

SUICIDE IN MODERN IRELAND
NEW DIMENSIONS, NEW RESPONSES

International Prevention Programmes
Friday Afternoon 12 November

**PREVENTION OF REPEATED SUICIDAL BEHAVIOUR:
EFFICACY OF EXISTING TREATMENT PROGRAMMES**

Presenter: Dr Ella Arensman, Medical Director,
National Suicide Research Foundation

Introduction by: Prof. Kevin Malone

Kevin Malone: "You are more than welcome to the 3Ts Conference following the official opening ceremony by President McAleese. I certainly for one was significantly touched by the compassion, sincerity and forthright views that she put out there and it certainly is going to be a valuable resource for the people of Ireland that she's taken on this particular issue as one of her important issues of her next Presidency and we certainly are going to do all we can in that regard.

A little word about the conference. We put this together over the past couple of months and we being the 3Ts, Turning the Tide of Suicide, a sort of eclectic movement mixture of science, business, education, administration, concerned people who wanted to try and help. We have been involved in awareness for the last year or so and we decided that it would be a good time to try and move from awareness into education and knowledge. With that in mind, I was given the task of putting together a conference that might pull together some strands from society, not necessarily Irish Society but from society that would go beyond the standard debate about suicide which is obviously one that's filled with grief but it is also one that people have experienced in different countries; people have seen responses in different countries; different people in Ireland have been thinking long and deep about the problem about suicide in Ireland but haven't necessarily addressed it as some other people might have. So we decided to put together a conference that embraced the science, arts and humanities, youth, vulnerable groups, the aftermath and international prevention initiatives. So that's really the programme that went out. We got the programme out in a hurry over a month ago and so there are people who have been just hearing about this in the last week or so and for that we're sorry that we didn't get the voice out longer but it's a very difficult signal to noise problem in Irish society trying to get your voice out there that you have a conference going on when everybody else is saying that there are other things going on as well. We are so delighted that you all signed up and joined and will be with us for the next two and half days, hopefully, as you choose.

The other model that we chose and it is important and that is a 'leave your ego at the door' type conference so this is not about experts and non-experts. This is all about people in the one conference together sharing, as President McAleese said and we didn't prompt her, sharing pieces of the jigsaw with a view to gleaning new knowledge, new information, hearing about new initiatives and in that way trying to make a contribution to the field.

We are taping the proceedings and we'll have those proceedings made available in due course. They won't be available overnight but they will be made available at some point in the future. So are plan is to reach out to a new audience, present new ideas, international and local, we want to hear new voices from the arts and humanities and we want to share new knowledge.

I should say that all the contributors have agreed to be here voluntarily and for that it is no insignificant point. Anyway, I'm not going to dwell anymore because I'm the Chairperson and I'm meant to be looking after time and we've done reasonably well on time given the opening ceremony.

We're going to move on to the first session which we broadly titled 'International Prevention Programmes'. Our plan was to put together an Irish dimension and then an international dimension and so we invited from the National Suicide Research Foundation in Cork, Dr. Ella Arensman, who is the Medical Director of the National Suicide Research Foundation who has been with them for about a year now and has been previously in active research in the University of Leiden and also studied in the UK. She has been putting together a collaborative research programme particularly on studying suicidal behaviour and understanding more about suicidal behaviour. Then we'll follow that by Prof. John Mann's presentation so without any further adieu, could you please welcome Dr. Ella Arensman. Thank you.

Dr. Ella Arensman: Thank you very much Prof. Malone for introducing me and also thank you very much for asking me here to contribute to this very important conference today and in the coming days. Also thank you very much to the organising committee and all the people who are here today.

I agree very much with Prof. Malone that the speech by President McAleese was very focused and also very much committed with the topic of suicidal behaviour. In my presentation, I really hope that I can contribute to some aspect of the jigsaw puzzle because I honestly believe after many years in this field, both from the point of view of research but also clinical work, that there is no single discipline or not a single intervention that can really address the issue of suicide and suicidal behaviour on its own. This is a very specific difference with some more specific types of psychopathology and definitely very different from some medical diseases. One correction to make, I'm not a medical director. I'm originally a clinical psychologist. I did a lot of research over about 15 years with some clinical training as well but I'm not a medical director. I am research director with the National Suicide Research Foundation since September last year.

A few words about the National Suicide Research Foundation. I'm not sure if everybody is familiar with it but the National Suicide Research Foundation was set up by Dr. Michael Kelleher in 1995. Dr. Michael Kelleher can definitely be considered a pioneer in the field of research but also prevention work in suicidal behaviour in Ireland. Particularly thinking of the timing when the National Suicide Research Foundation started, it was only 2 years after the decriminalisation law and I think because of the, let us say, easiness with which Michael was able to address the issue and bring it to the audience, I think that has been an important aspect in that period of time. I have met Michael many, many times and I think he does a great job. Unfortunately, he didn't have a lot of time because he died of cancer in 1998 and it is wonderful that so many people were able to continue his work until today and that it is now expanding very broadly.

Also, only a very few words about the work we do in current times. Our main focus is research, firstly, in the area of epidemiological or etiological research. In lay terms it is to determine the extent of the problem but also to see what are the specific high risk groups in different settings and in the population and also to follow trends over time.

Research Strategy NSRF

Descriptive Epidemiological / Aetiological Research into Deliberate Self Harm and Suicide, e.g.

- National Parasuicide Registry
- Child and Adolescent Self Harm study
- Socio-ecological factors associated with suicide

Research into the efficacy of intervention and prevention programmes for depression, deliberate self harm and suicide, and attitudes towards suicidal behaviour and its prevention, e.g.

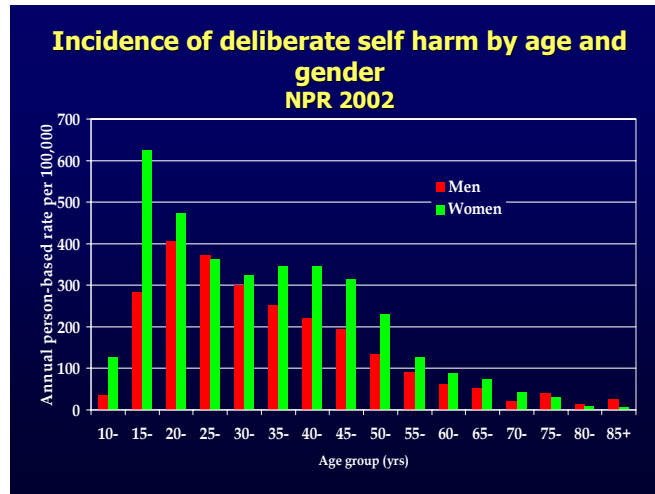
- RCT Cognitive-Behavioural Therapy for DSH patients
- Pilot four-level community based intervention
- Attitudes towards suicidal behaviour and its prevention in different professional groups

Many of you might be familiar with the National Para-Suicide Registry. I will get back to the findings a bit later on. This study was an idea of Dr. Michael Kelleher but after his death it has been continued by Prof. Ivan Perry, Paul Corcoran and Eileen Williamson have also done a lot of work in setting up this registry. The registry is actually a very unique study because Ireland is currently the only country in the world with a nearly nationwide registry of non-fatal suicidal behaviour and a lot of people here might not know but I have been involved in a registry in the Netherlands but it was only one region which is the case in most countries. Suicide data nowadays is available in all countries from the Central Statistical Offices but this is an important point to make.

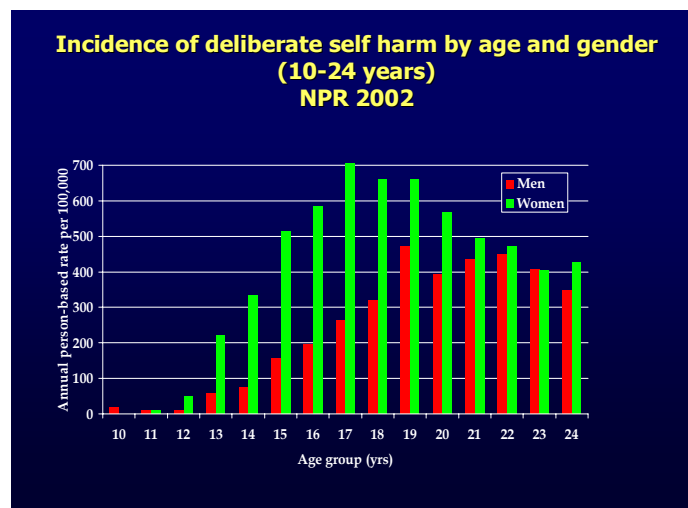
Another example is the Child and Adolescent Self Harm Study of which we recently launched our first report and that was also a major study in the Southern Health Board where we examined deliberate self-harm in 15-17 year olds by going into 39 schools. Dr. Helen Keeley who is coming here tomorrow will present the first findings of this study at this conference.

Another piece of important work is socio-ecological factors associated with suicide because we all know that it is not only the individual aspect but environmental aspects play an important role as well. These are only a few examples. The other important layer or avenue of research is research into the efficacy of intervention and prevention programmes both for depression, deliberate self-harm and suicide because these phenomena are very much inter-related. This is still a very young area but we think it makes a lot of sense to have these two areas combined so during my presentation I will present findings of some of the initiatives here as well.

There is an important point I have to make during my presentation. Unfortunately, I have to start with negative news mainly related to the extent of the problem in specific risk groups. However, I'm actually quite happy because before preparing this presentation I went back to most recent years and looking at relevant intervention and prevention programmes and I must definitely admit that in the last 7-10 years enormous progress has been made in the area of finding important intervention strategies that really seem to be effective so I hope that I can end with a positive note and that that note can be part of the jigsaw puzzle.



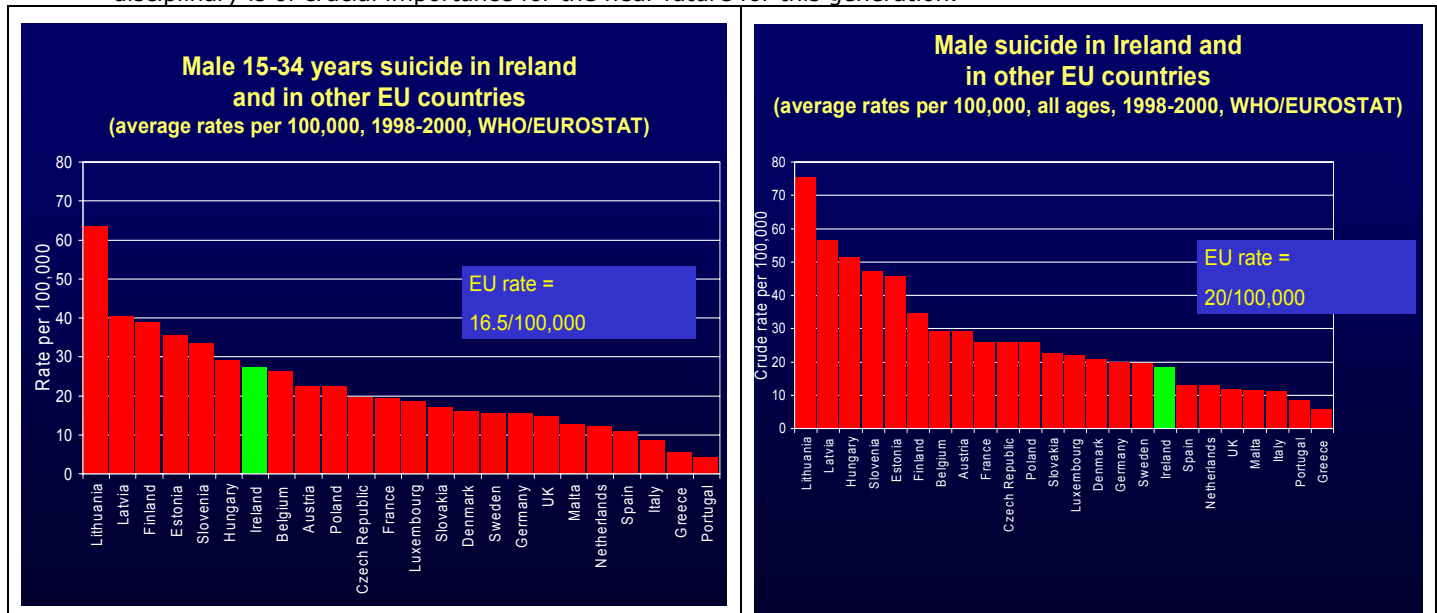
Looking at the incidents of deliberate self-harm in Ireland based on the National Para-Suicide Registry, we see that deliberate self harm is extremely high in the young females. A rate of over 600 per 100,000 which you see in the age group 15-19yrs is extremely high. Not only, locally but if we compare that with other countries, we can consider Ireland to be fourth or fifth highest in Europe with regard to these incidents. One important clarification on the term 'deliberate self-harm', this is nowadays used interchangeably with suicide attempts and we prefer to use the term 'deliberate self harm' because there are many more motives playing an important role than only the wish to die. I come back to that later in giving you an overview of the different motives.



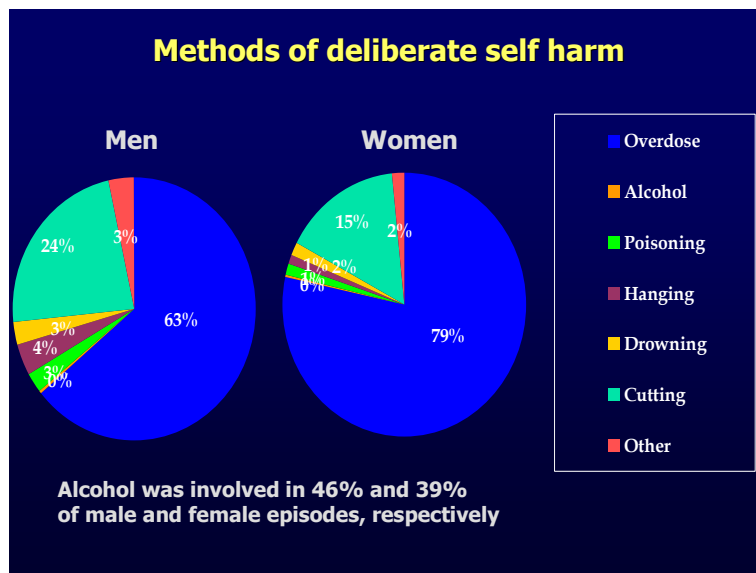
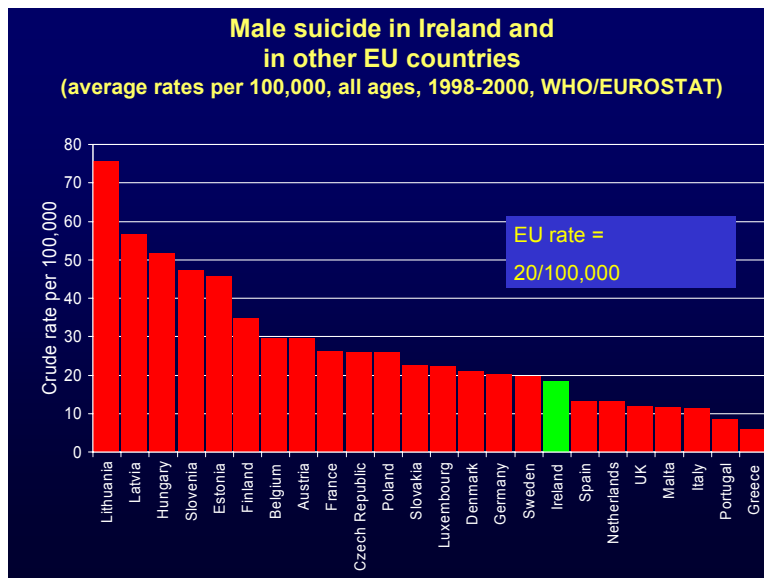
In terms of seeing the different rates for the females and males, we shouldn't be biased by the graph in saying the rates in young males are quite low or relatively low. Again, if we compare that to international standards, a rate of over 400 per 100,000 for boys or young adult men in the age group 20-25yrs is very high. Because of that high risk young age group, I also took with me a slide to look at the specific ages and to see are there any important fluctuations in this particular age group. Here we start even with the age 10 yrs and you can see there are. So females of the age 17 yrs have a particularly high risk followed by those you are 18 yrs and 19 yrs so even the rate of 700 is extra proportionally high. Also, as a kind of reference, if you look at the rate among girls 13 yrs, it is just

over 200. By the time I left the Netherlands, this was a rate which wasn't even visible or observable in adult females in the Netherlands, so you have an indication of extent of the problem here.

A very important point I want to make here is many, many studies, I would say sufficient studies, nowadays have been pointing at the importance of the relationship between having been engaged in one episode of deliberate self harm and the risk for repetition or also the risk for suicide and that is one of the strongest connections we see throughout the research in many different countries. If we take this as a piece of information, then I think the perspective for the future at the moment is not positive at all. Combining the relevant interventions that seem to be effective and to be much more multi-disciplinary is of crucial importance for the near future for this generation.



Moving from deliberate self harm to fatal suicidal behaviour, I picked out this slide particularly to show you the figures with regard to males because if we compare non fatal to fatal suicidal behaviour we see that the gender pattern is completely reversed. This is the same pattern in most of the countries worldwide with a very clear exception of Finland. We see that their males have a higher rate for deliberate self-harm compared to females which is different from any other country. If you see this figure we might be misled by the information that has already been given also during the speech of the President because here we are looking at the total rate for suicide based on the period 1998 – 2000 comparing to other countries. But it is only the total rate and we see that Ireland is then just below average for the males. If we then look at the rates in the particular age group 15 – 34 years there is a huge shift from almost being just below average to being really above average and among the countries with the highest rates in Europe. I did not bring a slide for the female suicide rates but that is significantly lower compared to the men. Although I must say that in recent years when we saw the increase of suicide in males, there was also an increase of suicide in females. I do not want to show too many statistics because I also want to move on to more specific details and what we can do about the problem.



To give you an idea of what sort of behaviour we can think of in terms of deliberate self-harm, these are also findings based on the National Parasuicide Registry and you see that in those men and women, the most frequently used methods of deliberate self harm is taking an overdose of medication. However, it is important to note that this is very often in combination with the intake of alcohol. We don't yet know all the details there but one particular problem might be that there is a disinhibiting effect from alcohol. So losing more control when you drink more might lower the threshold of taking medication even at a time when you are not even sure if you want to undertake the act or want to take the medication. This might be one of the explanations of why we see so many, let us say, cases of deliberate self-harm in weekend hours. Again, I don't want to bombard you with statistics but we see that the peak rate of deliberate self harm is starting Saturday night and continues to early Sunday morning.

Another important aspect to note is there is even a significant difference between males and females in terms of self-cutting and this seems to be a very typical Irish phenomenon because in most other countries self-cutting, repeated cutting, is very typical for females and particularly females with personality disorders eg. borderline personality disorder. Even the UK figures, because there are some similarities with regard to the rates between Ireland and the UK, do not see this strong pattern of self-cutting in Irish men. We are currently preparing a new research project to investigate this in more detail. It might be that there is also a stronger link there with alcohol but we simply don't know the definite answers here.

Motives for Deliberate Self-Harm

Categories of motives:

Range:

- | | |
|--------------------------------|-----------|
| • Wish to die: | 44% - 72% |
| • Losing control: | 38% - 70% |
| • Appeal / cry for help: | 39% - 46% |
| • Making it easier for others: | 27% - 43% |
| • Self-punishment | 25% - 39% |
| • Revenge: | 10% - 27% |

❖ *Often more than 1 motive reported at the same time.*

What about motives for deliberate self-harm or non-fatal suicidal behaviour? This is a range based on many different studies which I have been looking at. You can see that 'wish to die' is still one of the most prevalent reported motives but it is definitely not the only one. Losing control and an appeal or a cry for help to the environment or to healthcare services is also an important one; making it easier for other self punishment and revenge.

In some of the studies they have not really investigated are there individuals who engage in this behaviour and who only primarily report a wish to die. There is not too much evidence on that but when we finalised our first analysis on the school based study which I previously mentioned in the Southern Health Board, we looked this issue up and we couldn't find a case where 'wish to die' was reported as the only main motive. It was always in combination with other motives liking losing control or having an appeal or cry for help. This is important information, especially for people working clinically with this population because it is quite unlikely that suicidal behaviour occurs from one second to another. Of course, we know of impulsive behaviour, but if we look back then we always see certain important vulnerability factors. Impulsive suicidal behaviour is a bit more typical for males compared to females, especially certain groups but reporting contradictory motives definitely reflects ambivalence. People do not only express the wish to die. I recently got a short report from a well known Dutch writer. He has been writing a biography and he had manic depression throughout his life. He doesn't even know how many times he was engaging in an act of deliberate self-harm but he said 'One thing I know and am completely sure, on none of these occasions I wanted to die. I simply wanted to have a different life.' I think that is important to take into account because I think as long as there is ambivalence, there is scope to change and scope to reverse the pattern.

During a number of long term studies I have been also really trying to get a detailed picture of what is happening on the spot when somebody thinks of taking an overdose, thinks of other aspects for example getting help and then actually does it. Many people said "if by the time there was my GP or I could speak to that person, maybe I wouldn't have done it", so the closer connection with relevant people and perhaps firstly the relevant healthcare people is still something I think that can be and should be improved.

Briefly, because Prof. Mann will say more about international prevention programmes, I recently came across an overview of the effectiveness of existing suicide prevention activities. For most of the larger suicide prevention activities, we still don't know whether it is really effective in reducing different types of suicidal behaviour. However, there are some promising examples. I was recently at the IAS Conference where a person from Finland was presenting the findings on their National Suicide Prevention Programme and they were one of the first in Europe to have such a programme in place. They found a reduction in suicide following the implementation of the National Suicide Prevention programme but it still was difficult to say to what extent was the change and the reduction in suicide specifically related to putting in place the National Programme. They were not able to detect whether there was a change with regard to the non-fatal suicidal behaviour because they simply did not record it as a base line and a follow-up assessment but it is at least a promising example of a National Prevention Programme.

Very, very recently Prof. Keith Haughton from Oxford published a very interesting article, you should all look it up. It is in the British Medical Journal, only one or two weeks ago. They published the result of a policy change in altering the sales packages of analgesics and the most important one is Paracetamol but it has been expanded to Ibuprofen and other types as well. They saw a huge decrease in suicide but also in non-fatal suicidal behaviour and they had a very strong baseline and a very strong follow-up assessment. It was important news. Although we know that it is not the only avenue to walk along to get effective or reduce this behaviour, I think it is an important one to take into account. I was working with Prof. Haughton for one year and at that time, in 1996, he said they were struggling with the problem and that Paracetamol was one of the most fashionable or popular methods among young girls.

Even at that time when I worked with some people from a local hospital, they said that if they come in and they have a triage and they walk out, they can buy a big bottle of paracetamol when they are out almost on the door step. So that has changed with apparently very good findings. So it is not only negative.

There are some methodological problems in being able to measure whether your programme is effective or not and with many of these programmes the populations are too small and the follow-up is not long enough to really see if there is any outcome in the end.

Another very important aspect which I would like to address with an example of a positive programme, is we sometimes forget that so many people need help or could be helped very positively if we saw them in the health services at a very early stage, because very often you see them at the very end of a lot of misery and problems. This is underlined with an important finding that a majority of people with depression are either still misdiagnosed or not diagnosed at all. In the Southern Health Board study, in young people aged 15-17, there was a relatively large group, 11% of a very large sample, who reported self harm and of that group only 85% had been in contact with a healthcare service either before or after the act of deliberate self harm. This was one of the main outcomes of the study. Apparently there is a hidden population we need to discover in time.

The authors who did this review also conclude as well, there is not one particular prevention route that seems to be the best and the only one, so there is a need for multidisciplinary and multilevel approaches. Perhaps it is not a coincidence that Dr Althaus & Prof Hegerl have developed a new approach, actually very recently and only in the last year the first findings became known. We are actually at the moment participating with them so I would like to show you the example of that study. Before we go over to repetition and because of the very important link between a first attempt and a risk and the increased risk for repetition, I would like to try to give you an idea of what we could do in terms of preventing a very first episode of deliberate self harm.

Review of existing Prevention Activities for Suicidal Behaviour Althaus & Hegerl, 2003

- Except for a few intervention/prevention programmes, there is little evidence for the efficacy of suicide prevention activities (partly due to methodological problems)
- Absence of *long-term* follow-up studies examining the efficacy of intervention/prevention programmes
- Many people at risk do not get in contact (in time) with health care institutions
- No single approach by itself seems to contribute to a substantial decline in suicidal behaviour
- Need to investigate the efficacy of multi-level (multidisciplinary) intervention / prevention programmes

The people in Germany have developed a couple of years ago a so-called multi level or a 4- level community based intervention programme initially for depression but they broadened this to suicidal behaviour as well simply because of the inter-relation. They did a pilot intervention in the area of Nuremburg with a control region in the nearby region or Wurzburg. The unique aspect of this was first of all that they combined so many different levels in one and the same programme with a core level of addressing or increasing awareness and also improving skills among general practitioners supporting the high risk groups, as well as self-help activities. One important risk group is the deliberate self-harm patients themselves. It proceeded with training of a large group of community facilitators, e.g. teachers, priests, ambulance service, police etc. They also had a public relations campaign informing people about depression and suicidal behaviour. I went through all their material and it was very simple sometimes but they had a very wide range of posters saying "Depression can be Treated" because from an attitude survey among a large group of the population which they did before, a lot of people felt once you are depressed you will really never get over it or your relapse is already waiting as soon as you think you might get better. Especially if we look at treatment interventions of the past year including also pharmacological treatments, it is definitely possible to treat depression so they want to get across that message very clearly.

Pilot study: Efficacy of a 4-level community-based intervention programme for depression and suicidal behaviour

(Nuremberg – Wurzburg, Hegerl, Althaus et al, 2003)

- Two-year intervention programme in the area of Nuremberg at 4 levels:

- 1) Training of General Practitioners and support through different materials
- 2) Support for high risk groups as well as self-help activities
- 3) Training of community facilitators (e.g., teachers, priests, ambulance service, police)
- 4) Public relations campaign informing about depression and suicidal behaviour

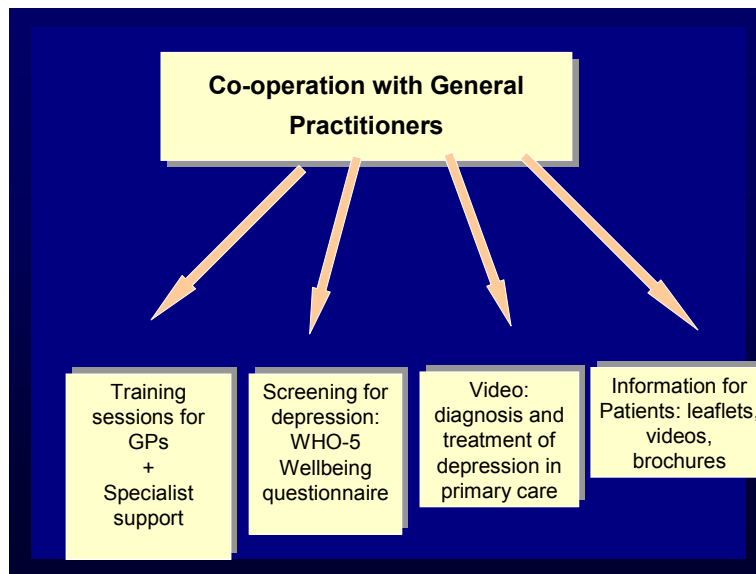
The testing of this pilot intervention was done by having a one year base line and a controlled region and they had four main outcome measures:

- Change in deliberate self-harm and suicide;
- Changes in the public opinion (stigmatisation), they also really wanted to work on the stigmatisation which I came across in Ireland as well, especially among young people. That still seems to be a big problem nowadays;
- The number of referrals from primary care doctor to specialist;
- Prescription of anti depressants and other psycho active drugs.

I would like to make one critical comment. Already in addition to Germany, this study has been piloted by Prof. Moritius in Slovenia and they found a huge increase in the prescription of anti depressants over 2 years. On the one hand they say this is great but I think we have to be careful, especially if at the current time we say we have to collaborate and we have to bring the different disciplines together in order to optimise the care for depressed people and people who harm themselves. So I think if we look at the outcome measures in a more moderate way, I think as long as we can do that I think that would be wise.



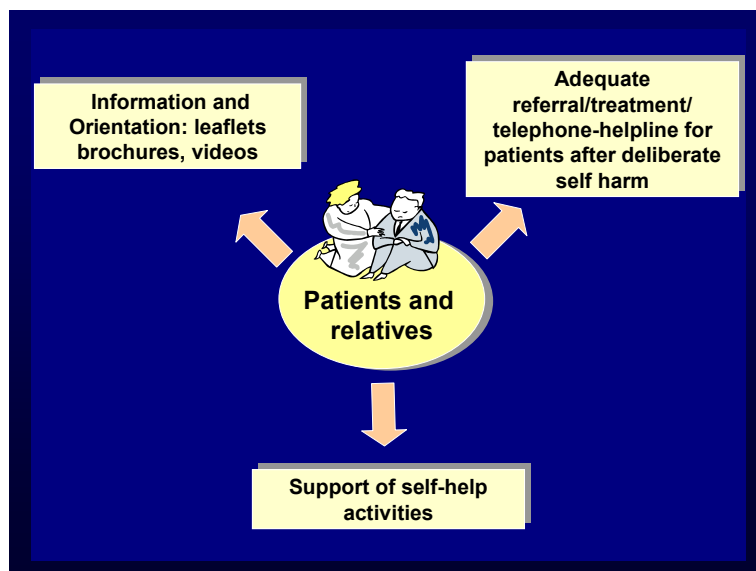
This is an overview of the network they set up in the area of Nuremberg. Firstly, it was an experience for them to find out what sort of activities are already going on because the intention was not to reinvent the wheel. So they got some funding initially and if there were relevant activities for example carried out in the psychiatric hospital, they were there to facilitate this as well. They had this group or representatives of these groups in an advisory panel to hear from them what their needs were or how they could work better together to optimise the care. As an example, having GPs together with a number for instance other services like social workers and also psychotherapists, would be important to diminish the gap. There are so many gaps where in particular deliberate self-harm patients fall in very quickly after an attempt and the risk of repetition is the highest in the first few weeks following an initial attempt.



With regard to the level of GPs, they had quite an intensive approach with four main aspects.

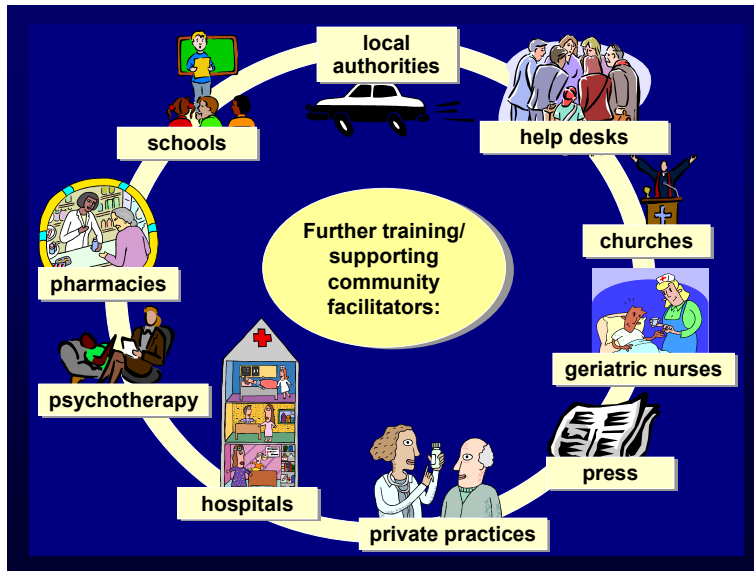
- *Training:* We called it training but you could also call it working with the GPs because it was very interactive. They wanted to know what their needs were and then they addressed this in training and in a type of workshop. They provided specialist support during the 2 years. There was a telephone line available with the group. If they had a complicated case they could call and ask for advice.
- *Screening for Depression:* They have used a highly sensitive measure so it is not really specific but at least also to facilitate communication about the possible presence of a depressive disorder or maybe indications for suicidal behaviour.
- *Video:* They also received a video, but this was more to let them repeat the information that was worked on in the workshops on depression but it also included information on suicidal behaviour.
- *Information:* In addition to that there was information leaflets for patients to hand out but they were very clearly instructed on how to transfer the information, not just giving it almost blindly at the door step but it was part of a coherent approach.

During the 2 years, they trained nearly 80 GPs in the area of Nuremburg and they also kept contact with them in terms of the evaluation and in terms of the changing attitudes.

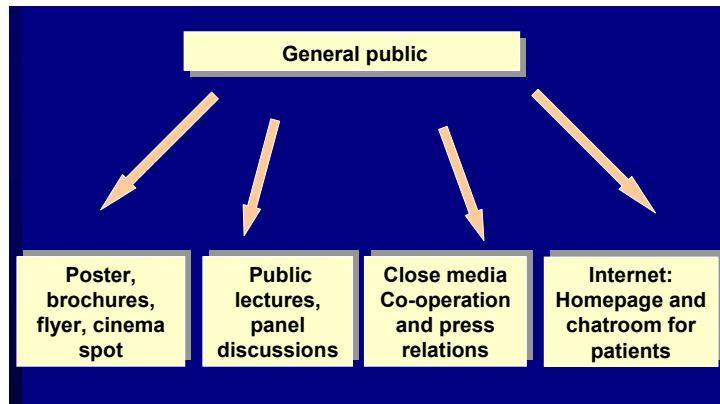


- At the level of high risk groups, specific intervention was to facilitate the referral and the treatment and also to put in place a telephone help-line which was distributed among an emergency card.

- *Support of self help activities:* In recent times in Ireland I received many calls from people, not of victims, we also receive calls from people who lost somebody by suicide, but also people who were confronted with people who repeatedly harm themselves and say there is nothing for us so that is an avenue for more work. So they addressed that area also intensively.
- *The community facilitators:* In the 2 years they trained over 2,000 community facilitators in that particular area. Also by the concept of training the trainers so they couldn't do all the work themselves but it was by that concept also to get it implemented in the area.

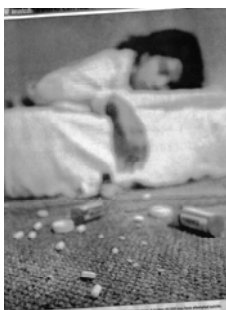


The general public was addressed by I think at least 150,000 leaflets and brochures, a very intensive approach: cinema spots, television, radio interviews, public lectures, close media cooperation.



I would like to highlight this also in the Irish context because I have only been here a year and sometimes I think there might be differences between countries but the media especially in relation to young people who are vulnerable could be very let us say suggestive and I think that's an important aspect to take into account. Dr. John Connolly has been doing a lot of work on that already but despite that work we still see examples like this.

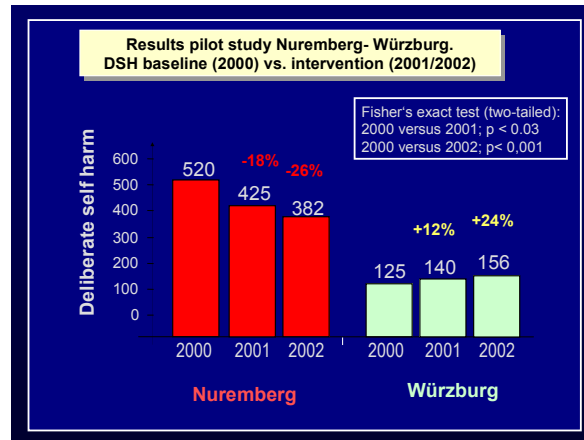
Irish Examiner, 31.05.2004
 Headline:
"Society Failing its Young People"



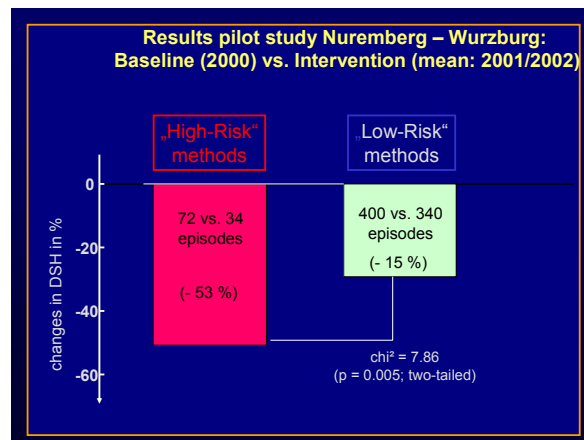
This appeared in The Irish Examiner in May and I think this is definitely a photograph that can be very suggestive to young girls who are moody or depressed. It is even deliberately made blurred or vague to almost romanticise the idea of undertaking this behaviour so I think it is definitely something that

can be damaging. We know of follow-up studies with, let us say, documentaries or reports in the media that there is definitely a harmful effect.

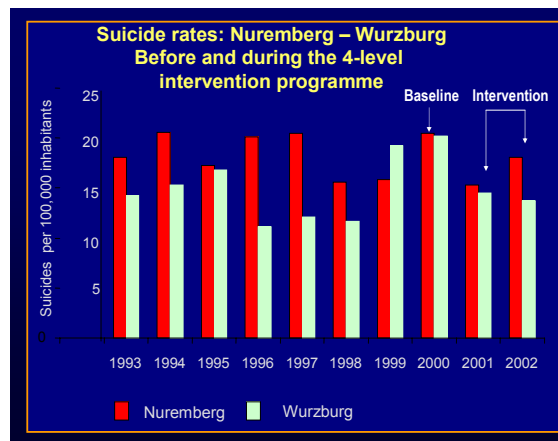
There are some German studies on this also.



I explained already a bit on the design so as a final comment, unfortunately due to time constraints, I have to stop, but I would like to show you the most important findings, the outcome of the intervention. After 2 years in the intervention region they saw a very significant drop in the number of deliberate self-harm cases or non-fatal suicidal behaviour, much more significant than the pattern that was observed in the control region. They had information from the fluctuations of deliberate self-harm beforehand and they have never spotted this pattern beforehand so there is scope to believe that at least some effect was going out of this intervention.



Another supportive element is that in previous years they had never seen such a big shift as after the two years of this intervention with regard to a change in the type of methods being used for deliberate self-harm and non-fatal suicidal behaviour. They saw a big shift from a reduction in using highly lethal methods like weapons or an effort to hang yourself or jumping in front of a vehicle. There was a significant reduction there too.



With regard to suicide, unfortunately we don't have even the data here for 2003. They did not detect a significant drop and it was even a very similar fluctuation to what they saw in previous years. But we have to keep in mind that still, fortunately, relatively speaking suicide is still much more of an exceptional phenomenon than the non-fatal suicidal behaviour which is by itself characterised by fluctuation. So they need to do more monitoring in the coming years to see whether there will be a trend towards a reduction.

I end here and will pass the remaining slides to Prof. Malone for distribution within the transcripts.

Because of the positive outcomes of this example the people who coordinated this in Munich got €1.2 million from the European Union to expand this pilot all over Europe. Ireland is also part of testing this type of intervention now in the Southern Health Board. If you divide that huge amount of money among so many countries, it is not too much. We therefore definitely want to work very much together with the initiatives that are already being put in place because especially as I said at the beginning, although at the beginning of the 90's we were really at the start of pioneering work here in some areas, the speed with which activities have taken place in Ireland is huge. So in this collaborative effort I think we are not going to reinvent the wheel, we just work with all the wheels that are there already.

So the rest of my presentation is on the slides below.

Thank you for your attention.

Prof. Malone: We are going to take questions at the end. One of the advantages to the forum and the model that we've put out there is the talking and listening. Hopefully Dr. Arensman will be available certainly afterwards and perhaps tomorrow as well, so that she can continue to share the new information that is coming out of the National Suicide and her role there as Research Director.

Countries currently undertaking a pilot study, testing the efficacy of the 4-level community-based approach in one region



Review of the efficacy of psychosocial and pharmacological treatments for DSH patients

(Hawton et al., 1998; Arensman et al., 2000)

Objective and methods:

- **Objective:** To identify and synthesise the findings from all randomised controlled trials that have examined the treatments for DSH patients
- **Methods:**
 - Systematic review incl. quality assessment
 - Searching electronic databases and hand searching
 - Population: DSH patients who had engaged in one or more than one episode of DSH shortly before entry into the study
 - N studies = 20, N patients (all studies) = 2452 /.
 - Main outcome measure: Repetition of self harm

Main outcomes (significant effects)

- Dialectical Behaviour therapy vs. Standard aftercare (N studies=1)
 - ⇒ Lower rate of repeated DSH in experimental group ($p < .05$)
- Flupenthixol vs. Placebo (N studies=1)
 - ⇒ Lower rate of repeated DSH in experimental group ($p < 0.02$)

Main outcomes (positive, non-significant effects)

- Problem solving therapy vs. Standard aftercare (N studies= 4)
 - ⇒ Reduced repetition of DSH in experimental groups (NS)
- Emergency card vs. Standard aftercare (N studies=2)
 - ⇒ Reduced repetition of DSH in experimental groups (NS)

Efficacy of problem-solving treatments for DSH patients with regard to other outcome measures

(Townsend et al., 2001)

Problem-solving therapy versus standard aftercare (significant effects)

Experimental group vs. Control group:

- Greater improvement in Depression scores
- Greater improvement in Hopelessness scores
- Greater reduction in number of reported problems

Recommendations based on systematic review

- Adequate sample sizes are required and power calculations should be performed
- Authors should provide more information regarding the method of randomisation, blinding procedures and participants who withdraw from trials
- Authors should provide more detailed information on the interventions that are evaluated, such as "treatment as usual" or "routine aftercare"
- Further trials are indicated for specific subgroups of DSH patients, e.g. DSH patients who frequently repeat, patients with substance abuse and adolescents

Treatment trials in the last 7 years Significant effects

- Home-based Family Problem-Solving + standard aftercare vs. Standard aftercare only among DSH patients aged ≤ 16 years (N=162) (Harrington et al., 1998)
 - ⇒ Decrease in *suicidal ideation* (not repeated DSH) in patients without major depression in experimental group ($p < .01$)
- Cognitive-Behavioural Therapy vs. Standard aftercare among DSH patients (N=40) (Raj et al., 2001)
 - ⇒ Decrease in *suicidal ideation, hopelessness, depression* in experimental group ($p < .000 - p < .01$); Repeated DSH (N=1, 5% control group)

Treatment trials in the last 7 years ctd. Significant effects

- Dialectical behaviour therapy vs. Standard aftercare in DSH patients with Borderline Personality Disorder (N=58) (Verheul et al., 2003)
 - ⇒ Lower rate of repeated DSH in experimental group ($p < .01$)
- Adherence to outpatient treatment for adolescents with DSH*
- Compliance Enhancement Intervention vs. Standard planning among adolescents with DSH (N=63) (Spirito et al., 2002)
 - ⇒ Higher number of treatment sessions attended by those in the experimental group: Experimental group: M=8.4 vs. Control group: M=5.8 ($p < .01$)

Treatment trials published in the last 7 years ctd.

Significant effects

- Brief Psychodynamic Interpersonal Therapy vs. Standard aftercare among DSH patients (N=119) (Guthrie et al., 2001):
 - ⇒ Lower rate of repeated DSH in experimental group: ($p < .009$)
- Psychoanalytically oriented partial hospitalization vs. Standard psychiatric care in DSH patients with BPD (N=44) (Bateman & Fonagy, 2001)
 - ⇒ Lower rate of repeated DSH in experimental group ($p < .05$)

Treatment trials in the last 7 years ctd.

Significant effects

Pharmacological treatment

- Paroxetine vs. Placebo among DSH repeaters (N=63) (Verkes et al., 1998)
 - ⇒ Lower rate of repeated DSH in Exp. Group (comparing DSH patients with less than 5 previous episodes) vs. Control group ($p < .01$)

Treatment trials in the last 7 years ctd.

Positive, non-significant effects

- Manual-assisted Cognitive-Behaviour Therapy vs. Standard aftercare among DSH repeaters (N=34) (Evans et al., 1999)
 - ⇒ Lower rate of repeated DSH in experimental group (NS)
- Multicentre trial: Manual-assisted Cognitive-Behaviour Therapy vs. Standard aftercare among DSH repeaters (N=480) (Tyrer et al., 2003)
 - ⇒ Lower rate of repeated DSH in experimental group (NS)

Treatment trials in the last 7 years ctd.

Negative effect

- Consultation with GP focusing on assessment and management of DSH vs. Standard GP aftercare among DSH patients (N=1932) (Bennewith et al., 2002)
 - ⇒ Lower rate of repeated DSH in control group (NS)

Proposal: Multidisciplinary and integrative treatment approach to repeated self harm (in line with Van Heeringen, 2001)

- 1) Detailed psychiatric assessment and detailed assessment of self-harming behaviour and associated risk factors
- 2) In stead of dichotomisation of psychotherapeutic and pharmacological treatment, integration of biological and psychotherapeutic treatment
- 3) Decisions for an emphasis on psychotherapeutic or biological treatment depend upon specific phases (crisis, severe depression, psychotic symptoms, etc) and may change over time
- 4) Self harming behaviour should be adressed specifically in treatment, and treated separately from associated psychiatric disorders (focus on trait-dependent characteristics related to self harming behaviour)