

Reference guide for the management of deliberate self-harm: Key points and recommendations from the RANZCP clinical practice guideline 2016



The Royal Australian & New Zealand College of Psychiatrists

The full RANZCP clinical practice guideline provides guidance on the management of hospital-treated deliberate self-harm and community deliberate self-harm.

This reference guide contains the key points and the recommendations made in each section of the guideline.

The full guideline and this reference guide are intended for psychiatrists and other healthcare professionals.

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Key to recommendations

EBR: evidence-based recommendation

Evidence-based recommendations were formulated when there was sufficient evidence on a topic after conducting systematic reviews or structured (non-systematic) literature searches. Levels of evidence for evidence-based recommendation are based on National Health and Medical Research Council levels for intervention studies (NHMRC 2009), see table below.

CBR: consensus-based recommendation

Consensus-based recommendations were developed based on the working group's clinical experience and research knowledge.

NHMRC Levels of evidence for intervention studies

Level	Design
I	A systematic review of level II studies
II	A randomised controlled trial
III-1	A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: Non-randomised, experimental trial Cohort study Case-control study Interrupted time series with a control group
III-3	A comparative study without concurrent controls: Historical control study Two or more single arm studies Interrupted time series without a parallel control group
IV	Case series with either post-test or pre-test/post-test outcomes

Reference

National Health and Medical Research Council (2009) NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Melbourne, Australia: NHMRC.

Background

The categories of 'hospital-treated' deliberate self-harm and 'community' deliberate self-harm overlap to some extent. Community deliberate self-harm is not clearly defined in clinical literature; it can refer broadly to people who deliberately self-harm within the community, regardless of whether and where they receive medical care, or it can sometimes be restricted to those who self-harm and do not attend hospital. Community deliberate self-harm and hospital-treated deliberate self-harm also overlap with the concept of 'non-suicidal self-injury'.

International data show that hospital-treated deliberate self-harm is predominately by self-poisoning (Gunnell et al., 2005), is slightly more common among females than males, and is associated with suicidal ideation (Hjelmeland et al., 2002). Community deliberate self-harm is predominantly by self-injury (e.g. cutting or minor burning), occurs at about the same rate among males and females, is less likely to be suicidal in intention, and is more likely to be motivated by the need to regulate distressing psychological experiences (Hamza et al., 2012).

After an episode of hospital treatment for deliberate self-harm, an estimated 16% of patients have a repeat of hospital-treated non-fatal deliberate self-harm within 1 year (Carroll et al., 2014). Suicide rates after hospital-treated deliberate self-harm are estimated at 1.6% within 1 year and 3.9% within 5 years (Carroll et al., 2014).

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Epidemiology

Recommendations

Number	Recommendation	Type	Level of evidence
Epidemiology			
1	Better information systems should be developed to collect data on rates of deliberate self-harm among people presenting to acute care services.	CBR	N/A
2	Sentinel surveillance units should be established in general hospitals to collect regional data on deliberate self-harm rates, to enable more accurate estimates of prevalence, incidence and trends.	EBR	III-2
3	National surveys should be designed to collect data on rates of hospital-treated deliberate self-harm and community deliberate self-harm in Australia and New Zealand.	EBR	IV
4	National surveys should be designed to collect data on rates of non-suicidal self-injury in Australia and New Zealand.	EBR	IV
5	Systems should be developed to effectively monitor the prevalence, incidence and trends of community and hospital-treated deliberate self-harm in Australia and New Zealand.	CBR	N/A

Overview

- In Australia, the overall age-standardised incidence of hospital-treated deliberate self-harm events (not individuals) for the most recent period with available data (2010–2011) was 117/100,000/year (95% confidence interval [CI] 116–118) (Pointer, 2013).
- In New Zealand, the recorded incidence of hospital-treated deliberate self-harm in 2010 was 76 per 100,000 (95% CI 64–69) (New Zealand Ministry of Health, 2012).
- The difference between New Zealand and Australian rates is probably due in part to the use of differing definitions for data collection.
- Rates of hospital-treated deliberate self-harm in Australia and New Zealand are higher among females than males.
- In Australia between 1999 and 2010 the incidence of hospital-treated deliberate self-harm among males remained stable at approximately 90 per 100,000, while the rate for females increased from approximately 140 per 100,000 to 150 per 100,000 (Pointer, 2013). This apparent increase could be

due in part or in whole to changes in admission practices or coding of admissions.

- In New Zealand between 1996 and 2008 the incidence of hospital-treated deliberate self-harm showed a sustained decline both for males (from approximately 65 per 100,000 to 40 per 100,000) and females (from approximately 100 per 100,000 to 75 per 100,000), followed by an increase between 2008 and 2010 (New Zealand Ministry of Health, 2012).
- The most common methods of hospital-treated deliberate self-harm in Australia and New Zealand are self-poisoning (more than 80% of cases) and cutting (approximately 15–20% of cases) (Pointer, 2013; Hatcher et al., 2009).
- Published deliberate self-harm rates are likely to be underestimates. Institutional data sources underestimate hospital-treated deliberate self-harm (Swannell et al., 2014; Johnston et al., 2009; Beautrais, 2006).
- Estimates of community deliberate self-harm in Australia and New Zealand come from infrequent national surveys with limited questions (Swannell et al., 2014; Johnston et al., 2009; Beautrais, 2006).
- Current estimates of non-suicidal self-injury in Australia come from a single national cross-sectional study (Martin et al., 2010).

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Organisation of services

Recommendations

Number	Recommendation	Type	Level of evidence
Organisation of services			
1	Minimise waiting times for people who present to emergency departments after deliberate self-harm and monitor the reception area closely to ensure patients do not leave before psychosocial assessment is completed.	CBR	N/A
2	Psychosocial assessment should be performed by a trained mental health professional for every patient treated in hospital after deliberate self-harm.	EBR	III-2
3	Do not use risk assessment scales or tools to determine the need for clinical services or follow-up in people treated in hospital after deliberate self-harm.	EBR	III-2
4	If patients abscond from the emergency department or hospital before completion of assessment and treatment for deliberate self-harm, staff should follow them up and attempt to re-engage them through phone contact, their GP, the treating mental health team, crisis team or the police, if necessary.	CBR	N/A
5	Services that provide care for people with deliberate self-harm should show respect for patients who self-harm and should improve communication and collaboration between patients and clinical staff during treatment.	EBR	IV
6	For patients who attend frequently for deliberate self-harm, identify primary and specialist care providers who can work with hospital staff and, where appropriate, the service user (patient), to create an active management plan for future presentations. This should be linked to a hospital alert so the management plan is available early in each episode of care.	CBR	N/A
7	Services that provide care for people with deliberate self-harm should implement strategies to improve staff knowledge about deliberate self-harm and increase empathy.	EBR	I
8	Access to aftercare and information about deliberate self-harm should be improved for patients, carers and the public.	EBR	III-2

9	People who have self-harmed should be treated by specialist multidisciplinary teams, if possible.	EBR	III-2
10	Self-harm planning groups should address the service planning and operational policies of the hospital for this patient group. Members should include hospital managers, emergency department, medical staff, nursing, psychiatry, medical ward, primary care and service users.	CBR	N/A
11	Seek the advice of senior clinicians and the hospital legal team, where appropriate, in complex situations (e.g. when a patient refuses treatment, lacks the capacity to make decisions about their care due to unconsciousness or delirium, when a patient has a 'do not resuscitate' advanced directive, when the patient's family disputes management and the person lacks decision-making capacity, when the patient has a terminal illness and suicide is seen as a legitimate solution by themselves and their family).	CBR	N/A

Overview

- Very few studies have measured the effects of service organisation on rates of repetition of deliberate self-harm.
- Hospital presentation following self-harm represents an opportunity for assessment and intervention; an estimated 84% of adults and 81% of adolescents who present for hospital-treated deliberate self-harm have an underlying psychiatric disorder, of which depression, anxiety and alcohol misuse are the most common (Hawton et al., 2013). Attention-deficit hyperactivity disorder and conduct disorder are also common among adolescents who present with DSH (Hawton et al., 2013).
- There is not enough evidence to determine the effects of psychosocial assessment on rates of repetition of deliberate self-harm. Evidence from observational studies is conflicting (Kapur et al., 2008; Kapur et al., 2013; Bergen et al., 2010). Psychosocial assessment (or mental health assessment) by a trained mental health professional may reduce rates of repetition of deliberate self-harm (Bergen et al., 2010).
- There are no widely accepted tools for clinically assessing a patient's risk of subsequent deliberate self-harm or suicide (Haney et al., 2012). No empirical studies have demonstrated that categorising patients as being at low risk or high risk of future fatal or non-fatal deliberate self-harm can contribute to a reduction in overall rates of deliberate self-harm (Wand, 2012).

- Patients who leave emergency departments before receiving assessment or treatment have a higher risk of repetition of deliberate self-harm and suicide (Hickey et al., 2001).
- Hospital staff may have negative attitudes towards people who self-harm – particularly frequent attenders (Saunders et al., 2012), who may have experienced many negative interactions with clinical staff (Taylor et al., 2009).
- Studies evaluating active training have reported consistent improvements in staff knowledge and attitudes toward patients who self-harm (Saunders et al., 2012), and some recent studies have demonstrated beneficial changes in clinician behaviour (Osteen et al., 2014).

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Interventions to reduce or prevent repetition of DSH

Recommendations

Number	Recommendation	Type	Level of evidence
Interventions to reduce or prevent repetition of DSH			
1	If antidepressant medication would not otherwise be indicated, do not initiate treatment with antidepressant medicines specifically to reduce the risk of repetition of deliberate self-harm in people treated in hospital for deliberate self-harm.	EBR	I
2	If depot flupenthixol or depot fluphenazine deconate are not otherwise indicated, do not use these agents specifically to reduce the risk of repetition of deliberate self-harm in a patient treated in hospital for deliberate self-harm.	EBR	II
3	If lithium carbonate treatment is not otherwise indicated, do not initiate it specifically to reduce the risk of repetition of deliberate self-harm in a patient treated in hospital for deliberate self-harm.	EBR	II
4	Services that provide treatment for people who have self-harmed should offer or arrange after-care using psychological or psychosocial interventions aimed at reducing repetition of deliberate self-harm.	EBR	I
5	Offer any of the following therapies: cognitive behavioural therapy (CBT), psychodynamic interpersonal therapy, or outreach combined with psychological therapy.	EBR	II
6	Provide alcohol-reduction-focused interventions if otherwise indicated for people who have self-harmed, but do use these interventions for the specific purpose of reducing the risk of repetition of deliberate self-harm.	EBR	II

Overview

- Few randomised controlled trials have evaluated the effectiveness of pharmacological treatment for the prevention of repetition of deliberate self-harm.
- Overall, available evidence does not support the use of medication, including treatment with antidepressant agents, as primary treatment for deliberate self-harm (Hawton et al., 1999; Battaglia et al., 1999; Lauterbach et al., 2008). In

specific patient populations, such as those with major depression or bipolar disorder, antidepressants and lithium may have benefits for suicide-related outcomes (e.g. suicidal ideation, suicide attempts, suicide mortality).

- Meta-analysis of 36 randomised controlled trials showed that, overall, psychological or psychosocial interventions were effective in reducing repetition of any deliberate self-harm episode, compared with comparators (mainly treatment as usual): risk ratio RR 0.84; 95% CI 0.74 to 0.96; Number Needed to Treat =33) (Hetrick et al., 2016).
- Meta-analysis of data from five randomised controlled trials showed that CBT was associated with a significant reduction in pooled risk ratio for subsequent deliberate self-harm of 0.77 (95% CI 0.64–0.93) (Hetrick et al., 2016).
- Meta-analysis of data from 13 studies evaluating psychological therapy combined with assertive outreach (including regular care provider-initiated contact, rapid crisis response, solution-focused counselling and ongoing motivational support to engage in therapy) showed that this treatment approach was associated with a non-significant reduction in pooled risk ratio for subsequent deliberate self-harm of 0.90 (95% CI 0.73–1.11) (Hetrick et al., 2016).
- A single study of a manualised form of psychodynamic interpersonal therapy was associated with a reduction in self-reported repetition of deliberate self-harm at 6 months' follow-up, compared with treatment as usual (9% versus 28%) (Guthrie 2001).
- Meta-analysis of data from eight randomised controlled trials showed that problem-solving-focused therapies were associated with a non-significant reduction in pooled risk ratio for subsequent deliberate self-harm of 0.96 (95% CI 0.80–1.16) (Hetrick et al., 2016).

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Special populations

Recommendations

Number	Recommendation	Type	Level of evidence
Special populations			
<i>Borderline personality disorder</i>			
1	People with borderline personality disorder who self-harm should be offered psychological therapies that have been shown to reduce the number of repetitions of deliberate self-harm, such as dialectical behaviour therapy (DBT), cognitive-behavioural therapy (CBT) or mentalisation-based treatment (MBT).	EBR	I
2	Consider DBT for women with borderline personality disorder who self-harm.	EBR	I
3	Do not rely on group therapy alone (e.g. skills-based training for DBT) to reduce the risk of repetition of deliberate self-harm in people with borderline personality disorder who self-harm.	EBR	II
4	Do not use pharmacotherapy specifically for the purpose of reducing the risk of repetition of deliberate self-harm in people with borderline personality disorder who self-harm.	EBR	I
<i>Children and adolescents</i>			
5	For children and adolescents who self-harm, consider offering CBT, MBT or DBT, where suitable.	EBR	II
6	Interventions should be developed specifically for children and adolescents who self-harm, incorporating motivation to change, maintenance of sobriety, familial or non-familial support, promotion of positive affect and healthy sleep.	CBR	N/A
<i>Older adults</i>			
7	Prevention strategies and interventions should be developed specifically for older adults who self-harm.	CBR	N/A
<i>Māori</i>			
8	Better institutional information systems should be developed to collect data on rates of deliberate self-harm among Māori presenting to acute care services.	CBR	N/A
9	National surveys in New Zealand should include questions designed to collect data on rates of deliberate self-harm among Māori.	CBR	N/A

10	Interventions to reduce repetition of deliberate self-harm in Māori populations should be developed and evaluated with leadership from Māori.	CBR	N/A
<i>Aboriginal and Torres Strait Islander Peoples</i>			
11	Australian emergency departments and hospitals should ask all patients whether they identify as Aboriginal or Torres Strait Islander, to ensure that population-specific data can be collected for deliberate self-harm and other presenting problems.	CBR	N/A
12	Interventions for reducing repetition of deliberate self-harm among Aboriginal and Torres Strait Islander peoples should be developed and evaluated with leadership from these communities.	CBR	N/A
<i>First episode psychosis</i>			
13	Services should be organised to ensure that people with first-episode psychosis are offered treatment as soon as possible	EBR	III-2

Overview

Borderline personality disorder

- A meta-analysis of 10 randomised controlled trials showed that, overall, psychological therapy was effective in reducing the number of suicide attempts and deliberate self-harm events, compared with treatment as usual: standardised mean difference 0.439 (95% CI -0.607 to -0.271) (NHMRC, 2012).
- Three meta-analyses of randomised controlled trials evaluating DBT in patients with borderline personality disorder have reported reductions in deliberate self-harm (Kliem et al., 2010; NHMRC, 2012; Panos et al., 2013).
- CBT has been associated with reductions in suicidal acts (Davidson et al., 2006) and frequency and severity of deliberate self-harm (Weinberg et al., 2006), compared with treatment as usual, in people with borderline personality disorder.
- Two trials (n=38 and n=134) that compared MBT with treatment as usual in people with borderline personality disorder each reported that the intervention was associated with reduction in deliberate self-harm (Bateman and Fonagy, 1999; Bateman and Fonagy, 2009).
- Although group therapy is a component in many of the therapies shown to be effective in reducing DSH among people with borderline personality disorder (NHMRC, 2012), group therapy (e.g skills-based training in DBT) alone has not been shown to reduce DSH.

- A meta-analysis of four randomised controlled trials showed that pharmacological treatments had no effect on suicidality and number of self-harm episodes in people with borderline personality disorder: standardised mean difference -0.131 (95% CI -0.499 to 0.188) (NHMRC, 2012).

Children and adolescents

- Overall, psychological interventions in hospital-treated DSH populations of children and adolescents have not been shown to be more effective than treatment as usual for reducing repetition of DSH (Newton et al., 2010; Robinson et al., 2011; Ougrin et al., 2012).
- Some specific types of therapy appear promising and warrant optional implementation and further evaluation. These include CBT, MBT adapted for adolescents, and DBT adapted for adolescents (Brent et al., 2013; Mehlum et al., 2014).
- Five factors have been identified for inclusion when designing interventions to prevent repetition of deliberate self-harm in children and adolescents: motivation to change, maintenance of sobriety, familial or non-familial support, promotion of positive affect, and healthy sleep (Brent et al., 2013).

Older adults

- Few studies have evaluated treatment options for reducing repetition of deliberate self-harm in older adults.
- DSH among older adults is associated with a higher level of lethal intent and less impulsivity than DSH among younger age groups (Chan et al., 2007).
- In an Australian cluster randomised controlled trial, an intervention involving 373 GPs (practice audit, personalised automated audit feedback, and targeted printed educational material over 2 years provided) was associated with a reduction in deliberate self-harm among 21,762 patients aged 60 years or older (OR 0.80; 95% CI 0.68–0.94), compared with control (Almeida et al., 2012).
- Overall, available evidence suggests that reduction of deliberate self-harm among older adults requires a multifaceted, multilayered approach that encompasses the broad spectrum of suicidal behaviour and depression, including prevention of depression by addressing factors like social isolation and chronic pain.

Māori

- Rates of hospital-treated deliberate self-harm in New Zealand are higher among Māori than other New Zealanders, but better systems are needed to collect more accurate data.
- An exploratory qualitative study examining Māori views on factors that influence suicidal behaviour identified the following as common social and cultural themes for Māori: alienation from traditional Māori culture and social

institutions that provide support such as connection to whānau, hapū and marae, poor self-concept and lack of Māori identity, especially for Māori youth, the impact of negative social construct of Māori, historical effects of New Zealand social and economic change to Māori population, adjustment to re-emergence of Māori cultural identity as a prominent part of New Zealand society, and rapid change in social values and norms such as gender and social roles (Hirini and Collings, 2005).

- Very little evidence is available from studies assessing interventions to manage or prevent deliberate self-harm among Māori. A small (n=167) trial compared a complex intervention (regular postcards, problem solving therapy, patient support, risk management, improved access to primary care and cultural assessment, in addition to usual care) with usual care in Māori who were treated for DSH in New Zealand emergency departments (Hatcher et al., 2016). The main outcome measure was the self-rated change in scores on the Beck Hopelessness Scale at one year and a secondary outcome was any repetition of DSH. There was a statistically significant benefit in hopelessness scores at 3 months but no difference after 12 months, and a statistically significant benefit for repetition of DSH at 3 months (10.4 vs. 18.0 %) but no difference after 12 months, compared with the control group.
- It is essential for Māori communities to lead the development and evaluation of interventions for reducing repetition of deliberate self-harm in Māori populations. The New Zealand Suicide Prevention Strategy (New Zealand Ministry of Health, 2006) is designed to build capability and support among families, whānau, hapū, iwi and communities to prevent suicide and reduce the impact of suicide, through culturally relevant education and training that focusses on building resilience and leadership.

Aboriginal and Torres Strait Islander peoples

- Rates of hospital-treated deliberate self-harm in Australia are higher among Aboriginal and Torres Strait Islander peoples than other Australians, but better systems are needed to collect more accurate data.
- Very little evidence is available from studies assessing interventions to manage or prevent deliberate self-harm among Aboriginal and Torres Strait Islander peoples.
- It is essential for Aboriginal and Torres Strait Islander communities to lead the development and evaluation of interventions for reducing repetition of deliberate self-harm in Aboriginal and Torres Strait Islander peoples.
- All mental health clinicians working in Australia should have an understanding of the current relevance of post-colonisation history for Aboriginal and Torres Strait Islander peoples (particularly in regard to incarceration, and collective grief, trauma and loss), psychosocial determinants of mental health in Aboriginal and Torres Strait Islander populations (particularly unstable poor quality accommodation, poor access to health care, unemployment, social exclusion, stress, trauma, violence and substance use), and the principles of A contributing life (National Mental Health Commission, 2012): timely and

effective care and treatment, meaningful activity, and meaningful connections with family, friends, culture and community.

Prison

- There is insufficient evidence to recommend any specific intervention in the prevention or treatment of DSH in prison populations.

Immigration detention

- There is insufficient evidence to recommend any specific intervention in the prevention or treatment of DSH in immigrant detention populations.

First-episode psychosis and schizophrenia

- Early psychosis detection services have been associated with reduced rates of deliberate self-harm prior to treatment in the mental health services, possibly by engaging and treating people earlier in the course of illness (Harris et al., 2008; Melle et al., 2006).
- Early intervention services have been associated with reduced suicide mortality for the duration of treatment and in the immediate follow-up period (Harris et al., 2008; Chen et al., 2011).
- A large (n=980) multicentre trial (Meltzer et al., 2003) comparing clozapine with olanzapine in patients with schizophrenia found that clozapine treatment was associated with a significant reduction in suicidal behaviour (a composite outcome of suicide attempt or hospitalisation as a result of imminent suicide risk): hazard ratio 0.76, (95% CI 0.58–0.97, p=0.03), and a significant reduction in suicide severity (Clinical Global Impression of Suicide Severity Scale): hazard ratio 0.78, (95% CI 0.61–0.99, p=0.04).

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Rarer forms of deliberate self-harm

Recommendations

Number	Recommendation	Type	Level of evidence
Rarer forms of deliberate self-harm			
1	Patients with major self-mutilation should be considered to have a psychotic illness until proved otherwise.	EBR	IV
2	Immediate treatment after major self-mutilation should aim both to facilitate optimal surgical care and to prevent further self-injury by close nursing supervision.	EBR	IV
3	People presenting with self-immolation should have access to suitably experienced mental health clinicians as part of their burn care.	CBR	N/A
4	Mental health care should include: (1) a thorough assessment and formulation of premorbid difficulties, to inform multidisciplinary treatment planning, (2) the identification and treatment of acute trauma responses, and (3) ongoing psychiatric care and therapy to facilitate adjustment to physical disfigurement in the rehabilitation phase.	CBR	N/A

Overview

- Major self-mutilation differs from other forms of deliberate self-harm: it is very rare, suicide intent is usually absent, it usually results in a loss of bodily function and it is strongly associated with psychosis (Favazza and Rosenthal, 1993; Large et al., 2009).
- Following major self-mutilation patients may have a lucid (non-psychotic) period. However, even those who are not obviously hallucinated or deluded should be provisionally considered to be suffering from psychosis (Large et al., 2009).
- Most self-amputations occur in association with delusions that the amputated part is in some way a threat to them or others. Appropriate antipsychotic and sedative treatment should be instituted as rapidly as possible and should have the aims of both treating the underlying psychosis and facilitating urgent medical and surgical care. Most patients who present with major self-mutilation will require a surgical admission, followed by a period of observation and treatment in an acute psychiatric unit, and then a period of rehabilitation.
- Self-immolation is a relatively rare method of deliberate self-harm that accounts for around 1% of all suicides in developed countries. In developed

countries, men are more likely to self-immolate than women, and self-immolation is associated with affective disorders and, to a lesser extent, substance abuse, psychosis and personality disorders (Poeschla et al., 2011).

- Very few studies have measured rates of repetition of deliberate self-harm after self-immolation. One study found that four out of five patients reported an intention to kill themselves. Another study reported that three out of eight patients had made a further suicide attempt (Hahn et al., 2013).
- Mental health clinicians have several important roles in the care of patients who have attempted self-immolation: thorough assessment and formulation of premorbid difficulties, including psychiatric disorders, to inform multidisciplinary treatment planning, identification and treatment of acute trauma responses, and support to access appropriate treatment in the rehabilitation phase, including ongoing psychiatric care and adjustment to physical disfigurement (Hahn et al., 2013).

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Other interventions and populations

Recommendations

Number	Recommendation	Type	Level of evidence
Other interventions and populations			
5	All GPs should maintain up-to-date training in the detection and effective treatment of mental illness, particularly depression.	EBR	I
6	Access to lethal methods of self-harm should be restricted, where possible (e.g. by limiting sale of or access to medicines associated with overdose).	EBR	I
7	Gatekeeper training programs should be delivered to relevant professions (e.g. GPs, youth workers, teachers, police, ambulance staff, human resources professionals and employers) to equip them to facilitate access to appropriate services for people at risk of suicide or self-harm.	EBR	III-1
8	Public awareness campaigns should be implemented to reduce stigma associated with depression and suicidal behaviour and to promote help-seeking behaviour and attitudes among those at risk.	EBR	III-1
9	Inpatient and outpatient acute care services should improve their capacity to provide immediate after-care for people who self-harm.	EBR	III-2
10	Media, health policy makers and academics should actively participate in developing and adhering to media guidelines on public reporting of suicide.	EBR	III-2

Overview

Community-based interventions for DSH and suicide

- There is conflicting evidence on the effects of public awareness campaigns in reducing self-harm (van der Feltz-Cornelis et al., 2011).
- ‘Gatekeeper’ training (teaching people how to identify those at high risk for suicidal behaviours and how to refer them for treatment) is most effective when pathways to treatment are clearly identified (Mann et al., 2005) and when it targets gatekeepers with low basic skills (Coppens et al., 2014). This approach has been reported to be effective in Australian Aboriginal communities (Capp et al., 2001).
- All GPs need training in the detection and effective treatment of mental illness, particularly depression. Screening for depression in primary care can enhance detection and treatment of depression (Mann et al., 2005), but is

only effective when accompanied by adequate follow-up and adequate availability of treatment (Gilbody et al., 2008).

- The manner of reporting suicide in the media may affect community rates. Research literature demonstrates a clear relationship between certain types of media reporting and suicide (Pirkis and Blood, 2001; Stack, 2003). The development and adoption of media reporting guidelines for suicide has had mixed success in New Zealand (McKenna et al., 2010) and Australia (Pirkis et al., 2002).
- Available evidence suggests that the following elements should be included in multilevel prevention interventions that aim to reduce suicide mortality: GP training in the detection and effective treatment of mental illness (particularly depression), gatekeeper training to facilitate access to appropriate services (particularly among those with poor knowledge), restriction of access to lethal methods of self-harm, awareness campaigns to reduce stigma around depression and promote help-seeking behaviour, enhancement of existing healthcare services (particularly appropriate inpatient or outpatient care after an episode of self-harm), and active participation by media, health service decision makers and academics in developing and adhering to media guidelines on the reporting of suicide (van der Feltz-Cornelis et al., 2011; Mann et al., 2005; Coppens et al., 2014).

Web-based programs for suicidal behaviour

- Data from randomised controlled trials show that websites targeting depression have specific beneficial effects on depression (Moritz et al., 2012; Christensen et al., 2013).
- A small (n=116) randomised controlled trial found that an online self-help program (six modules of CBT with dialectical behaviour therapy, problem-solving therapy, mentalisation-based treatment, weekly assignments and automated motivational emails) was associated with reductions in suicidal thoughts and levels of hopelessness, compared to waitlist, in a general public population with mild-to-moderate suicidal ideation, recruited via the internet (van Spijker et al., 2014).

School-based interventions

- A large European trial found that a universal mental health awareness program with 15-year-olds (a 5-hour classroom-based program for mental health awareness) halved the risks of severe suicidal ideation (OR 0.50, 95% CI 0.27-0.92; p=0.025) and suicide attempts at 12-month follow-up (OR 0.45, 95% CI 0.24-0.85; p=0.014), compared with a control group, although the absolute risk reduction was small (Wasserman et al., 2015).

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Other relevant clinical practice guidelines

For clinical practice guidelines on the management of specific disorders that may be associated with deliberate self-harm, refer to www.ranzcp.org/guidelines

- Schizophrenia – Galletly C, Castle D, Dark F, et al. (2016) Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of schizophrenia and related disorders
- Eating disorders – Hay P, Chinn D, Forbes D, et al. (2014) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders.
- Mood disorders – Malhi GS, Bassett D, Boyce P, et al. (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders.
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Other clinical practice guidelines for the management of self-harm

National Collaborating Centre for Mental Health (2011) Self-harm: longer-term management. NICE Clinical Guideline 133. Manchester: National institute for Health and Care Excellence.

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