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Deliberate Self-Harm in Oxford 2009

Keith Hawton, Deborah Casey, Elizabeth Bale,
Dorothy Rutherford, Helen Bergen, Sue Simkin,
Fiona Brand and Karen Lascelles

CENTRE FOR SUICIDE RESEARCH
Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX

&

Barnes Unit, Department of Psychological Medicine,
John Radcliffe Hospital, Oxford

This report is based on data collected by the Oxford Monitoring System for Attempted Suicide, which was first established in 1976. Information is collected on all cases of deliberate 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 2009. 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, under the consultant leadership of Drs. Christopher Bass and Eleanor Feldman. Thanks are owed to all members of the service who have helped collect the data, including Fiona Brand, Clare Bowthorpe-Weller, John Ryall, Karen Lascelles, Adrian Bradshaw-Jones 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 2009. We thank Delecia Perera, Emergency Department Information Officer at the John Radcliffe Hospital, 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 National Information Governance Board under Section 251 of the NHS Act 2006 and 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>

Please address any correspondence to:

Professor Keith Hawton, Centre for Suicide Research, University Department of Psychiatry,
Warneford Hospital, Oxford, OX3 7JX (email: keith.hawton@psych.ox.ac.uk)

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DEFINITION OF DELIBERATE SELF-HARM

Deliberate self-harm (DSH) is defined as intentional self-injury or self-poisoning, irrespective of type of motivation or degree of suicidal intent.ⁱ This definition, which is used widely in a similar way in countries in Europeⁱⁱ and elsewhereⁱⁱⁱ, thus encompasses both 'suicide attempts' and acts with other motives or intentions. This reflects the often mixed nature of intentions associated with self-harm^{iv,v} and also the fact that suicidal intent is a dimensional rather than unitary phenomenon.^{vi} 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 deliberate self-harm. Self-injury is defined as any injury that has been deliberately self-inflicted (e.g. self-cutting, jumping from a height).

ⁱ Hawton K, Harriss L, Hall S, Simkin S, Bale E, Bond A. Deliberate self-harm in Oxford, 1990-2000: a time of change in patient characteristics. *Psychol Med* 2003; **33**: 987-96.

ⁱⁱ Schmidtke A, Bille Brahe U, De Leo D, Kerkhof A, Bjerke T, Crepet P, et al. Attempted suicide in Europe: rates, trends and sociodemographic characteristics of suicide attempters during the period 1989-1992. Results of the WHO/EURO Multicentre Study on Parasuicide. *Acta Psychiatr Scand* 1996; **93**: 327-38.

ⁱⁱⁱ Carter G, Reith DM, Whyte IM, McPherson M. Repeated self-poisoning: increasing severity of self-harm as a predictor of subsequent suicide. *Br J Psychiatry* 2005; **186**: 253-7.

^{iv} Bancroft JHJ, Skrimshire AM, Simkin S. The reasons people give for taking overdoses. *Br J Psychiatry* 1976; **128**: 538-48.

^v 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.

^{vi} 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 Psychiatry* 2005; **186**: 60-6.

SUMMARY OF TRENDS AND FINDINGS OF NOTE

- The total number of deliberate self-harm (DSH) presentations to the John Radcliffe Hospital in 2009 was 1593. This represented a 4.4% decrease compared with 2008. This reversed some of the increase seen in 2008 (+7.1%). The 2009 figure was 5.8% greater than the annual average in 1998-2000 (i.e. 10 years previously). The decrease in 2009 compared with 2008 was more marked in males (-8.6%) than in females (-1.8%). In 2008 there had been a considerable increase in males (+16.8%).
- The number of individual persons presenting in 2009 (N = 1098) was a decrease on 2008 (1177; -6.7%). This decrease occurred in both genders (males -7.1%; females -6.5%).
- The sex ratio (female to male) for persons in 2009 was 1.5:1.
- Overall person-based rates of DSH in Oxford City have decreased somewhat in recent years, following an upward trend. This finding should be interpreted with caution as population figures used to calculate rates were based on the 2001 census. The previous indication of a possible age cohort effect in males, which we highlighted previously has persisted, with rates of DSH in 15-24 year-olds decreasing since they peaked in mid-1990s, those of 25-34 year-olds having decreased since they peaked in the late 1990s, and rates in 35-54 year-olds having steadily increased, now showing a downturn.
- In 2009, 60.4% of patients were under 35 years of age. There were 68 under-16 year-olds. Twenty-seven patients were aged 65 years or more.
- Six out of ten patients were single (60.2%), one-fifth separated, divorced or widowed (20.2%), and one-fifth (19.5%) married. This represents a small decrease in those who were single and an increase in those who were married compared with 2008.
- The ethnic distribution of the patients in 2001-2009 showed a small excess of non-White ethnic groups compared with the general population of Oxfordshire.
- The proportion of patients who were unemployed in 2009 was 21.5%, a somewhat elevated figure compared to 2007 and 2008 (18.4% and 18.3%).

- The episode:persons ratio in 2009 was 1.5:1, a similar figure to recent years. The percentage of patients repeating within a year of an episode in 2008 (22.2%) was similar to the previous year (21.7%). In terms of gender, 20.9% of males and 23.0% of females repeated. In 2009, 35.8% of assessed patients were self-harming for the first time.
- Of all DSH episodes 72.8% involved self-poisoning, 19.0% self-injury and 8.7% both methods.
- The proportion of overdoses involving paracetamol (including compounds) in 2009 was 46.8%. In under-16-year-olds, two-thirds (66.7%) of overdoses involved paracetamol.
- In 2009 only five overdoses involved co-proxamol (one in 2008). This reflects reduced availability following the announcement in January 2005 by the MHRA of its withdrawal in the UK by January 2008 due to its high toxicity in overdose.
- Antidepressants were involved in 29.1% of overdoses in 2009. Of these 60.4% involved SSRIs/SNRIs, 19.9% tricyclics, 20.7% other antidepressants and 9.0% mood stabilisers.
- The proportion of DSH episodes involving self-injury was somewhat greater in 2009 than in 2008, continuing a rise seen in recent years. As in previous years the most frequent method was self-cutting (80.3%). Numbers of individuals presenting following hanging, strangulation or asphyxiation were similar to recent years.
- Alcohol use in the 6 hours before DSH occurred in over half the episodes (55.4%). Alcohol was consumed as part of the act of DSH in 34.4% of episodes. Both figures represent an increase compared with 2008. Alcohol involvement in DSH 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) was recorded for 58.0% of males and 41.9% of females, continuing an increase seen in recent years in both sexes.

- Suicide intent scores (a measure of the extent to which patients wished to die) were in the high or very high range in 29.1% of episodes. Suicide intent scores (averaged for 2007 – 2009) increased with age, especially in females.
- The most frequent problems preceding DSH were relationship difficulties (71.1%). The five most frequent problems in males concerned: a partner (45.8%), alcohol (44.7%), employment/studies (40.7%), other family members (33.1%), and finances (29.5%). In females, the five most frequent problems involved: a partner (44.1%), other family member(s) (42.9%), alcohol (32.3%), employment/studies (28.4%), and finances (20.9%).
- Nearly three-quarters (74.4%) of the presentations to the hospital occurred between 5 p.m. and 9 a.m. The peak time of presentation was 10 p.m. to 2 a.m.. The increase in presentations in the late evening and early hours of the morning was almost entirely related to episodes 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 2009 was 1011.
- Just under half (47.4%) of the assessments were conducted by psychiatric nurses and over half by doctors (52.6%).
- The proportion of patients offered aftercare with the Barnes Unit service in 2009 (22.9%) continued a recent increase (13.6% in 2007; 16.3% in 2008), reflecting a recent increase in staffing.
- In a total of 582 episodes, patients left the hospital without a psychosocial assessment. While in 181 cases patients took their own discharge, in 217 cases patients were not identified (i.e. referred) for assessment. This continues an increasing trend in spite of NICE guidance in 2004 that all self-harm patients should receive a psychosocial assessment. Non-assessment was especially frequent in patients who self-harmed by cutting (in spite of such patients having a greater risk of repetition of self-harm and of suicide compared to self-poisoning patients).

DELIBERATE SELF-HARM IN OXFORD 2009

Report on presentations to the John Radcliffe Hospital

Numbers of persons and episodes

The total numbers of episodes of deliberate self-harm (DSH) presenting to the John Radcliffe Hospital in 2009 are shown in Table 1, together with the numbers of individual persons involved.

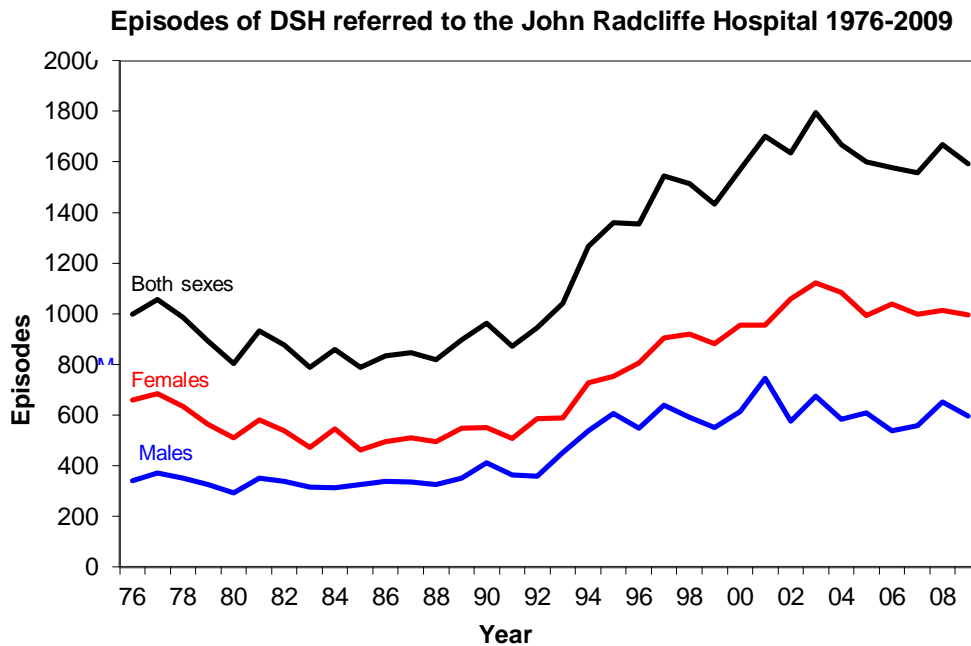
TABLE 1			
Numbers of episodes, and persons involved, in 2009			
	Males	Females	Total
Episodes of DSH	597	996	1593
Persons	432	666	1098

The number of DSH **episodes** in 2009 decreased compared with 2008 (-74 cases; -4.4%) (see Figure 1). It was the seventh highest number of cases. The 2009 figure was 5.8% greater than the average for 1998-2000 (N = 1505), i.e. 10 years previously.

The decrease in the number of episodes in 2009 compared to 2008 was mainly due to a decline in episodes involving males (-8.6%), with a much smaller decrease in females (-1.8%) (see Figure 1). The 2009 figure for females represents an increase of 7.7% compared with the annual average for 1998-2000 (N = 919) and that for males a 1.8% increase. 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 2009 individual females were responsible for 38, 18, 17 and 14 episodes respectively, and individual males were responsible for 31, 24 and 13 episodes.

There was a decrease in the number of **persons** who presented in 2009 compared with 2008 (-6.7%). The number in 2009 was the eleventh highest recorded. The number of males decreased by 7.1% and the number of females decreased by 6.5%.

FIGURE 1



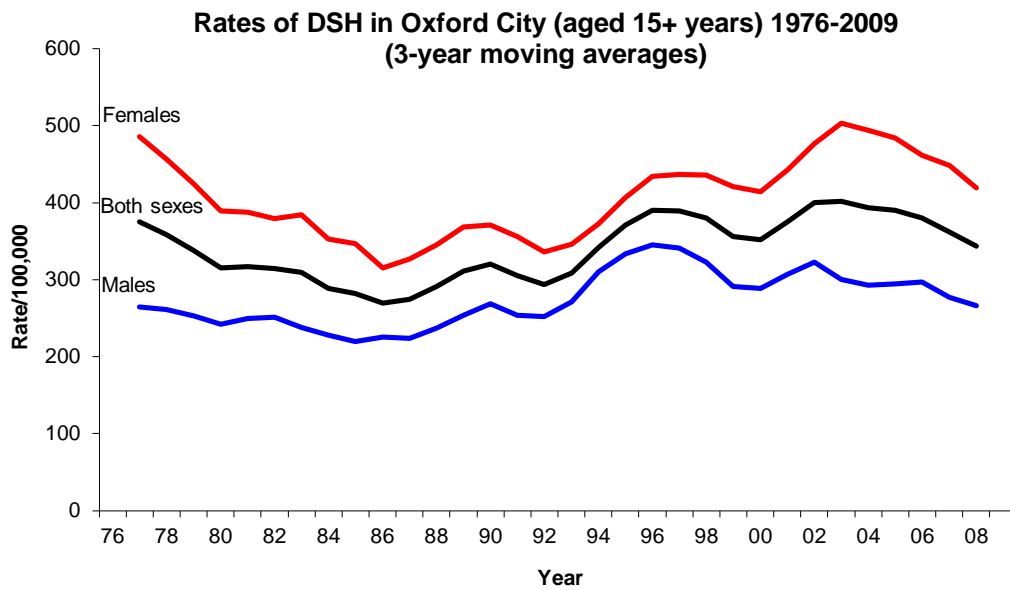
Oxford City Rates

We calculate rates just for people living in Oxford City because all DSH cases presenting to hospital from the city are seen at the John Radcliffe Hospital (whereas some in the north of the county and near the county boundary may go to other hospitals).

Figure 2 shows the DSH rates as 3-year moving averages (which smoothes out annual variations to show underlying trends). The general trend suggests a decrease in overall rates in both males and females. In 2009 the male rate (277 per 100,000, 95% C.I. 237-322) was the same as in 2008. The rate in females (388 per 100,000, 95% C.I. 342-437) was lower than 2008 (448).

The discrepancy between overall changes in numbers of DSH episodes and persons involved reported above and trends in rates for Oxford City may reflect more significant socio-economic influences in the population of the county outside of the city. However, since the population data used to calculate rates for Oxford City are based upon figures projected from the 2001 Census they could have become increasingly inaccurate over time.

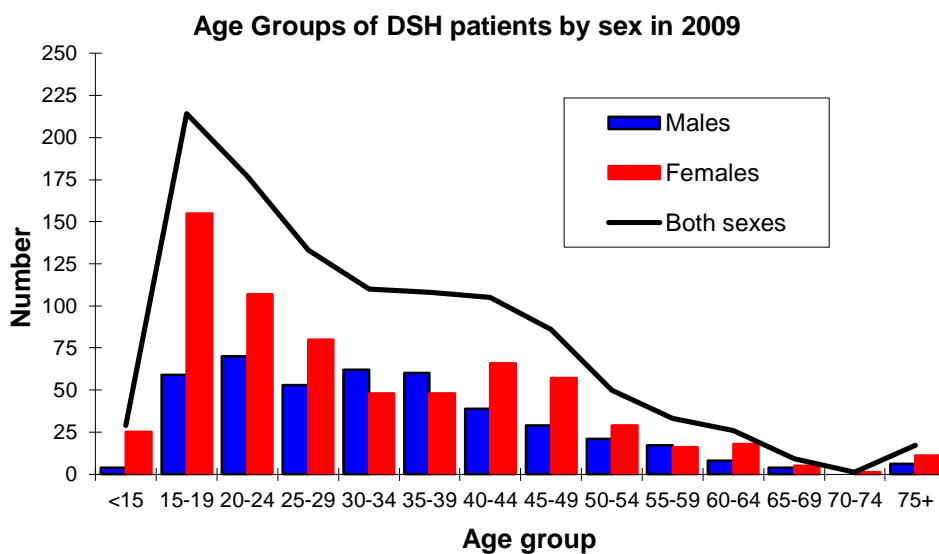
FIGURE 2



Age and sex

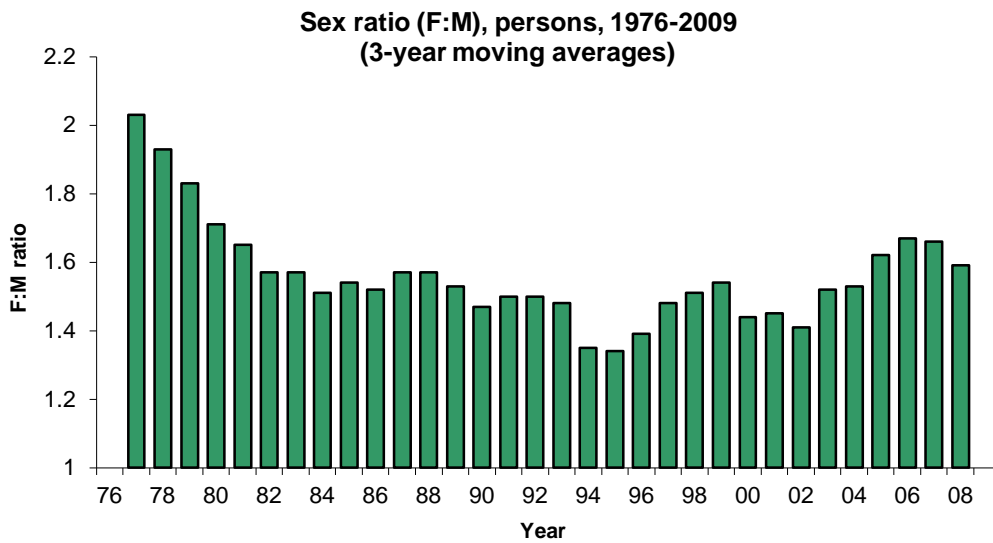
The **age distribution** of DSH patients in 2009 was broadly similar to that in previous years (Figure 3). In 2009, 60.4% of patients were under 35 years of age. The largest numbers of females were in the 15-19 (155 cases) and 20-24 (107 cases) year age groups. The largest numbers of male patients were in age groups 20-24 years (N = 70) and 30-34 years (N = 62). There were 27 patients aged 65 years and over. The oldest patient was aged 91 years. In 2009 there were 68 under-16 year-old patients. The youngest patients were aged 11 years.

FIGURE 3



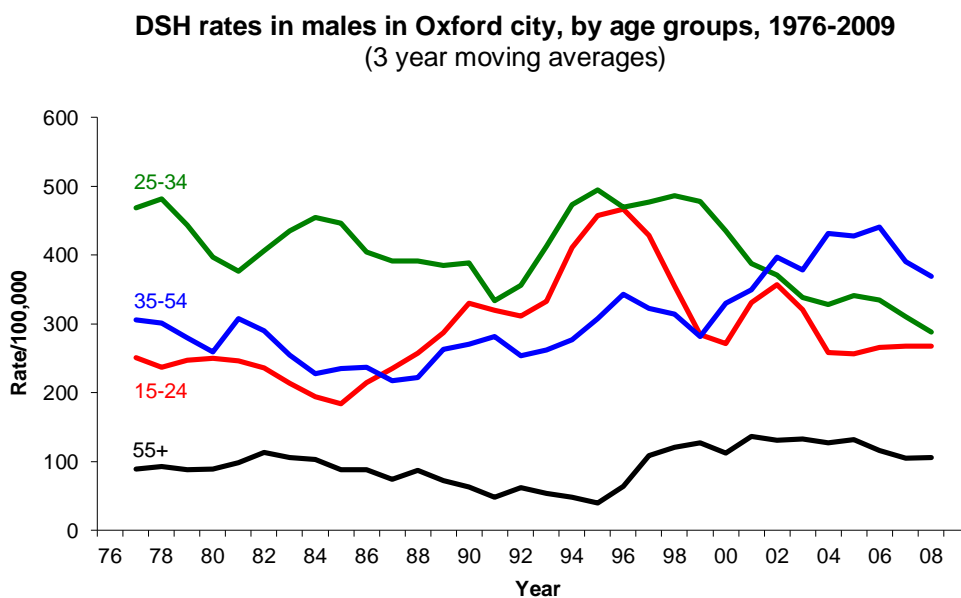
The **sex ratio** (female to male) for persons in 2009 was 1.5:1. The moving average figure appears to have levelled off following an increase over recent years (see Figure 4).

FIGURE 4



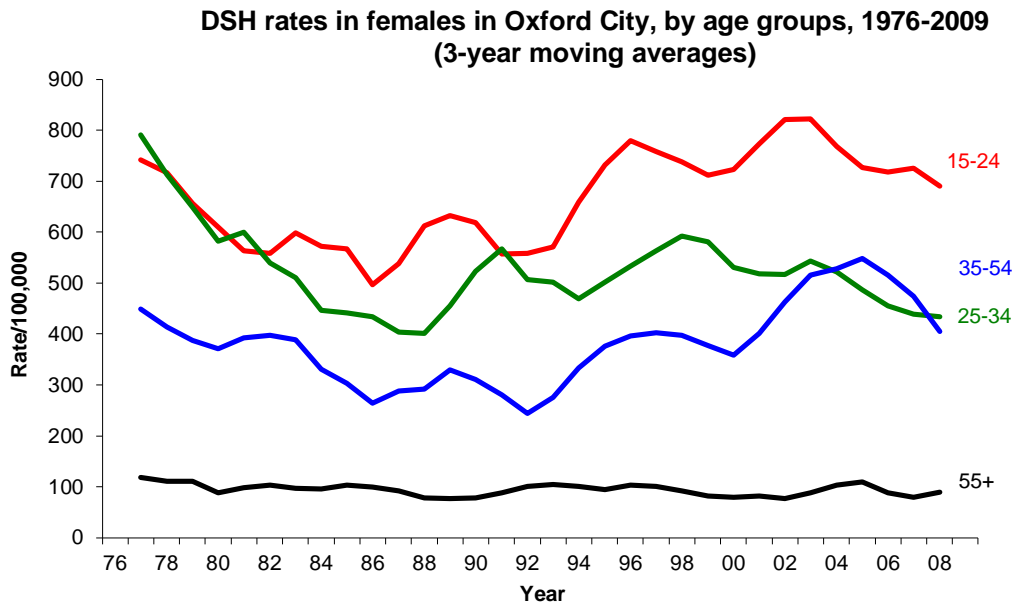
The **age group- and sex-specific 3-year moving average rates** for **males** in Oxford City are shown in Figure 5. Rates of DSH in 15-24 year-old males have decreased since their peak in the mid-1990s, those in 25-34 year-olds have decreased since they peaked in the late 1990s, while the rates in 35-54 year-olds decreased in 2008 and 2009 following a steady increase in recent years. We have noted previously that this pattern would be in keeping with a cohort effect (i.e. high risk shared by a group of males as they move through the life cycle), and this impression is maintained.

FIGURE 5



The **3 year moving average rates in females** in Oxford City (Figure 6) indicate a continuing high rate in 15-24 year-olds, with some reversal of the underlying upward trend seen since 1990. Rates in 25-34 and 35-54 year-olds have also declined.

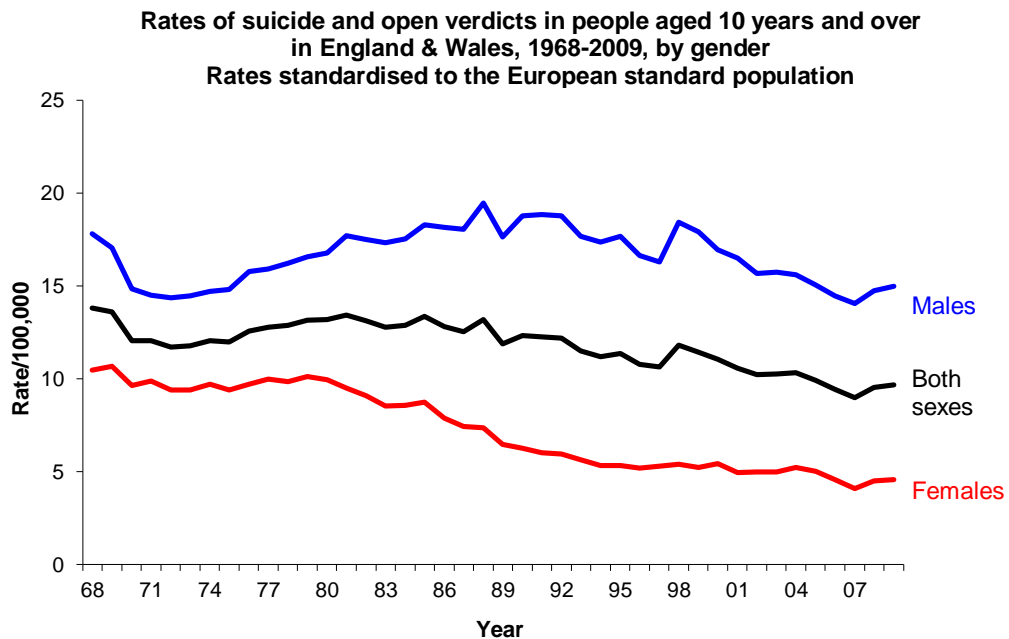
FIGURE 6



Suicide rates by sex and age groups in England and Wales

Figure 7 shows overall rates of suicide (including open verdicts) by gender, in persons aged 10 years and over, for England and Wales from 1968 to 2009. Suicide rates had been declining steadily in both genders in recent years but there was a rise in rates in both males and females in 2008 and 2009.

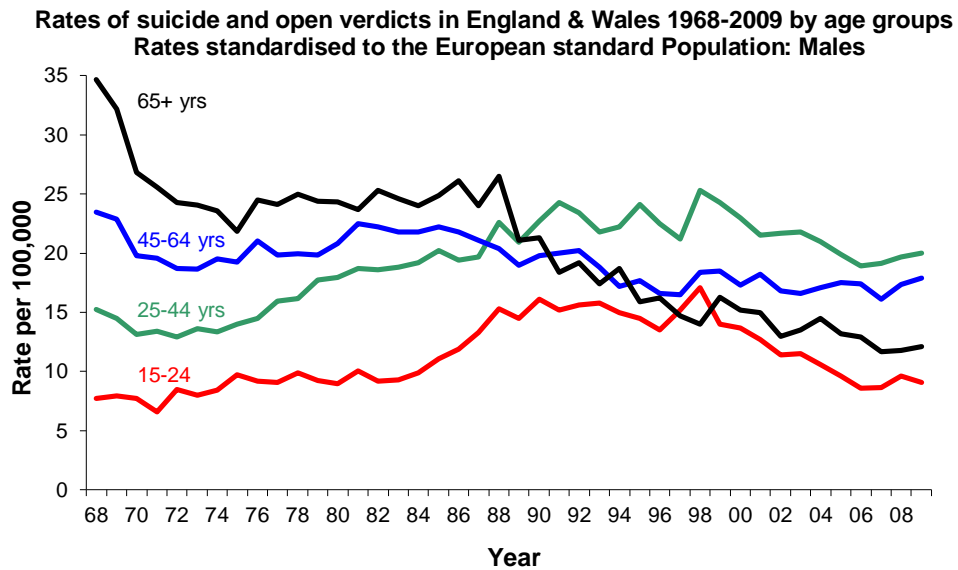
FIGURE 7



Source: Office for National Statistics

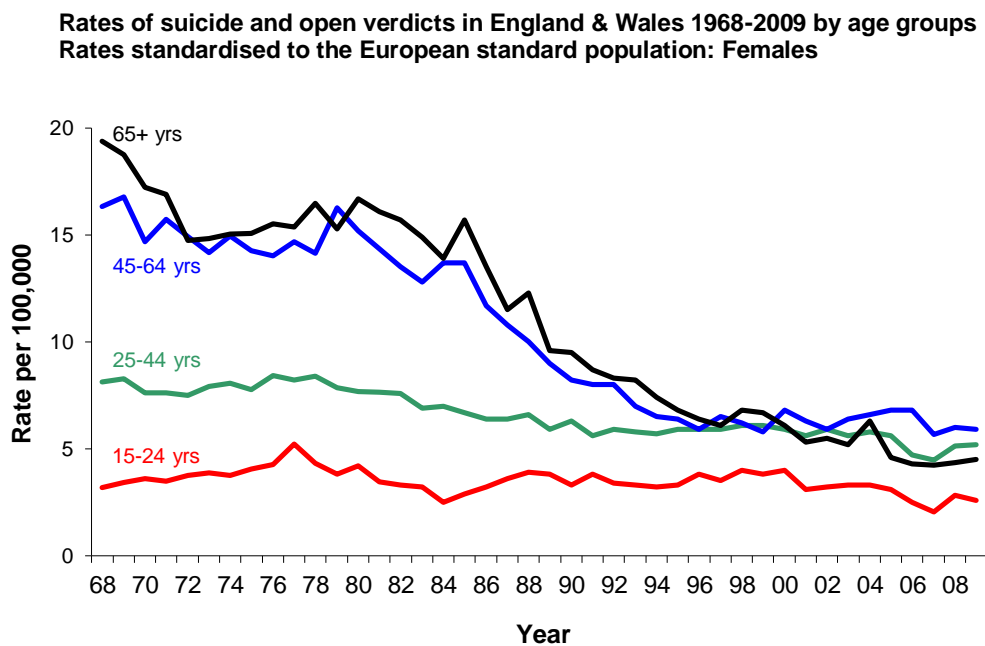
Figures 8 and 9 show suicide rates (suicides and open verdicts) for England and Wales between 1968 and 2009 for specific age groups, by gender. In males the recent rise in suicide rates was seen across all ages except 15-24 year olds (Figure 8). Small rises in suicide rates occurred in females in age groups 25-44 and 45-64 years in 2008 and 2009.

FIGURE 8



Data are for registrations of death in each calendar year

FIGURE 9

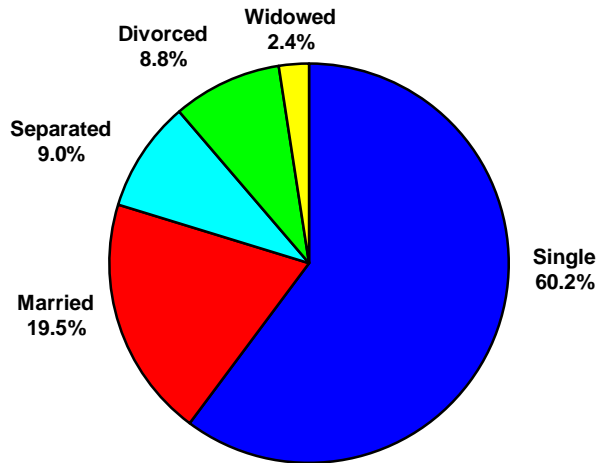


Data are for registrations of death in each calendar year

Marital status

As in previous years, the majority of assessed DSH patients in 2009 were single (Figure 10).

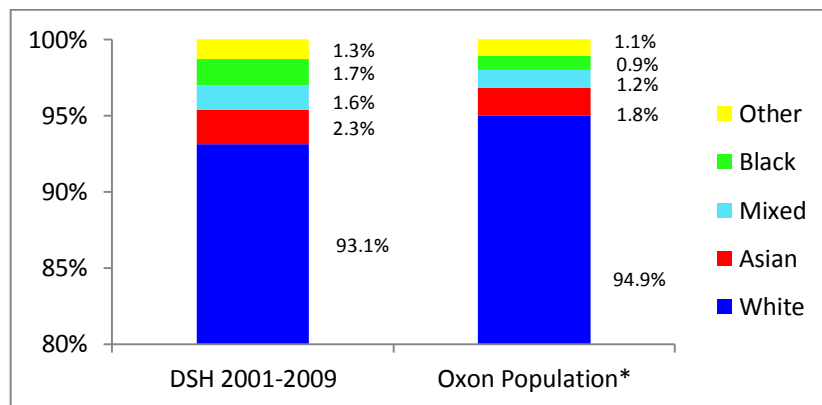
FIGURE 10
Marital status of assessed patients (aged 16+ years) in 2009



Ethnicity

In 2001-2009 (the period for which we have data on ethnicity), information on ethnicity was recorded for 7235 (91.2%) of assessed DSH patients. All broad ethnic groups other than White were somewhat over-represented (overall, 6.9% compared with 5.0% in the general Oxfordshire population), as can be seen in Figure 11.

Figure 11
Ethnicity in Oxford District vs ethnic makeup of Oxford District population



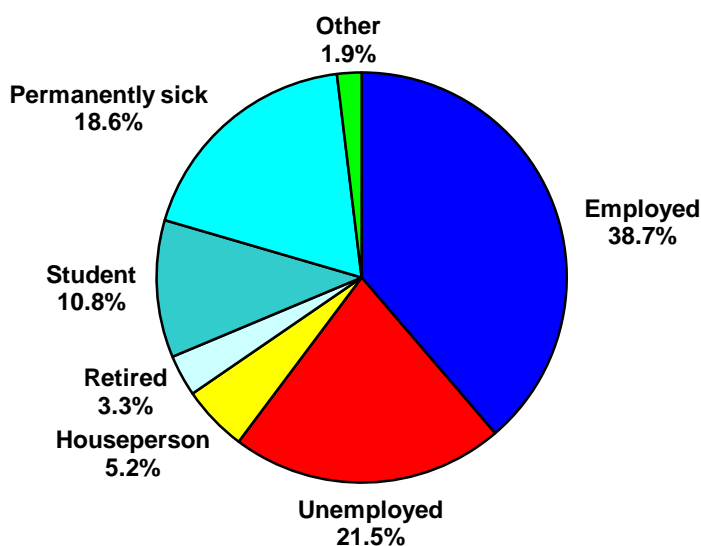
* Data from 2001 Census

Employment status

In 2009, 21.5% of the DSH patients (aged 16 years and over) were **unemployed** (Figure 11), a similar figure to 2008. Of those persons for whom the duration of unemployment was known, 27.2% had been unemployed for **more than a year** and 18.4% for **less than one month**.

FIGURE 12

Employment status of assessed DSH patients (aged 16+ years) in 2009



University Students

Of the assessed DSH patients 73 were **students** (including school students) in 2009. These included 12 **Oxford University students** (8 females and 4 males) and 11 **Oxford Brookes University students** (6 females and 5 males).

Living situation

The majority of assessed patients in 2009 **lived with family members or friends** (70.2%). The remainder (29.8%) were **living in lodgings, alone, or in an institution**, or were of **no fixed abode**. A significantly greater proportion of males (37.7%) than females (25.1%) were not living with relatives or friends ($\chi^2 = 13.37$, $p < 0.001$). Thirty patients were of **no fixed**

abode, representing 4.0% of all assessed patients whose living situation was known (8.5% (N = 24) of males and 1.3% (N = 6) of females).

Repetition of DSH

One measure of repetition is the ratio of the number of DSH episodes to the number of persons. In 2009 the ratio was 1.5, which is similar to recent years. 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 1.4 and for females was 1.5.

Another measure of repetition is the actual proportion of patients who repeat DSH 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 (2008) and repetition will only be identified for those who present to the general hospital following subsequent episodes. Of patients who presented in **2008**, 22.2% repeated DSH within a year. The repetition rate for females was 23.0% and for males 20.9%.

Another relevant measure is the extent to which people are engaging in their first-ever episode of DSH. In 2009, 35.8% (39.4% males, 33.3% females) of the assessed patients whose DSH history was known self-harmed for the first time.

Of those patients who were assessed in **2008** and had no previous history of DSH 12.2% repeated within the following year (11.5% males, 12.5% females) compared with 28.1% of those who had a known previous history of DSH (28.5% males, 27.9% females). These figures are in keeping with many research findings showing that a history of previous DSH is the best predictor of future repetition.

Methods used for DSH

In 2009, 72.4% of DSH episodes involved **self-poisoning**, 19.0% **self-injury** and 8.7% **both methods**.

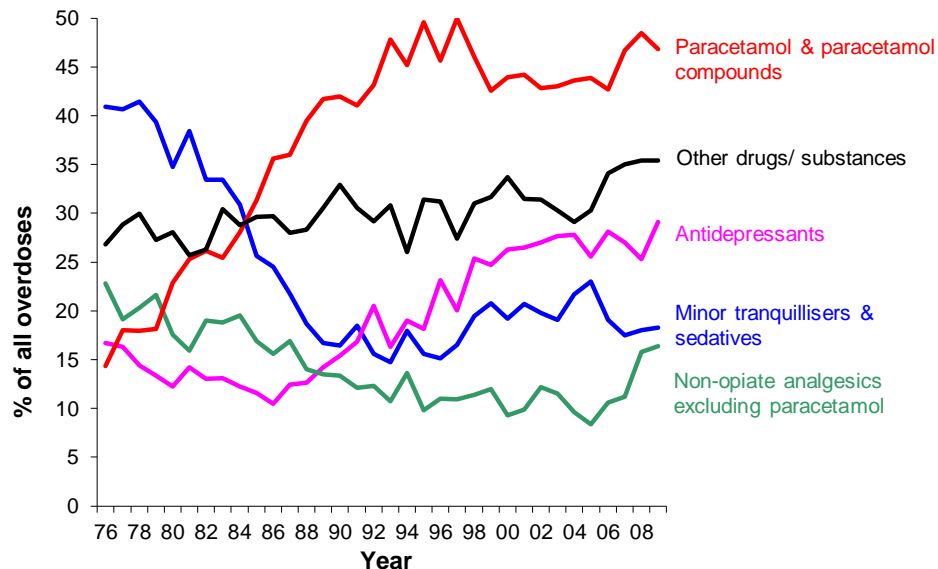
Figure 12 shows the percentages of overdoses involving specific groups of drugs. The proportion of overdoses involving **paracetamol** (including compounds) was 46.8% in 2009. This proportion reversed the increase seen in 2007 and 2008.

In 2009 116 (10.4%) of overdoses involved paracetamol and codeine combined preparations, e.g. co-codamol. In 2008 there were 113 (8.2%) such overdoses. (N=122, 9.5% in 2007). These preparations made up 19.2% of all paracetamol (including compound) overdoses.

Pure paracetamol was involved in 79.8% of all paracetamol overdoses and paracetamol in compound form in 24.0% (some involved both forms of paracetamol). Just five overdoses involved **co-proxamol** (paracetamol with dextropropoxyphene). In January 2005 the Medicines and Healthcare Products Regulatory Agency announced its withdrawal 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, whereas in 2005-2009 the annual average was 11.8. Non-steroidal anti-inflammatory drugs were involved in 16.1% of overdoses in 2009.

In 2009 66.7% of overdoses by under-16 year-olds involved paracetamol.

FIGURE 13
Substances used in self-poisoning 1976-2009



Minor tranquillisers and sedatives were involved in 18.3% of overdoses, a similar percentage to recent years.

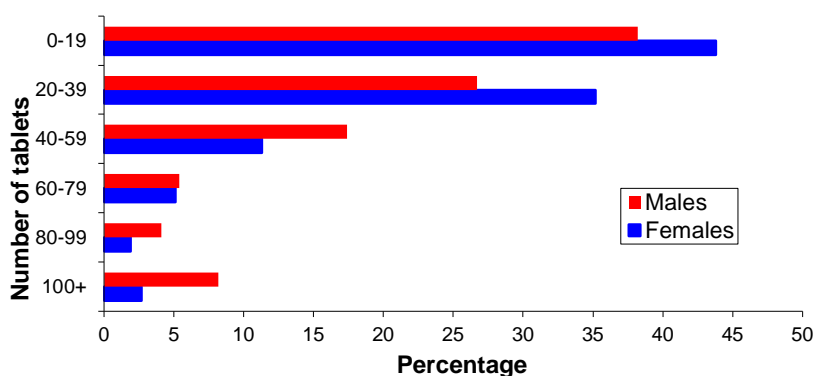
Antidepressants (including mood stabilisers) were involved in 29.1% of overdoses, the highest proportion we have recorded. Of these overdoses, 60.4% involved **SSRIs/SNRIs**, 19.9% **tricyclics**, 20.7% **other antidepressants** (e.g. trazodone, mirtazapine), 0.3% **MAOIs** and 9.0% **mood stabilisers**.

In 2009, 25 overdoses by under-18 year-olds (18 persons) involved antidepressants, compared with 22 in 2008 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

2009 7 of the 25 antidepressant overdoses in this age group involved fluoxetine, compared with 23 out of 91 (25.3%) overdoses during 2001-2003, and 9 involved sertraline.

Information on the **number of tablets** taken in overdoses was available for 1061 cases in 2009. The average number taken in overdose was 38.2 (SD 39.1) tablets. As can be seen in Figure 14, the majority of overdoses involved less than 40 tablets (73.8%). There was a significant difference between males and females (median values: males 26.0, females 24.0; $z = 3.637$, $p < 0.001$). This is shown in more detail in Figure 14. These figures have remained remarkably consistent since we began reporting them in 2003.

FIGURE 14
Numbers of tablets taken in overdose in 2009, by sex



Of the self-injuries, **self-cutting** was as usual the most common, this being the method used by 80.3% (N = 350) of self-injurers (76.2% males, 82.7% females) in 2009. Other methods included hanging, strangulation and asphyxiation (18), and jumping (16). The number of hangings, strangulations and asphyxiations (11 by males and 7 by females) was similar to recent years.

Alcohol

In 2009, as in previous years, **alcohol** was often consumed **at the time of DSH** (34.4% of assessed episodes). This figure was much higher in males (42.8%) than females (29.5%). Alcohol had very often been consumed **during the six hours before the episode** (55.4%), again more commonly by males (64.4%) than females (50.0%).

Alcohol involvement in DSH (based on data for 2007-09) varied by age group (see Figure 15). In males, alcohol involvement was most frequent in those aged 15-44 years and 65+ years. In females, this was most prevalent in 45-54 year-olds (in which more episodes by females

than males involved alcohol). Alcohol was least involved in DSH episodes by females aged 65 years and over. There was a tendency for greater involvement of alcohol in males presenting on Tuesday to Saturday (less on Sunday and Monday) and in females presenting on Saturday and Sunday (see Figure 16).

FIGURE 15
Alcohol involvement in DSH by age group

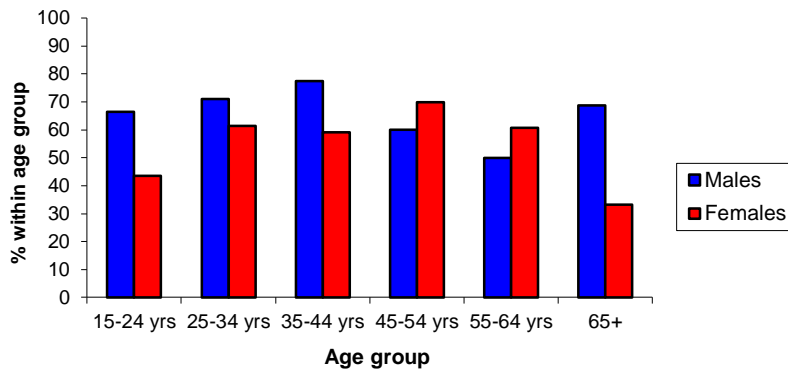
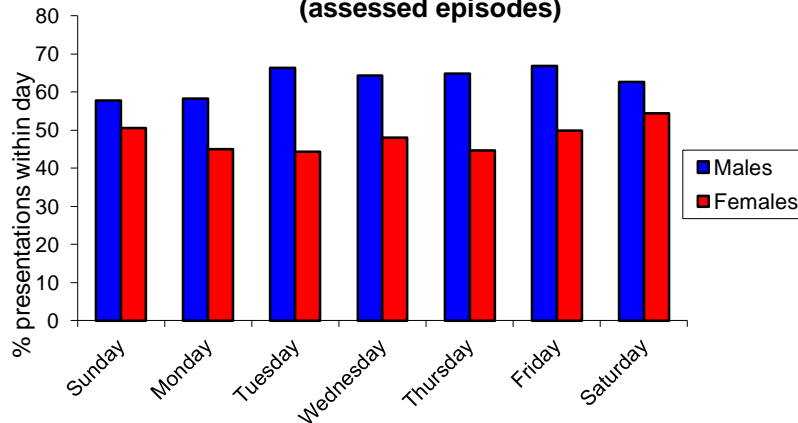


FIGURE 16
Alcohol involvement in DSH by day of presentation
(assessed episodes)



Suicide intent

The **Suicide Intent Scale** (which measures the extent to which patients appeared to want to die) (see Figure 17) was completed by the clinical assessors for 771 episodes (76.3% of episodes in which an assessment occurred in 2009). The median suicide intent score for males was 10 and for females was 7 ($z = 3.66, p < 0.001$). The classification of scores into low, moderate, high and very high categories indicated that the scores of 29.1% of cases were in the high (13-20) or very high (21+) range. High or very high scores were recorded for

34.3% of males and 25.8% of females. Nearly half the episodes in those aged 55 years and over involved relatively high scores.

Suicide intent scores by age and sex for the years 2007-2009 combined, in terms of those having relatively high scores, showed, as in previous years, scores increasing significantly with age group in both males (χ^2 for linear trend = 8.97, $p < 0.01$) and females (χ^2 for linear trend = 12.45, $p < 0.001$) (Figure 18).

FIGURE 17
Scores on the Beck Suicide Intent Scale 2009

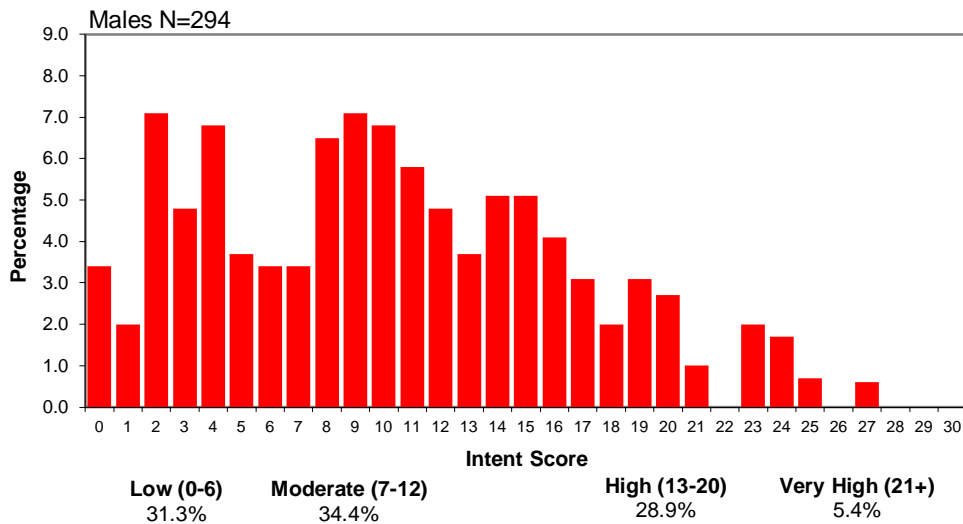
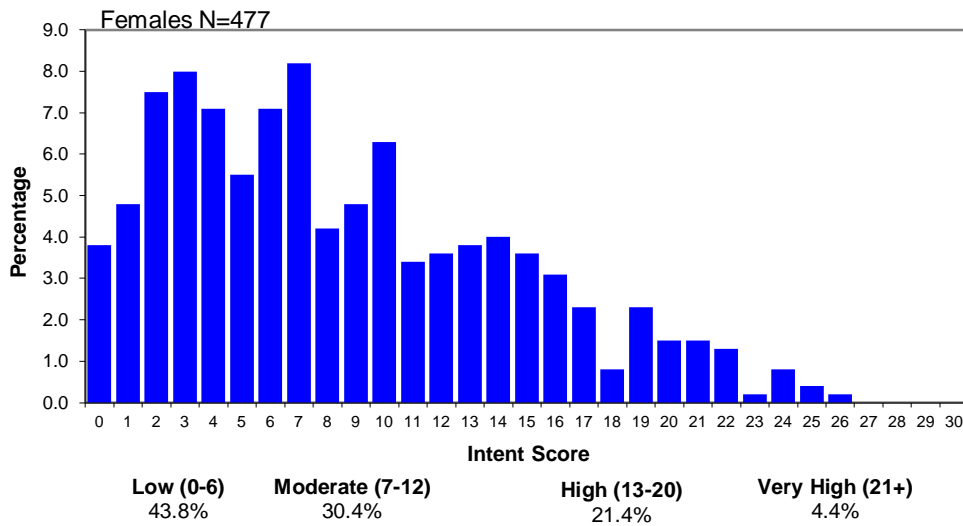
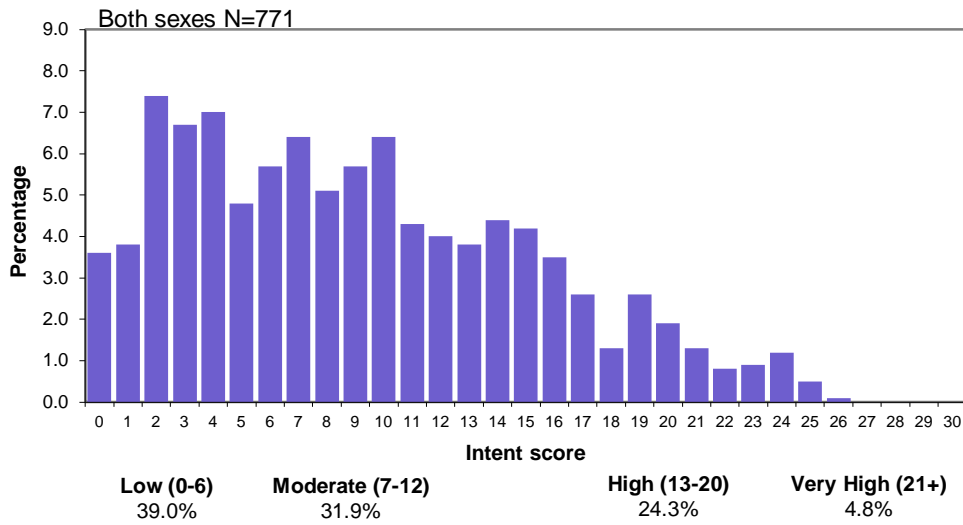
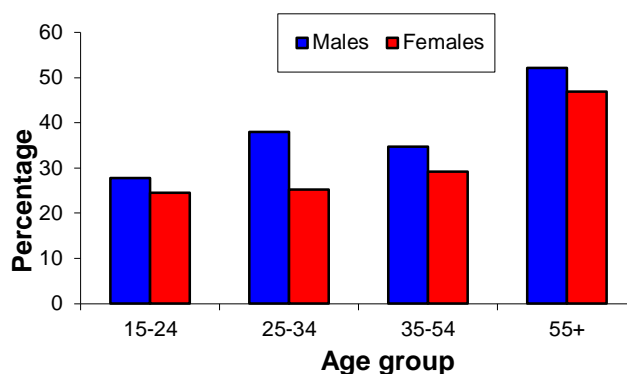


FIGURE 18

**Suicide Intent by age and sex, 2007-2009
High and Very High scores (SIS = 13-30)****Psychiatric disorder and substance misuse**

On the basis of a global rating of patients who were assessed in 2009, 41.1% (36.0% of the males and 44.2% of the females) were reported as having a **major psychiatric disorder**. These figures will considerably under-represent the proportions with any type of psychiatric disorder. In addition, **misuse of alcohol** was recorded for 58.0% of the males and 41.9% of the females, somewhat higher figures than in 2008. Those misusing alcohol included for males (females in brackets): 8.9% (3.2%) with **chronic alcoholism**, 16.4% (6.7%) with **alcohol dependence** and 32.8% (32.0%) who were known to be **drinking more than the recommended maximum safe number of units**. The proportions of patients with chronic alcoholism or alcohol dependence has increased in both genders in recent years, as has the proportion of females misusing alcohol.

Drug misuse was recorded for 18.1% of the patients in 2009, including 24.4% of the males and 14.2% of the females.

Personality disorder was identified in 27.5% of patients in 2009, including 20.5% of the males and 31.7% of the females. These figures are likely to reflect those with more severe personality disorders.

Problems at the time of DSH

A 'problem' is defined as a factor that was causing current distress for the patient and/or contributed to the episode of DSH. As found in previous years, the most frequent problems identified at the time of the DSH episodes were **relationship difficulties** (71.1%). As usual, difficulties with a partner was the most common problem, followed by problems with a family member, more common in females than males (Table 2).

TABLE 2				
The most frequent types of problems identified at assessment in 2009				
Problem	Both sexes (N=944)	Males (N=356)	Females (N=588)	p
	%	%	%	
Partner	44.8	45.8	44.2	ns
Other family member	39.2	33.1	42.9	<0.01
Alcohol	37.0	44.7	32.3	<0.001
Employment /studies	33.1	40.7	28.4	<0.001
Financial	24.2	29.5	20.9	<0.01
Social isolation	19.5	21.3	18.4	ns
Housing	17.8	23.0	14.6	<0.001
Friends	11.5	9.8	12.6	ns
Drugs	8.9	16.8	5.6	0.001
Physical health	8.2	6.7	9.0	ns
Bereavement	7.0	6.5	7.3	ns
Childhood sexual abuse	7.7	2.0	11.2	<0.001

Males were more likely to suffer from problems with **alcohol, employment/studies, finances, drugs, and housing**. Problems with **other family members** and **friends** were more frequent in the females. **Eating disorders problems** were present in 7.5% of the females. Problems due to **the consequences of childhood physical abuse** were recorded in 5.6% of the females and 2.2% of the males. Problems related to **chronic pain** were identified in 3.1% of males and 3.2% of females.

Assessments by the Emergency Psychiatric Service (Barnes Unit)

A total of 1282 DSH episodes resulted in **admission to a bed in the general hospital** in 2009 (80.5% 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.

1011 **assessments of DSH patients** were conducted by members of the Emergency Psychiatric Service in the John Radcliffe Hospital in 2009. Overall, 63.5% of patients were assessed. Just over a quarter (26.0%) of non-admitted patients received an assessment.

TABLE 3 Referrals to the general hospital and those assessed by the hospital psychiatric service following DSH in 2009						
	Admitted (N=1282; 80.5%)		Not Admitted (N=311; 19.5%)		Overall (N=1593)	
Assessed						
Yes	72.5%	(930)	26.0%	(81)	63.5%	(1011)
No	27.5%	(352)	74.0%	(230)	36.5%	(582)

The number of episodes where the patient **left the hospital without being assessed** was 582 (217 males, 365 females). Of those not assessed, 181 took their own discharge, 22 refused assessment, there was a policy decision not to assess the patient in 29 presentations, 76 were in current psychiatric inpatient care, 42 were in current psychiatric outpatient care, and 11 were not assessed for other reasons. The remaining 217 patients were not identified for assessment. This continues an increasing trend in spite of NICE guidance in 2004 that all self-harm patients should receive a psychosocial assessment. A further four patients died.

In 2009, 47.4% (N=479) DSH patients were assessed by nurses or social workers and 52.6% (N=532) 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 deliberate self-harm service, when the number of nursing staff was reduced.

An assessment was conducted following 68.5% of episodes of self-poisoning but only 41.6% of self-injuries. 39.3% of episodes of self-cutting alone were assessed whereas 48.6% of episodes involving any other form of self-injury alone received an assessment.

Time of presentation in the Emergency Department

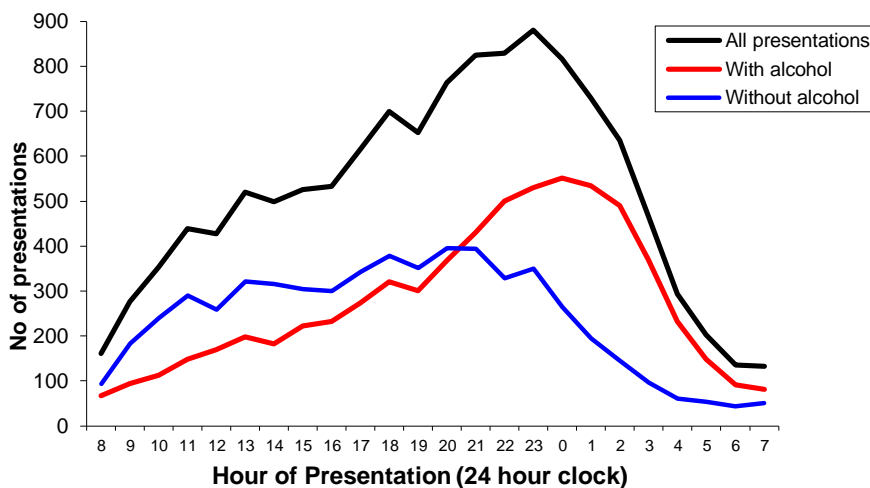
Time of presentation to the Emergency Department was recorded for 1593 episodes. There was the usual diurnal variation, with a peak in presentations between 10 p.m. and 2 a.m. (see Figure 18). Of all episodes, 24.2% (385) involved presentations between 9 a.m. and 5 p.m. and 74.4% (1185) between 5 p.m. and 9 a.m.

As can be seen from Figure 19, which is for assessed patients, the increase in presentations outside the working day, especially in the late evening and early hours of the morning, was

mainly related to DSH episodes in which alcohol was consumed shortly beforehand and/or as part of the act.

FIGURE 19

Time of presentation to the Emergency Department, overall, and whether or not DSH episode involved alcohol (during 6 hours beforehand and/or as part of act)*



*Assessed presentations only

For patients who were admitted, the time of presentation to the Emergency Department made no difference to whether or not they received a psychiatric assessment, in that 73.0% of those presenting between 9 a.m. and 5 p.m. were assessed compared with 72.6% of those presenting after 5 p.m. ($\chi^2 = 0.017$, ns).

Time of presentation made a significant difference to assessment of those not admitted to a hospital bed in that 36.5% of those who presented in the daytime were assessed compared with 23.0% of those who presented after 5 p.m. ($\chi^2 = 4.735$, $p < 0.05$).

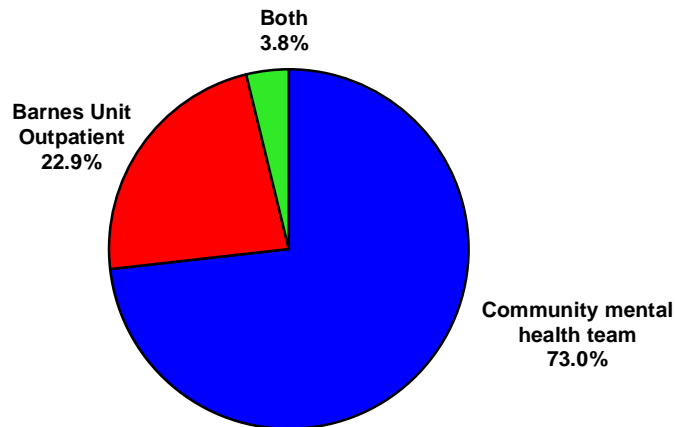
This pattern, which is different to previous years, appears to reflect a reduction in the proportion presenting between 9 am and 5 pm who were assessed.

Aftercare

Of the DSH episodes which resulted in a referral for **psychiatric aftercare** (N = 642), in 48.0% of cases patients were known to be receiving psychiatric care at the time of their episode. The main form of aftercare was **outpatient/community psychiatric care**, which was offered in 86.3% of these episodes. The breakdown is shown in Figure 20.

FIGURE 20

Psychiatric and community outpatient care



The proportion of cases in 2009 in which **inpatient psychiatric care** in Oxford was offered following discharge from the John Radcliffe was 6.4% (N = 65) (Table 4). Just under half (30/65, 46.2%) of these were new admissions, the remainder (53.8%) being by people who were inpatients at the time of their DSH episodes.

TABLE 4
Aftercare accepted following assessment in 2009 (N=1011)
according to whether or not patients were in current psychiatric care

	% ²	n	New patient		Current patient	
			%	n	%	n
Inpatient psychiatric care	6.4	65	3.0	30	3.5	35
Outpatient psychiatric care						
Community MH Teams	34.4	348	14.6	148	19.8	200
Barnes Unit	13.6	137	11.6	117	2.0	20
Crisis Resolution Team	10.4	105	6.2	63	4.2	42
Day patient psychiatric care	0.3	7	0.2	2	0.5	5
GP care (alone or for GP-led services)	23.4	237				
Other¹	7.1	72				
Took own discharge	0.7	7				

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

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

The proportion of patients **referred back to GP care** alone in 2009 was 23.4%. This figure is a gross underestimate when account is taken of the number of patients discharged without a psychosocial assessment. In 2009 21.5% (N = 218) of patients were offered telephone '**open access**' to the emergency psychiatric service.

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.

Epidemiology and trends in non-fatal self-harm in three centres in England: 2000-2007

Bergen, H; Hawton, K; Waters, K; Cooper, J; Kapur, N *British Journal of Psychiatry* 2010;**197**:493-8.

Background Self-harm is a common reason for presentation to a general hospital, with a strong association with suicide. Trends in self-harm are an important indicator of community psychopathology, with resource implications for health services and relevance to suicide prevention policy. Previous reports in the UK have come largely from single centres.

Method To investigate trends in non-fatal self-harm in six general hospitals in three centres from the Multicentre Study of Self-harm in England, and to relate these to trends in suicide. Data on self-harm presentations to general hospital emergency departments in Oxford (one), Manchester (three) and Derby (two) were analysed over the 8-year period 1 January 2000 to 31 December 2007.

Results Rates of self-harm declined significantly over 8 years for males in three centres (Oxford: -14%; Manchester: -25%; Derby: -18%) and females in two centres (Oxford: -2% (not significant); Manchester: -13%; Derby: -17%), in keeping with national trends in suicide. A decreasing proportion and number of episodes involved self-poisoning alone, and an increasing proportion and number involved other self-injury (e.g. hanging, jumping, traffic related). Episodes involving self-cutting alone showed a slight decrease in numbers over time. Trends in alcohol use at the time of self-harm and repetition within 1 year were stable.

Conclusions There were decreasing rates of non-fatal self-harm over the study period that paralleled trends in suicide in England. This was reflected mainly in a decline in emergency department presentations for self-poisoning.

Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses.

Bergen H, Hawton K, Waters K, Cooper J, Kapur N. *Journal of Affective Disorders* 2010;**127**:257-65

Background Self-harm is a common reason for presentation to the Emergency Department. An important question is whether psychosocial assessment reduces risk of repeated self-harm. Repetition has been investigated with survival analysis using various models, though many are not appropriate for recurrent events.

Method Survival analysis was used to investigate associations between psychosocial assessment following an episode of self-harm and subsequent repetition, including (i) one repeat, and (ii) recurrent repetition (≤ 5 repeats) using (a) an independent episodes model, and (b) a stratified episodes model based on a conditional risk set. Data were from the Multicentre Study on Self-harm in England, 2000 to 2007.

Results Psychosocial assessment following an index episode of self-harm was associated with a 51% (95% CI 42%-58%) decreased risk of a repeat episode in persons with no psychiatric treatment history, and 26% (95% CI 8%-34%) decreased risk in those with a treatment history. For recurrent repetition, assessment was associated with a 57% (95% CI 51%-63%) decreased risk of repetition assuming independent episodes, and 13% (95% CI 1%-24%) decreased risk accounting for ordering and correlation of episodes by the same person (stratified episodes model). All models controlled for age, gender, method, history of self-harm, and centre differences.

Conclusions Psychosocial assessment appeared to be beneficial in reducing the risk of repetition, especially in the short-term. Findings for recurrent repetition were highly dependent on model assumptions. Analyses should fully account for ordering and correlation of episodes by the same person.

A comparative study of non-fatal self-poisoning with antidepressants relative to prescribing in three centres in England

Bergen, H., Murphy, E., Cooper, J., Kapur, N., Stalker, C., Waters, K. and Hawton, K. *Journal of Affective Disorders* 2010; **123**, 95-101

Background Antidepressants are used frequently in non-fatal self-poisoning. There are national guidelines for prescribing antidepressants. There have been few investigations of how non-fatal self-poisoning with antidepressants varies in relation to prescribing and to patient characteristics.

Method A comparative study of the use of specific antidepressants (amitriptyline and dosulepin (tricyclics), citalopram, fluoxetine, paroxetine and sertraline (selective serotonin reuptake inhibitors) and venlafaxine (serotonin norepinephrine reuptake inhibitor) for non-fatal self-poisoning (episode-based), relative to prescribing, in three centres in England, 2004 to 2006.

Results There was marked variation between centres in the ratio of rates of self-poisoning to prescribing for specific antidepressants. Higher rates of self-poisoning relative to prescribing for all antidepressants combined, and for venlafaxine, were found in the centre with greater proportions of patients with a history of self-harm and/or previous psychiatric treatment. Within each centre, higher rates of self-poisoning relative to prescribing for either amitriptyline or dosulepin were also similar to sertraline, which is of concern given the known toxicity of tricyclics.

Conclusions Marked differences found in ratios of self-poisoning with antidepressants to levels of prescribing, in three centres of England, are likely to reflect differences in both prescribing practices (despite clear national guidance) and patient characteristics. Risk of overdose and toxicity should be considered when local prescribing policy and clinical practice relating to antidepressant are under review.

Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study.

Cooper J, Murphy E, Webb R, Hawton K, Bergen H, Waters K, Kapur N. *British Journal of Psychiatry*. 2010;**197**: 212-8.

Background: Studies of self-harm in Black and minority ethnic (BME) groups have been restricted to single geographical areas, with few studies of Black people. We aimed to calculate age- and gender-specific rates of self-harm by ethnic group in three cities and compare characteristics and outcomes.

Method: A population-based self-harm cohort presenting to five emergency departments in three English cities during 2001 to 2006.

Results: A total of 20 574 individuals (16-64 years) presented with self-harm; ethnicity data were available for 75%. Rates of self-harm were highest in young Black females (16-34 years) in all three cities. Risk of self-harm in young South Asian people varied between cities. Black and minority ethnic groups were less likely to receive a psychiatric assessment and to re-present with self-harm.

Conclusions Despite the increased risk of self-harm in young Black females fewer receive psychiatric care. Our findings have implications for assessment and appropriate management for some BME groups following self-harm.

Living alone and deliberate self-harm: a case-control study of characteristics and risk factors.

Haw C, Hawton K. *Social Psychiatry and Psychiatric Epidemiology*. 2011; **46**: 1115-1125

Background . An increasing proportion of the UK population live alone. Little is known about deliberate self-harm (DSH) patients who live alone. We conducted a study of the characteristics of DSH patients who live alone using data from the Oxford Monitoring System for Attempted Suicide.

Method Data on patients presenting to the general hospital in Oxford with an episode of DSH between 1993 and 2006 were analysed by gender and age group (15-24 years, 25-54 years and 55+ years) and according to whether or not they lived alone.

Results In total, 1,163/7,865 (14.8%) patients lived alone. Having a problem with social isolation was more common in those living alone compared with those living with others, especially in those aged 55+ years. In the 25-54 years age group several variables concerning psychiatric problems were more common in those living alone, as was higher suicide intent associated with the current DSH episode and past DSH, and for females, repetition of DSH within 12 months. In patients aged 55+ years those living alone were more likely to have problems due to bereavement. Significantly more individuals living alone died from any cause. More also died by suicide, although the difference between the groups was non-significant after adjusting for age.

Conclusions These results have implications for psychiatric services assessing DSH patients who live alone, since, depending on the patient's age and living circumstances, different psychiatric and social interventions may be needed. Middle-aged DSH patients who live alone appear to be particularly vulnerable. DSH patients who live alone may not have supportive social networks and may be at increased risk of repetition of DSH and suicide.

Suicide and deliberate self-harm in Oxford University students over a 30-year period.

Hawton K, Bergen H, Mahadevan S, Casey D, Simkin S. *Social Psychiatry and Psychiatric Epidemiology*. 2010; DOI 10.1007/s00127-010-0310-3

Background The aim was to determine whether rates of suicide and self-harm in university students differ from those in other young people.

Methods We obtained information on Oxford University students who died by suicide or presented to hospital following deliberate self-harm (DSH) between 1976 and 2006 from official records and a General Hospital monitoring system in Oxford. Rates of suicide and self-harm in the students and in other young people in the general population were calculated from university, local and national population figures.

Results Forty-eight Oxford University students (32 males and 16 females) died by suicide. Most (N = 42) were aged 18-25 years. The suicide rate did not differ from that of other people in this age group in England and Wales (SMR 105.4; 95% CI 75.2, 143.4). There was evidence of clustering of methods of suicide over time. During the same period, 602 students (383 females and 219 males) presented to the General Hospital following DSH. Most (90.7%) were aged 15-24 years, in which age group rates of DSH (per 100,000) during term-time were lower than in other young people in Oxford City (females: 206.5 vs. 285.6, $z = -5.03$, $p < 0.001$; males: 75.9 vs. 111.2, $z = -4.35$; $p < 0.001$). There was an excess of student DSH episodes in the main exam term.

Conclusions Contrary to earlier findings and popular belief, suicide rates in Oxford University students do not differ from those in other young people. Rates of DSH are significantly lower than in other young people. Risk of DSH may increase around the time of examinations.

Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose.

Hawton K, Bergen H, Simkin S, Cooper J, Waters K, Gunnell D, Kapur N. *British Journal of Psychiatry*, 2010;196:354-8

Background Self-poisoning is a common method of suicide and often involves ingestion of antidepressants. Information on the relative toxicity of antidepressants is therefore extremely important.

Aims To assess the relative toxicity of specific tricyclic antidepressants (TCAs), a serotonin and noradrenaline reuptake inhibitor (SNRI), a noradrenergic and specific serotonergic antidepressant (NaSSA), and selective serotonin reuptake inhibitors (SSRIs).

Methods Observational study of prescriptions (UK), poisoning deaths involving single antidepressants receiving coroners' verdicts of suicide or undetermined intent (England and Wales) and non-fatal self-poisoning episodes presenting to six general hospitals (in Oxford, Manchester and Derby) between 2000 and 2006. Calculation of fatal toxicity index based on ratio of rates of deaths to prescriptions, and case fatality based on ratio of rates of deaths to non-fatal self-poisonings.

Results Fatal toxicity and case fatality indices provided very similar results (rho for relative ranking of indices 0.99). Case fatality rate ratios showed greater toxicity for TCAs (13.8, 95% CI 13.0–14.7) than the SNRI venlafaxine (2.5, 95% CI 2.0–3.1) and the NaSSA mirtazapine (1.9, 95% CI 1.1–2.9), both of which had greater toxicity than the SSRIs (0.5, 95% CI 0.4–0.7). Within the TCAs, compared with amitriptyline both dosulepin (relative toxicity index 2.7) and doxepin (2.6) were more toxic. Within the SSRIs, citalopram had a higher case fatality than the other SSRIs (1.1, 95% CI 0.8–1.4 v. 0.3, 95% CI 0.2–0.4).

Conclusions There are wide differences in toxicity not only between classes of antidepressants, but also within classes. The findings are relevant to prescribing decisions, especially in individuals at risk, and to regulatory policy.

Impact of withdrawal of the analgesic co-proxamol on nonfatal self-poisoning in the UK

Hawton, K., Bergen, H., Waters, K., Murphy, E., Cooper, J., Kapur, N. 2009; *Crisis*, 32:81-87

Background In early 2005 the UK Committee on Safety of Medicines (CSM) announced gradual withdrawal of the analgesic co-proxamol because of its adverse benefit/safety ratio, especially its use for intentional and accidental fatal poisoning. Prescriptions of co-proxamol were reduced in the 3-year withdrawal phase (2005 to 2007) following the CSM announcement. We aimed to assess the impact of the CSM announcement in January 2005 to withdraw co-proxamol on nonfatal self-poisoning with co-proxamol and other analgesics.

Method Interrupted time series analysis of general hospital presentations for nonfatal self-poisoning (five hospitals in three centres in England), comparing the 3-year withdrawal period 2005–2007 with 2000–2004.

Results A marked reduction in the number of episodes of nonfatal self-poisoning episodes involving co-proxamol was found following the CSM announcement (an estimated 62% over the period 2005 to 2007 compared to 2000 to 2004). There was no evidence of an increase in nonfatal self-poisoning episodes involving other analgesics (co-codamol, codeine, co-dydramol, dihydrocodeine, and tramadol) in relation to the CSM announcement over the same period, nor a change in the number of all episodes of self-poisoning.

Conclusions The impact of the policy appears to have reduced nonfatal self-poisoning with co-proxamol without significant substitution with other analgesics. This finding is in keeping with that for suicide

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

As part of the *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 Mental Health NHS 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-harm¹; 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, and findings have been published^{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 2000-2007 have been merged into a multicentre database (51,206 episodes by 31,278 individual persons aged 7 years or more) to allow projects to be conducted on:

- a) Risk of suicide and other types of death following self-harm, including risk factors⁹.
- b) Extent of self-harm in ethnic groups and older people, and the characteristics, clinical management, and outcome of those involved.
- c) Type of hospital management following self-harm and its relationship to outcome, and to refine a clinical assessment tool for use by ED staff.
- d) How specific antidepressants are related to self-harm¹⁰, their relative toxicity in overdose¹¹, and the impact of national legislation to reduce pack sizes of paracetamol and aspirin and to withdraw co-proxamol.

- 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 adolescents¹².

-
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