Introduction: Deliberate self-harm (DSH) is a strong indicator of psychological distress and constitutes a significant risk factor for subsequent mortalities.
Objectives: In this study we want to gain insights into cause-specific mortalities in self-harming patients and to disentangle important factors differentiating the risks so that to inform follow-up care and mortality prevention.
Methods: Retrospective data from nationwide registries were interlinked to follow all patients presenting to specialist healthcare with non-fatal DSH from January 2008 through December 2018. Data on cause of death, personal socioeconomic status, clinical features of DSH and other medical covariates were retrieved. The Fine and Gray competing risks model was used to identify significant factors impacting subsequent mortality risk by specific causes of death in the cohort.
Results: The cohort of 43153 DSH patients comprised 24286 females and 18867 males, with 45.3% being 10-34 years old, 38.1% being 35-64 years old and 16.6% above 65 years old at index DSH episode. Of these patients, 7041 died during the follow-up period, including 2290 within the first 1-year, corresponding to a mortality rate of 31.9 per 1000 person-years in the follow-up period and 54.9 per 1000 person-years in the first year. Common causes of death included suicide (n=911), other external causes (n=1020), cancer (n=896), cardiovascular diseases (n=1523), respiratory disease (n=787) and mental and substance misuse disorders (n=463), but the causes of death varied greatly by age groups and other factors. The risk of dying by suicide was highly associated with middle-age, male gender, tertiary education, psychiatric history, and DSH by injury, clear intent of self-harm, comorbid affective or personality disorder, referral to psychiatric treatmen, as well as DSH repetition during the period of follow-up. Significant risk factors for death by other external causes included male gender, old or middle age, single marital status, lowest quartile income, history of psychiatric treatment, and DSH by injury and comorbid substance misuse. For death by natural causes, the relative risk was highest among the elderly and the middle-aged, with other significant risk factors including male gender, single marital status, low education, lowest quartile income, and comorbid substance misuse. Attendance in psychiatric treatment after DSH appeared to be beneficial reducing the risk for mortality by suicide, other external causes and natural causes as well.
Conclusions: Patients with DSH represent a high-risk group for suicide, other external and natural cause mortalities. Mental healthcare is essential in follow-up care and personalized care should take into account patients´ socio-demographic background and clinical features of self-harm.

Disclosure of Interest: None Declared

E-mental Health

O0037

Co-design of a digital violence prevention and management tool for psychiatric inpatient care: focus on supporting integration into electronic health record system

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Introduction: Violence in psychiatric inpatient settings is a global challenge. Several methods have been developed and tested to help staff prevent the occurrence of violence on the wards. One novel and effective method is eDASA+APP, originating from Australian forensic psychiatric settings (Maguire *et al.* Int J Ment Health Nurs 2019; 281186-1197, Griffith *et al.* Psychiatr Serv 2021; 72 885-890). This electronic method contains an instrument (DASA) to assess the risk for imminent violence and includes evidence-based violence risk management methods for risk levels. It is important to ensure that this electronic intervention is integrated into daily clinical practice. This can be done in co-design between all that are involved e.g., staff and experts by experience, and by encouraging them to achieve a common goal and gain benefits by working together.
Objectives: This prevention gives an overview of how the Finnish version of eDASA+APP was co-designed with healthcare staff and experts by experience, focusing on integration into the electronic patient health record system. The presentation is part of a larger research project testing eDASA+APP in Finnish psychiatric inpatient care.
Methods: Co-design workshops focusing on three major themes: 1) identifying current practices and how eDASA+APP would fit in those, 2) producing a linguistically and culturally appropriate version of eDASA+APP, and 3) preferred use of eDASA+APP in an electronic patient health record system. Notes were kept during the workshops by researchers. Qualitative material were analysed with deductive content analysis. Results from the third theme are shared in this presentation.
Results: Staff and experts by experience described that integration of eDASA+APP in electronic patient health record system is supported if it 1) brings clear and fast information to the staff about the violence risk of a patient, 2) is a visible measure that is concretely in sight in electronic patient health record system, 3) provides information about which violence prevention and management interventions have worked with a patient, 4) involves patient preferences, and 5) consist of joint decisions that have been agreed multi-professionally.
Conclusions: Integration of eDASA+APP in the electronic patient health record system has the potential to succeed if it is realized in cooperation with staff and experts by experience, is technically easy to use, and the users have an understanding of its benefits to everyone involved.

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O0038

Guidance on how to involve people with lived experience in research on digital mental health interventions

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