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Self-Harm in Oxford 2011

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This report is based on data collected by the Oxford Monitoring System for Self-harm, which was first established in 1976. Information is collected on all cases of self-harm presenting to the John Radcliffe Hospital. Detailed information (e.g. concerning socio-economic and clinical characteristics) is available for patients assessed by the hospital Psychiatric Service, based in the Barnes Unit, Department of Psychological Medicine. This report includes information on patients coming to the hospital in 2011. Comparison is usually made with previous years. We collect a considerable amount of additional information not contained in this report and will be happy to discuss provision of further details if requested.

The collection of these data has only been possible because of the continuing collaborative involvement of members of the psychiatric service in the John Radcliffe. Thanks are owed to all members of the service who helped collect the data including: Erin Booth, Cathy De Pruski, Fiona Brand, John Ryall, Karen Lascelles, Jacklyn Patsanza, Caroline Stevens, and Sarah Twine as well as Adrian Bradshaw-Jones, Suzanne Lucas and colleagues in the SPARC team, and also to the medical staff who were either attached to the unit or provided on-call cover during 2011. We thank Delecia Perera, Specialist Information Analyst for Oxford University Hospitals NHS Trust, for her invaluable help; and the Office for National Statistics for data on suicides and open verdicts in England and Wales.

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This work has approval from the NHS Health Research Authority (NRES Committee South Central – Berkshire) as well as from the Health Research Authority Confidentiality Advisory Group under Section 251 of the NHS Act 2006. The work fully complies with the requirements of the Data Protection Act, 1998.

An electronic copy of this Report and further information about the work of the Centre for Suicide Research are available on our website: **http://www.psych.ox.ac.uk/csr.**

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DEFINITION OF SELF-HARM

Self-harm is defined as intentional self-injury or self-poisoning, irrespective of type of motivation or degree of suicidal intent.[i,ii] This definition, which is used widely in a similar way in countries in Europe [iii] and elsewhere[iv], thus encompasses both 'suicide attempts' and acts with other motives or intentions. This reflects the often mixed nature of intentions associated with self-harm[v,vi] and also the fact that suicidal intent is a dimensional rather than unitary phenomenon.[vii] Self-poisoning is defined as the intentional self-administration of more than the prescribed or recommended dose of any drug (e.g. analgesics, antidepressants), and includes poisoning with non-ingestible substances (e.g. household bleach), overdoses of 'recreational drugs', and severe alcohol intoxication where clinical staff consider such cases to be acts of self-harm. Self-injury is defined as any injury that has been deliberately self-inflicted (e.g. self-cutting, jumping from a height).

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[v] Bancroft JHJ, Skrimshire AM, Simkin S. The reasons people give for taking overdoses. Br J Psychiatry 1976; 128: 538-48

[vi] Hjelmeland H, Hawton K, Nordvik H, Bille-Brahe U, De Leo D, Fekete S, et al. Why people engage in parasuicide: A cross-cultural study of intentions. Suicide Life Threat Behav 2002; 32: 380-93.

[vii] Harriss L, Hawton K, Zahl D. Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. Br J Pychiatry 2005; 186:60-6

SUMMARY OF TRENDS AND FINDINGS OF NOTE

- The total number of self-harm presentations to the John Radcliffe Hospital in 2011 was 1588. This represented a 2.7% increase compared with 2010. This reversed the small declines seen 2009 and 2010. The increase in 2011 compared with 2010 was due to a 9.8% increase in males. Presentations by females actually decreased by 1.4%.

- The number of individual persons presenting in 2011 (N = 1165) was an increase on 2010 (1125; +3.6%). This increase was entirely accounted for by a large increase over 2010 in males (+11.2%); the numbers of females showed a small decrease (-1.2%).

- The sex ratio (female to male) for persons in 2010 was 1.4**:**1, somewhat lower than in recent years.

- In 2011 62.5% of patients were under 35 years of age. There were 68 under-16 year-olds. Thirty-four patients were aged 65 years or more.

- Overall person-based rates of self-harm in Oxford City have decreased somewhat in females in recent years, but show an upturn in males.

- An extended catchment area, including Oxfordshire wards beyond the city from which at least 90% of hospital admissions for self-harm were admitted to the John Radcliffe hospital, had somewhat lower rates of self-harm than Oxford City, except in 15-24 year old females.

- Nearly two-thirds of patients were single (64.8%), one-fifth separated, divorced or widowed (18.9%), and less than one-fifth (16.3%) married.

- The ethnic distribution of the patients in 2011 showed a similar proportion of non-White ethnic groups overall compared with the general population of Oxfordshire.

- The proportion of patients who were unemployed in 2011 was 24.3%. This figure is a small increase over recent years. However, the proportion of people registered permanently sick or disabled (14.2%) continues the decline in recent years, presumably reflecting the introduction of stricter criteria for registration as sick or disabled.

- The episode**:** persons ratio in 2011 was 1.4**:**1, the same as in 2010.

- The percentage of patients repeating within a year of an episode in 2010 (19.4%) was similar to that of recent years. In terms of gender, 19.0% of males and 19.7% of females repeated. Half (50.7%) of those who repeated within a year did so in the first three months after their first presentation in 2010, more than a quarter (27.9%) within one month. In 2011 31.6% of assessed patients were self-harming for the first time.

- Of all self-harm episodes 70.7% involved self-poisoning, 22.9% self-injury and 6.4% both methods.

- The proportion of overdoses involving paracetamol (including compounds) in 2011 was 43.7%, similar to figures in recent years. In under-16-year-olds, over three-quarters (78.3%) of overdoses involved paracetamol.

- In 2011 only one overdose involved co-proxamol (two in 2010; five in 2009). This reflects the impact of withdrawal of this drug in the UK by the MHRA due to its high toxicity in overdose.

- Antidepressants were involved in 31.6% of overdoses in 2011, a similar figure to 2010 (32.1%). Of these 62.0% involved SSRIs/SNRIs, 23.0% tricyclics, 17.1% other antidepressants and 7.2% mood stabilisers.

- In 2011 29.3% of self-harm episodes involved self-injury. As in previous years the most frequent method was self-cutting (77.0%). Numbers of individuals presenting following hanging, strangulation or asphyxiation continued the increase seen in recent years.

- Alcohol use in the 6 hours before self-harm occurred in half the episodes in which a psychosocial assessment occurred (49.5%). Alcohol was consumed as part of the act of self-harm in 28.0% of episodes. Alcohol involvement in self-harm (based on data for 2009-2011) was more frequent in males than females; however, this pattern was reversed in 45-54 and 55-64 year-olds.

- Regular misuse of alcohol (including those with alcohol abuse disorders) in patients who received a psychosocial assessment was recorded for 44.5% of males and 32.7% of females, the figure for females representing a marked increase over recent years.

- Suicide intent scores (a measure of the extent to which patients wished to die) were in the high or very high range in 28.1% of assessed episodes. Suicide intent scores (averaged for 2009-2011) increased with age. Over 40% of episodes were of high or very high intent in those aged 55 years and over.

- The five most frequent problems preceding self-harm in assessed males concerned: partner (41.9%), employment/studies (34.5%), alcohol (34.2%), other family member(s) (30.1%) and finances (27.6%). In females, the five most frequent problems involved: other family member(s) (42.6%), partner (39.4%), employment/studies (27.1%), alcohol (22.9%), and finances (19.7%).

- Nearly three-quarters (73.2%) of the presentations to the hospital occurred between 5 p.m. and 9 a.m. As in previous years, there was a higher proportion of presentations in the late evening and early hours of the morning in which alcohol was consumed shortly before and/or as part of the act.

- The number of patient assessments conducted by members of the general hospital psychiatric service in 2011 was 1,067, an increase over 2009 (1,011) and 2010 (1047).

- A psychosocial assessment by a member of the psychiatric service occurred in 65.6% of presentations, this being far more frequent in patients admitted to a bed in the general hospital (82.9%) than in non-admitted patients (30.3%).

- 44.9% of the assessments were conducted by psychiatric nurses and the remainder (55.1%) by doctors.

- Of all assessed patients offered community psychiatric aftercare in 2011, for 16.2% this was with the Barnes Unit service.

- In a total of 542 episodes, patients left the hospital without a psychosocial assessment. While in 208 cases patients took their own discharge, in 189 cases patients were not identified (i.e. referred) for assessment. This continues an increasing trend in spite of NICE guidance in 2004 (reinforced in 2011) that all self-harm patients should receive a psychosocial assessment. Non-assessment was especially frequent in patients who self-harmed by self-injury.

SELF-HARM IN OXFORD 2011

Report on presentations to the John Radcliffe Hospital

Numbers of persons and episodes

The total numbers of episodes of self-harm presenting to the John Radcliffe Hospital in 2011 are shown in Table 1, together with the numbers of individual persons involved.

TABLE 1
Numbers of episodes, and persons involved, in 2011

	Males	Females	Total
Episodes of self-harm	616	972	1588
Persons	478	687	1165

The number of self-harm **episodes** in 2011 increased compared with 2010 (+41 cases; +2.7%) (see Figure 1). This is a little lower than average annual numbers presenting a decade ago (-3.0%).

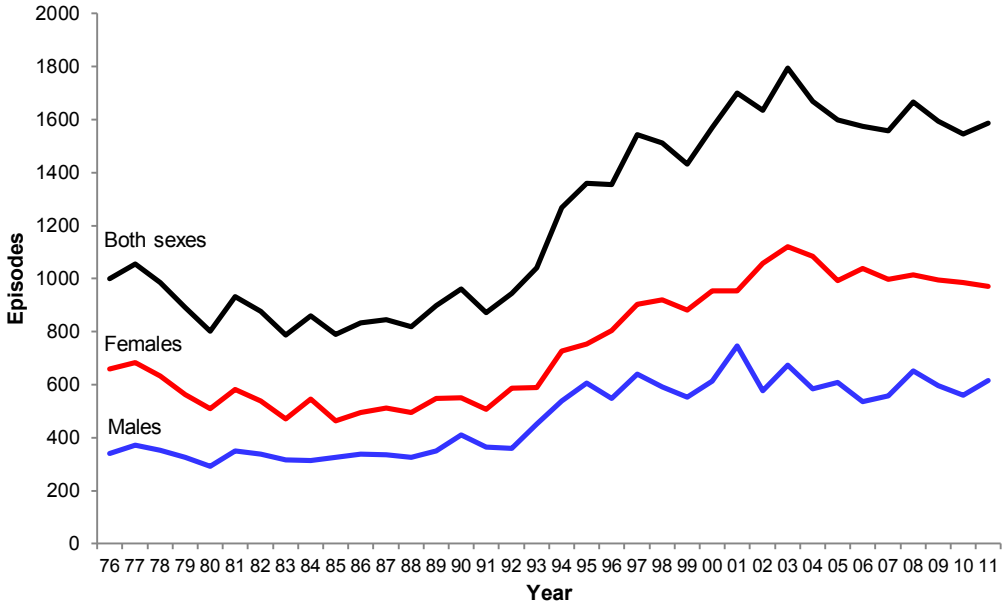
The increase in the number of episodes in 2011 compared to 2010 was mainly due to a 9.8% increase in episodes involving males. There was a small decrease (-1.4%) in females (see Figure 1). The 2011 figure for episodes by females (972) is 1.9% lower than the annual average of 990 for 2000-2002, and for males, the 2011 figure of 616 shows a 4.8% decrease on the annual average of 646 for 2000-2002.

In interpreting findings for the number of episodes it must be emphasised that a few patients may account for a very large number of episodes: for example, in 2011 individual females were responsible for 19 and 13 episodes respectively, with several females having 10 episodes during the year. Individual males were responsible for 22, 12 and 10 episodes.

There was an increase in the number of **persons** who presented in 2011 compared with 2010 (3.6%). The number of males increased by 11.2% although the number of females decreased slightly, by 1.2%.

FIGURE 1

Episodes of self-harm presenting to the John Radcliffe Hospital 1976-2011

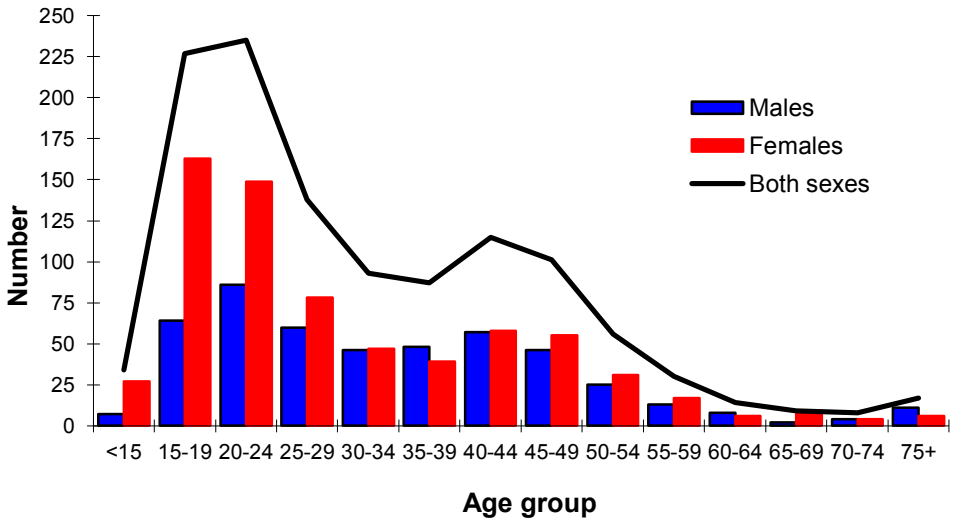


Age and sex

The **age distribution** of self-harm patients in 2011 was broadly similar to that in previous years although there were more patients in the 15-19 and 20-24 year age groups (Figure 2). In 2011, 62.5% of patients were under 35 years of age. The largest numbers of females were in the 15-19 (163 cases) and 20-24 (149 cases) year age groups. The largest numbers of male patients were in the age group 20-24 years (N = 86). There were 34 patients aged 65 years and over. The oldest patient was aged 94 years. In 2011 there were 68 under-16 year-old patients. The youngest patients were aged 12 years.

FIGURE 2

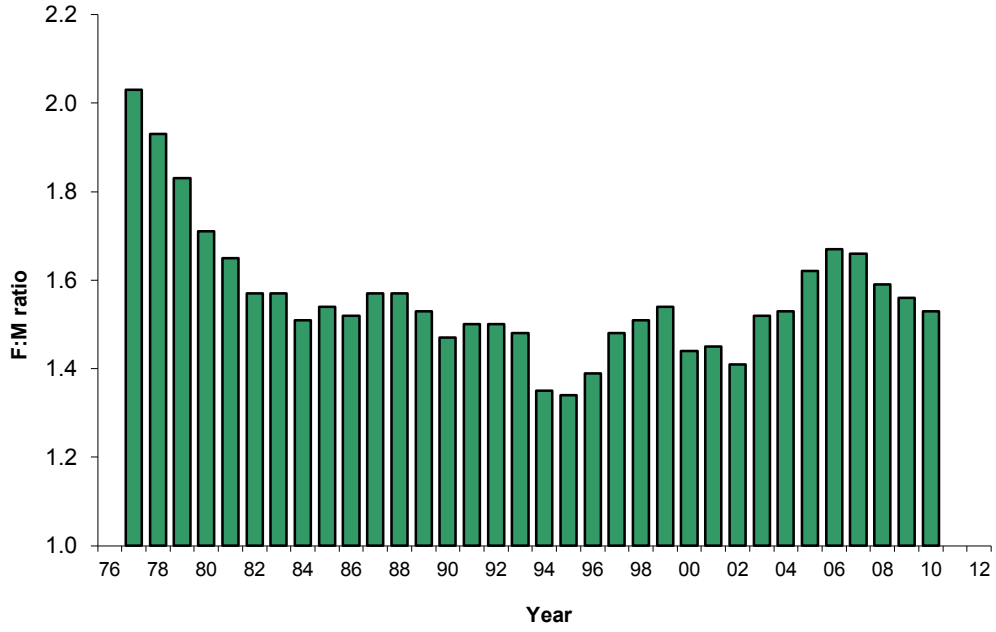
Age Groups of self-harm patients by sex in 2011



The **sex ratio** (female to male) for persons in 2011 was 1.4**:**1. The moving average figure appears to have levelled off following an increase over recent years (see Figure 3).

FIGURE 3

Sex ratio (F:M), persons, 1976-2011
(3-year moving averages)



Oxford City and extended area self-harm rates

We usually calculate rates just for people living in Oxford City because all self-harm cases presenting to hospital from the city are seen at the John Radcliffe Hospital. As in 2010, we also present rates for an extended area, including beyond the city (see Figure 4) from where we know at least 90% of hospital-admitted self-harm patients will go to the John Radcliffe Hospital. This should provide a more accurate picture of rates of self-harm in Oxfordshire.

Figure 5 shows the rates for males and females by age groups for the extended area of Oxfordshire. The extended area shows slightly lower rates in all age groups aged 25 years and over than in Oxford City. The rate for females aged 15-24 years was elevated (compare Figure 5 with Figures 7 and 8).

FIGURE 4

Areas of Oxfordshire used to calculate self-harm rates

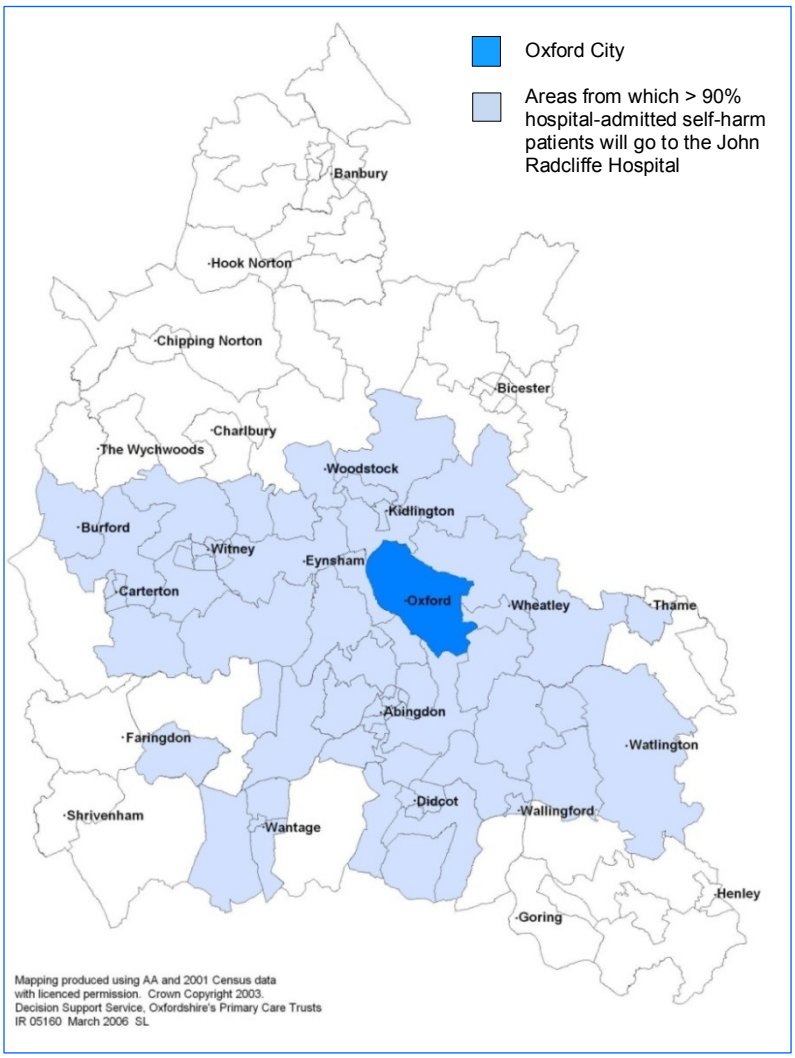
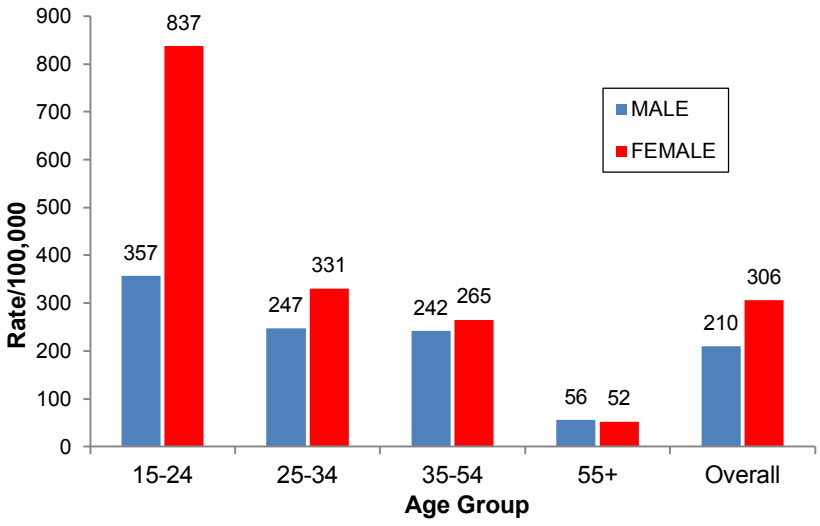


FIGURE 5

Self-harm rates in 2011 by age group and sex using extended area of Oxford District



The rates shown in Figure 5 are for numbers presenting in 2011 alone. For Oxford City we have also presented 3-year moving averages (which smooth out annual variations to show underlying trends). The overall rates by sex are shown in Figure 6.

The **age group and sex-specific 3-year moving average rates** for **males** in Oxford City are shown in Figure 7. Rates of self-harm increased in 15-24 year-old and 35-54 year-old males, although rates decreased in the 25-34 and 55+ age groups.

FIGURE 6

Rates of self-harm in Oxford City (aged 15+ years) 1976-2011 (3-year moving averages)

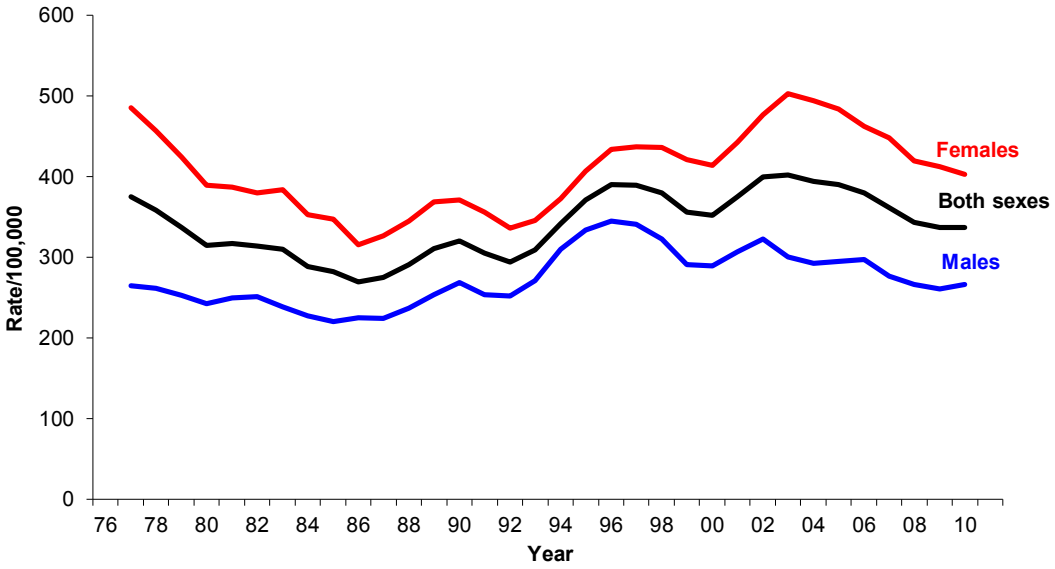
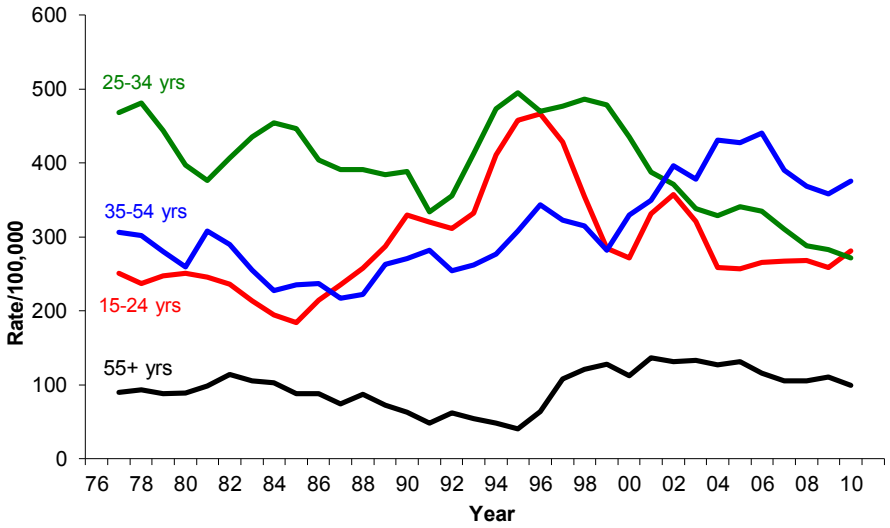


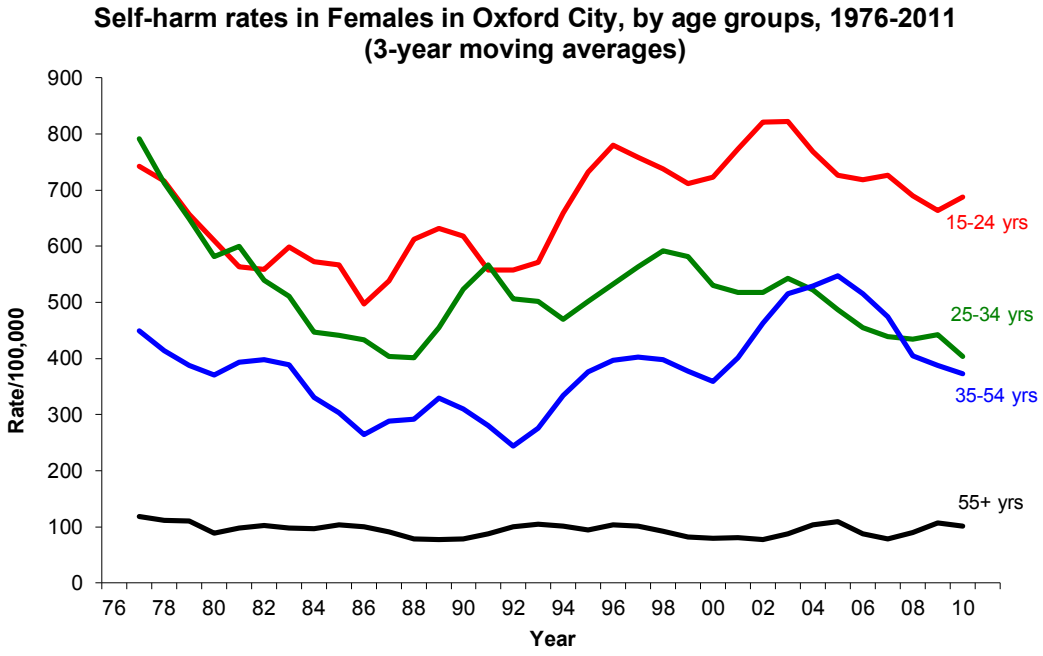
FIGURE 7

Self-harm rates in Males in Oxford city, by age groups, 1976-2011 (3 year moving averages)



The **3 year moving average rates in females** in Oxford City (Figure 8) show an increase and continue the very high rate in 15-24 year-olds, although rates in all other age groups declined.

FIGURE 8

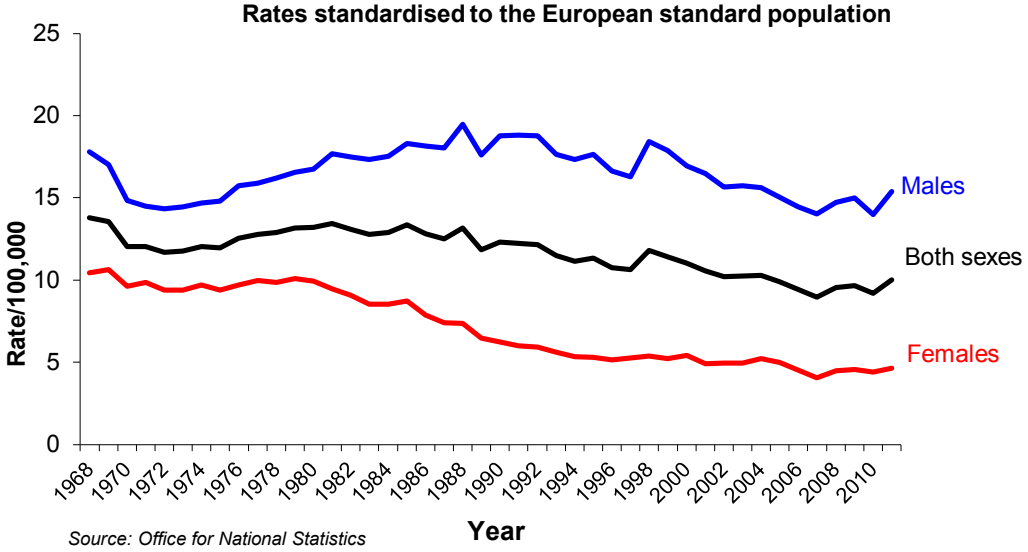


Suicide rates by sex and age groups in England and Wales

Figure 9 shows overall rates of suicide (including open verdicts) by gender, in persons aged 10 years and over, for England and Wales from 1968 to 2011. Suicide rates had been declining steadily in both genders in recent years, though they have been increasing since 2008, especially in males.

FIGURE 9

Mortality from suicide and open verdicts in people aged 10 years and over in England and Wales, 1968-2011, by gender
Rates standardised to the European standard population

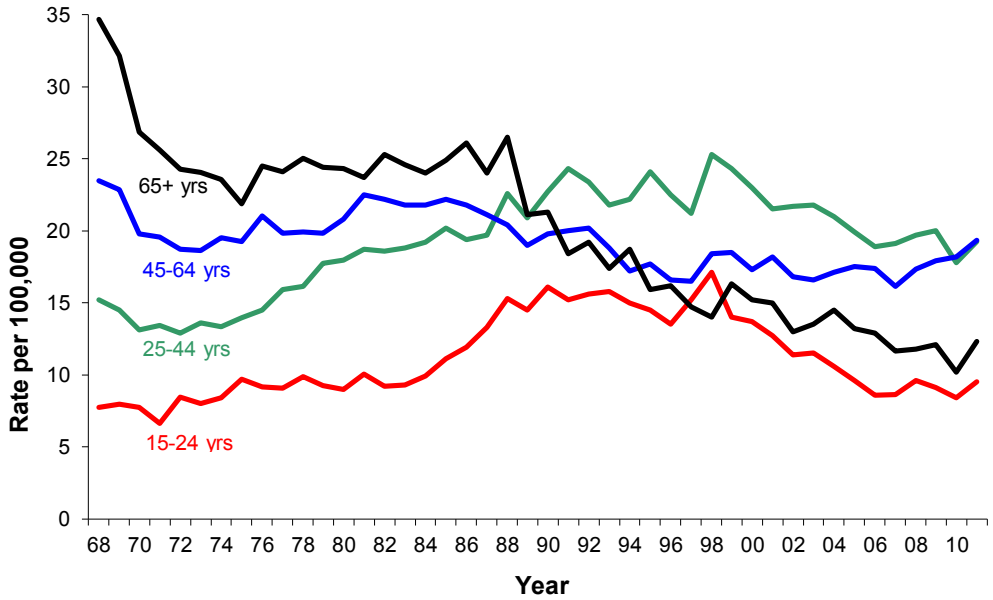


Source: Office for National Statistics

Figures 10 and 11 show suicide rates (suicides and open verdicts) for England and Wales between 1968 and 2011 for specific age groups, by gender. In 2011, rates in males increased in 45-64 year-olds. In females the rates increased in all age groups.

FIGURE 10

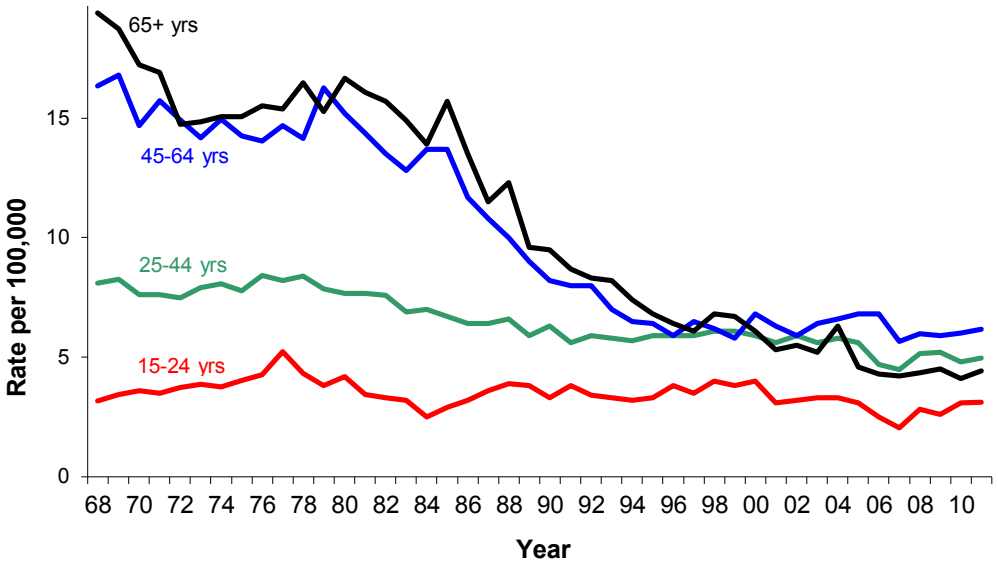
Rates of suicide and open verdicts in England & Wales 1968-2011 by age groups
Rates standardised to the European standard population: Males



Data are for registrations of death in each calendar year

FIGURE 11

Rates of suicide and open verdicts in England & Wales 1968-2011 by age groups
Rates standardised to the European standard population: Females



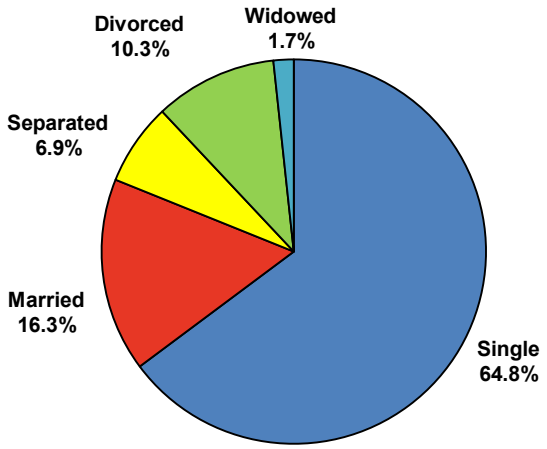
Data are for registrations of death in each calendar year

Marital status

As in previous years, the majority of assessed self-harm patients in 2011 were single (Figure 12).

FIGURE 12

Marital status of assessed patients (aged 16+ years) in 2011

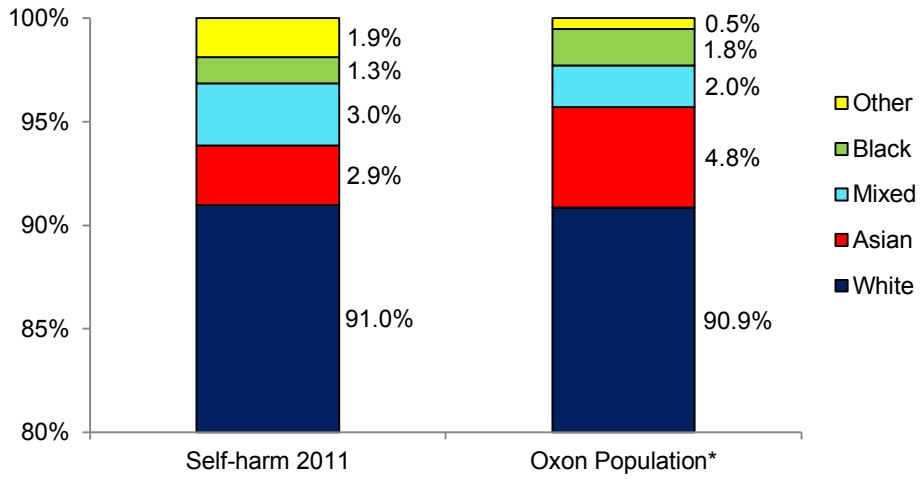


Ethnicity

In 2011, information on ethnicity was recorded for 93.6% of assessed self-harm patients. Overall, white patients reflected the proportions found in the 2011 Census for Oxfordshire. However, Asian and Black groups were under-represented and Mixed and Other groups over-represented compared with the general population, as can be seen in Figure 13.

FIGURE 13

Ethnicity in Oxfordshire self-harm patients vs. ethnic makeup of Oxford District population



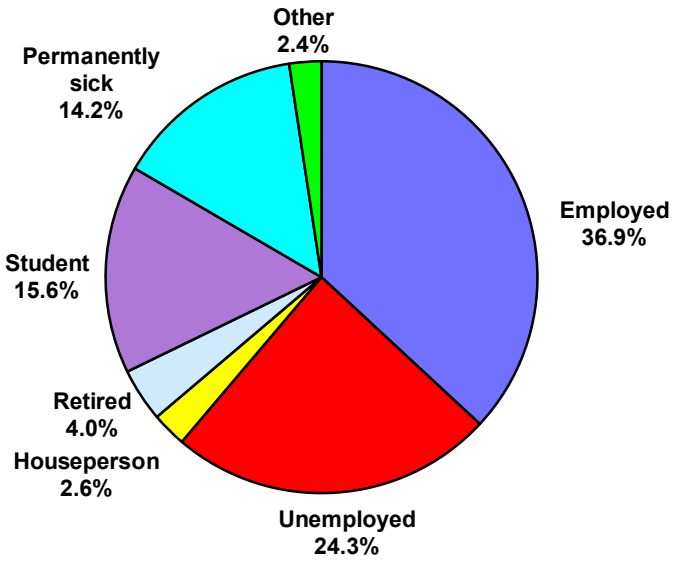
**Data from 2011 Census*

Employment status

In 2011, 24.3% of the self-harm patients (aged 16 years and over) were **unemployed** (Figure 14), a higher figure than in 2010 (22.6%). 14.2% were permanently sick, lower than 2010 (15.9%), which may indicate that some patients are being taken off sickness benefits and transferred to the unemployment register. Of those persons for whom the duration of unemployment was known, 55.3% had been unemployed for **more than a year** and 10.6% for **less than one month**.

FIGURE 14

Employment status of assessed self-harm patients (aged 16+ years) in 2011



University Students

Of the assessed self-harm patients in 2011, 112 were **students** (including school students). These included 23 **Oxford University students** (18 females and 5 males) and 20 **Oxford Brookes University students** (17 females and 3 males).

Living situation

The majority of assessed patients in 2011 **lived with family members or friends** (65.3%). The remainder (34.7%) were **living in lodgings, alone,** or **in an institution,** or were of **no fixed abode**. A significantly greater proportion of males (40.1%) than females (30.9%) were not living with relatives or friends ($\chi^2 = 6.60$, $p<0.05$). Twenty-four patients were of **no fixed abode**, representing 3.3% of all assessed patients whose living situation was known: 6.2% of males (N = 19) of males and 1.2% (N = 5) of females).

Repetition of self-harm

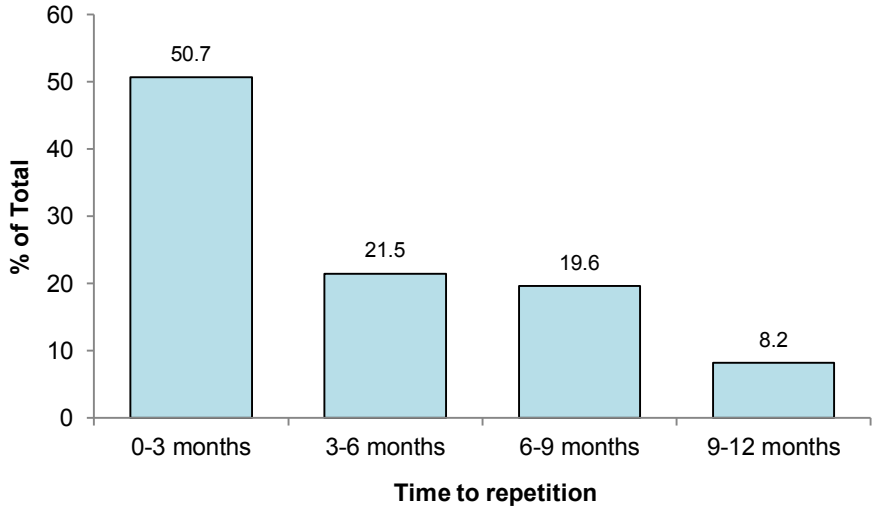
One measure of repetition is the ratio of the number of self-harm episodes to the number of persons. In 2011 the ratio was 1.4, the same as in 2010. However, it should be noted that

individual patients having very large numbers of episodes could distort this figure. The episodes to persons ratio for males was 1.3 and for females was 1.4.

Another measure of repetition is the actual proportion of patients who repeat self-harm within twelve months of their first episode in a calendar year. We can of course only measure this for patients who presented in the previous year (2010) and repetition will only be identified for those who present to the general hospital following subsequent episodes. Of patients who presented in **2010**, 19.4% repeated self-harm within a year. The repetition rate for females was 19.7% and for males 19.0%. Figure 15 gives the timing of these episodes and shows that more than half of patients who re-present to the general hospital within a year will do so within three months. More than one-quarter (27.9%) repeated within one month of their initial presentation.

FIGURE 15

Patients who presented during 2010 and re-presented to hospital within one year: Time to repetition



Another relevant measure is the extent to which people are engaging in their first-ever episode of self-harm. In 2011, 31.6% (33.5% males, 30.2% females) of the assessed patients whose self-harm history was known harmed themselves for the first time.

Of those patients who were assessed in **2010** and had no previous history of self-harm, 11.3% repeated within the following year (12.8% males, 10.2% females) compared with 22.9% of those who had a known previous history of self-harm (25.7% males, 21.5% females). These figures are in keeping with many research findings showing that a history of previous self-harm is the best predictor of future repetition.

Methods used for self-harm

In 2011, 70.7% of self-harm episodes involved **self-poisoning**, 22.9% **self-injury** and 6.4% **both methods**.

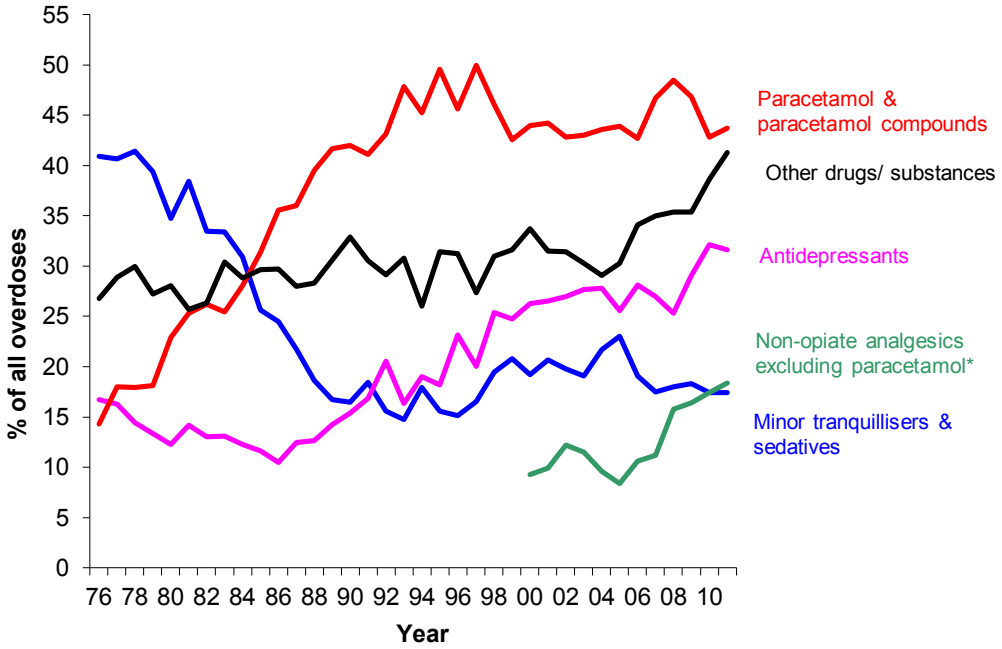
Figure 16 shows the percentages of overdoses involving specific groups of drugs. The proportion of overdoses involving **paracetamol** (including compounds) was 43.7% in 2011. In under-16 year-olds 78.3% of all overdoses involved paracetamol.

In 2011, 118 (9.6%) of overdoses involved paracetamol and codeine combined preparations (e.g. co-codamol); in 2010 there were 111 (8.8%) such overdoses. These preparations made up 22.1% of all paracetamol (including compound) overdoses.

Pure paracetamol was involved in 80.0% of all paracetamol overdoses and paracetamol in compound form in 26.2% (some involved both forms of paracetamol). Just one overdose involved **co-proxamol** (paracetamol with dextropropoxyphene). In January 2005 the Medicines and Healthcare Products Regulatory Agency announced withdrawal of co-proxamol from January 2008, with a three year withdrawal phase (2005-2007), when no new patients could be prescribed this drug. In 2000-2004 an average of 53.6 co-proxamol overdoses per year were seen. Non-steroidal anti-inflammatory drugs were involved in 18.1% of overdoses in 2011.

FIGURE 16

Substances used in self-poisoning 1976-2011



** Accurate figures available from 2000 onwards*

Minor tranquillisers and sedatives were involved in 17.4% of overdoses, a similar percentage to recent years.

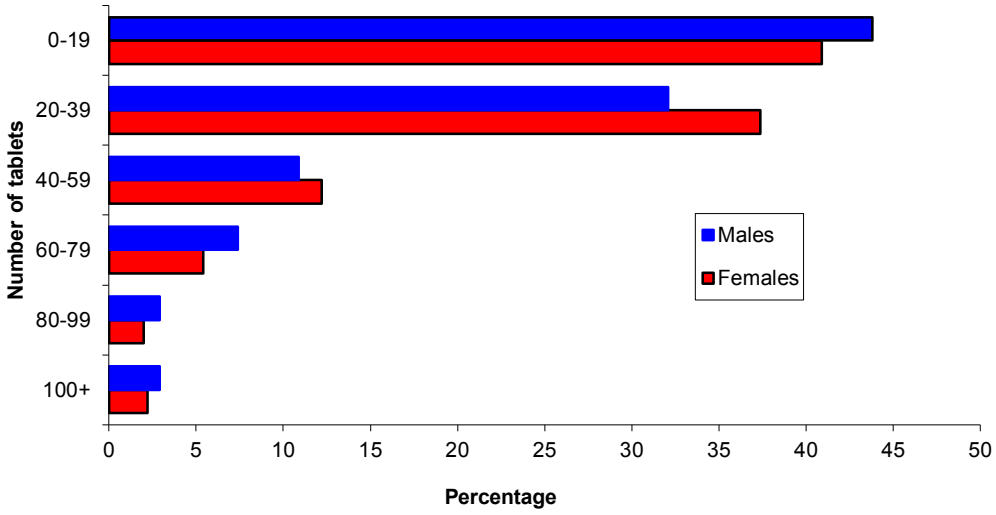
Antidepressants (including mood stabilisers) were involved in 31.6% of overdoses, the highest proportion we have recorded. Of these overdoses, 62.0% involved **SSRIs/SNRIs**, 23.0% **tricyclics,** 17.1% **other antidepressants** (e.g. trazodone, mirtazapine) and 7.2% **mood stabilisers** (some overdoses involved more than one type of antidepressant)

In 2011, 26 overdoses by under-18 year-olds (26 persons) involved antidepressants, compared with 19 in 2010 and an annual average of 30 during 2001-2003. In December 2003 the MHRA discouraged the use of SSRIs, except for fluoxetine, in under-18 year-olds. In 2011 10 (38.5%) of the 26 antidepressant overdoses in this age group involved fluoxetine, compared with 23 out of 91 (25.3%) overdoses during 2001-2003, and 6 involved citalopram. Four individuals took tricyclic antidepressants and two overdosed on mood stabilisers.

Information on the **number of tablets** taken in overdoses was available for 937 cases in 2011. The mean number taken in overdose was 29.4 (SD 25.8, median = 22.0) tablets. As can be seen in Figure 17, the majority of overdoses involved less than 40 tablets (77.4%). There was no significant difference between males and females (median values: males 21, females 22; z = 0.148, ns).

FIGURE 17

Numbers of tablets taken in overdose in 2011, by sex



Of the self-injuries, **self-cutting** was as usual the most common, this being the method used by 77.0% (N = 359) of self-injurers (69.4% males, 82.0% females) in 2011. Other methods included hanging, strangulation and asphyxiation (28), and jumping (20). The number of hangings, strangulations and asphyxiations (13 by males and 15 by females) remains high, particularly in females.

Alcohol

In 2011, as in previous years, **alcohol** was often consumed **at the time of self-harm** (28.0% of assessed episodes). This figure was similar in males and females (27.6% males, 28.3% females), unlike previous years when the proportion has been higher in males. Alcohol had very often been consumed **during the six hours before the episode** (49.5%), though here more commonly by males (52.6%) than females (47.4%).

Alcohol involvement in self-harm (based on data for 2009-11) varied by age group (see Figure 18). In males, alcohol involvement was most frequent in those under 45 years. In females, this was most prevalent in 45-54 and 55-64 year-olds (in which more episodes by females than males involved alcohol). Alcohol was least involved in self-harm episodes by females aged 65 years and over. There was a tendency for greater involvement of alcohol in females presenting at weekends. Levels in males were high all week, but lower on Tuesdays than on other days (see Figure 19).

FIGURE 18

Alcohol involvement in self-harm by age group

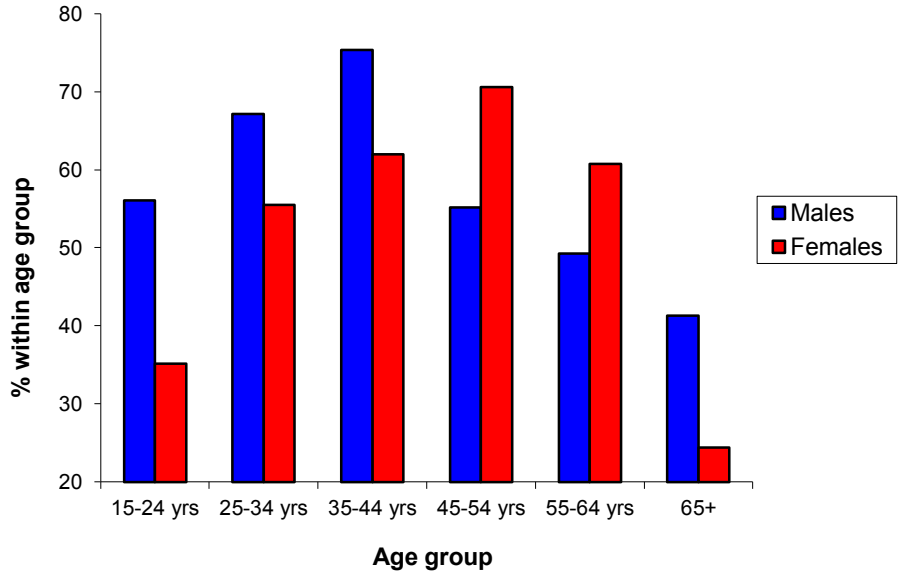
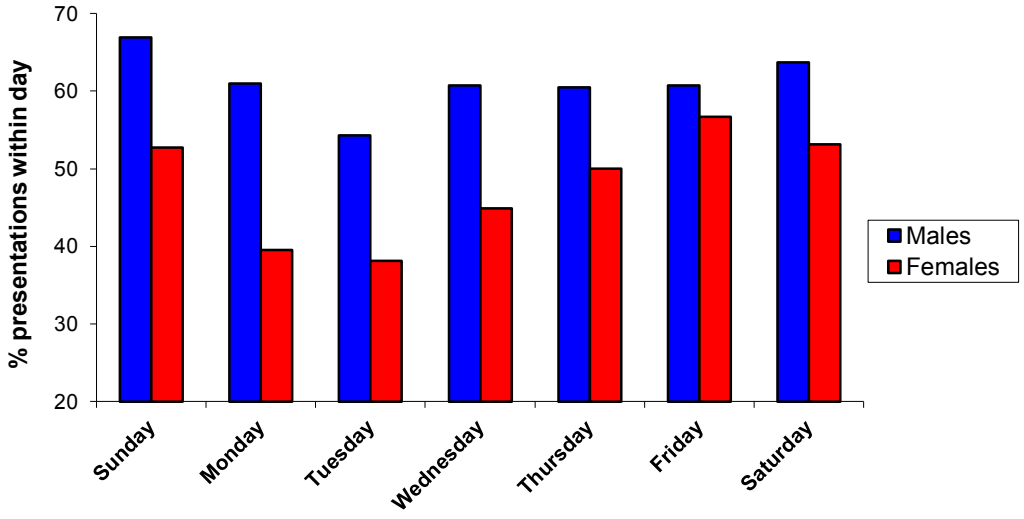


FIGURE 19

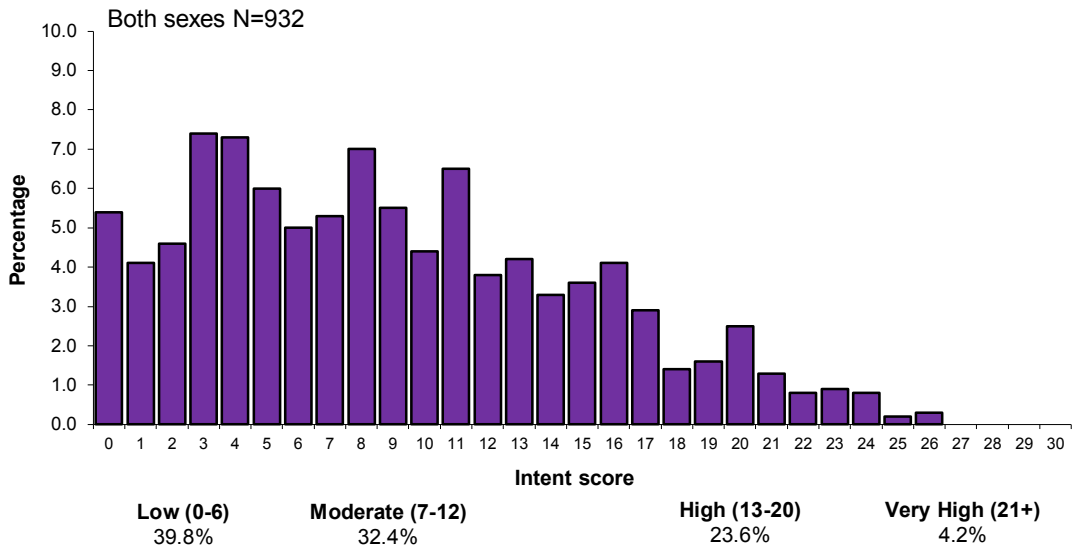
Alcohol involvement in self-harm by day of presentation (assessed episodes)

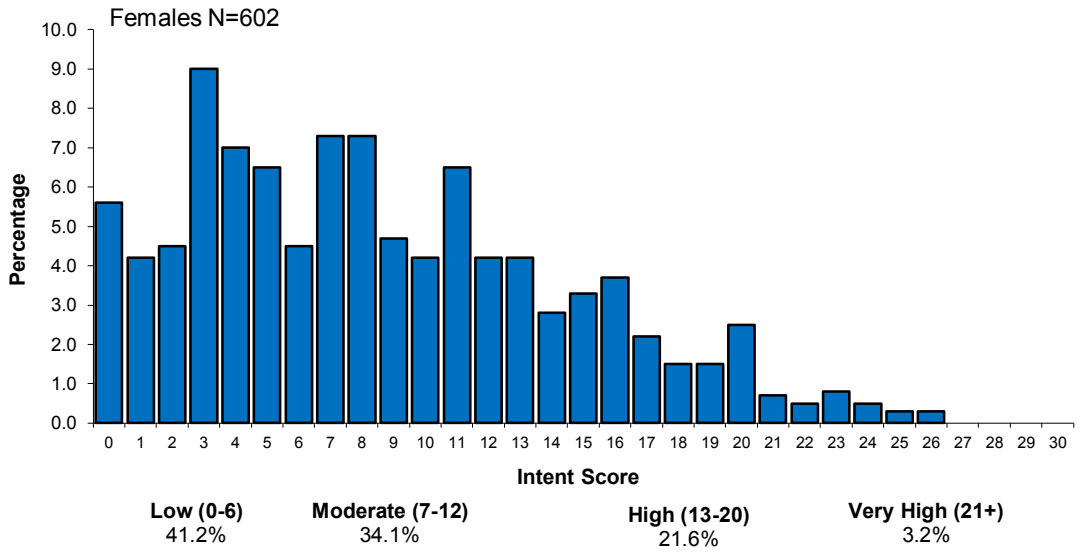


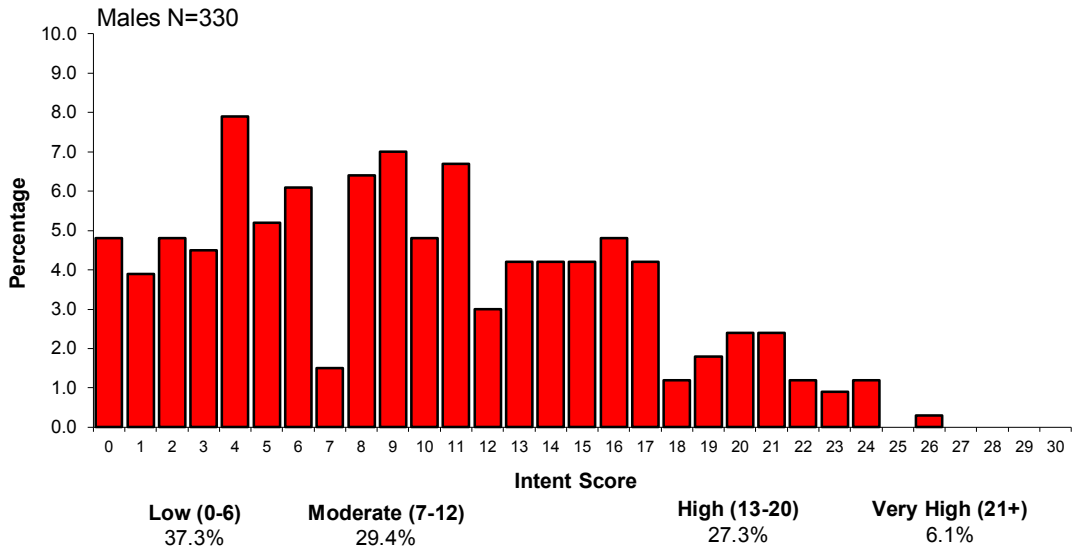
Suicide intent

The **Suicide Intent Scale** (which measures the extent to which patients appeared to want to die) (see Figure 20) was completed by the clinical assessors for 868 episodes in 2011 (83.4% of episodes in which an assessment occurred). The median suicide intent score for males was 10 and for females was 8 ($z = 1.967$, $p<0.049$). The classification of scores into low, moderate, high and very high categories indicated that the scores of 28.1% of cases were in the high (13-20) or very high (21+) range. High or very high scores were recorded for 30.0% of males and 26.8% of females.

FIGURE 20
Suicide Intent Scale scores, overall and by sex



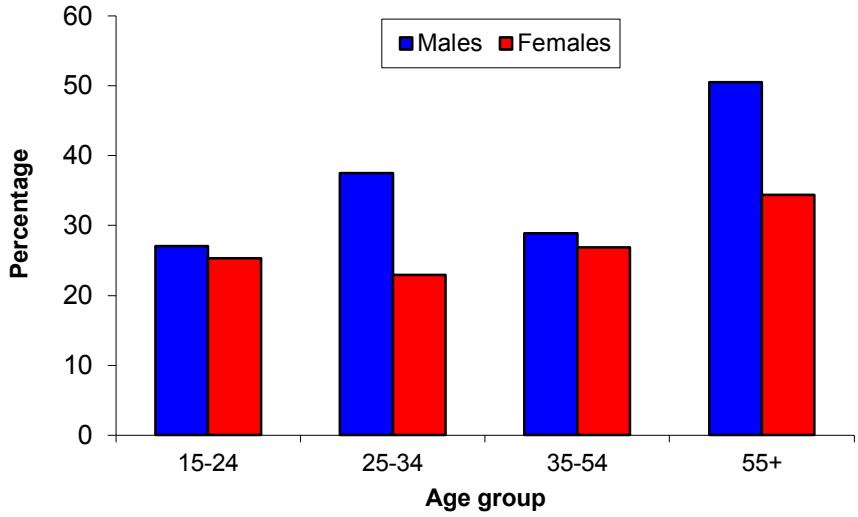




Suicide intent scores by age and sex for the years 2009-2011 combined, in terms of those having relatively high scores, showed, as in previous years, scores increasing with age group in both sexes. This was significant in males (χ^2 for linear trend = 6.15, $p < 0.05$) although not for females (χ^2 for linear trend = 2.23, p=0.14, n.s.). Over 40% of episodes in those aged 55 years and over involved relatively high scores (Figure 21)

FIGURE 21

Suicide intent by age and sex, 2009-2011
High and Very High scores (SIS = 13-30)



Psychiatric disorder and substance misuse

On the basis of a global report for patients who were assessed in 2011, 43.3% were reported as having a **major psychiatric disorder** (39.8% of the males and 45.6% of the females)**.** These figures will considerably under-represent the proportions with any type of psychiatric disorder. In addition, **misuse of alcohol** was recorded for 44.5% of the males and 32.7% of the females, a somewhat higher figure for females than in 2010. Those misusing alcohol included for males (females in brackets): 4.2% (1.6%) with **chronic alcoholism**, 8.8% (2.4%) with **alcohol dependence** and 31.5% (28.7%) who were known to be **drinking more than the recommended maximum safe number of units**.

Drug misuse was recorded for 16.5% of the patients in 2011, including 23.0% of males and 12.1% of females.

Personality disorder was identified in 23.0% of patients in 2011, including 17.5% of the males and 26.6% of the females. These figures are likely to reflect those with more severe personality disorders.

Problems at the time of self-harm

A 'problem' is defined as a factor that was causing current distress for the patient and/or contributed to the episode of self-harm. As found in previous years, the most frequent problems identified at the time of the self-harm episodes were **relationship difficulties** (66.3%). As usual, difficulties with a partner was the most common problem, with a similar frequency in males and females, followed by problems with a family member, which was more common in females than males (Table 2).

TABLE 2

The most frequent types of problems identified at assessment in 2011

Problem	Both sexes (N=794)	Males (N=322)	Females (N=472)	p
	%	%	%	
Partner	40.4	41.9	39.4	ns
Other family member	37.5	30.1	42.6	<0.001
Employment /studies	30.1	34.5	27.1	<0.05
Alcohol	27.5	34.2	22.9	<0.001
Financial	22.9	27.6	19.7	<0.01
Housing	15.9	17.4	14.8	ns
Social isolation	15.5	15.5	15.5	ns
Friends	12.5	7.5	15.9	<0.001
Drugs	11.8	17.4	8.1	<0.001
Physical health	9.7	9.6	9.7	ns
Bereavement	8.8	9.9	8.1	ns
Childhood sexual abuse	7.3	5.0	8.9	<0.05

Males were more likely to suffer from problems with **employment, alcohol, finances and drugs**, whereas problems with **other family members, friends, and childhood sexual abuse** were more frequent in the females. **Eating disorders problems** were present in 5.1% of the females. Problems due to **the consequences of childhood physical abuse** were recorded in 5.1% of the females and 4.0% of the males, and those due to childhood emotional abuse in 8.5% of females and 5.6% of males. Problems related to **chronic pain** were identified in 4.0% of males and 3.2% of females.

Assessments by the Emergency Psychiatric Service (Barnes Unit)

A total of 1067 self-harm episodes resulted in **admission to a bed in the general hospital** in 2011 (67.2% of all episodes; Table 3). It should be noted that for the purpose of our monitoring, admission to the Clinical Decision Unit or Emergency Assessment Unit is counted as a hospital admission.

1042 **assessments of self-harm patients** were conducted by members of the Emergency Psychiatric Service in the John Radcliffe Hospital in 2011. Overall, 65.6% of patients were assessed. Only 30.3% of the non-admitted patients received an assessment.

TABLE 3

Referrals to the general hospital and those assessed by the hospital psychiatric service following self-harm in 2011

	Admitted (N=1066; 67.1%)		Not Admitted (N=522; 32.9%)		Overall (N=1588)	
Assessed						
Yes	82.9%	(884)	30.3%	(158)	65.6%	(1042)
No	17.1%	(182)	69.7%	(364)	34.4%	(546)

The number of episodes where the patient **left the hospital without being assessed** was 542 (341 males, 203 females). Of those not assessed, 208 took their own discharge, 35 refused assessment, there was a policy decision not to assess the patient in 7 presentations, 69 were in current psychiatric inpatient care, 14 were in current psychiatric outpatient care, and 20 were not assessed for other reasons. The remaining 189 patients were not identified for assessment. This is in spite of NICE guidance that all self-harm patients should receive a psychosocial assessment. A further four patients died before assessment.

In 2011, 44.9% (N=468) self-harm patients were assessed by nurses or social workers and 55.1% (N=574) by doctors. This continues the change from the previous pattern when a far greater proportion of patients were assessed by nurses and fewer by doctors. The change began during the second half of 2006 following reconfiguration of the self-harm service, when the number of nursing staff was reduced.

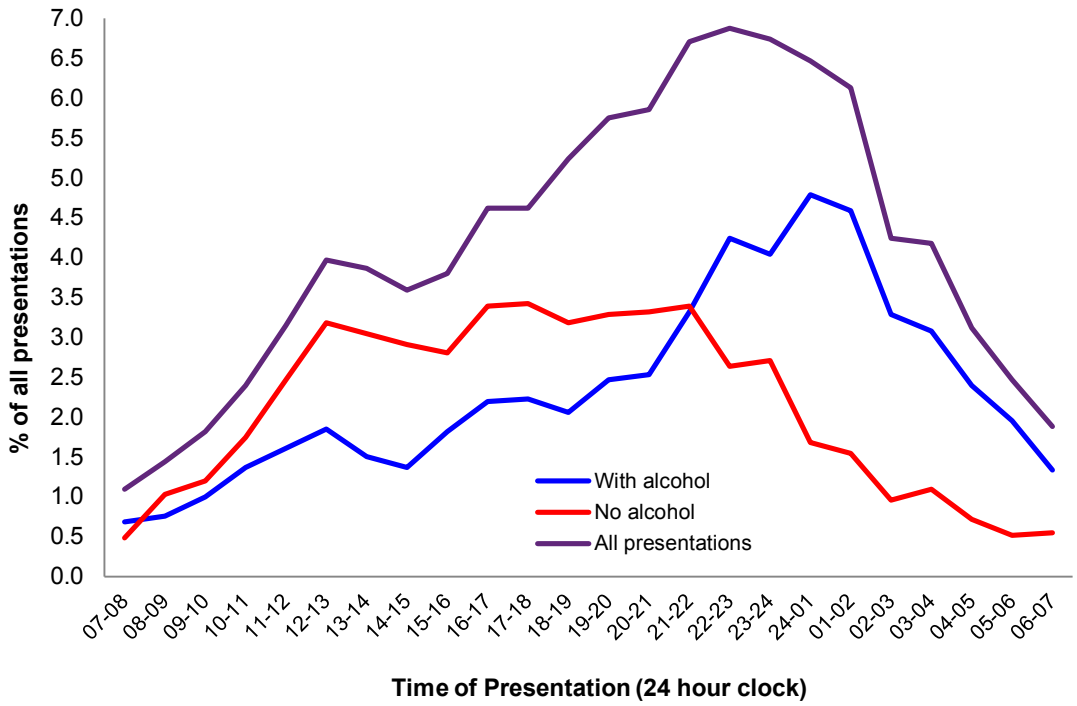
An assessment was conducted following 72.1% of episodes involving self-poisoning but in only 43.7% of self-injuries alone. Just 41.9% of episodes of self-cutting alone resulted in an assessment whereas an assessment occurred in 50.0% of episodes involving any other form of self-injury alone.

Time of presentation in the Emergency Department

Figure 22 shows the time of presentation to the Emergency Department for assessed self-harm episodes in **2009-2011**. Outside the working day, especially in the late evening and early hours of the morning, in the majority of self-harm episodes alcohol had been consumed shortly before and/or as part of the act.

FIGURE 22

Time of presentation to the Emergency Department, overall, and whether or not self-harm episode involved alcohol (during 6 hours beforehand and/or as part of act)*; 2009-2011



Assessed presentations only

In 2011, 26.3% of all patients (including those who were not assessed) presented between 9 a.m. and 5 p.m. and the remainder (73.2%) between 5 p.m. and 9 a.m.

For patients who were admitted to a hospital bed in the general hospital, the time of presentation to the Emergency Department made no significant difference to whether or not they received a psychiatric assessment, in that 84.1% of those presenting between 9 a.m. and 5 p.m. were assessed compared with 82.4% of those presenting after 5 p.m. (χ^2 = 0.427, ns).

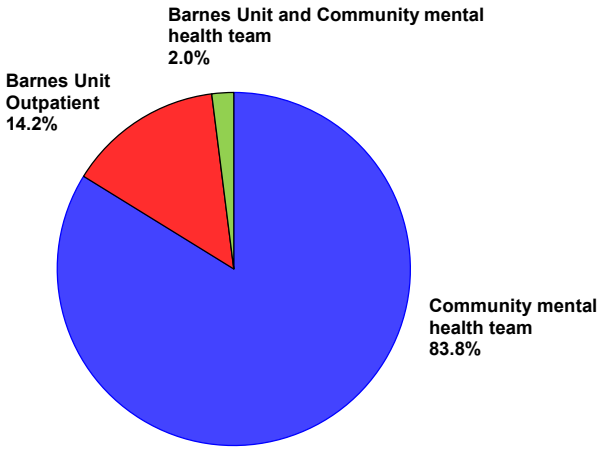
Time of presentation also made no significant difference to assessment of those not admitted to a hospital bed in that 36.1% of those who presented in the daytime were assessed compared with 28.3% of those who presented after 5 p.m. (χ^2 = 2.662, ns).

Aftercare

Of the assessed self-harm episodes which resulted in a referral for **outpatient psychiatric aftercare** (N = 543), in 48.8% of cases patients were known to be receiving psychiatric care at the time of their episode. For those patients offered **Outpatient/community psychiatric care,** the type of care offered is shown in Figure 23. In 16.2% of cases this included follow-up by the Barnes Unit service.

FIGURE 23

Psychiatric and community outpatient care in patients offered aftercare



The proportion of assessed cases in 2011 in which I**npatient psychiatric care** in Oxford was arranged following discharge from the John Radcliffe was 6.2% (N = 64) (Table 4). 43.8% (28/64) were new admissions, the remainder (56.3%) being people who were already psychiatric patients at the time of their self-harm episodes. Thus an episode of new inpatient care was provided for 2.7% of all assessed patients.

TABLE 4

Aftercare accepted following assessment in 2011 (N=1040) according to whether or not patients were in current psychiatric care

			New patient		Current patient	
	%[2]	n	%	n	%	n
Inpatient psychiatric care	*6.2*	64	*2.7*	28	*3.5*	36
Outpatient psychiatric care:						
Community MH Teams	*41.8*	435	*17.8*	185	*24.0*	250
Barnes Unit	*8.5*	88	*7.4*	77	*1.1*	11
Crisis Resolution Team	*12.0*	125	*5.5*	57	*6.5*	68
Day patient psychiatric care	*0.9*	9	*0.1*	1	*0.8*	8
GP care (alone or for GP-led services)	*30.4*	316				
Other[1]	*14.3*	149				
Took own discharge	*0.2*	2				

[1] Other includes e.g. Social Services, voluntary agencies, Elmore team and probation or custody

[2] The percentages total more than 100% because some patients have more than one outcome (e.g. outpatient care and referral to voluntary agency).

The proportion of assessed patients **referred back to GP care** alone in 2011 was 30.4%, although this would have included cases where primary care-led treatment (e.g. counselling) or GP referral for treatment were recommended. This figure is a gross underestimate when account is taken of the number of patients discharged without a psychosocial assessment.

RECENT RESEARCH FINDINGS FROM THE OXFORD MONITORING SYSTEM FOR ATTEMPTED SUICIDE

Below are brief summaries of some projects based on data collected through the monitoring system which have recently been published. The abstracts have been modified from those in the original publications.

Premature death following self-harm: a multicentre cohort follow-up study

Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S. & Kapur, N. (2012) *The Lancet*, **380**, 1568-1574.

BACKGROUND: People who self-harm have an increased risk of premature death. The aim of this study was to investigate cause-specific premature death in individuals who self-harm, including associations with socioeconomic deprivation.

METHODS: We undertook a cohort study of patients of all ages presenting to emergency departments in Oxford, Manchester, and Derby, after self-poisoning or self-injury between Jan 1, 2000, and Dec 31, 2007. Postcodes of individuals' place of residence were linked to the Index of Multiple Deprivation 2007 in England. Mortality information was supplied by the Medical Research Information Service of the National Health Service. Patients were followed up to the end of 2009. We calculated age-standardised mortality ratios (SMRs) and years of life lost (YLL), and we tested for associations with socioeconomic deprivation.

RESULTS: 30 950 individuals presented with self-harm and were followed up for a median of 6·0 years (IQR 3·9-7·9). 1832 (6·1%) patients died before the end of follow-up. Death was more likely in patients than in the general population (SMR 3·6, 95% CI 3·5-3·8), and occurred more in males (4·1, 3·8-4·3) than females (3·2, 2·9-3·4). Deaths due to natural causes were 2-7·5 times more frequent than was expected. For individuals who died of any cause, mean YLL was 31·4 years (95% CI 30·5-32·2) for male patients and 30·7 years (29·5-31·9) for female patients. Mean YLL for natural-cause deaths was 25·9 years (25·7-26·0) for male patients and 25·5 years (25·2-25·8) for female patients, and for external-cause deaths was 40·2 years (40·0-40·3) and 40·0 years (39·7-40·5), respectively. Disease of the circulatory (13·1% in males; 13·0% in females) and digestive (11·7% in males; 17·8% in females) systems were major contributors to YLL from natural causes. All-cause mortality increased with each quartile of socioeconomic deprivation in male patients (X^2 trend 39·6; p<0·0001), female patients (13·9; p=0·0002), and both sexes combined (55·4; p<0·0001). Socioeconomic deprivation was related to mortality in both sexes from natural causes (51·0; p<0·0001) but not from external causes (0·30; p=0·58). Alcohol problems identified at the time of self-harm were associated with death from digestive-system disease, drug misuse with mental and behavioural disorders, and physical health problems with circulatory-system disease.

CONCLUSION: Physical health and life expectancy are severely compromised in individuals who self-harm compared with the general population. In the management of self-harm, clinicians assessing patients' psychosocial problems should also consider their physical needs.

Risk factors associated with repetition of self-harm in black and minority ethnic (BME) groups: a multi-centre cohort study

Cooper, J., Steeg, S., Webb, R., Kaiser-Stewart, S., Applegate, E., Hawton, K., Bergen, H., Waters, K. & Kapur, N. (2013) *Journal of Affective Disorders,* **148**, 435-439.

BACKGROUND: Little information is available to inform clinical assessments on risk of self-harm repetition in ethnic minority groups.

METHODS: In a prospective cohort study, using data collected from six hospitals in England for self-harm presentations occurring between 2000 and 2007, we investigated risk factors for repeat self-harm in South Asian and Black people in comparison to Whites.

RESULTS: During the study period, 751 South Asian, 468 Black and 15,705 White people presented with self-harm in the study centres. Repeat self-harm occurred in 4379 individuals, which included 229 suicides (with eight of these fatalities being in the ethnic minority groups). The risk ratios for repetition in the South Asian and Black groups compared to the White group were 0.6, 95% CI 0.5-0.7 and 0.7, 95% CI 0.5-0.8, respectively. Risk factors for repetition were similar across all three groups, although excess risk versus Whites was seen in Black people presenting with mental health symptoms, and South Asian people reporting alcohol use and not having a partner. Additional modelling of repeat self-harm count data showed that alcohol misuse was especially strongly linked with multiple repetitions in both BME groups.

LIMITATIONS: Ethnicity was not recorded in a third of cases which may introduce selection bias. Differences may exist due to cultural diversity within the broad ethnic groups.

CONCLUSION: Known social and psychological features that infer risk were present in South Asian and Black people who repeated self-harm. Clinical assessment in these ethnic groups should ensure recognition and treatment of mental illness and alcohol misuse.

Does clinical management improve outcomes following self-harm? Results from the Multicentre Study of Self-Harm in England

Kapur, N., Steeg, S., Webb, R., Haigh, M, Bergen, H., Hawton, K., Ness, J, Waters, K, Cooper, J. (2013) *PLOS ONE,* **8**, 1-7

BACKGROUND: Evidence to guide clinical management of self-harm is sparse, trials have recruited selected samples, and psychological treatments that are suggested in guidelines may not be available in routine practice.

AIMS: To examine how the management that patients receive in hospital relates to subsequent outcome.

METHODS: We identified episodes of self-harm presenting to three UK centres (Derby, Manchester, Oxford) over a 10 year period (2000 to 2009). We used established data collection systems to investigate the relationship between four aspects of management (psychosocial assessment, medical admission, psychiatric admission, referral for specialist mental health follow up) and repetition of self-harm within 12 months, adjusted for differences in baseline demographic and clinical characteristics.

RESULTS: 35,938 individuals presented with self-harm during the study period. In two of the three centres, receiving a psychosocial assessment was associated with a 40% lower risk of repetition, Hazard Ratios (95% CIs): Centre A 0.99 (0.90–1.09); Centre B 0.59 (0.48–0.74); Centre C 0.59 (0.52–0.68). There was little indication that the apparent protective effects were mediated through referral and follow up arrangements. The association between psychosocial assessment and a reduced risk of repetition appeared to be least evident in individuals from the most deprived areas.

CONCLUSION: These findings add to the growing body of evidence that thorough assessment is central to the management of self-harm, but further work is needed to elucidate the possible mechanisms and explore the effects in different clinical subgroups.

The sad truth about the SADPERSONS Scale: an evaluation of its clinical utility in self-harm patients

Saunders, K., Brand, F., Lascelles K., Hawton K. (2013) *Emergency Medicine Journal* doi 10.1136/emermed-2013-202781

BACKGROUND: The SADPERSONS Scale is commonly used as a screening tool for suicide risk in those who have self-harmed. It is also used to determine psychiatric treatment needs in those presenting to emergency departments. To date, there have been relatively few studies exploring the utility of SADPERSONS in this context.

OBJECTIVES: To determine whether the SADPERSONS Scale accurately predicts psychiatric hospital admission, psychiatric aftercare and repetition of self-harm at presentation to the emergency department following self-harm.

METHODS: SADPERSONS scores were recorded for 126 consecutive admissions to a general hospital emergency department. Clinical management outcomes following assessment were recorded, including psychiatric hospital admission, community psychiatric aftercare and repetition of self-harm in the following 6 months.

RESULTS: Psychiatric hospital admission was required in five cases (4.0%) and community psychiatric aftercare in 70 (55.5%). 31 patients (24.6%) repeated self-harm. While the specificity of the SADPERSONS scores was greater than 90% for all outcomes, sensitivity for admission was only 2.0%; for community aftercare was 5.8%; and for repetition of self-harm in the following 6 months was just 6.6%.

CONCLUSIONS: For the purposes of suicide prevention, a low false negative rate is essential. SADPERSONS failed to identify the majority of those either requiring psychiatric admission or community psychiatric aftercare, or to predict repetition of self-harm. The scale should not be used to screen self-harm patients presenting to general hospitals. Greater emphasis should be placed on clinical assessment which takes account of the individual and dynamic nature of risk assessment.

MULTICENTRE MONITORING OF SELF-HARM: A PROJECT IN SUPPORT OF THE NATIONAL SUICIDE PREVENTION STRATEGY FOR ENGLAND

As part of the first *National Suicide Prevention Strategy for England,*[1] multicentre monitoring of self-harm has been established with funding from the Department of Health. This study is being co-ordinated by the Centre for Suicide Research at the University of Oxford using data from the Oxford Monitoring System for Attempted Suicide, with collaborating centres at the University of Manchester, the University of Leeds and Derbyshire Healthcare NHS Foundation Trust. The aims of this project are:

- Provision of accurate data on national trends and patterns in self-harm that can inform suicide and self-harm prevention strategies;
- Identification of differences between centres which can be related to local characteristics or styles of service provision (for instance, assessment and admission policies);
- Detection of changing patterns of self-harm, including the study of less common methods of self-harm;
- Provision of information relevant to healthcare costs of self-harm;
- Establishment of a database that can be used to evaluate national initiatives (for example, the National Institute for Clinical Excellence (NICE) guideline on the short-term treatment and management of self-harm;[2] and
- Establishment of a network that can take on other specific research projects, including evaluation of treatments and prevention initiatives.

In the initial phase of the project, analysis of retrospective data for the 18-month period 1st March 2000 to 31st August 2001 was undertaken.[3,4,5,6,7,8]

The project has since been extended and data on self-harm collected in six general hospitals in Oxford, Manchester and Derby for 2000-2010 have been merged into a multicentre database (71,493 episodes by 41,427 individual persons) aged 7 years or more). Mortality information was provided by the Data Linkage Service of the NHS, and patients have been followed up to the end of 2012. Studies using the multicentre database have included:

a) Risk of suicide and other types of death following self-harm, including risk factors.[9,10,11]

b) Extent of self-harm in ethnic groups,[12] older people,[11] and children and adolescents[13,14,] and the characteristics, clinical management, and outcome of those involved.

c) Type of hospital management following self-harm and its relationship to outcome[19], and to refine a clinical assessment tool for use by Emergency Department staff[20].

d) How specific antidepressants are related to self-harm[15], their relative toxicity in overdose,[16] and the impact of national legislation to reduce pack sizes of paracetamol and aspirin and to withdraw co-proxamol.[17]

e) Trends in the prescribing of and self-poisoning with antidepressants in relation to warnings from the Committee for Safety of Medicines on use of SSRI antidepressants for adolescents.[18]

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