



Self-Harm in Oxford 2012

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Ethical Approval

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.

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A pdf of this report and further information about the work of the Centre for Suicide Research are available at our website: <http://www.psych.ox.ac.uk/csr>.

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SELF-HARM IN OXFORD 2012

Report on presentations to the John Radcliffe Hospital

Background and Introduction

The Oxford Monitoring System

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 2012. 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.

Aims of the Monitoring System

We aim to find out how many people present to hospital following self-harm and to monitor trends in self-harm over time. We look at demographic and clinical factors relating to patients who present after self-harm in order to inform clinical services and provide better patient care.

Advisory Group

We have an advisory group made of service users, carers, clinical staff and researchers, which gives stakeholders an opportunity to shape current and future research.

Multicentre Monitoring of Self-harm project

As part of the *National Suicide Prevention Strategy for England*, multicentre monitoring of self-harm was 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 and Derbyshire Healthcare NHS Foundation Trust. There is more information about this project on page 27.

Definition of Self-harm

Self-harm is defined as intentional self-injury or self-poisoning, irrespective of type of motivation or degree of suicidal intent¹. This definition, which is used widely in a similar way in countries in Europe and elsewhere, thus encompasses both 'suicide attempts' and acts with other motives or intentions. This reflects the often mixed nature of intentions associated with self-harm and also the fact that suicidal intent is a dimensional rather than unitary phenomenon. 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).

¹ 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

Summary of trends and findings of note

Numbers of persons/episodes, age, and rates of self-harm

- The total number of self-harm presentations to the John Radcliffe Hospital in 2012 was 1538 which represented a 3.1% decrease on 2011. The decrease was seen in both males (down 2.9%) and females (down 3.3%).
- The number of individual persons presenting in 2012 was 1126, a decrease of 3.3% on 2011 (a decrease of 1.7% in males and 4.5% in females)
- In 2012 58.4% of patients were under 35 years of age. There were 54 patients under the age of 16 and 43 patients aged 65 years or more.
- The sex ratio (female to male) in 2012 was 1.4:1, the same as in 2011.
- Person-based rates of self-harm had been slowly declining since a peak in 2003. However, the rate in females showed an upturn in 2012. The highest rate of self-harm is in females 15-24 years, in whom rates have recently increased. The highest rate in males is in those aged 35-54 years.

Demographic characteristics of patients

- 59% of patients were single, one-fifth (21.7%) married and one-fifth (19.3%) divorced, separated or widowed.
- The ethnic distribution of patients presenting in 2012 was broadly similar to the ethnic distribution of the Oxfordshire population. The white self-harm population was very slightly over-represented and ethnic minorities, especially Asian, slightly under-represented compared with the general population.
- The proportion of patients who were unemployed was 26.2% (more than half for over a year) compared with 24.3% in 2011 and 22.6% in 2010. 15.1% of patients were registered as sick or disabled.
- 30.9% of assessed patients were living alone, in lodgings, in an institution or were of no fixed abode. The remainder (69.1%) were living with family or friends.

Clinical characteristics of patients

- The percentage of patients repeating within a year of an episode in **2011** (21.0%) was similar to recent years.
- Repetition within one year occurred in 22.4% of females and 19.0% of males. More than half (54.7%) of those who repeated within a year did so within the first three months of their first presentation in **2011**, and one-third (33.5%) re-presented within one month of their initial presentation.
- In 2012, 31.8% of assessed patients were presenting with self-harm for the first time.
- Misuse of alcohol (including drinking more than the maximum recommended number of units and alcohol abuse disorders) in patients who received a psychosocial assessment was recorded for 50.5% of males and 30.9% of females.
- Drug misuse was recorded for 25.0% of male and 8.4% of female assessed patients.
- The five most frequent problems preceding self-harm in assessed males concerned difficulties with a partner, alcohol, employment/studies, financial and relationships with other family members. In females the five most frequent problems involved relationships with other family members, difficulties with a partner, employment/studies, alcohol and drugs.

- Suicide intent scores (a measure of the extent to which patients wished to die) were in the high or very high range in 24.7% of assessed episodes. Suicide intent scores (averaged for 2010-2012) increased with age. Over one-third (34%) of episodes in those aged 55 years or over were of high or very high intent.

Methods used in self-harm

- Of all self-harm episodes, 70.2% involved self-poisoning, 23.0% self-injury and 6.8% both methods.
- The proportion of overdoses involving paracetamol (including compounds) in 2012 was 42.7%, similar to figures in recent years.
- In 2012, for the first time, there were no co-proxamol overdoses (1 in 2011, 2 in 2010). This reflects the impact of the phased withdrawal of this drug in the UK by the MHRA during 2005-2008 due to its high toxicity in overdose.
- Antidepressants were involved in 28.5% of overdoses in 2012 compared with 31.6% in 2011. Of these, 63.2% involved SSRIs/SNRIs, 18.4% tricyclics, 21.7% other antidepressants and 7.4% mood stabilisers.
- The majority (77.6%) of overdoses involved less than 40 tablets.
- In 2012, 29.8% of self-harm episodes involved self-injury (including some combined with self-poisoning). As in previous years, the most common method was self-cutting (77.0%).
- Alcohol use in the 6 hours before self-harm occurred in half (49.0%) the episodes in which a psychosocial assessment occurred. Alcohol was consumed as part of the act of self-harm in 26.1% of episodes. Alcohol involvement in self-harm (based on data for 2010-2012) was more frequent in males than females in all age groups except 45-54 years, where the proportions were identical in the two genders.

Clinical management of self-harm episodes

- 1,112 presentations (73.2%) resulted in an admission to a general hospital bed.
- The number of patient assessments conducted by members of the general hospital psychiatric service in 2012 was 1,057, compared with 1,067 in 2011 and 1,047 in 2010.
- 68.8% of all presentations were assessed by the psychiatric service. This was more common in patients admitted to a bed in the general hospital (84.7%) than in non-admitted patients (27.1%). While the proportion of cases with a psychosocial assessment indicated that guidance from NICE that all self-harm patients should receive an assessment is not always being followed, the proportion assessed is far higher than in most general hospitals in England (58%, based on a recent study in 32 hospitals¹).
- Three-quarters (75.0%) of the presentations to the hospital occurred between 5pm and 9am. As in previous years, presentations in the late evening and early hours of the morning were more likely to involve consumption of alcohol shortly before and/or as part of the act.
- Of all assessed patients offered community psychiatric aftercare in 2012, for 8.5% this involved follow-up with the Emergency Department Psychiatric Service (Barnes Unit).

¹ Cooper, J, Steeg, S, Bennewith, O, Gunnell, D, House, A, Hawton, K, Kapur, N *Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England* BMJ Open (2013) doi: 10.1136/bmjopen-2013-003444

- In a total of 480 episodes, patients left the hospital without a psychosocial assessment. While in 192 cases patients took their own discharge, in 113 cases patients were not referred to the psychiatric service for assessment. This continues an increasing trend in spite of NICE guidance in 2004 (reinforced in 2011) that all self-harm patients should be offered a psychosocial assessment. Patients presenting with self-injury were particularly likely not to receive an assessment (52.7%).

Self-harm in patients under 18 years of age

- 127 individuals in this age group (82.7% females) presented with 267 episodes of self-harm episodes in 2012.
- 83.3% of under-16 year-olds were admitted to a general hospital bed (NICE recommends that all in this age groups should be admitted).
- Psychosocial assessments occurred in 72.7% of episodes.
- Paracetamol overdoses and self-cutting were common methods of self-harm.
- Relationship issues were the main problems faced by individuals in this age group, especially problems with family. More younger than older adolescents had problems with friends and more older adolescents problems with boy/girlfriends.
- The majority (81.0%) were offered psychiatric or psychological care, especially via CAMHS services.

Self-harm in Older adults (65 years and over), 2009-2012

- 159 individuals in this age group were involved in 201 episodes of self-harm.
- Over half (52.2%) the individuals were male.
- Most patients were admitted to a general hospital bed (90.5% of presentations) and received a psychosocial assessment (80.1% of presentations).
- Self-poisoning was the most common method of self-harm (88.6%). Other methods often involved particularly dangerous acts, in keeping with the relatively high suicidal intent of most of these patients.
- The most frequent problems concerned physical health and social isolation.
- A quarter of episodes resulted in admission to psychiatric inpatient care (Table 15). Nearly half the patients were offered outpatient psychiatric care.

Number of persons and episodes

The total numbers of episodes of self-harm presenting to the John Radcliffe Hospital in 2012 are shown in Table 1, together with the numbers of individual persons involved.

TABLE 1			
Numbers of episodes, and persons involved, in 2012 (2011)			
	Males	Females	Total
Episodes of self-harm	598 (616)	940 (972)	1538 (1588)
Persons	470 (478)	657 (687)	1126 (1165)

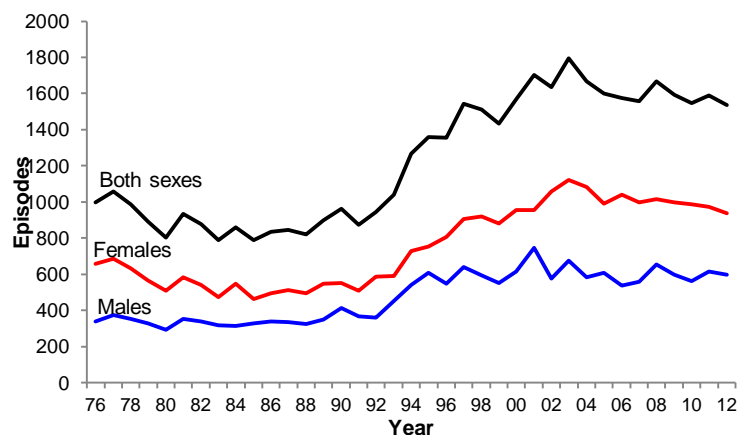
The number of self-harm **episodes** in 2012 was a little lower than in 2011 (-50 cases; -3.1%) (see Figure 1). This decrease was seen in both sexes, with a 2.9% decrease in presentations of males and a 3.3% decrease in presentations of females.

We compared the 2012 presentations with figures for a decade earlier, using the annual average for 2001-2003. The number of presentations in 2012 was 10.1% lower than average annual numbers presenting a decade ago (when numbers peaked). This change was similar for presentations both by males (10.2% lower) and females (10.0% lower).

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 2012 individual females were responsible for 21, 20 and 19 episodes respectively, with several having 10 episodes during the year. One male was responsible for 10 episodes during the year.

There was a small decrease in the number of **persons** who presented in 2012 compared with 2011 (-3.3%). The number of males decreased by 1.7% and females by 4.5%.

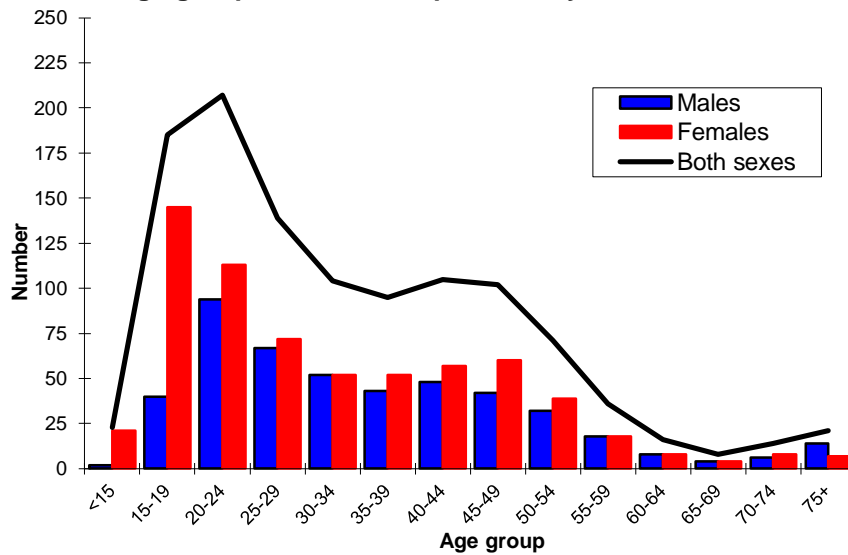
FIGURE 1
Episodes of self-harm presenting to the John Radcliffe Hospital 1976-2012



Age and sex

The **age distribution** of self-harm patients in 2012 was broadly similar to that in previous years, with 58.4% of patients being under 35 years of age. The largest numbers of females were in the 15-19 (145 patients) and 20-24 (113 patients) year age groups. The largest numbers of male patients were aged 20-24 years (N = 94). There were 43 patients aged 65 years and over. The oldest patient was 94 years old (see page 23 for section on older adults). In 2012 there were 54 patients under the age of 16. The youngest patient was aged 11 years (see page 22 for section on children and adolescents).

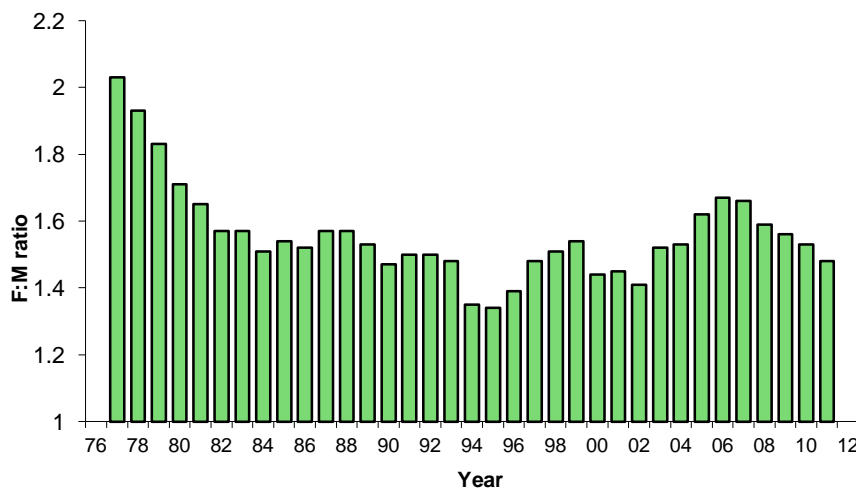
FIGURE 2
Age groups of self-harm patients, by sex, in 2012



Sex Ratio

The sex ratio (female to male) for persons in 2012 was 1.4:1. The moving average ratio has been steadily decreasing since 2006 (figure 3).

FIGURE 3
Sex ratio (F:M), persons, 1976-2012 (3-year moving averages)



Rates of self-harm and suicide rates

Oxford City and extended area self-harm rates

We usually calculate rates just for people living in Oxford City because almost all self-harm cases presenting to hospital from the city are seen at the John Radcliffe Hospital. As in 2010 and 2011, 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 4
Areas of Oxfordshire used to calculate self-harm rates

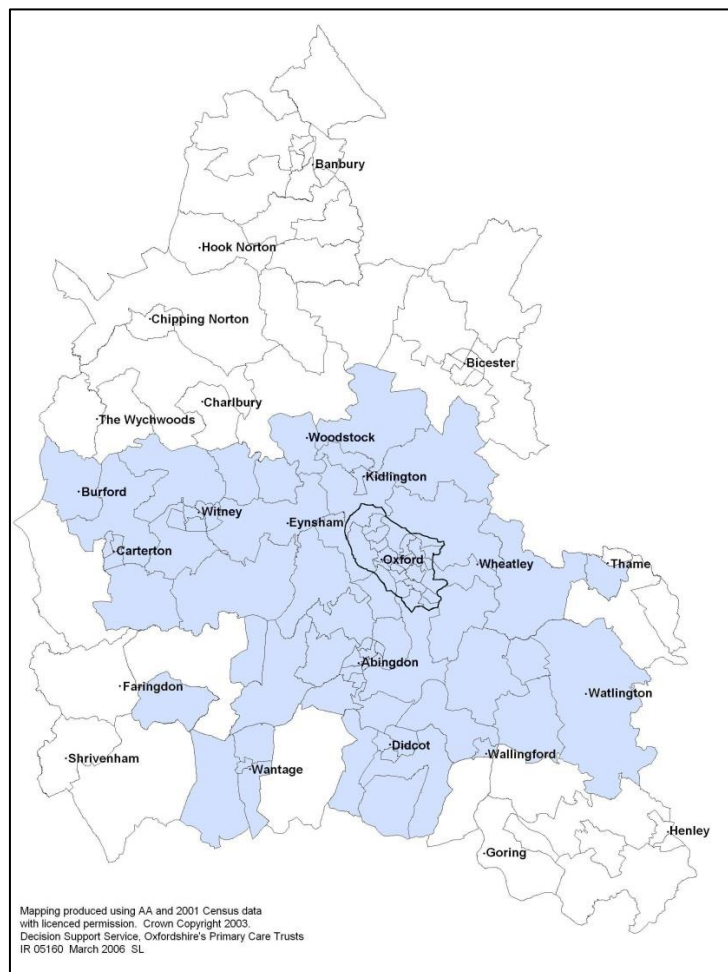
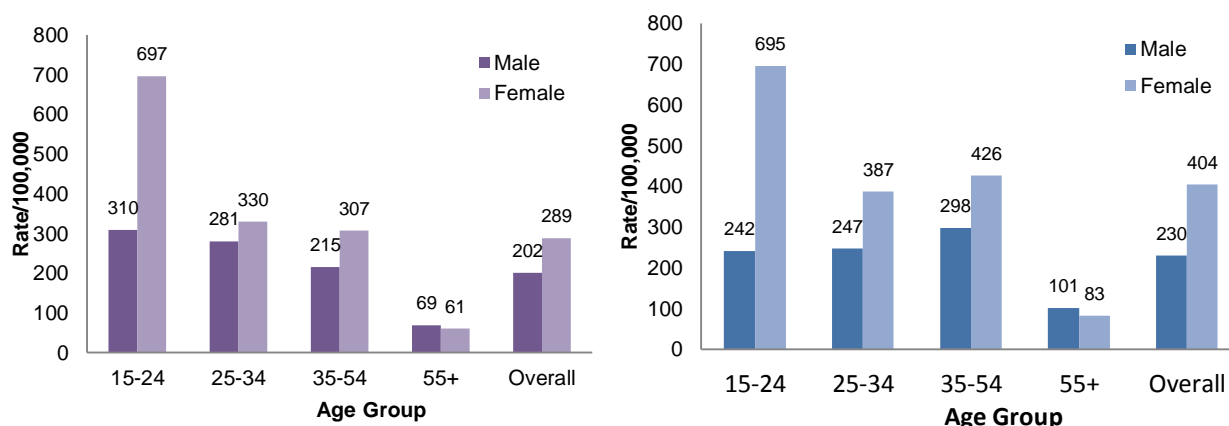


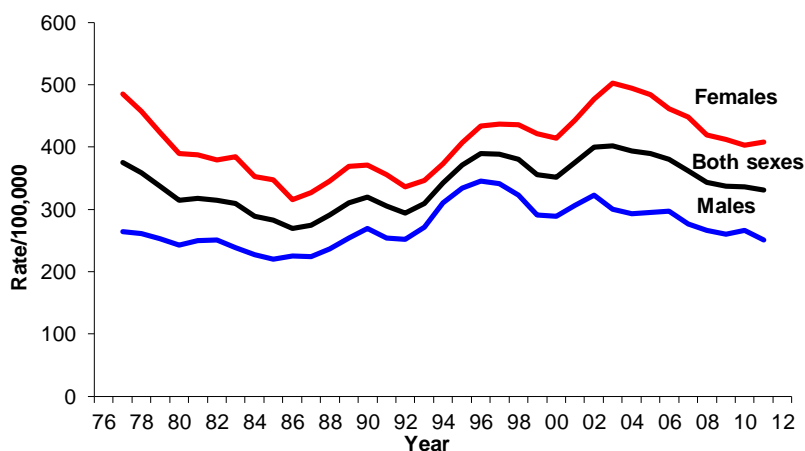
Figure 5 shows the 2012 self-harm rates by age groups and sex for both Oxford City and the extended area. Rates in Oxford City were higher, especially in females. However, rates in the extended area were higher in males under 35 years, and similar in the two areas for females aged 15-24 years.

FIGURE 5
Self-harm rates in 2012 by age group and sex
Oxfordshire Oxford City



For Oxford City we have also presented 3-year moving averages (which smooth out annual variations to show underlying trends), for the whole period for which data has been collected. Rates peaked around 2003, then declined in both genders, but showed an upturn in females in the most recent years (Figure 6).

FIGURE 6
Rates of self-harm in Oxford City (aged 15+ years)
1976-2012 (3 year moving averages)

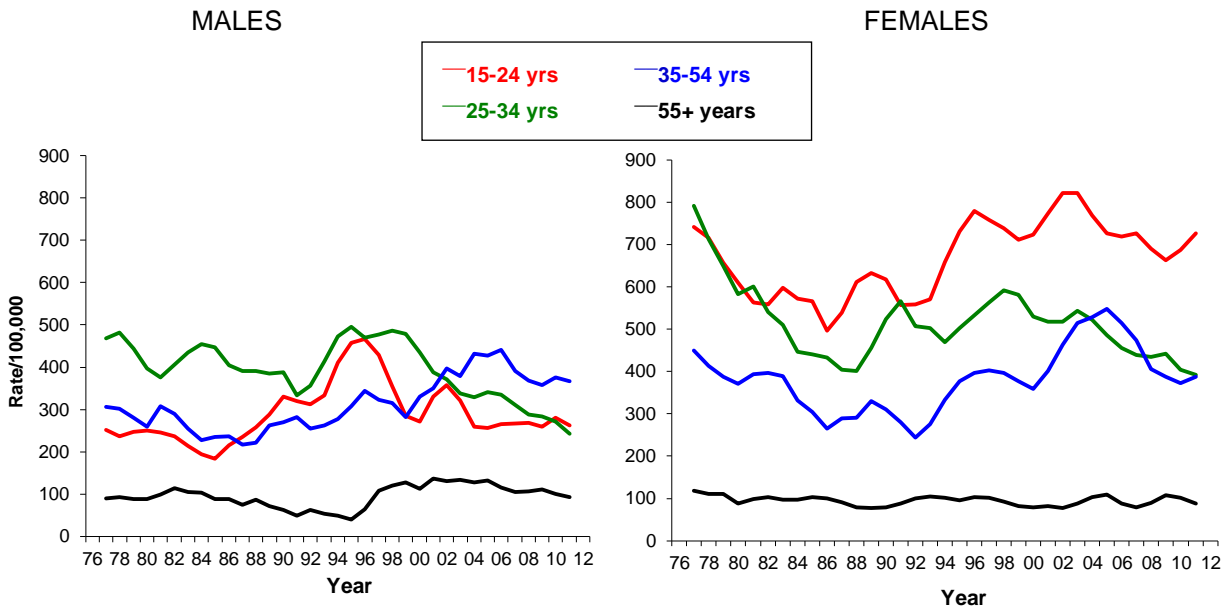


The **age group and sex-specific 3-year moving average rates for males** in Oxford City are shown in Figure 7. Rates of self-harm have decreased in 25-34 year-olds and those aged 55+ years, but not in other age groups.

The **3 year moving average rates in females** in Oxford City (Figure 7) show an upturn in 15-24 year-olds, and a levelling off in the rate for 35-54 year-olds. There was a small recent decline in rates in the other age groups.

FIGURE 7

Rates of self-harm in Oxford City, by age groups, 1976-2012 (3 year moving averages)

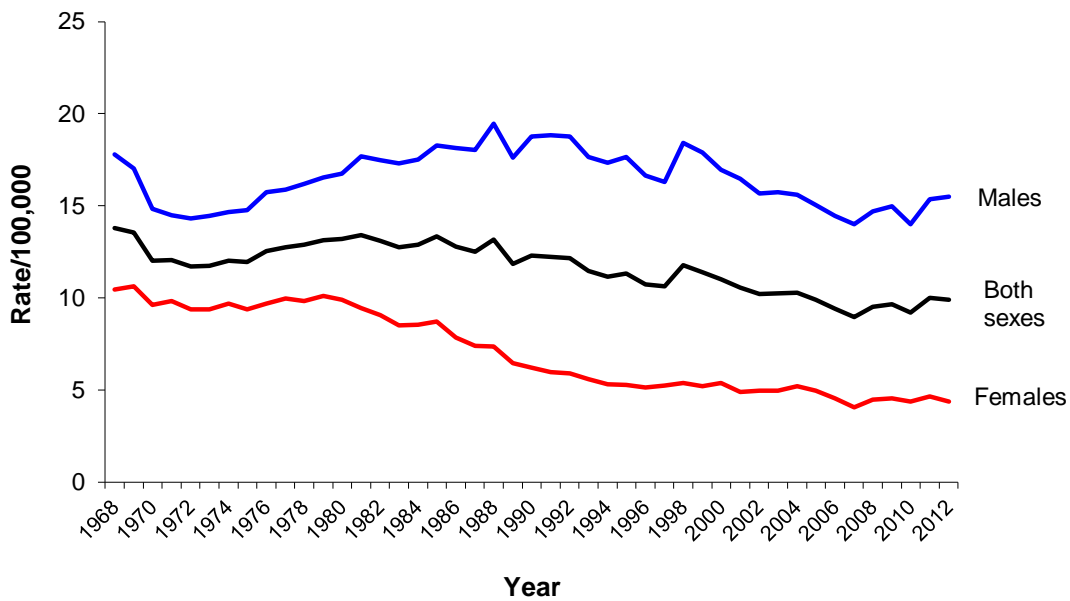


Suicide rates by sex and age groups in England and Wales

Figure 8 shows overall rates of suicide (including open verdicts) by gender, in persons aged 10 years and over, for England and Wales between 1968 and 2012. Suicide rates had been declining steadily in both genders until 2007, after which they increased somewhat, especially in males, while rates in females have levelled off.

FIGURE 8

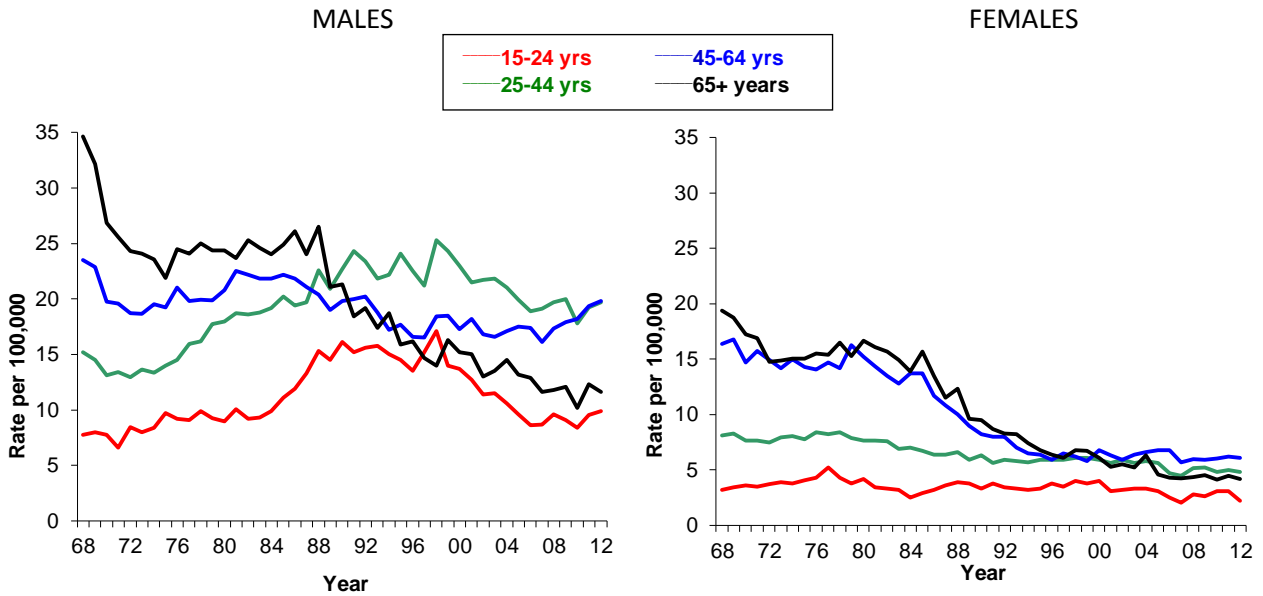
Mortality from suicide and open verdicts in people aged 10 years and over in England and Wales, 1968-2012, by gender
Rates standardised to the European standard population



Source: Office for National Statistics

Figure 9 show suicide rates (suicides and open verdicts) for England and Wales between 1968 and 2012 for specific age groups, by gender. In 2012, rates in males increased in all age groups except 65 years and over. Rates in females decreased slightly in all age groups.

FIGURE 9
Rates of suicide and open verdicts in England & Wales 1968-2011 by age groups
Rates standardised to the European standard population



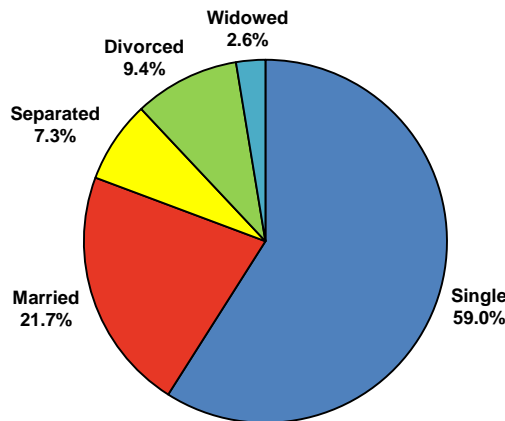
*Data are registrations of death in each calendar year
 Source: Office for National Statistics*

Demographic characteristics

Marital status

The majority of assessed self-harm patients in 2012 were single (Figure 10).

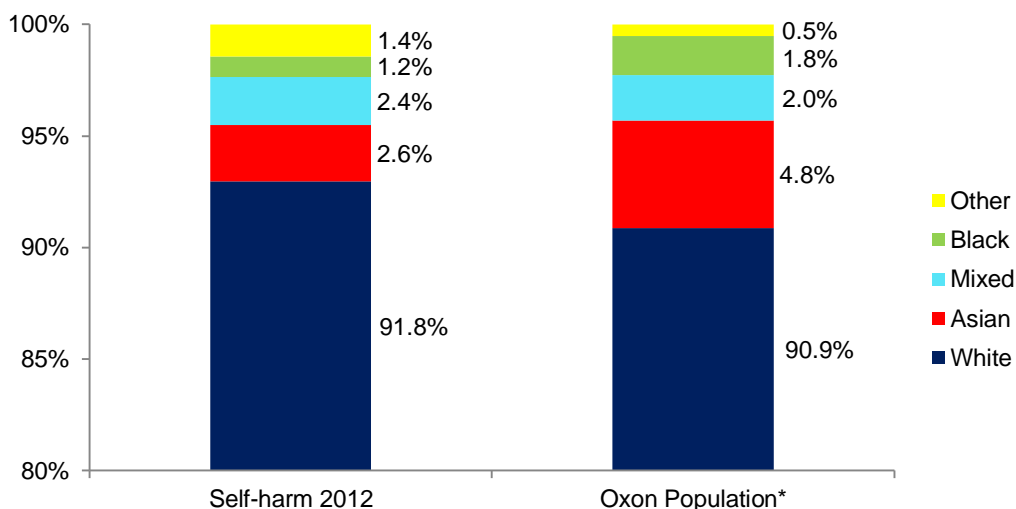
FIGURE 10
Marital status of assessed patients (aged 16+ years) in 2012



Ethnicity

In 2012, information on ethnicity was recorded for 91.8% of assessed self-harm patients. Overall, the proportion of white patients roughly reflected that found in the 2011 Census for Oxfordshire. However, Asian and Black groups were under-represented and Mixed and Other groups were somewhat over-represented compared with the general population (Figure 11).

FIGURE 11
Ethnicity in Oxfordshire self-harm patients 2012 vs. ethnic makeup of Oxford District population

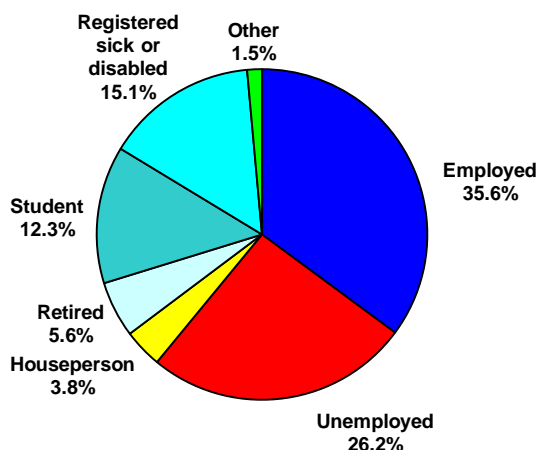


*Source: ONS 2011 Census

Employment status

In 2012, 26.2% of the self-harm patients (aged 16 years and over) were **unemployed** (Figure 12). This figure has been rising in recent years (2011, 24.3%; 2010, 22.6%). 15.1% were permanently sick, a similar figure to 2011 (14.2%). Of those persons for whom the duration of unemployment was known, 51.1% had been unemployed for **more than a year** and 16.3% for **less than one month**.

FIGURE 12
Employment status of assessed self-harm patients (aged 16+ years) in 2012



University Students

Of the assessed self-harm patients in 2012, 93 were **students** (including school students). These included 22 **Oxford University students** (19 females and 3 males) and 15 **Oxford Brookes University students** (10 females and 5 males).

Living situation

The majority of assessed patients in 2012 **lived with family members or friends** (69.1%). The remainder (30.9%) were **living in lodgings, alone or in an institution**, or were of **no fixed abode**. A significantly greater proportion of males (39.8%) than females (24.7%) were not living with relatives or friends ($X^2 = 21.24$, $p < 0.001$). Twenty-six patients were of **no fixed abode**, representing 3.2% of all assessed patients whose living situation was known: 5.4% of males ($N = 18$) of males and 1.6% ($N = 8$) of females).

Clinical characteristics of self-harm patients

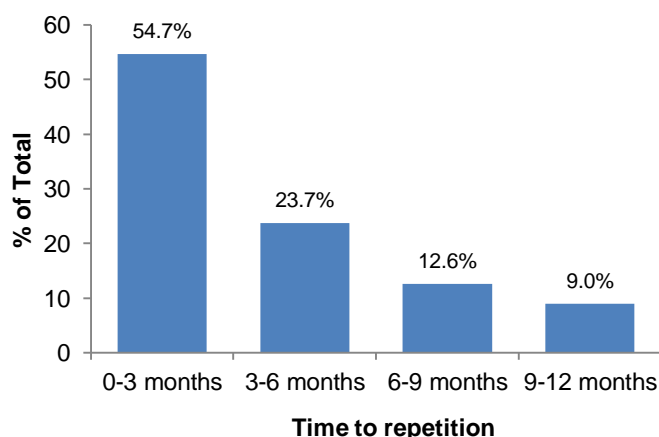
Repetition of self-harm

One measure of repetition is the ratio of the number of self-harm episodes to the number of persons. In 2012 the ratio was 1.4, the same as in 2011. 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 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 (2011) and repetition will only be identified for those who present to the general hospital following subsequent episodes. Of patients who presented in **2011**, 21.0% repeated self-harm within a year. The repetition rate for females was 22.4% and for males 19.0%. Figure 13 shows the timing of these episodes; more than half of patients who re-presented to the general hospital within a year did so within three months and more than one-third (33.5%) repeated within one month of their initial presentation.

FIGURE 13

Patients who presented during 2011 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 2012, 31.8% (38.7% males, 27.1% females) of the assessed patients whose self-harm history was known harmed themselves for the first time.

Of those patients who were assessed in **2011** and had no previous history of self-harm, 9.7% repeated within the following year (8.8% males, 10.4% females) compared with 28.% of those who had a known previous history of self-harm (25.6% males, 25.1% 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.

Psychiatric disorder and substance misuse

In patients who were assessed in 2012, 39.6% were reported as having a **major psychiatric disorder** (36.7% of males and 41.7% of females). These figures will considerably under-represent the proportions with any type of psychiatric disorder.

Personality disorder was identified in 23.9% of patients in 2012, including 19.9% of males and 26.7% of females. These figures are likely to reflect those with more severe personality disorders.

In addition, **misuse of alcohol** was recorded for 50.3% of males and 30.9% of females, a higher figure for males than in 2011 (44.5%). Those misusing alcohol included for males (females in brackets): **chronic alcoholism** 5.8% (1.3%), **alcohol dependence** 6.5% (4.6%) and known to be **drinking more than the recommended maximum safe number of units** 38.1% (24.9%).

Drug misuse was recorded for 15.2% of patients in 2012, including 25.0% of males and 8.4% of females.

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 in previous years, the most frequent problems identified at the time of the self-harm episodes were **relationship difficulties** (62.9%). 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).

Problem	Both sexes (N=824) %	Males (N=336) %	Females (N=488) %	p
Partner	38.2	38.7	37.9	n.s.
Other family members	33.7	26.2	38.9	<0.001
Alcohol	29.1	35.4	24.8	0.001
Employment /studies	26.9	28.3	26.0	n.s.
Financial	22.0	26.2	19.1	0.01
Drugs	19.4	19.0	19.7	n.s.
Housing	17.2	20.2	15.2	<0.05
Social isolation	17.0	14.9	18.4	n.s.
Relationship with friends	10.2	6.0	13.1	<0.001
Physical health	9.1	10.4	8.2	n.s.
Bereavement	9.0	9.8	8.4	n.s.
Childhood emotional abuse/ neglect	6.3	5.4	7.0	n.s.
Childhood sexual abuse	5.9	4.2	7.2	<0.05

Males were more likely to have problems with **alcohol, finances and housing**, whereas problems with **other family members, friends, and childhood sexual abuse** were more frequent in females. **Eating disorders problems** were present in 3.3% of females. Problems due to **the consequences of childhood physical abuse** were recorded in 4.1% of females and 3.0% of males. Problems related to **chronic pain** were identified in 4.2% of males and 4.7% of females.

Suicide intent

The **Suicide Intent Scale**, which measures the extent to which patients appeared to want to die (Figure 14), was completed by the clinical assessors for 858 episodes in 2012 (81.2% of episodes in which an assessment occurred). The median suicide intent score for males was 9 and for females was 7 ($z = 2.783$, $p < 0.01$). The classification of scores into low, moderate, high and very high categories indicated that the scores of 24.7% of cases were in the high (13-20) or very high (21+) range. High or very high scores were recorded for 33.1% of males and 19.0% of females.

Suicide intent scores by age and sex for the years **2010-2012** combined (as in previous years) showed that the proportions of patients with relatively high scores increased with age in both sexes. This was significant in females (X^2 for linear trend = 4.40, $p < 0.05$) although not for males (X^2 for linear trend = 0.74, n.s.). Almost 34% of episodes in those aged 55 years and over involved relatively high scores (Figure 15).

FIGURE 14
Suicide Intent Scale scores in assessed patients, overall and by sex, 2012

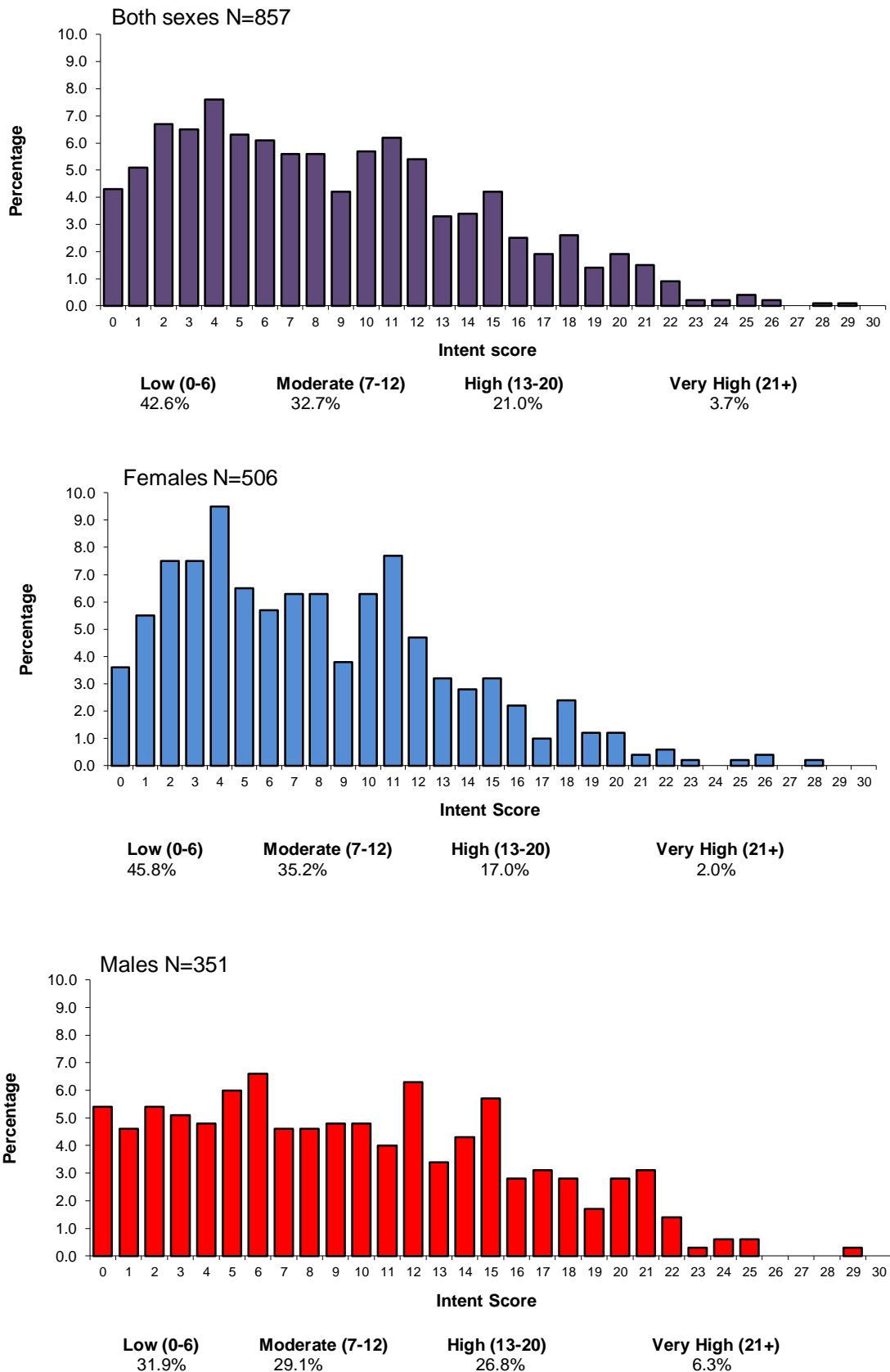
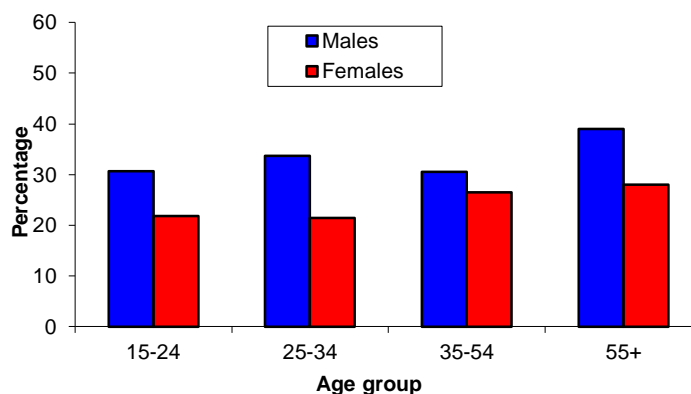


FIGURE 15
Suicide intent by age and sex, 2010-2012
High and very high scores (SIS = 13-30)



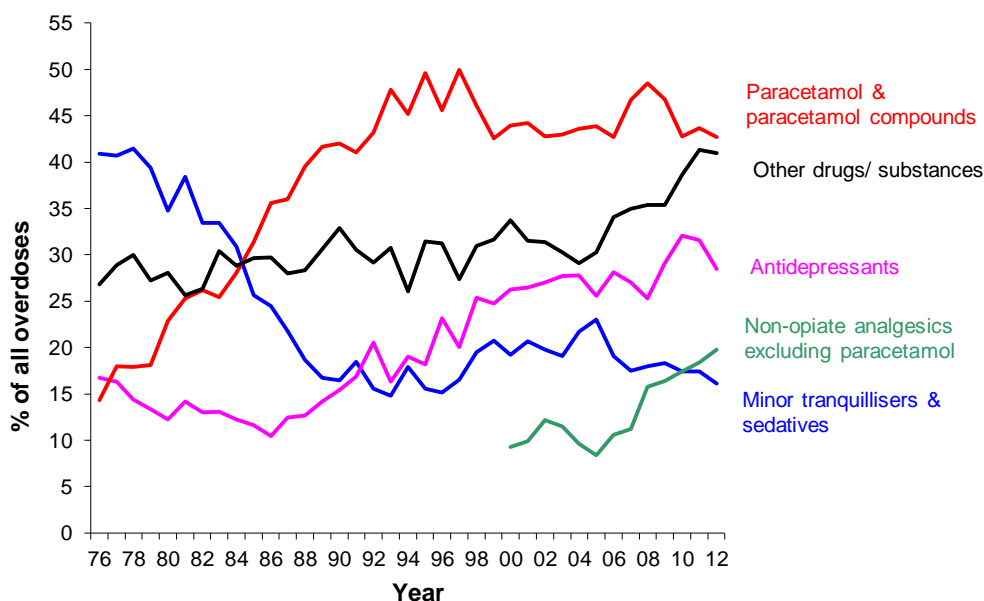
Methods used for self-harm

Drugs used for self-poisoning

In 2012, 70.2% of self-harm episodes involved **self-poisoning**, 23.0% **self-injury** and 6.8% **both methods**. Figure 16 shows the trends in percentages of overdoses involving specific groups of drugs.

The proportion of overdoses involving **paracetamol** (including compounds) was 42.7% in 2012. 83 (7.0%) overdoses involved **paracetamol and codeine combined preparations** (e.g. co-codamol); in 2011 there were 118 (9.6%) such overdoses. These preparations made up 16.4% of all paracetamol (including compound) overdoses. Pure paracetamol was involved in 82.8% of all paracetamol overdoses and paracetamol in compound form in 23.2% (some overdoses involved both forms of paracetamol). In 2012, for the first time, there were no overdoses involving **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 in Oxford. **Non-steroidal anti-inflammatory drugs** (including those prescribed) were involved in 17.1% of overdoses in 2012.

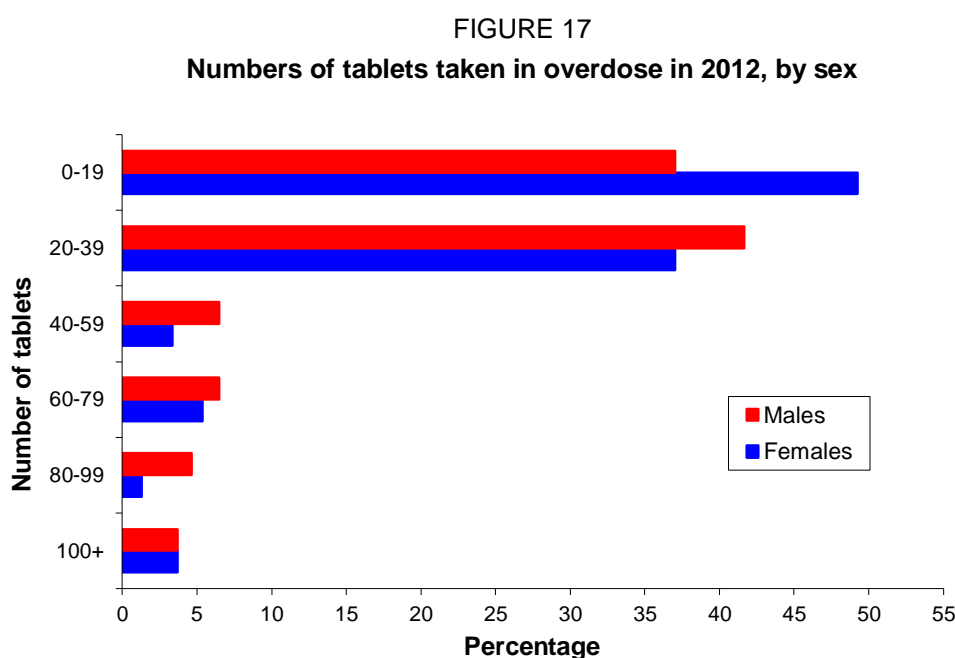
FIGURE 16
Substances used in self-poisoning 1976-2012



Antidepressants (including mood stabilisers) were involved in 28.5% of overdoses (compared with 31.6% in 2011). Of these overdoses, 63.2% involved **SSRIs/SNRIs**, 18.4% **tricyclics**, 21.7% **other antidepressants** (e.g. trazodone, mirtazapine) and 7.4% **mood stabilisers** (some overdoses involved more than one type of antidepressant).

Minor tranquillisers and sedatives were involved in 16.1% of overdoses, a similar percentage to recent years.

Information on the **number of tablets** taken in overdoses was available for 864 cases in 2012. The mean number taken in overdose was 29.8 (SD 28.6, median = 20.0) tablets. As can be seen in Figure 17, the majority of overdoses involved less than 40 tablets (77.6%). In general, males tended to take larger overdoses than females (median values: males 25, females 20; $z = 3.518$, $p < 0.001$).



Methods of self-injury

Of the self-injuries, **self-cutting** was, as usual, the most common method, used by 77.0% (N = 359) of those self-injuring (69.4% males, 82.0% females) in 2012. 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) is notable.

Alcohol involvement

In 2012, as in previous years, **alcohol** was often consumed **at the time of self-harm** (26.1% of assessed patients). This figure was higher in males than females (31.1% males, 22.7% females). Alcohol had very often been consumed **during the six hours before the episode** (49.0%), again more commonly by males (59.8%) than females (41.5%) (Figure 18).

Alcohol involvement in self-harm (based on data for 2010-12) 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 the 45-54 age group (in which slightly 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 and increasing involvement of alcohol between Monday and Friday. Levels in males were high all week, but lower on Mondays than on other days (Figure 19).

FIGURE 18
Alcohol involvement in self-harm by age group

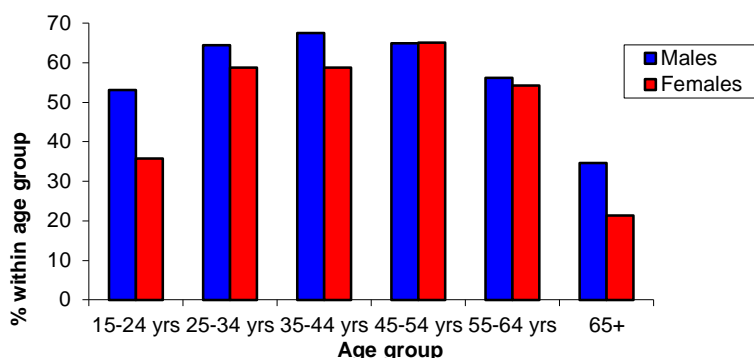
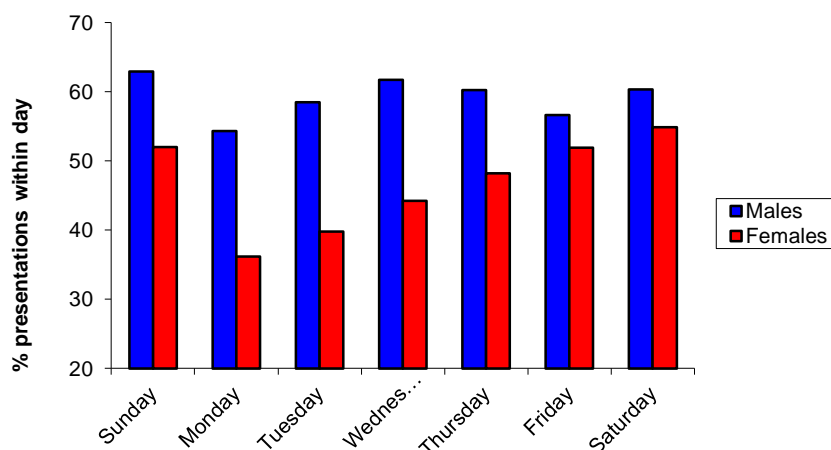


FIGURE 19
Alcohol involvement in self-harm by day of presentation



Clinical Management of self-harm patients

Assessments by the Emergency Psychiatric Service (Barnes Unit)

A total of 1113 self-harm episodes resulted in **admission to a bed in the general hospital** in 2012 (72.3% of all episodes; Table 3). It should be noted that for the purpose of our monitoring, admission to the Emergency Assessment Unit is counted as a hospital admission.

1057 **assessments of self-harm patients** were conducted by members of the Emergency Department Psychiatric Service in the John Radcliffe Hospital in 2012. Overall, 68.8% of episodes resulted in an assessment. In only 27.1% of the non-admitted episodes was there an assessment. There was little difference between males and females in the proportions which resulted in an assessment.

In 481 episodes the patient **left the hospital without being assessed** (170 males, 311 females). Of those not assessed, 193 took their own discharge, 38 refused assessment, there was a policy decision not to assess the patient in 10 presentations, 73 were in current psychiatric inpatient care, 25 were in current psychiatric outpatient care, and 29 were not assessed for other reasons. The remaining 113 patients were not identified for assessment.

		Admitted		Not Admitted		Overall	
		%	N	%	N	%	N
MALES:	Assessed	84.5%	387	29.3%	41	71.6%	428
	Not assessed	15.5%	71	70.7%	99	28.4%	170
FEMALES:	Assessed	84.7%	555	26.0%	74	67.0%	629
	Not assessed	15.3%	100	74.0%	211	33.0%	311
BOTH GENDERS:	Assessed	84.7%	942	27.1%	115	68.8%	1057
	Not assessed	15.3%	171	72.9%	310	31.2%	481

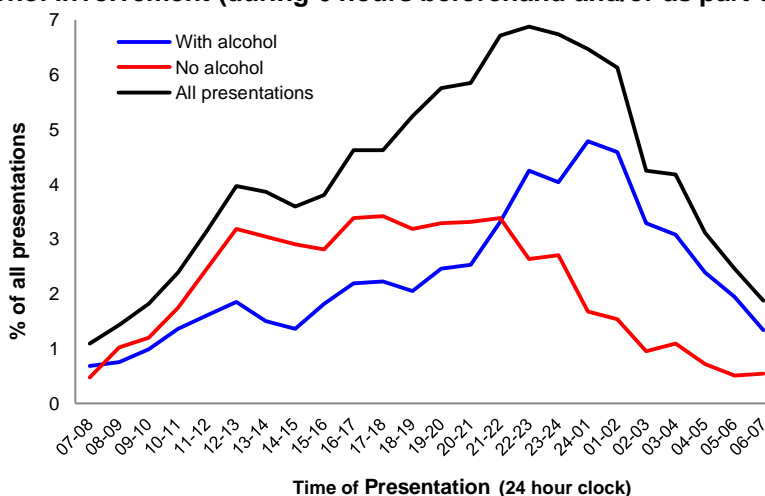
In 2012, 48.5% (N=513) of self-harm episodes resulted in assessment by nurses or social workers and 51.5% (N=544) by doctors. For the first time in several years, the proportion of assessments being conducted by nurses or social workers increased. This reflects changes in the self-harm service.

An assessment was conducted following 75.2% of episodes involving self-poisoning but in only 47.3% of self-injuries alone. Just 44.4% of episodes of self-cutting alone resulted in an assessment whereas an assessment occurred in 54.0% of episodes involving any other form of self-injury alone.

Time of presentation in the Emergency Department

Figure 20 shows the time of presentation to the Emergency Department for assessed self-harm episodes in **2010-2012**. In the majority of episodes presenting outside the working day, especially in the late evening and early hours of the morning, alcohol had been consumed shortly before and/or as part of the act.

FIGURE 20
Time of presentation to the Emergency Department for all assessed episodes, and those with or without alcohol involvement (during 6 hours beforehand and/or as part of act), 2010-2012



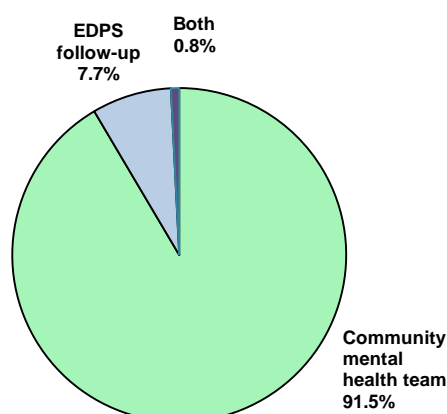
In 2012, 25.0% of all patients (including those who were not assessed) presented between 9 a.m. and 5 p.m. and the remainder (75.0%) between 5 p.m. and 9 a.m. Time of presentation was not recorded for 12 presentations.

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 83.8% of those presenting between 9 a.m. and 5 p.m. were assessed compared with 85.0% of those presenting after 5 p.m. ($\chi^2 = 0.236$, n.s.). Time of presentation also made no major difference to assessment of those not admitted to a hospital bed in that 34.2% of those who presented in the daytime were assessed compared with 25.4% of those who presented after 5 p.m. ($\chi^2 = 2.386$, n.s.).

Aftercare

Of the assessed self-harm episodes which resulted in a referral for **outpatient psychiatric aftercare** (N = 525), in 48.9% 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 21. In 8.5% of cases this included follow-up by the Emergency Department Psychiatric Service.

FIGURE 21
Psychiatric and community outpatient care in patients offered aftercare



The proportion of assessed cases in 2012 in which **Inpatient psychiatric care** in Oxford was arranged following discharge from the John Radcliffe was 5.9% (N = 62) (Table 4). 85.5% (53/62) were new admissions, the remainder (14.5%) 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 5.0% of all assessed patients.

TABLE 4
Aftercare accepted following assessment in 2012 (N=1057)
according to whether or not patients were in current psychiatric care

	Overall		New patient		Current patient	
	% ¹	(n)	% ¹	(n)	% ¹	(n)
Inpatient psychiatric care	5.9	(62)	5.0	(53)	0.9	(9)
Outpatient psychiatric care:						
Community MH Teams	39.4	(416)	18.2	(192)	21.2	(224)
EDPS follow-up	4.0	(42)	3.7	(39)	0.3	(3)
Crisis Resolution Teams	15.4	(163)	10.1	(107)	5.3	(56)
Day patient psychiatric care	0.8	(8)	0.3	(3)	0.5	(5)
GP care (alone or for GP-led services)	26.5	(280)				
PCAMHS	1.6	(17)				
IAPT	4.4	(46)				
Alcohol Services	11.7	(124)				
Other outcomes ²	10.7	(113)				
Took own discharge	0.7	(7)				

¹ The percentages total more than 100% because some patients have more than one outcome e.g. outpatient care and referral to voluntary agency.

² Other includes e.g. Social Services, voluntary agencies, Elmore team and probation or custody

The proportion of assessed patients **referred back to GP care** alone in 2012 was 26.5%. (This figure is a considerable underestimate when account is taken of the number of patients discharged without a psychosocial assessment.) In 87 (31.1%) of these assessed cases, patients were referred back to GP care with a recommendation for primary care-led treatment (e.g. counselling) or GP referral for psychological treatment.

Self-harm in patients under 18 years of age, 2012

Children and adolescents under 18 years of age accounted for 10.4% of presentations (11.3% of persons) during 2012. As will be seen from Table 5, the majority of these younger patients were female (82.7%) and repeated presentations were almost exclusively by females.

	Females		Males		Overall	
	Patients	Episodes	Patients	Episodes	Patients	Episodes
16 and 17 years	58	76	15	17	73	93
Under 16 years	47	64	7	8	54	118
Total	105	140	22	25	127	267

Admission to a general hospital bed occurred in approximately two-thirds of episodes (Table 6). In under-16 year-olds, 83.3% of episodes resulted in admission (NICE guidance is that all self-harm in this age range should be admitted). Psychosocial assessment occurred in 72.7% of episodes. Assessment occurred more frequently in females than males.

	Admitted to hospital bed			Psychosocial assessment		
	Females % (N)	Males % (N)	Overall % (N)	Females % (N)	Males % (N)	Overall % (N)
Under 16 yrs	71.1% (54)	75.0% (6)	83.3% (60)	82.8% (53)	62.5% (5)	80.6% (58)
16 and 17 yrs	78.1% (50)	58.8% (10)	64.5% (60)	68.4% (50)	58.8% (10)	66.7% (60)
Total	74.3% (104)	64.0% (16)	72.7% (120)	75.0% (105)	60.0% (15)	72.7% (130)

71.5% of episodes involved self-poisoning, 21.2% self-injury and 7.3% both. In terms of methods of self-harm used, there were no major differences between methods used by under-16 year-olds and 16-17 year-olds. Paracetamol was involved in 48.2% of self-poisoning episodes (Table 7). Of the self-injury episodes, 85.1% (40/47) involved self-cutting.

	N	%
Pure paracetamol	66	48.2
Paracetamol-containing drugs	12	8.8
Non-steroidal anti-inflammatory drugs	30	21.9
SSRI antidepressants	17	12.4

The main problems faced by younger patients were relationship issues: with family, friends and boyfriends/girlfriends (Table 8). A significant minority had problems with drugs. The younger adolescents were more likely to have problems related to friends, whereas more of the older adolescents had problems related to partners.

TABLE 8 Problems identified in assessed patients					
Problem:	Under 16 yrs N = 58		16-17 yrs N = 62		p
	n	(%)	n	(%)	
Family	31	(53.4%)	30	(48.4%)	n.s.
Friends	26	(44.8%)	15	(24.2%)	p< 0.05
Drugs	10	(17.2%)	10	(16.1%)	n.s.
Psychiatric problem	10	(17.2%)	10	(16.1%)	n.s.
Social isolation	9	(15.5%)	6	(9.7%)	n.s.
Bullying	8	(13.8%)	5	(8.1%)	n.s.
Partner	7	(12.1%)	20	(32.3%)	p< 0.05
Studies/employment	5	(8.6%)	8	(12.9%)	n.s.
Sexual abuse	4	(6.9%)	4	(6.5%)	n.s.
Housing	3	(5.2%)	8	(12.9%)	n.s.

Aftercare

Approximately half of all young people who received a psycho-social assessment following self-harm were referred to or returned to outpatient care with Child and Adolescent Mental Health services, with almost 81% receiving some form of psychiatric or psychological support. Of these, 48 (47.1%) were referred for new or additional psychiatric care with CAMHS or CAMHS Crisis Team. Approximately 10% were allowed home with no further follow-up agreed. We do not know in these cases whether treatment was offered but refused. In some cases the GP will have been contacted with advice to refer the patient to community mental health services.

TABLE 9 Aftercare agreed before discharge from hospital				
	Under 16 yrs N = 58		16-17 yrs N = 62	
	n	%	n	%
CAMHS	29	50.0%	30	48.4%
CAMHS Crisis Team	7	12.1%	15	24.2%
PCAMHs	9	15.5%	7	11.3%
GP care	7	12.1%	6	9.7%
Social services	4	6.9%	1	1.6%

Self-harm in Older Adults (Age 65 years and over)

The data presented for older adults is for the 4-year period 2009-2012 (because numbers presenting each year are relatively small).

As will be seen from Table 10, similar numbers of presentations occurred in both genders, unlike in younger adults where there are significantly more females than males. Older females had a lower risk of re-presenting to hospital following repetition of self-harm than males.

TABLE 10 Presentations for self-harm and number of patients aged 65 and over 2009-2012			
	Presentations	Patients	Presentations:Persons ratio
Females	96	88	1.1
Males	105	71	1.5
Total	201	159	1.3

The majority of episodes by older patients resulted in admission to a bed in the general hospital and in most cases there was a psychosocial assessment (Table 11).

TABLE 11 Proportion of presentations where patients were admitted or assessed 2009-2012			
	Females	Males	Total
Admitted to hospital bed	90/96 (93.8%)	92/105 (87.6%)	182/201 (90.5%)
Psychosocial assessment	74/96 (77.1%)	87/105 (82.9%)	161/201 (80.1%)

Self-poisoning was the most common method of self-harm (88.6%). Only 23 episodes over the 4 year period involved any form of self-injury. However, the methods used often suggested particularly dangerous attempts, in keeping with the higher suicidal intent in older self-harm patients (see page 14 and Table 14). 26.1% involved hanging, asphyxiation, attempted drowning or jumping from a height. A further 26.1% involved some form of self-stabbing self or mutilation.

TABLE 12 Most common drugs taken in overdose		
Drug taken in overdose (N=183)	% of all overdoses (N)	
Pure paracetamol	30.6	(56)
Other prescribed drugs	23.5	(43)
Antidepressants	23.0	(42)
Benzodiazepines and minor sedatives	21.9	(40)
Opiate pain killers	12.6	(23)
Other paracetamol-containing drugs	10.9	(20)
Non-steroidal anti-inflammatory drugs	4.9	(9)
Major Tranquilisers	4.4	(8)

The main problems faced by older patients concerned physical health and social isolation (Table 13). Relationship problems, either with partner or family members, were less frequently cited as a factor than in younger adults, although chronic pain and bereavement were more commonly mentioned.

TABLE 13		
Problems identified in assessed patients		
Problem (N=119):	n	(%)
Physical health problem	38	(48.7%)
Social isolation	34	(28.6%)
Psychiatric disorder	25	(26.9%)
Partner	30	(25.2%)
Family	27	(22.7%)
Chronic pain	16	(19.5%)
Bereavement	15	(12.6%)
Alcohol	15	(12.6%)

Suicide Intent

The median Suicide Intent Scale score for both males and females was 11, which is higher than found in the general self-harm population. The distribution of scores differs markedly from the overall distribution, with fewer older adults having low scores and more having higher scores (see Figure 20 on page 19).

TABLE 14		
Suicide intent in older adults, 2009-2012		
SIS score range:	Males	Females
Low	23.3%	22.9%
Moderate	30.2%	35.4%
High	32.6%	37.5%
Very High	14.0%	4.2%

Aftercare

A quarter of all older adults were admitted to inpatient psychiatric care following psychiatric assessment. A further 45% were referred to or returned to community mental health teams. 10.4% were offered other care, mainly general hospital inpatient care or social services. The remainder were referred back to their GP.

TABLE 15	
Aftercare offered	
Aftercare:	%
CMHT Outpatient care, including Crisis Team	45.6%
Inpatient psychiatric care	24.8%
GP care only	19.2%
Other (mainly other medical referrals or social services)	10.4%

RECENT RESEARCH FINDINGS FROM THE OXFORD MONITORING SYSTEM FOR SELF-HARM

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

Alcohol-related mortality following self-harm: a multicentre cohort study (2014)

Bergen, H., Hawton, K., Webb, R., Cooper, J., Steeg, S., Haigh, M., Ness, J., Waters K. and Kapur, N.

Background: We assessed alcohol-related premature death in people who self-harm compared to the general population, including variation by socioeconomic deprivation.

Methods We conducted a retrospective longitudinal cohort analysis from the Multicentre Study of self-harm in England. All individuals aged 15 years or more, presenting with self-harm to six emergency departments in Oxford, Manchester and Derby from 1 January 2000 to 31 December 2010 were included (N=39,014). Follow-up mortality information to 31 December 2012 from the Data Linkage Service of the Health and Social Care Information Centre was used to estimate standardised mortality ratios (observed/expected number of deaths: SMRs) and mean number of years of life lost (YLL) for alcohol-related mortality. Patients' characteristics and clinical management following self-harm were also examined.

Results: After 7.5 years' (median) follow-up, 2695 individuals (6.9%) had died, significantly more males (9.5%) than females (5.0%), including 307 (11.4%) from alcohol-related causes. Alcohol-related death was more frequent than expected in both males (SMR 8.5, 95% CI 7.3 to 9.8) and females (11.6, 9.8 to 13.7), equating to 33.7 YLL (95% CI 32.4 to 35.0) in males and 38.1 YLL (36.6 to 39.6) in females. It was not associated with area-level socioeconomic deprivation. Alcohol-related death was associated with unemployed/sick/disabled status, alcohol use during self-harm, referral to drug/alcohol services and lack of psychosocial assessment following self-harm.

Conclusion: Hospital presenting self-harm patients should receive assessment according to national guidance to enable early identification and treatment of alcohol problems.

Self-harm in people with epilepsy: A retrospective cohort study (2014)

Meier, N., Voysey, M., Holmes, J., Casey, D. and Hawton, K.

Background Little is known about self-harm in people with epilepsy, despite suicide being recognized as a leading cause of mortality in this population. We aimed to investigate the characteristics of self-harm in people with epilepsy, and associated demographic and psychosocial factors.

Methods Patients presenting to hospital following self-harm between 1994 and 2008 were identified from the Oxford Monitoring System for Self-Harm. Epilepsy diagnosis was confirmed through review of medical records. Demographic features, patient, and self-harm characteristics of 132 people with epilepsy and 9,778 self-harm patients without epilepsy were compared using a regression model, adjusting for age, sex, and repetition. Patients presenting between 1998 and 2008 were followed up for all-cause mortality to the end of 2011.

Results The rate of self-harm per individual with epilepsy was 2.04 (95% confidence interval [CI] 1.85-2.25) times that of the comparison group, and time between first and second self-harm events was shorter (hazard ratio 1.86; 1.46-2.38). People with epilepsy were significantly more likely to use antiepileptic medication in overdose, although overall methods of self-harm were similar in the two groups. No significant differences in suicide intent scores or the proportion of patients who died by suicide were found. Previous outpatient psychiatric treatment, longer duration of unemployment, experience of violence, and housing problems were associated with self-harm in people with epilepsy.

Conclusion People with epilepsy who self-harm do so more frequently than other self-harm patients. Clinicians should be aware of this and pay attention to contributory factors as these may enhance risk in this population

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

As part of the first *National Suicide Prevention Strategy for England* (Dept of Health 2002), 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 Self-harm, 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 (NICE, 2004); 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 (Hawton et al (2007); Bergen et al (2010a); Cooper et al (2007); Kapur et al (2008); Lilley et al (2008); Bergen et al (2010b)).

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 (Bergen et al, 2012a; 2012b; Murphy et al 2012; Bergen et al, 2014).
- b) Extent of self-harm in ethnic groups (Cooper et al, 2010), older people (Murphy et al, 2012), and children and adolescents (Hawton et al, 2010a; 2012b) and the characteristics, clinical management, and outcome of those involved.
- c) Type of hospital management following self-harm and its relationship to outcome (Kapur et al, 2013), and to refine a clinical assessment tool for use by Emergency Department staff (Steed et al, 2012).
- d) How specific antidepressants are related to self-harm (Bergen et al, 2010c), their relative toxicity in overdose (Hawton et al, 2010),¹⁶ and the impact of national legislation to reduce pack sizes of paracetamol and aspirin and to withdraw co-proxamol (Hawton et al, 2011).
- 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 (Bergen et al, 2009).

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