Diagnostic Questionnaire, DSM-IV version (Hyler, 1994) and the Structured Clinical Interview for DSM-IV Axis II personality disorders (SCID-II; First *et al*, 1994). Positive endorsement of DSM-IV diagnostic criteria for borderline personality disorder was required on both instruments. In contrast to Linehan's trial (Linehan *et al*, 1991), the sample consisted primarily of clinical referrals from both addiction treatment and psychiatric services, and participants were not required to have shown recent parasuicidal behaviour.

Randomisation procedure

Following the completion of the intake assessments, patients were randomly assigned to treatment conditions. A minimisation method was used to ensure comparability of the two treatment conditions on age, alcohol problems, drug problems and social problems (as measured by the European version of the Addiction Severity Index (Kokkevi & Hartgers, 1995)).

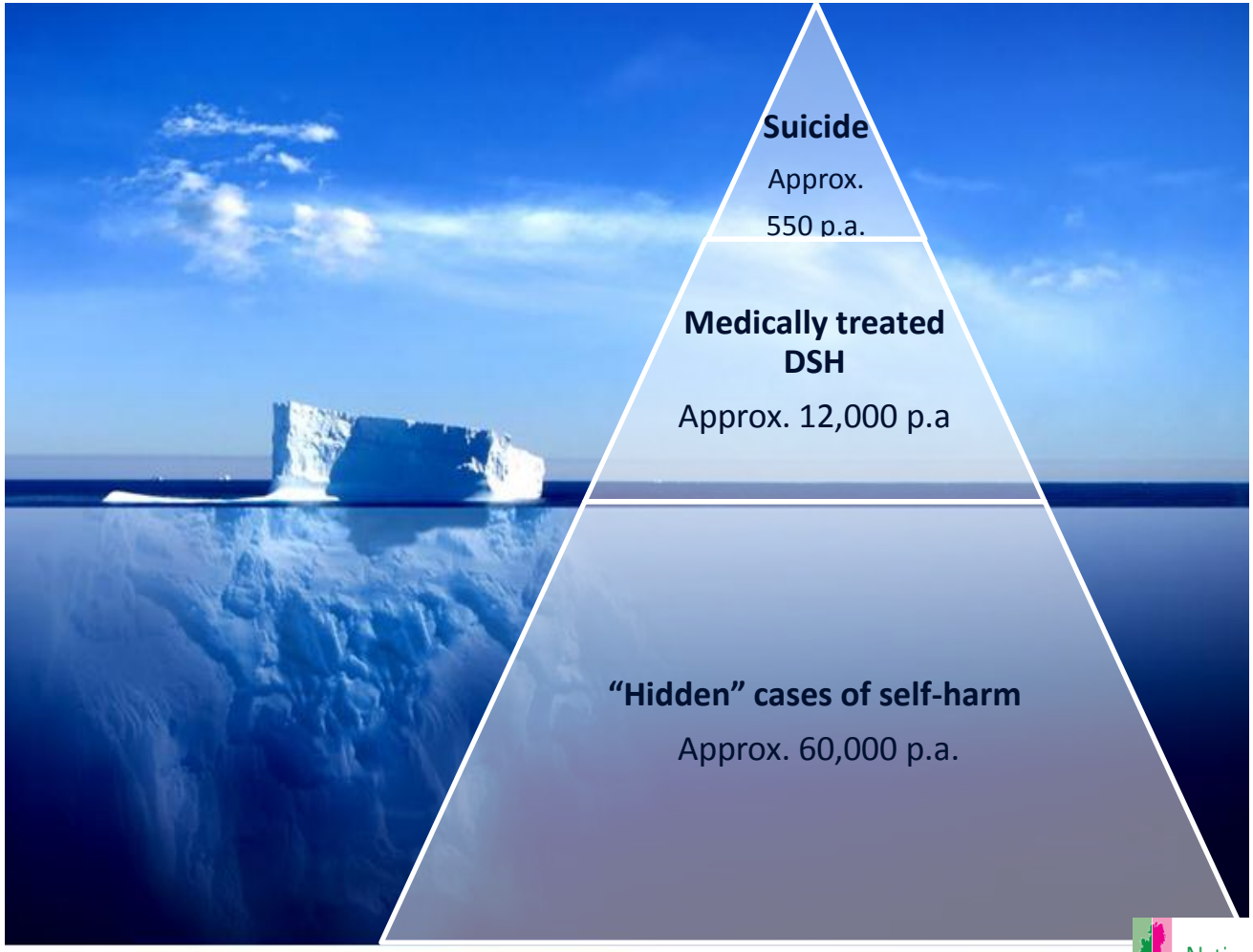
Treatments

Patients assigned to dialectical behaviour therapy received 12 months of treatment as specified in the manual (Linehan, 1993). The treatment combines weekly individual cognitive-behavioural psychotherapy sessions with the primary therapist, weekly skills-training groups lasting 2–2.5 h per session, and weekly supervision and consultation meetings for the therapists (Linehan, 1993). Individual therapy focuses primarily on motivational issues, including the motivation to stay alive and to stay in treatment. Group therapy teaches self-regulation and change skills, and skills for self-acceptance and

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

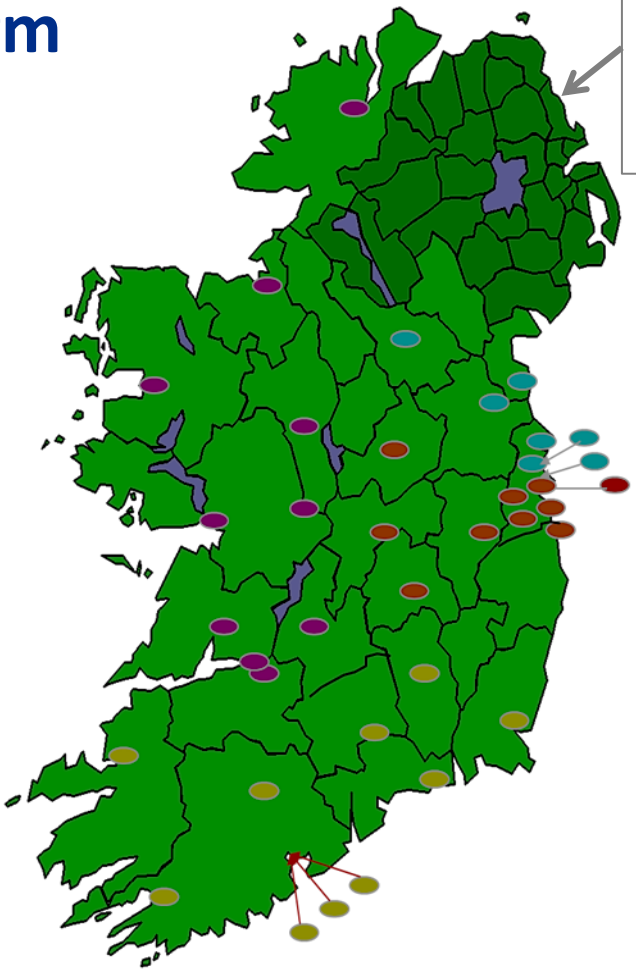
Suicide and medically treated deliberate self harm in Ireland: the tip of the iceberg



National Registry of Deliberate Self-Harm

A Northern Ireland registry operates across the 5 trusts in NI, with full coverage obtained as of 2012

HSC Public Health Agency



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

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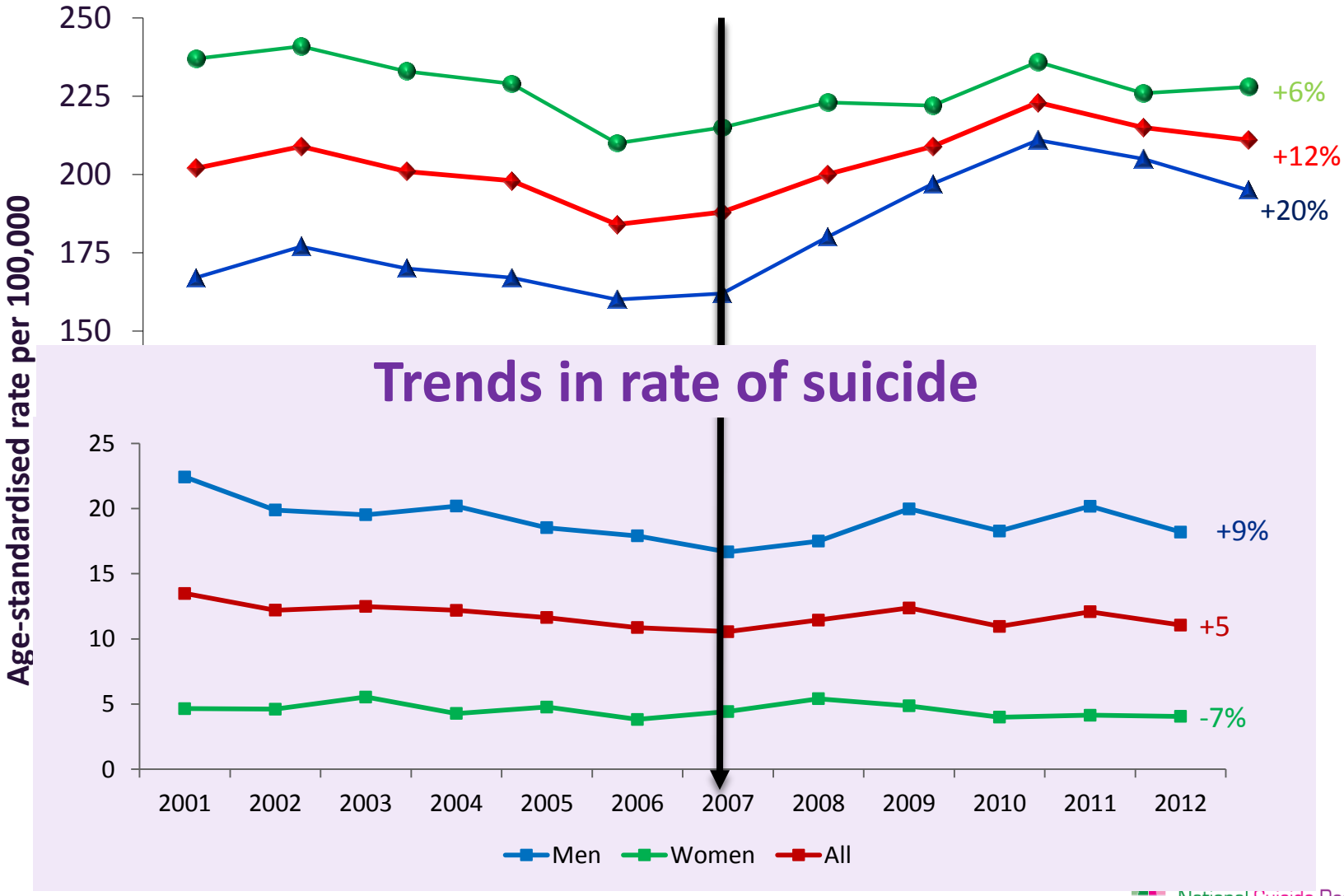
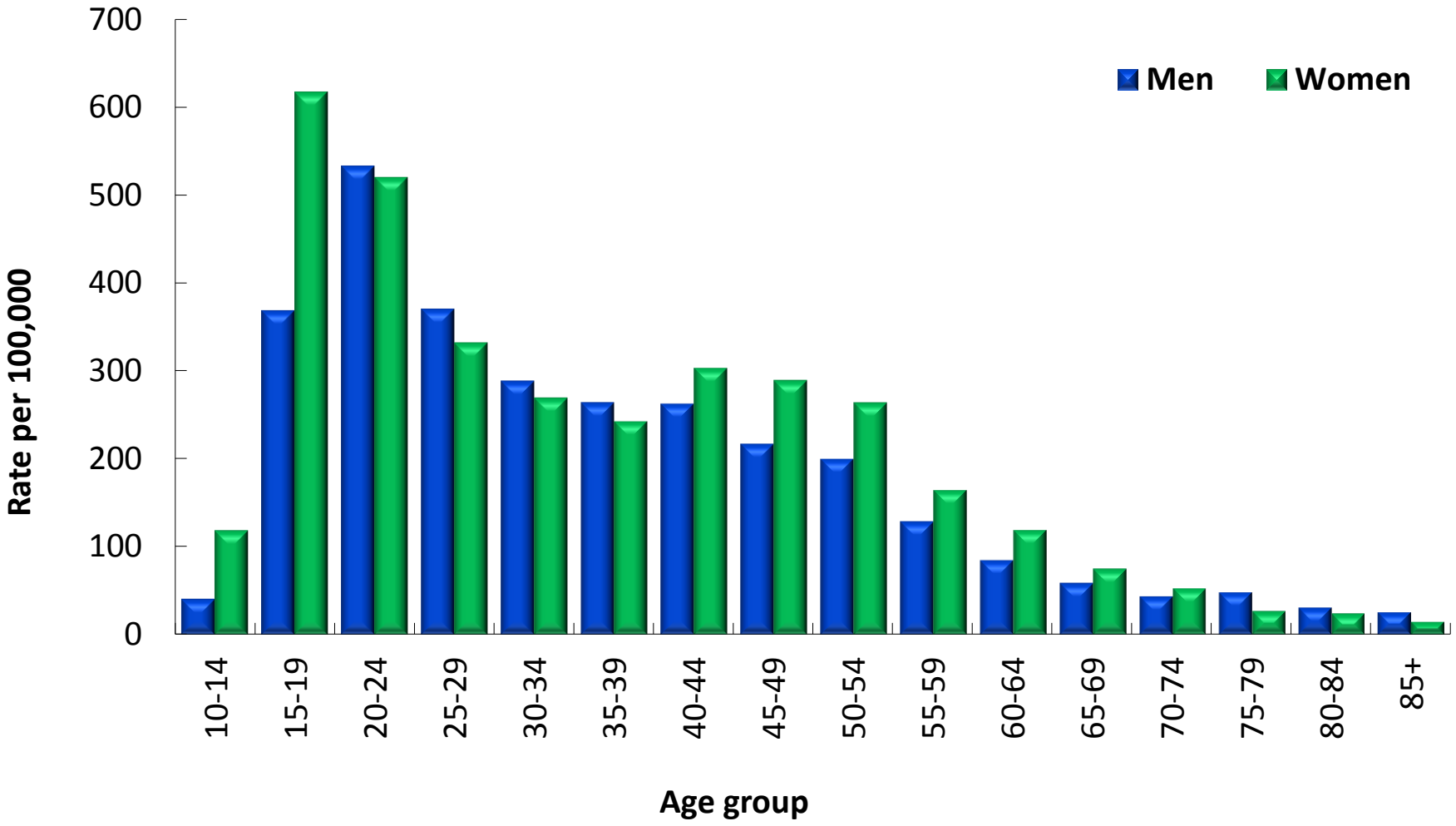
Trends in rates of self-harm and suicide in Ireland



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



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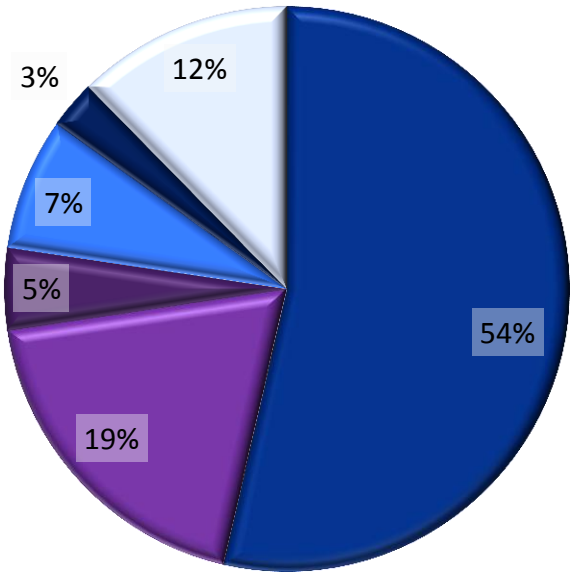
Methods of self-harm by gender

Men



Drug overdose only

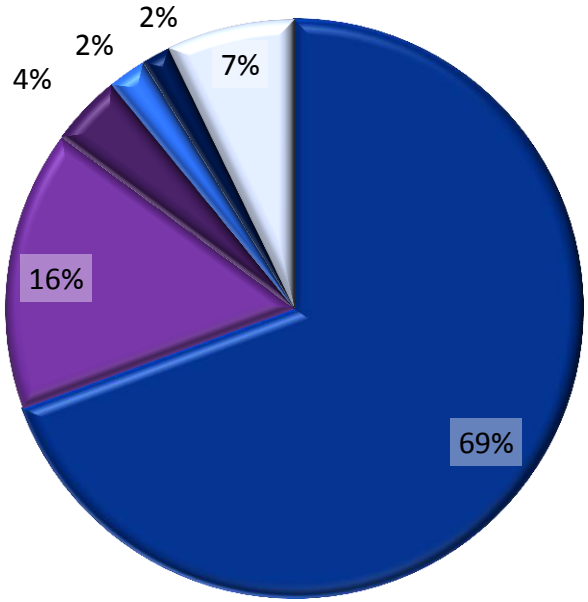
Self-cutting only

Overdose & self-cutting

Attempted hanging only

Attempted drowning only

Women



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

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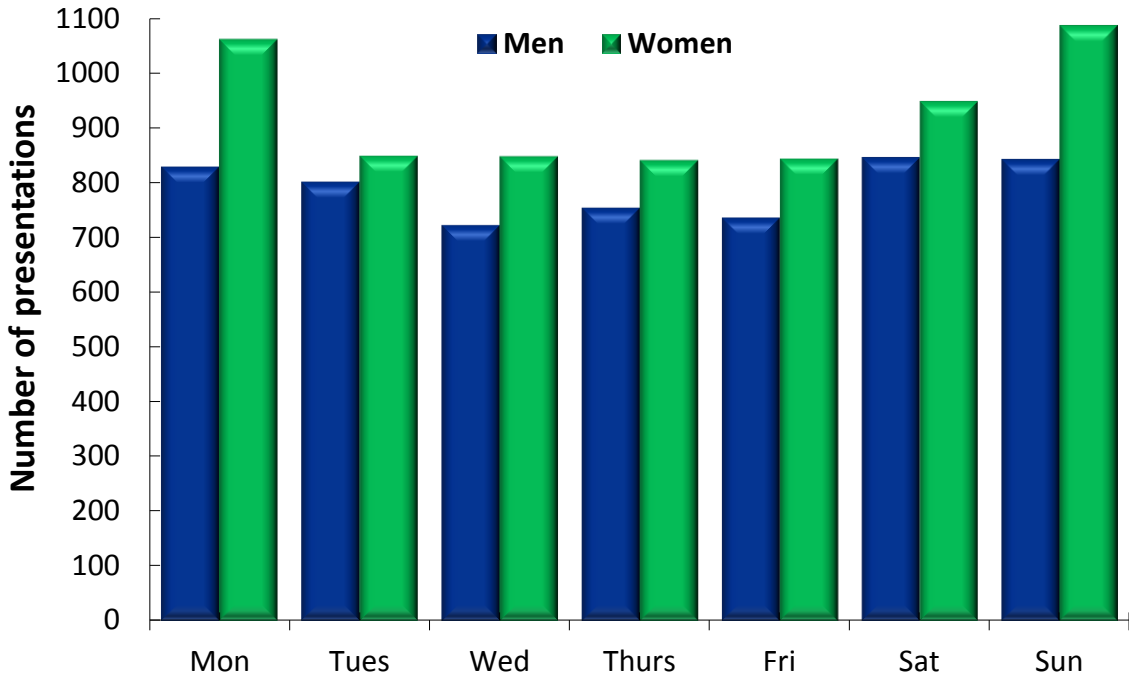
Consistent peaks of self-harm during the year and week

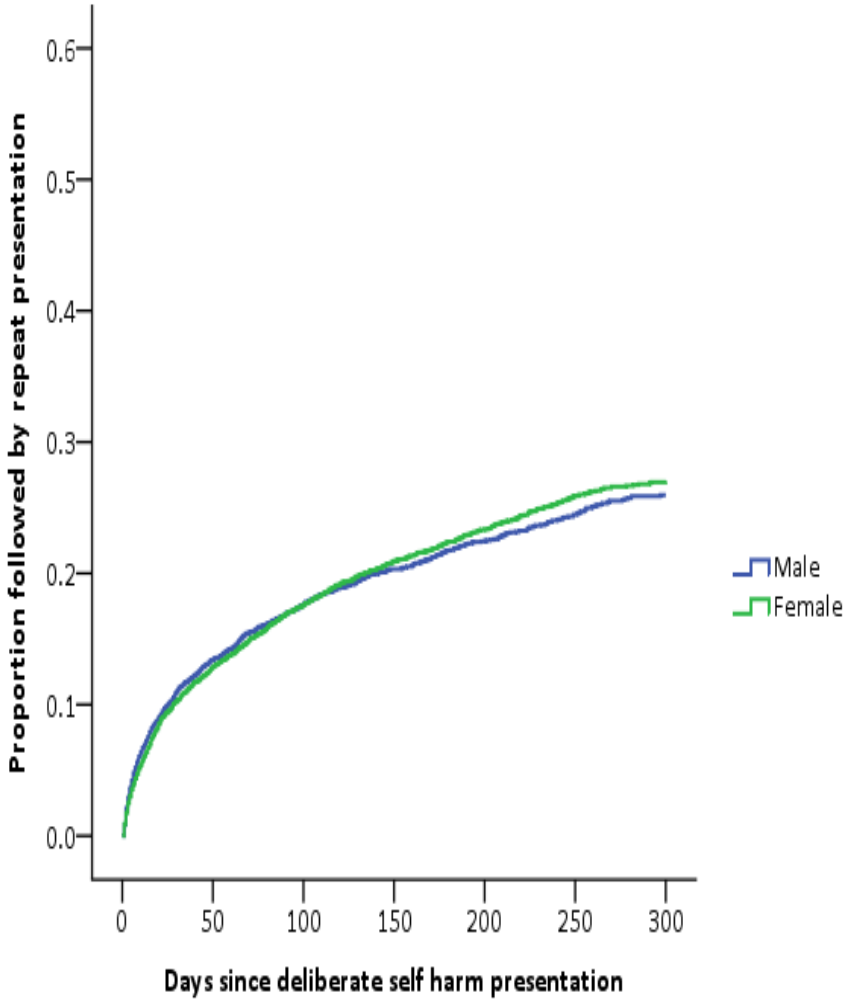
- Average number of self-harm presentations to hospital per day: n=33

- 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

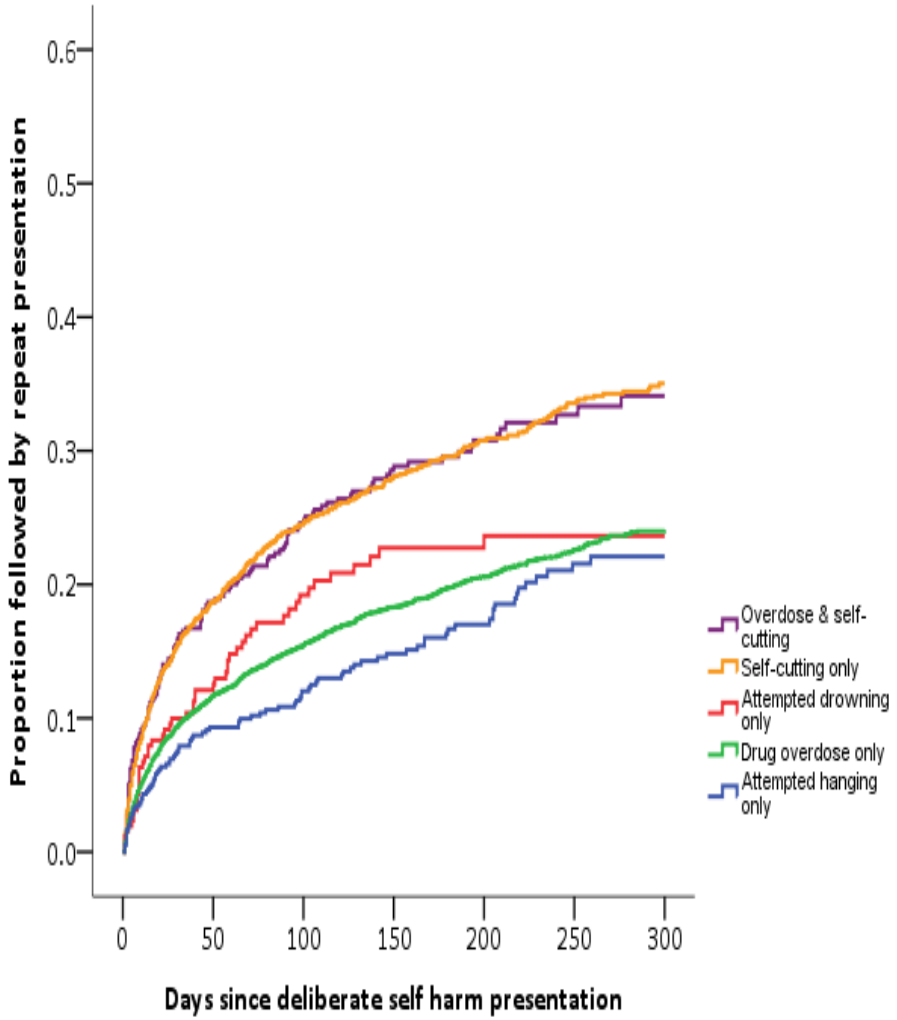
Self-harm by day of the week and gender



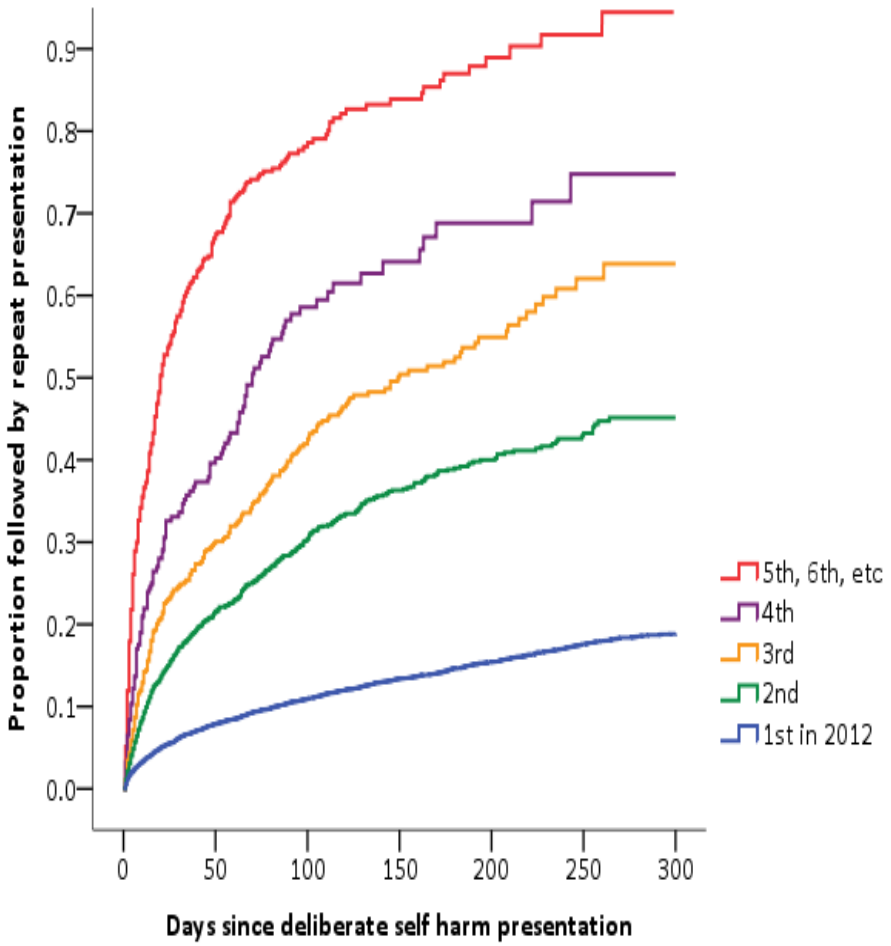
Repetition of self-harm by gender



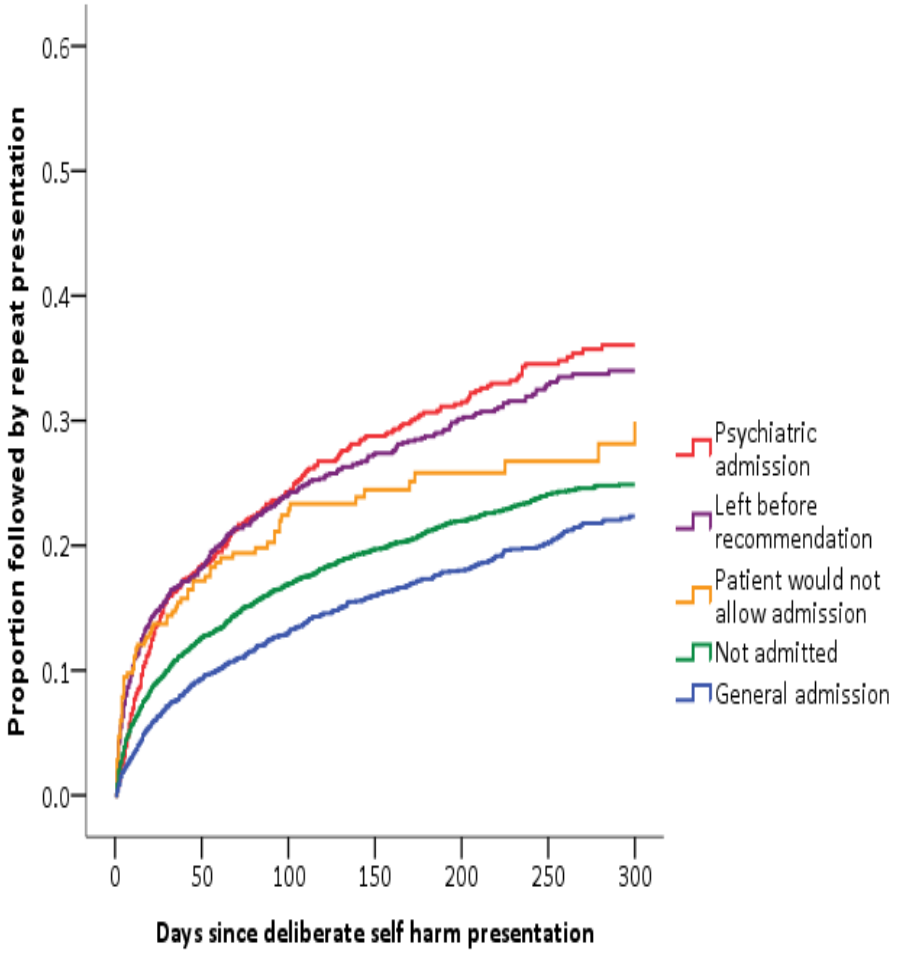
Repetition of self-harm by method



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%

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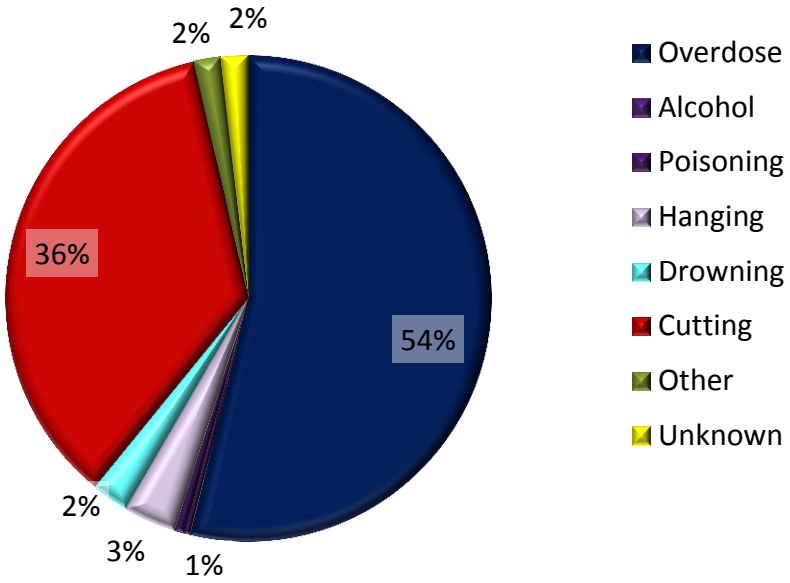
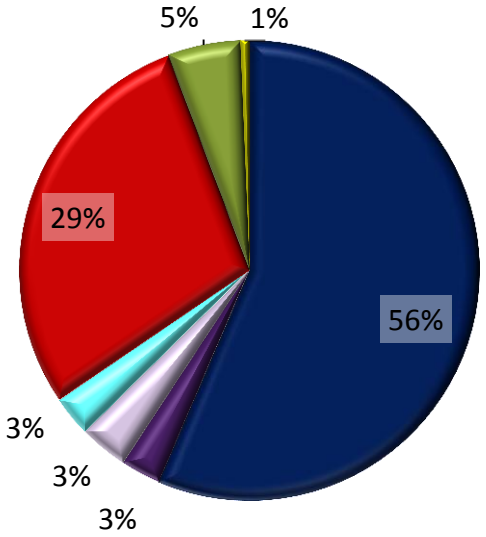
Methods of self-harm among those who repeat 10 times or more (women: 55%, men: 45%)

Men



Women



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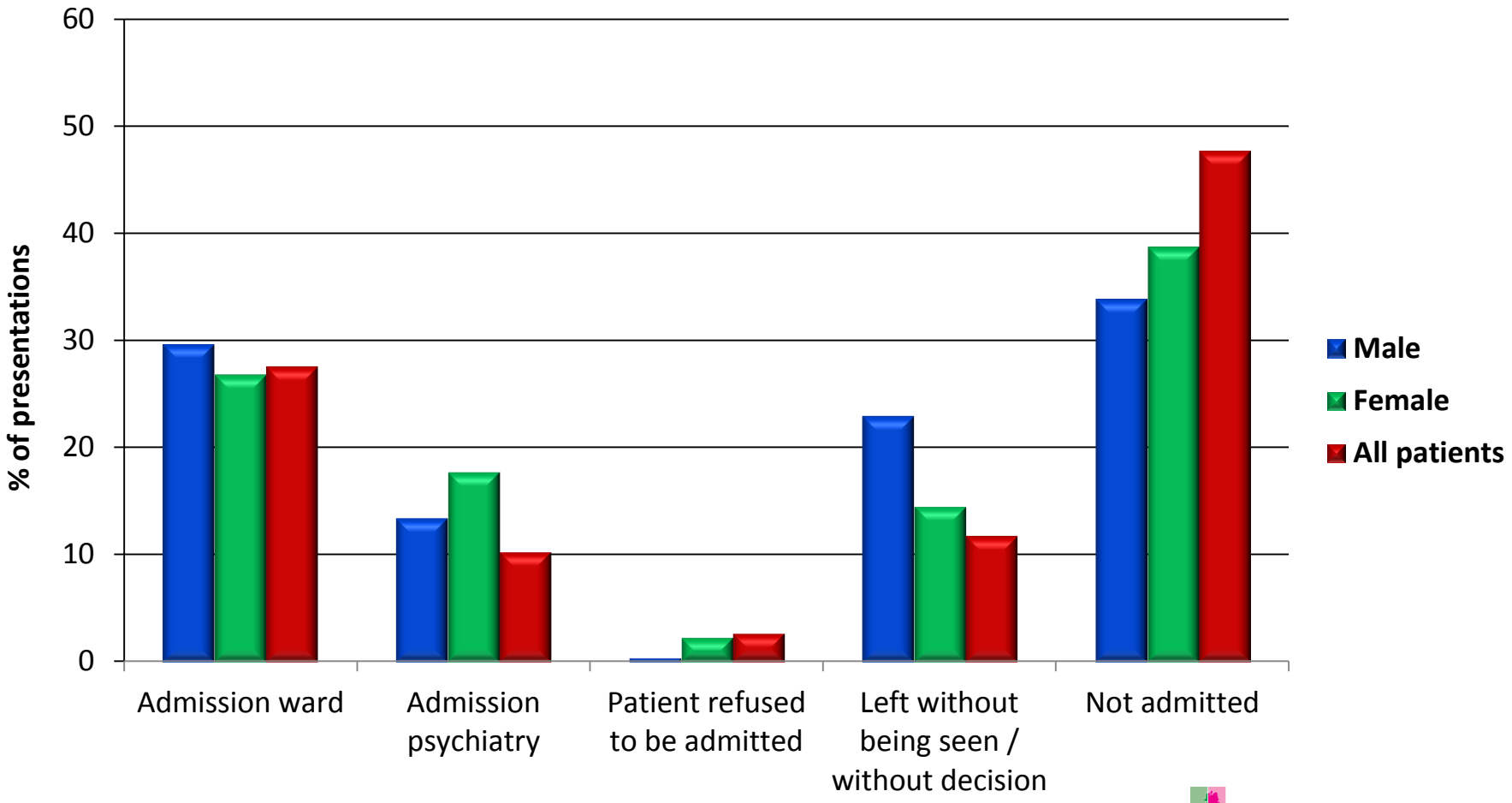
Recommended aftercare among those who repeat 10 times or more



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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

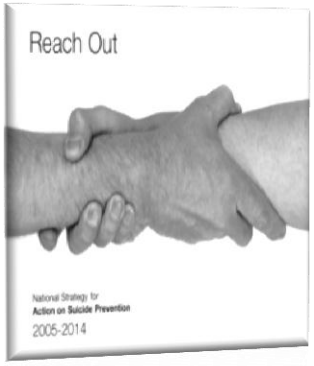
National Clinical Programme for Mental Health

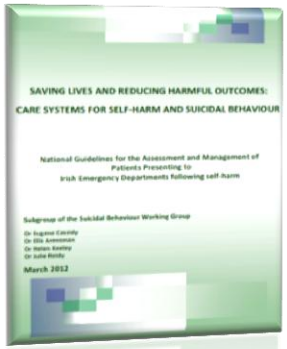
- A programme for the management of self-harm among people presenting to hospital emergency departments

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

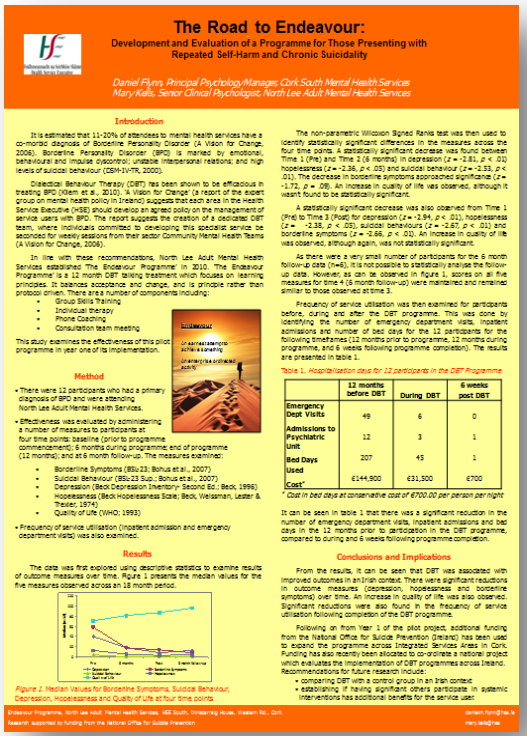
National Suicide Research Foundation

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)



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

Daniel Flynn, Principal Psychology Manager, Cork South Mental Health Services
Mary Kells, Senior Clinical Psychologist, North Lee Adult Mental Health Services

Introduction

It is estimated that 11-20% of attendees to mental health services have a co-morbid diagnosis of Borderline Personality Disorder (A Vision for Change, 2006). Borderline Personality Disorder (BPD) is marked by emotional, behavioural and impulse dyscontrol; unstable interpersonal relations; and high levels of suicidal behaviour (DSM-IV-TR, 2000).

Dialectical Behaviour Therapy (DBT) has been shown to be efficacious in treating BPD (Klein et al., 2010). 'A Vision for Change' (a report of the expert group on mental health policy in Ireland) suggests that each area in the Health Service Executive (HSE) should develop an agreed policy on the management of service users with BPD. The report suggests the creation of a dedicated DBT team, where individuals committed to developing this specialist service be seconded for weekly sessions from their sector Community Mental Health Teams (A Vision for Change, 2006).

In line with these recommendations, North Lee Adult Mental Health Services established The Endeavour Programme in 2010. The Endeavour Programme is a 12 month DBT tailoring treatment which focuses on learning principles. It balances acceptance and change, and is principle rather than protocol driven. There are a number of components including:

- Group Skills Training
- Individual therapy
- Phone Coaching
- Consultation team meeting

This study examines the effectiveness of this pilot programme in year one of its implementation.

Method

- There were 12 participants who had a primary diagnosis of BPD and were attending North Lee Adult Mental Health Services.
- Effectiveness was evaluated by administering a number of measures to participants at four time points: baseline (prior to programme commitment); 6 months during programme; end of programme (12 months); and at 6 month follow-up. The measures examined:
  - Borderline Symptoms (BSI-23; Bohus et al., 2007)
  - Suicidal Behaviour (BSI-23 Sup.; Bohus et al., 2007)
  - Depression (Beck Depression Inventory- Second Ed.; Beck, 1996)
  - Hopelessness (Beck Hopelessness Scale; Beck, Weissman, Lester & Trexler, 1974)
  - Quality of Life (WHO; 1993)
- Frequency of service utilisation (inpatient admission and emergency department visits) was also examined.

Results

The data was first explored using descriptive statistics to examine results of outcome measures over time. Figure 1 presents the median values for the five measures observed across an 18 month period.

Figure 1. Median Values for Borderline Symptoms, Suicidal Behaviour, Depression, Hopelessness and Quality of Life at four time points

The non-parametric Wilcoxon Signed Ranks test was then used to identify statistically significant differences in the measures across the four time points. A statistically significant decrease was found between Time 1 (Pre) and Time 2 (6 months) in depression ($z = -2.81$, $p < .01$) hopelessness ($z = -2.36$, $p < .05$) and suicidal behaviour ($z = -2.53$, $p < .01$). The decrease in borderline symptoms approached significance ($z = -1.72$, $p = .09$). An increase in quality of life was observed, although it wasn't found to be statistically significant.

A statistically significant decrease was also observed from Time 1 (Pre) to Time 3 (Post) for depression ($z = -2.94$, $p < .01$), hopelessness ($z = -2.38$, $p < .05$), suicidal behaviours ($z = -2.67$, $p < .01$) and borderline symptoms ($z = -2.66$, $p < .01$). An increase in quality of life was observed, although again, was not statistically significant.

As there were a very small number of participants for the 6 month follow-up data (n=4), it is not possible to statistically analyse the follow-up data. However, as can be observed in figure 1, scores on all five measures for time 4 (6 month follow-up) were maintained and remained similar to those observed at time 3.

Frequency of service utilisation was then examined for participants before, during and after the DBT programme. This was done by identifying the number of emergency department visits, inpatient admissions and number of bed days for the 12 participants for the following timeframes (12 months prior to programme, 12 months during programme, and 6 weeks following programme completion). The results are presented in table 1.

Table 1. Hospitalisation days for 12 participants in the DBT Programme

	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 Used	207	45	1
Cost*	€144,900	€31,500	€700

** Cost in bed days at conservative cost of €700.00 per person per night*

It can be seen in table 1 that there was a significant reduction in the number of emergency department visits, inpatient admissions and bed days in the 12 months prior to participation in the DBT programme, compared to during and 6 weeks following programme completion.

Conclusions and Implications

From the results, it can be seen that DBT was associated with improved outcomes in an Irish context. There were significant reductions in outcome measures (depression, hopelessness and borderline symptoms) over time. An increase in quality of life was also observed. Significant reductions were also found in the frequency of service utilisation following completion of the DBT programme.

Following on from Year 1 of the pilot project, additional funding from the National Office for Suicide Prevention (Ireland) has been used to expand the programme across Integrated Services Areas in Cork. Funding has also recently been allocated to co-ordinate a national project which evaluates the implementation of DBT programmes across Ireland. Recommendations for future research include:

- comparing DBT with a control group in an Irish context
- establishing if having significant others participate in systemic interventions has additional benefits for the service user.

Endeavour Programme, North Lee Adult Mental Health Services, HSE South, Shrubberry House, Western Rd., Cork
daniel.flynn@hse.ie
mary.kells@hse.ie
Research supported by funding from the National Office for Suicide Prevention

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

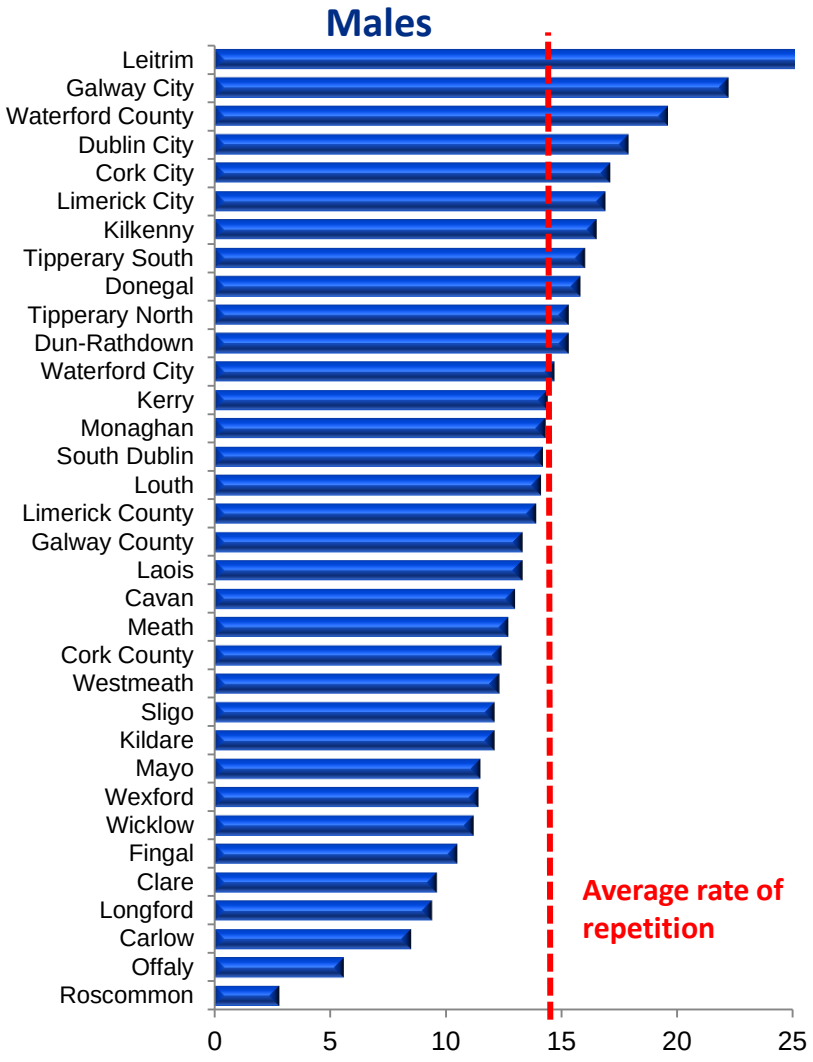
Action plan National DBT project

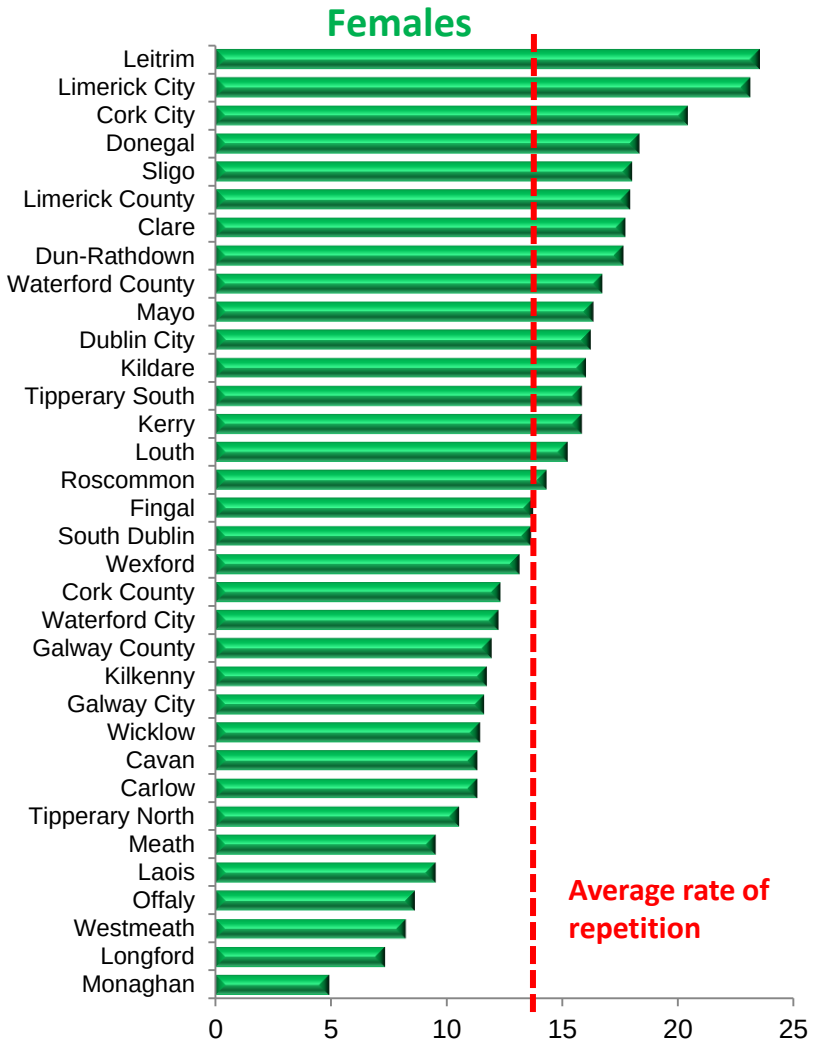
- Training 16 teams nationwide over a period of 2 years

- Teams selected on the basis of their area's incidence of repeated self-harm and local commitment to the implementation of DBT

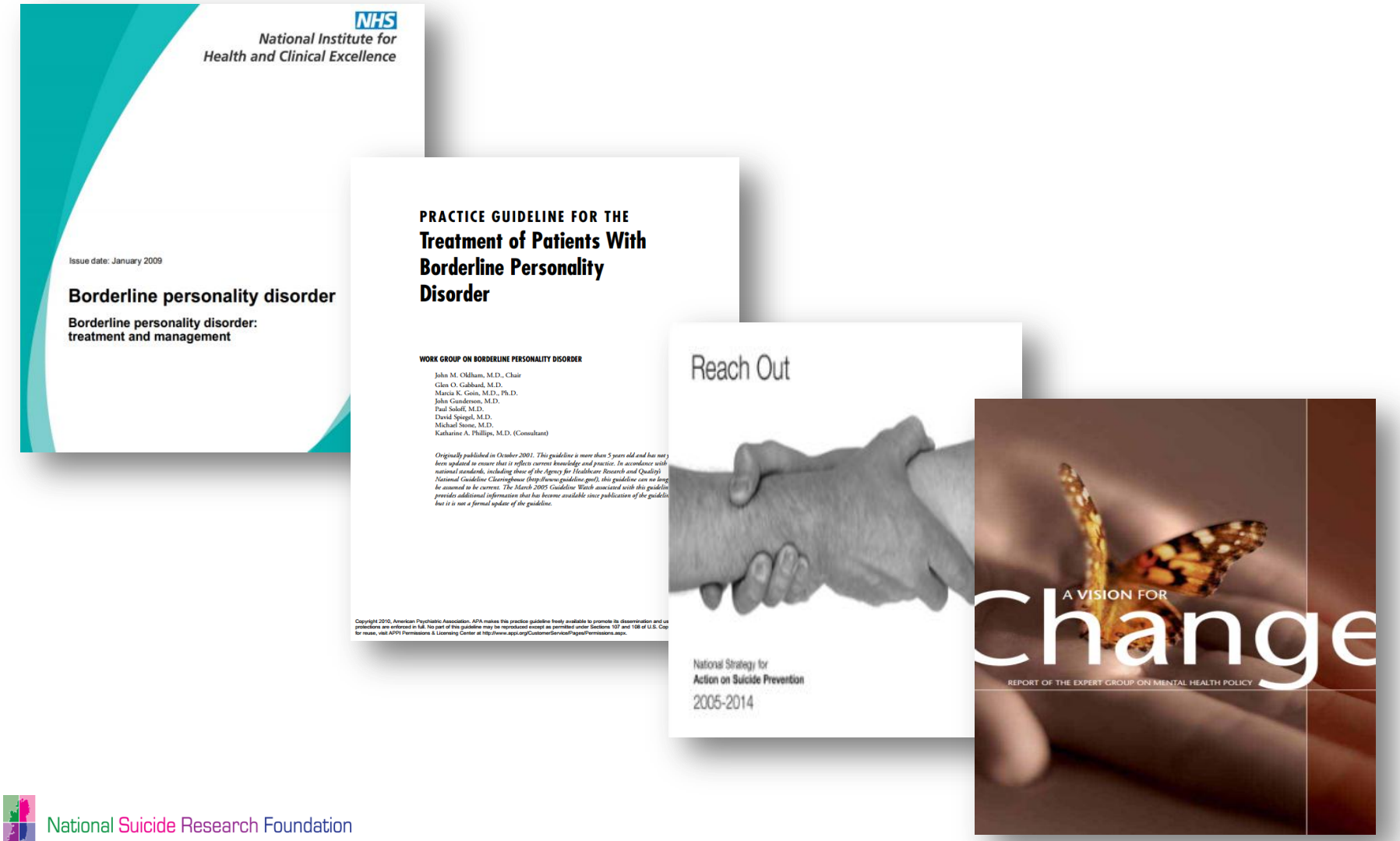
- Teams selected in year 1:
  - 4 adult (AMHS) and 4 adolescent (CAMHS)
  - Teams trained in December 2013
  - Delivery of DBT to start in March 2014
  - Training of further 8 teams in September 2014

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



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*)

Acknowledgements

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- **Health Service Executive:** National Office for Suicide Prevention, Suicide Prevention Resource Officers, Hospital staff, HSE departments/units

- **Department of Health**

Thank you!

Prof. Ella Arensman
National Suicide Research Foundation
Department of Epidemiology and Public Health
University College Cork
Ireland
T: 00353 214205551
E-mail: earensman@ucc.ie
www.nsrf.ie