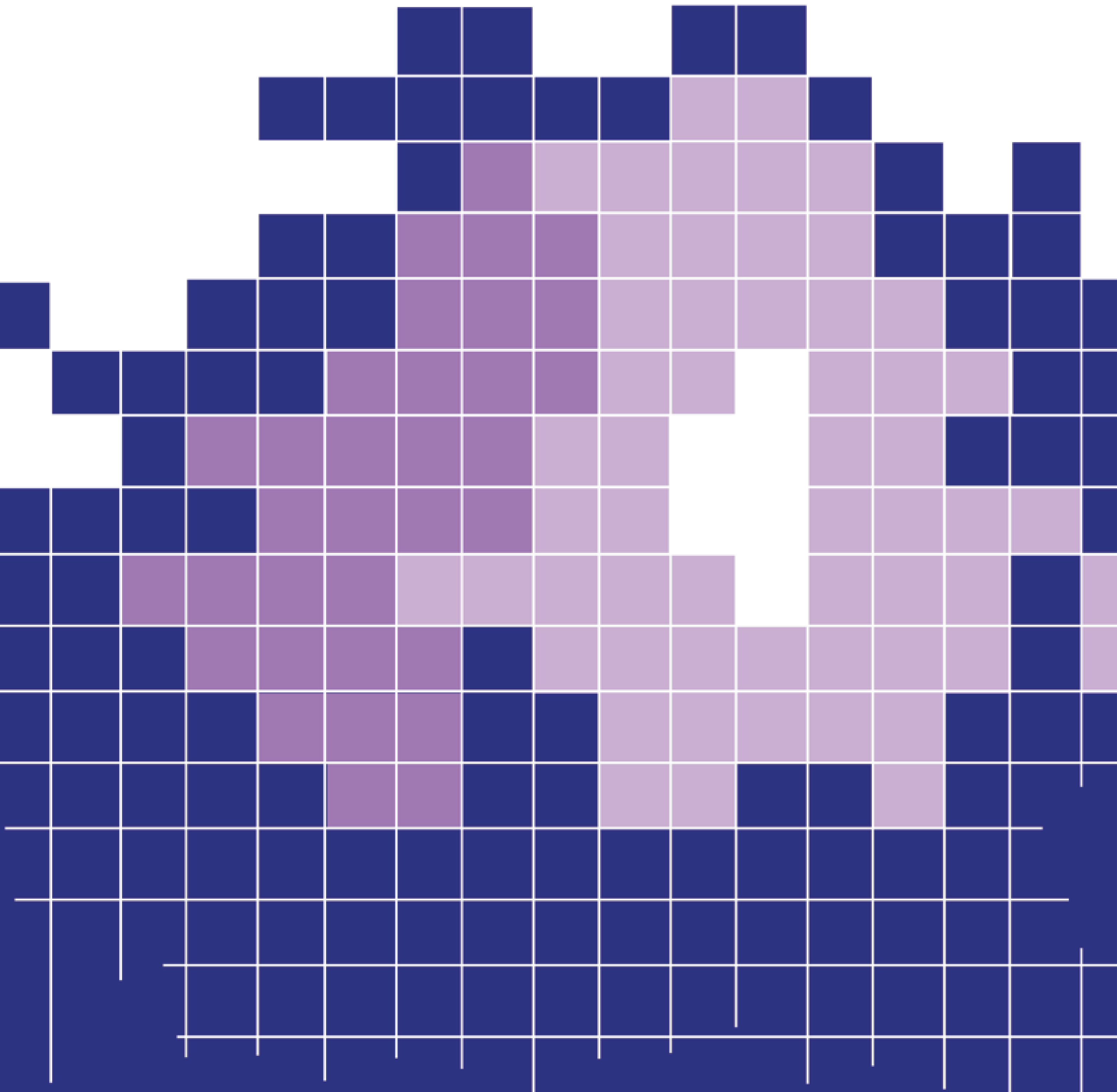
# Northern Ireland Registry of Deliberate Self-Harm
## Western Area



Two Year Report • 1 January 2007 – 31 December 2008


HSC Western Health and Social Care Trust
HSC Public Health Agency
HSC Health and Social Care Board
CAWT cooperation and working together
National Suicide Research Foundation
Department of Health, Social Services and Public Safety

# Foreword

Deliberate self-harm (intentional non-fatal self-poisoning or self-injury) is in many countries one of the most common reasons for general hospital presentation. It represents extensive psychosocial distress and is the most important risk factor for future suicide. In order to plan effective services it is essential to have a full understanding of the size of the problem, the characteristics of those involved, the nature of the self-harm acts, and the outcome following hospital presentation. This is also necessary for the development of initiatives that might prove effective for prevention of deliberate self-harm. Collection of information about deliberate self-harm is best done through establishment of monitoring through which information can be collected on all self-harm presentations to general hospitals. While such monitoring will not capture events that occur in the community and do not result in hospital presentation, it will identify individuals for whom provision of care is most feasible.

Monitoring of self-harm has been established in several centres in the UK for some time. It has also been ongoing for several years throughout the Republic of Ireland. The information obtained through these monitoring systems has proved invaluable. It is very welcome that a similar initiative has taken place in Northern Ireland with the establishment of the Self-harm Registry within the Western area. Importantly, this register is strongly linked with the Registry in the Republic of Ireland, allowing comparative analyses of information, which is in keeping with the cross-border objectives of the Co-operation and Working Together (CAWT) agency. Establishment of the Registry also contributes to the one of the objectives of the Northern Ireland Suicide Prevention Strategy.

This Report represents the first major fruits of this initiative. It includes a considerable array of information that is highly informative with regard to the problem of deliberate self-harm in this area of Northern Ireland. This information should feed directly into the design of service provision for self-harm patients. It will also kindle thinking about how best to prevent self-harm.

It has been a great pleasure for me to have had some limited input into this project. I trust that this Report will be widely disseminated and carefully read by all with an interest not

just in self-harm, but also mental health and social welfare issues more widely.  I hope and believe that it can result in substantial benefits for those individuals whose lives are so troubled that they turn to self-harm and also provide a basis for the development of new prevention initiatives.

Professor Keith Hawton
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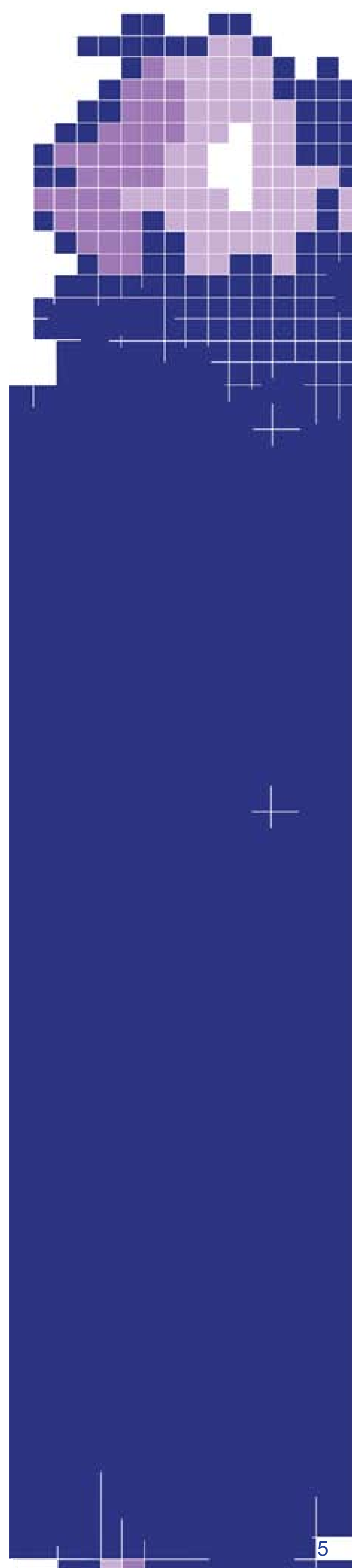


# Glossary of Terms

| | |
|---|---|
| **NI** | Northern Ireland |
| **RoI** | Republic of Ireland |
| **UK** | United Kingdom |
| **HSC** | Health and Social Care |
| **DSH** | Deliberate Self Harm |
| **EASR** | European Aged Standardised Rate |
| **CAWT** | Co-operation and Working Together |
| **PHA** | Public Health Agency |
| **DHSSPSNI** | Department of Health, Social Services and Public Safety, Northern Ireland |
| **HSCB** | Health and Social Care Board |
| **NSRF** | National Suicide Research Foundation |
| **WHSCT** | Western Health and Social Care Trust |

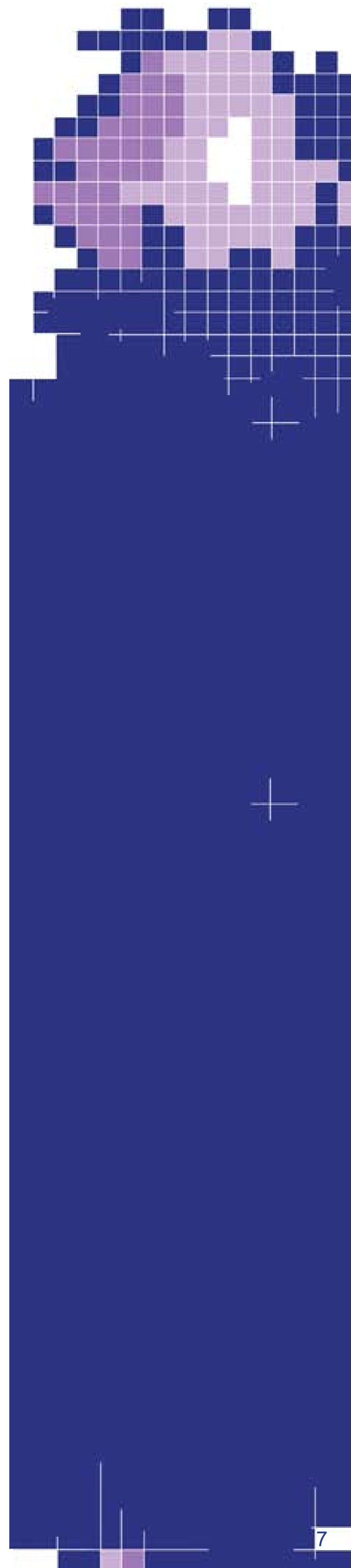
# Background

The Northern Ireland Suicide Prevention Strategy, 'Protect Life – A Shared Vision' (DHSSPS, 2006), seeks to tackle the issue of suicide and self-harm with actions targeting both the general population and those individuals and communities most at risk. The strategy also acknowledges the potential for parallel implementation with the Republic of Ireland's Suicide Prevention Strategy 'Reach Out' (HSE, 2005), and the subsequent benefits of North/South work on the issue. As a result, an all-island action plan was developed in conjunction with the National Office of Suicide Prevention in the Republic of Ireland.

Both strategies, North and South, recognise the importance of enhancing knowledge and understanding of suicide and self-harm, and improving the information available about these issues. The action plan identified the potential to pilot the Republic of Ireland's National Registry of Deliberate Self-Harm, in the Western area of Northern Ireland. The Western area includes all areas covered by the Western Health and Social Care Trust and Council areas of Derry, Strabane, Limavady, Omagh and Fermanagh.

The Registry in the Republic of Ireland, operated by the National Suicide Research Foundation (NSRF) in Cork, has collected data since 2002 on persons presenting to Hospital Emergency Departments as a result of deliberate self-harm. Since 2006, all General and Paediatric Hospital Emergency Departments in the Republic of Ireland have contributed data to the Registry.

In 2007, the Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI) commissioned Co-operation And Working Together (CAWT), to establish a pilot project to implement the work of the NSRF within the Western area of Northern Ireland. CAWT is a cross border health and social care partnership comprising the border counties of the Health Service Executive in the Republic of Ireland and the Southern and Western area Health and Social Care Trusts in Northern Ireland and the areas covered by the former Southern and Western Health and Social Care Boards which are now incorporated in the single Health and Social Care Board for Northern Ireland. CAWT manages a range of cross border health and social care programmes.



## Purpose of the Registry

The aim of the Registry is to identify the extent of self-harming behaviour by collecting relevant data from hospital Accident and Emergency departments. The analysis of this information will inform the development of policies and shape the implementation of measures aimed at preventing suicide and self-harm.

# Executive Summary

The Registry of Deliberate Self harm in the Western area of Northern Ireland was established in 2007 as a pilot project as part of the Northern Ireland Suicide Prevention Strategy 'Protect Life – A Shared Vision'. The Registry in the Western area is a collaboration with the National Registry of Deliberate Self harm in the Republic of Ireland which has been operating since 2002.

Using the same methodology as the Registry in the Republic of Ireland, the Western Registry extracts and collates anonymised data from existing records of self-harm attendances at the three Accident and Emergency (A&E)/ Urgent Care departments in the Western area.

This is the second report produced by the Registry in the Western area. The first report provided details of all attendances during 2007. This report presents the data obtained over the first two years of the Registry's existence i.e. 2007 and 2008 (calendar years).

The extent of self-harm outlined in this report highlights the challenges faced by health services in responding to this issue. The report also highlights some issues that contribute to self-harming behaviour that may require attention by wider society.

During the two years of data collection a considerable amount of useful information has been obtained to help initiate discussion, guide service provision and inform policy development. In some cases however, two years of data is insufficient to draw conclusions regarding trends. Data collection over future years will enable more robust analysis of trends to be carried out and firm conclusions drawn.

## Number of attendances

In 2007, 1,369 presentations due to self-harm were made by 1,043 individuals. There was only a slight difference in 2008 with 1,323 presentations due to self-harm made by 1,048 people.

## Repeat attendances

People who engage in self-harm may do so repeatedly and therefore may present to A&E on more than one occasion. Repeat attendances accounted for one in four (23.8%) of all attendances to the Emergency Departments in the Western area in 2007, this figure dropped to one in five (20.8%) in 2008.

## Age-groups and gender

Combined data from 2007 and 2008 show the highest rates of self-harm were among 35-44 year old females and 25-34 year old males.

Females represented a higher percentage of attendances, accounting for 53.1% of all attendances over the two year period. This was consistent for each of the two years i.e. 54.4% of the 1,043 individuals involved in 2007 and 54.8% of the 1,048 individuals involved in 2008.

There were 241 attendances among those aged under 18 years over the two year period. The majority of these were female.

## Day and time of presentation

There was a clear pattern in self-harm attendance over the course of the week with a greater number of presentations on Saturday and Sunday. This was particularly the case for self-harm incidents where alcohol was involved.

One fifth (21.6%) of all self-harm attendances at A&E occurred during normal working hours i.e. 9am-5pm. Attendances peaked around midnight and over one third (35.1%) of attendances occurred after 1am. This presents a challenge for health services in responding to this issue.

## Incidence rates

The incidence rate of self-harm presentation to hospital was considerably higher in the Western area (373 per 100,000) than in the Republic of Ireland (194 per 100,000). Within the Western area the highest rate of self-harm was in the Derry City Council area. The rate of self-harm in the Derry City Council area was considerably higher than for cities within the United Kingdom and Republic of Ireland for which data was available.

There was a higher level of self-harm within the urban area of Derry City Council (CC) than in more rural areas of Limavady District Council (DC), Strabane DC, Omagh DC and Fermanagh DC, with Altnagelvin Hospital dealing with 68.6% (n= 1846) of the overall total of 2,692 self-harm episodes recorded in 2007 and 2008.

The self-harm rate for males in Derry CC was more than double that of males in Limavady DC, and almost

double that of males within Fermanagh DC and Omagh DC. The self-harm rate for females in Derry CC was almost double that of the female rate in Limavady DC.

## Method of self-harm

In many self-harm attendances more than one method of self-harm was used. Drug overdose was the predominant method of self-harm particularly among females, and was used in 77.1% of all self-harm episodes. Self-cutting was the second most common form of self-harm, used in 17.1% of all self-harm episodes in both genders. Almost one in ten attendances involved attempted drowning or attempted hanging, methods which often indicate a high degree of suicidal intent.

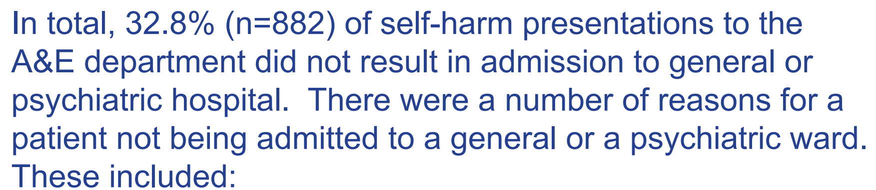
Alcohol, whilst rare as a main method of self-harm, featured as a major contributing factor and was involved in 63.8% of all episodes of self-harm. There was a 10% increase in episodes involving alcohol from 2007 to 2008 (59.2% and 68.5% respectively).

Alcohol was more likely to be involved in cases of self-harm among males (69.9%) than females (58.4%). This was considerably higher than in the Republic of Ireland where alcohol was involved in 46% of male and 38% of female attendances. When a patient is heavily intoxicated it is very difficult for staff to carry out an assessment of their mental state.

## Next care following A&E attendance

Of the 2,692 self-harm presentations, 58.8% (n=1582) resulted in an admission to the general acute hospital. Admission to an acute hospital facilitates treatment of any physical condition as well as enabling a mental health assessment to take place the following day. There was some variation across the three sites. Almost two thirds (63.7%) of self-harm presentations to Altnagelvin Hospital resulted in an admission to the general acute hospital, compared to approximately half of those who presented to Tyrone County Hospital (52.1%) and the Erne Hospital (43.8%).

In 8.5% (n=228) of all self harm attendances the patient was admitted directly from A&E to a psychiatric hospital. Direct psychiatric admission was lowest at 4.7% in Altnagelvin Hospital compared to 17.4% and 16.2% in Tyrone County Hospital and Erne Hospital respectively.



In total, 32.8% (n=882) of self-harm presentations to the A&E department did not result in admission to general or psychiatric hospital. There were a number of reasons for a patient not being admitted to a general or a psychiatric ward. These included:

- Patient leaving the A&E department before receiving treatment (2.7%, n=74);
- Patient leaving the A&E department after receiving treatment but before a decision was made regarding their next care (2.9%, n= 78);
- Patient being advised to stay for further assessment or admission but refusing to do so (5.1%, n=138);
- A health professional making the decision that admission was not required (22.0%, n= 592).

Of those attendances that did not result in admission to either the acute or psychiatric hospital, the majority (79.0%, n=697) did not receive a psychiatric assessment by a member of the mental health team prior to leaving the A&E department. This may in part be explained by the fact that 35.1% of all self-harm attendances to A&E presented outside the hours of current mental health service provision. They are however likely to have had a mental state assessment carried out by a member of A&E staff although this information is not captured by the Registry. The Erne Hospital had a higher percentage of patients who were discharged from A&E following emergency treatment (31.4%) than both Altnagelvin Hospital and Tyrone County Hospital (20.4% and 19.7% respectively).

Next care of the patient following A&E attendance varied depending on the main method involved in the self-harm act Almost half (46.8%) of self-harm patients who had used self-cutting were discharged from A&E after emergency treatment. This was considerably higher than for other methods.

## Ideation cases

In the Western area data was collected on cases of suicidal or self-harm ideation. These cases involved situations where a patient attended A&E in distress due to thoughts of self-harm and/or suicide where no act had yet taken place. There were 148 ideation cases recorded in 2007 and 207 ideation

cases recorded in 2008.  This data is not collected by the National Registry of Self-Harm in the Republic of Ireland but was felt to be useful locally in terms of assessing the need for mental health service provision to the A&E department.

## Key issues for consideration

This report has highlighted a number of important issues that may require further attention.

The scale of self-harming behaviour outlined in this report highlights the importance of maintaining close working relationships between the A&E department and mental health services and ensuring appropriate protocols are in place.

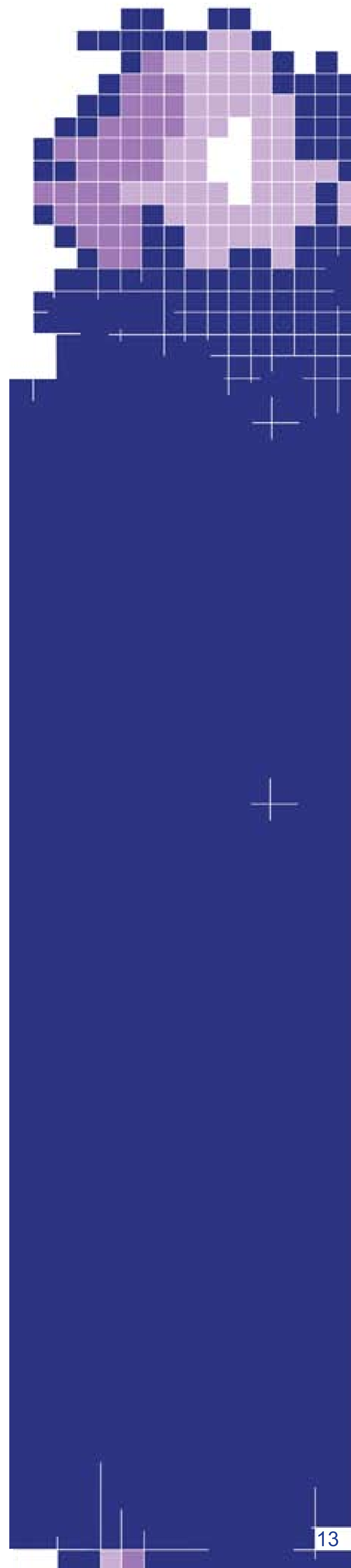
Almost one quarter of all self-harm attendances to A&E were repeat attendances and consideration should be given to whether any additional support can be provided to this group in order to reduce repetition.

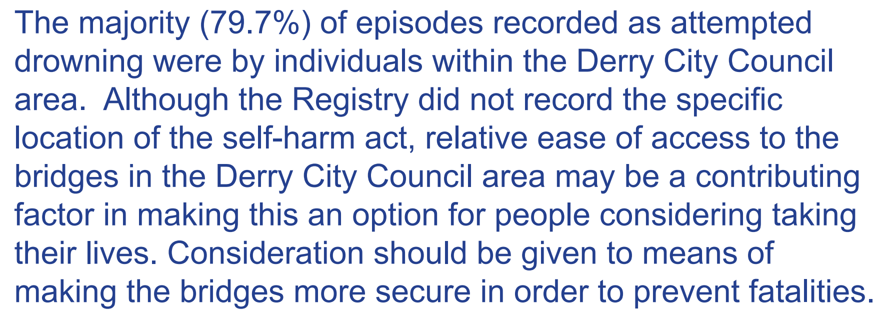
There are clear peaks in attendance around midnight and at weekends and health services may wish to consider how best to respond to this pattern of demand.

The Registry recorded 241 attendances over the two year period among people aged under 18 years. This presents a challenge for the health service in providing mental health practitioners skilled in the area of assessing young people's mental health.  It also highlights a need for mental health promotion and preventative work with young people.

The Registry is planning to add an additional data collection field to monitor the implementation of the 'Card Before You Leave Scheme'. This scheme will be introduced over coming months and involves patients who leave A&E without having had an assessment by a member of the mental health team being provided with a card by A&E staff indicating how they can receive a mental health assessment over the next few days.

The report has highlighted high rates of self-harm within the Western area generally but particularly in the Derry City Council area. A strong relationship with alcohol has also been identified. This information will be of interest to regional and local government and also to people working in the area of health promotion and prevention of alcohol misuse.





The majority (79.7%) of episodes recorded as attempted drowning were by individuals within the Derry City Council area. Although the Registry did not record the specific location of the self-harm act, relative ease of access to the bridges in the Derry City Council area may be a contributing factor in making this an option for people considering taking their lives. Consideration should be given to means of making the bridges more secure in order to prevent fatalities.

Plans are in place to extend this pilot project to the Belfast Trust area in the near future. In the longer term, coverage across Northern Ireland would bring great benefits in terms of informing service and policy developments and also in ensuring availability of comparable data across the island of Ireland.

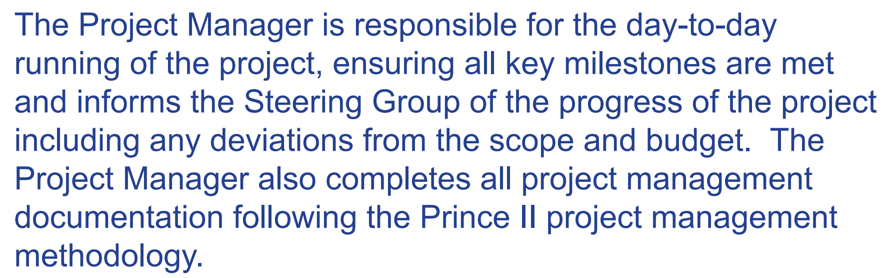
## Project Management

The Project Steering Group oversees the project and provides expertise on direction and implementation. The group monitor the progress of the project and ensure adherence to the project plan.

The Steering Group is made up of representatives from the Department of Health, Social Services & Public Safety Northern Ireland (DHSSPSNI), The Western Health & Social Care Trust (WHSCT), The Public Health Agency (PHA), The regional Health & Social Care Board (HSCB), The National Suicide Research Foundation, Cork (NSRF) and Co-operation and Working Together (CAWT). The Steering Group meet quarterly and receive regular updates from the Project Manager.

The Steering Group members are:

| | |
|---|---|
| Mr Martin Bell | Health Improvement Branch, DHSSPSNI (Chair) |
| Ms Edel O'Doherty | Deputy Chief Officer, CAWT |
| Ms Amanda O'Carroll | Project Manager, CAWT |
| Mr Bernard McAnaney | Assistant Director of Mental Health Services, WHSCT |
| Dr Sophie Graber | Accident & Emergency Doctor, WHSCT |
| Mr Barry McGale | Suicide Liaison Officer, WHSCT |
| Ms Dorothy Hutchinson | Strategic Commissioning Team Lead, HSCB |
| Mr Peter Moran | Information Governance Manager, HSCB |
| Mr Brendan Bonner | Investing for Health Manager, PHA |
| Dr Denise O'Hagan | Specialist Registrar, Public Health Medicine, PHA |
| Dr Ella Arensman | Director of Research, NSRF, Cork |
| Dr Udo Reulbach | Senior Researcher, NSRF, Cork |
| Dr Paul Corcoran | Deputy Director / Senior Statistician, NSRF, Cork |
| Prof. Keith Hawton | Consultant Psychiatrist at Oxford and Buckinghamshire Mental Health NHS Foundation Trust. Professor of Psychiatry and Director of Centre for Suicide Research, Oxford University |



The Project Manager is responsible for the day-to-day running of the project, ensuring all key milestones are met and informs the Steering Group of the progress of the project including any deviations from the scope and budget. The Project Manager also completes all project management documentation following the Prince II project management methodology.

# Methods of Data Collection

## Definition of Deliberate Self-harm

The term 'deliberate self-harm' was derived from the term 'Parasuicide'. The definition of 'Parasuicide' was developed by the WHO/Euro Multicentre Study Working Group as:

*'An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences.'*

Internationally, the term 'deliberate self-harm' has superseded 'parasuicide'. In recognition of this, the term 'deliberate self-harm' (DSH) has been used in this study.

## Inclusion Criteria

The following are considered to be deliberate self-harm cases:

- All methods of self-harm i.e. drug overdoses, alcohol overdoses, lacerations, attempted drownings, attempted hangings, gunshot wounds, etc. where it is clear that the self-harm was intentionally inflicted.

- All individuals who are alive on presentation to hospital following an act of deliberate self-harm.

## Exclusion Criteria

The following are NOT considered to be deliberate self-harm cases:

- Accidental overdoses e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm.

- Alcohol overdoses alone where the intention was not to self-harm.

- Accidental overdoses of street drugs i.e. drugs used for recreational purposes, without the intention to self-harm.

- Acts of self-harm by individuals with learning disability.

• Individuals who are dead on arrival at hospital as a result of suicide.

## Hospitals

The project is based on anonymised information collected from the three hospital Accident & Emergency / Urgent Care departments in the Western area i.e.

1. Accident and Emergency Department, Altnagelvin Area Hospital, Londonderry

2. Accident and Emergency Department, Erne Hospital, Enniskillen

3. Urgent Care and Treatment Centre, Tyrone County Hospital, Omagh

The Urgent Care and Treatment Centre in Omagh is a smaller unit dealing mainly with minor injuries and problems. As with the other two A&E departments, the Omagh unit operates 24 hours a day.

## Data Recording and Case Finding

Two of the three Emergency Departments in the hospitals within the Western area use the same system for collecting data called ‘Symphony’. A basic query is run using a key word search to identify potential self-harm cases. The data collector then checks each of the potential cases and, using the inclusion / exclusion criteria, identifies the actual self-harm cases. Anonymised information on these cases is then entered onto a data entry system for analysis.

The identification of cases and the detail regarding each episode recorded by the Registry is dependant on the quality of clinical records kept.

## Data Items

A minimal dataset has been developed to determine the extent of self-harm, the circumstances relating to the act and to examine trends by area. Reference numbers and area codes are encrypted prior to data entry to ensure that it is impossible to identify an individual on the basis of the data recorded.

- Reference Numbers
  Two reference numbers are recorded. One number refers to the A&E episode which is automatically assigned by the A&E computer system. The second reference number refers to the patient’s Health & Care number which is

used to highlight repeat attendances.  These numbers are encrypted prior to entry and can only be decrypted by the data recorder.

- Gender

- Age

- Date and Hour of Attendance

- Brought By
  The method of arrival is recorded to identify self-referrals and the use of the three emergency services.

- Transfer
  This identifies if the presentation was a transfer to / from another hospital.

- Admission
  Admission details are recorded to identify those who are subsequently admitted to either the general hospital or psychiatric hospital.  If the patient is not admitted then details are also captured on whether it was a planned discharge or whether the patient left the emergency department against medical advice.

- Method(s) Of Self-Harm
  The method(s) of self-harm are recorded according to the Tenth Revision of the WHO's International Classification of Diseases codes for intentional injury (ICD-10 X60-X84). The main methods included are overdose of drugs and medicaments (X60-X64), self-poisonings by alcohol (X65), poisonings which involve the ingestion of chemicals, noxious substances, gases and vapours (X66-X69) and self-harm by hanging (X70), by drowning (X71) and by sharp object (X78). Some individuals may use a combination of methods e.g. overdose of medications and laceration of wrists.

- Drugs Taken
  Where applicable, the name and quantity of the drugs taken are recorded.

- Area Code
  The post / area code is recorded.  Once entered, the postcode is replaced by a ward name to prevent the individuals post code data from potentially identifying them. This is non-reversible and is one of the security mechanisims employed to keep the system anonymised.

- Seen By
  This identifies cases that were seen by a clinician and those who leave before receiving any treatment.

## Study Period

Information for the pilot project was collected for 2 full calendar years (1st January 2007 – 31st December 2008).

## Confidentiality

Confidentiality is strictly maintained. The data collector has completed data protection training and is legally required to follow standards of the Data Protection Act and any additional data security policies set out by the Western Health & Social Care Trust, the regional Health & Social Care Board and the Public Health Agency. No identifiable client information is recorded or used in reports. The data collector is monitored by an appropriately qualified Regional Board Officer, and has direct access to this Officer if queries arise in relation to patient level data or data security.

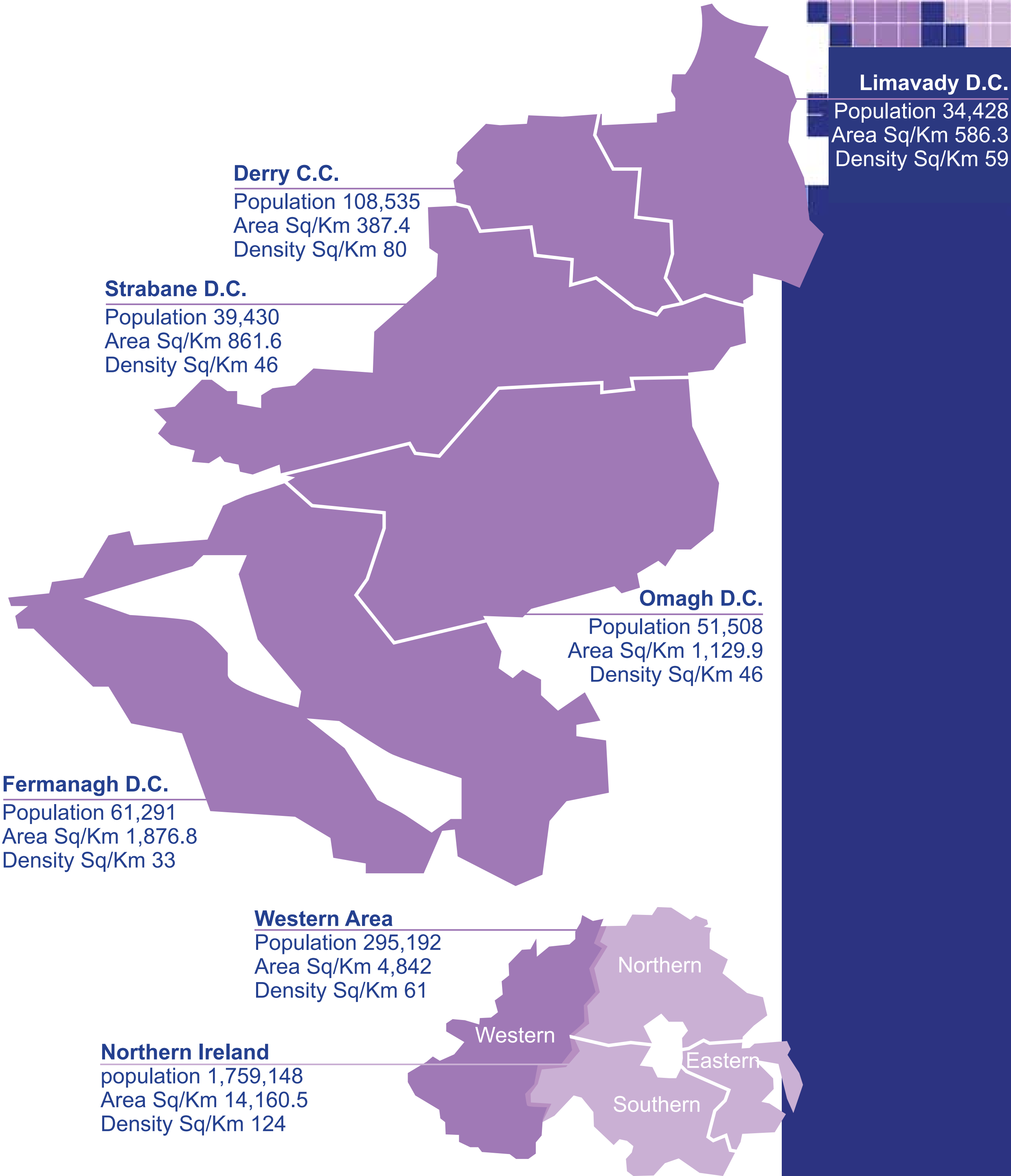
## Quality Assurance

A number of audits have been carried out to check the accuracy of the data collection process. The outcome of the audits concluded that the process used was both effective and efficient. A quality assurance exercise involved the data collector applying the same case finding process to data from another hospital which is participating in the Registry. The cases identified were compared with those identified by another data collector. The outcome of this provided assurance that both data collectors were working to the same level and applying the criteria correctly.

## Registry Coverage

Self-harm information was collected from the three hospitals within the Western area of Northern Ireland which comprises of five council areas; Derry City Council; Limavady District Council; Strabane District Council; Omagh District Council and Fermanagh District Council. These will be referred throughout this report as Derry CC, Limavady DC, Strabane DC, Omagh DC and Fermanagh DC. The current total population for the Western area is 295,192 (2007 MYEs, NISRA) The population density of each council area can be seen on the next page.

The geographical area covered varies widely from large urban centres in Derry CC to remote rural areas in Fermanagh DC



## Cautions

The identification of cases and the detail regarding each episode recorded by the Registry is dependant on the quality of clinical records kept.

Where differences between geographical areas are highlighted it is important to note that these are not necessarily statistically significant. This particularly applies to analyses by gender and age, where the numbers of cases may be relatively small. Therefore caution should be exercised in interpreting such findings.

## Calculation of Rates

Self-harm rates were calculated based on the number of persons resident in the relevant area who presented to a Western Trust hospital as a result of self-harm.

Crude and age-specific rates per 100,000 of the population were calculated by dividing the number of persons who engaged in self-harm (n) by the relevant population figure (p) and multiplying the result by 100,000, i.e. (n/p) 100,000. Calculation of rates has been based on 2007 mid-year estimates of the population of the Western area derived from the 2001 Census.

European age-standardised rates (EASRs) are the incidence rates that would be observed if the population under study had the same age composition as a theoretical European population. Adjusting for the age composition of the population under study ensured that differences observed by gender or by area are due to differences in the incidence of self-harm rather than differences in the composition of the populations. EASRs were calculated as follows: For each five-year age group, the number of persons who engaged in self-harm was divided by the population at risk and then multiplied by the number in the European standard population. The EASR is the sum of these age-specific figures.

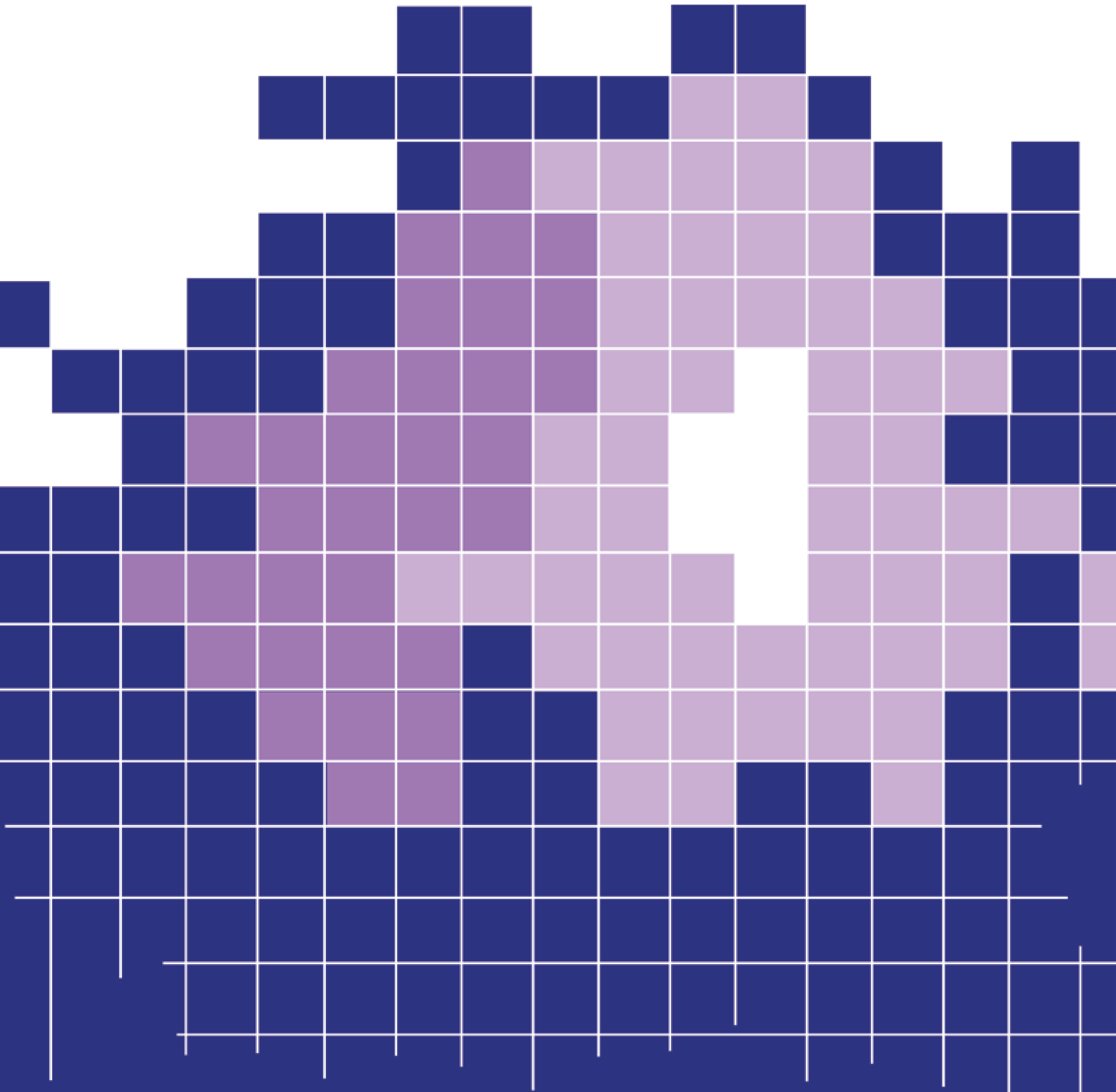
## Comparisons

Comparisons are made throughout this report with:

- 2007 and 2008 data from the National Suicide Research Foundation.

- (2007) Self-Harm in England: A Tale of Three Cities. Multicentre study of self-harm. Social Psychiatry and Psychiatric Epidemiology, 42, 513-521. Hawton, K., et al.

# Numbers and Rates of Self-Harm in the Western area of Northern Ireland



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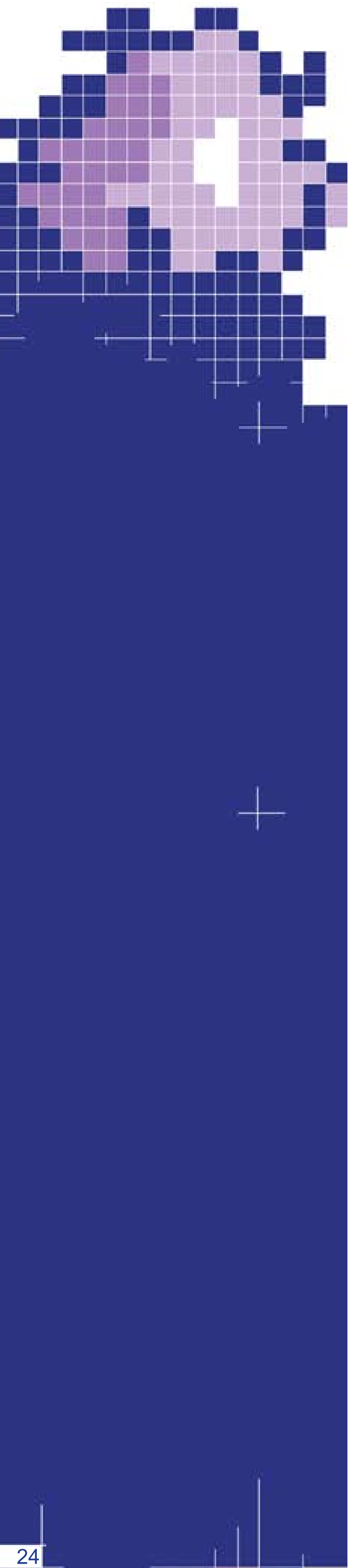
Department of Health, Social Services and Public Safety



# Number of Presentations

## Self-harm Presentations to Hospitals in the Western Area

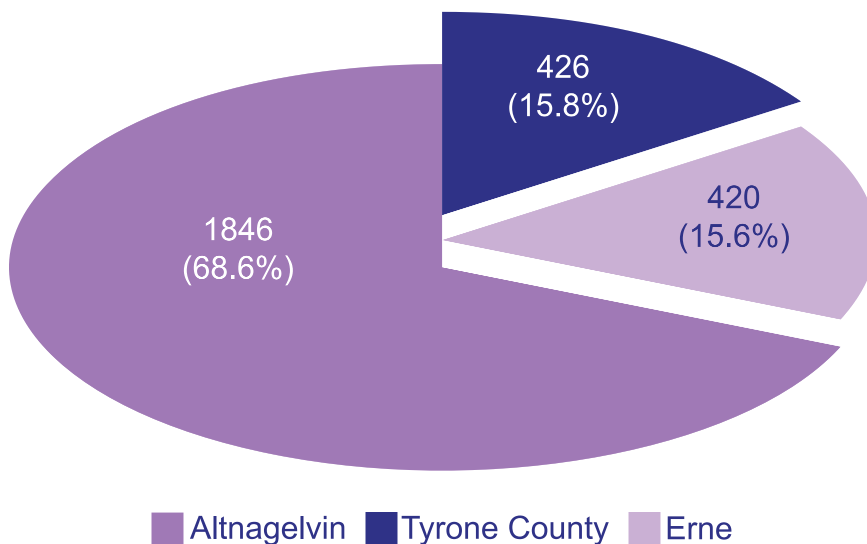
There were 2,692 presentations to three Accident & Emergency / Urgent Care departments between 1st January 2007 and 31st December 2008.

The three departments were:

1. Accident and Emergency Department, Altnagelvin Area Hospital, Londonderry
2. Accident and Emergency Department, Erne Hospital, Enniskillen
3. Urgent Care and Treatment Centre, Tyrone County Hospital, Omagh

The distribution of presentations between the three units is shown in figure 1:

**Figure 1: Breakdown of numbers of DSH episodes in the three hospitals in Western area, 2007-08.**




**Altnagelvin Hospital** had a total of 101,652 attendances to A&E in 2007 and 2008; 1,846 (2%) of these were due to deliberate self-harm.

**Tyrone County Hospital** had a total of 45,420 attendances to A&E in 2007 and 2008; 426 (1%) attended due to deliberate self-harm.

**Erne Hospital** had a total of 47,614 attendances to A&E in 2007 and 2008; 420 (1%) attended due to deliberate self-harm.

## Gender Distribution

The distribution of episodes (figure 2) showed that the female rate was higher in all three hospitals.

**Figure 2: Gender balance of self-harm episodes in the Western Area in 2007 and 2008.**

Erne

Tyrone County

Altnagelvin

Male Female

## Persons and Episodes

During the two year study period (2007-08) there were 2,692 presentations to an Emergency Department / Urgent Care Centre in the Western area. These are referred to as episodes. One individual may have had multiple episodes.

- In 2007, 1,369 presentations due to self-harm were made by 1,043 individuals. There was only a slight difference in 2008 with 1,323 presentations due to self-harm by 1,048 individuals.
- Repeat attendances accounted for one in four (24%) of all self-harm attendances to the Emergency Departments in the Western area in 2007, this figure dropped to one in five (21%) in 2008.

**Table 1: Person, episode figures of self-harm in the Western Area in 2007 and 2008.**

| **Episodes** | | **Males** | **Females** | **All** |
|---|---|---|---|---|
| 2007 | N | **652** | **717** | **1369** |
| | % | 47.6% | 52.4% | 100% |
| 2008 | N | **611** | **712** | **1323** |
| | % | 46.2% | 53.8% | 100% |
| **Difference** | | **- 41** | **- 5** | **- 46** |

| **Persons** | | **Males** | **Females** | **All** |
|---|---|---|---|---|
| 2007 | N | **472** | **567** | **1043** |
| | % | 45.6% | 54.4% | 100% |
| 2008 | N | **474** | **574** | **1048** |
| | % | 45.2% | 54.8% | 100% |
| **Difference** | | **- 2** | **+ 7** | **+ 5** |

## Age and Gender

- Females represented a higher percentage of attendances, accounting for 53.1% of the 2,692 presentations. This was consistent in both years with females accounting for 54.4% of the 1,043 individuals involved in 2007 and 54.8% of the 1,048 individuals involved in 2008 (Table 1).

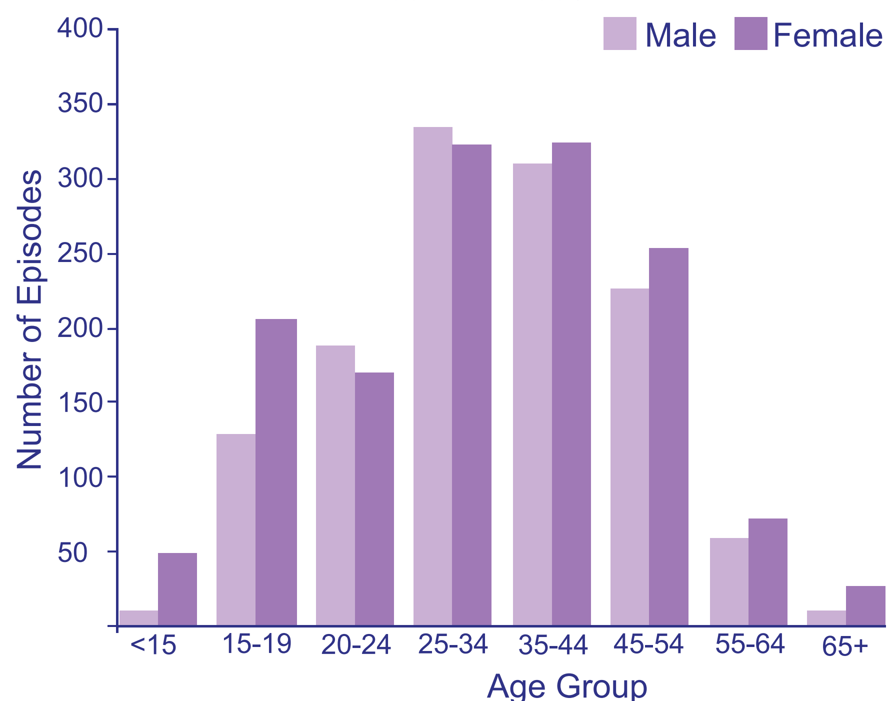
- Figure 3 illustrates the age and gender distribution of attendances. More than half (52.2%) of all Accident & Emergency / Urgent Care attendances due to self-harm in 2007 were under 35 years of age. This was consistent across all hospitals. The majority (86.5%) of episodes were by persons aged less than 50 years.

- Among the younger attenders, female episodes were considerably higher than male episodes, particularly within the 10-14 and 15-19 age groups.

- Almost all self-harm presentations under the age of 15 years were female (94.2%).

- Figure 3 demonstrates that the highest number of episodes of self-harm were among 25-34 and 35-44 year old females and 25-34 and 35-44 year old males.

**Figure 3: Rates of self-harm by age group in the Western Area 2007 and 2008**



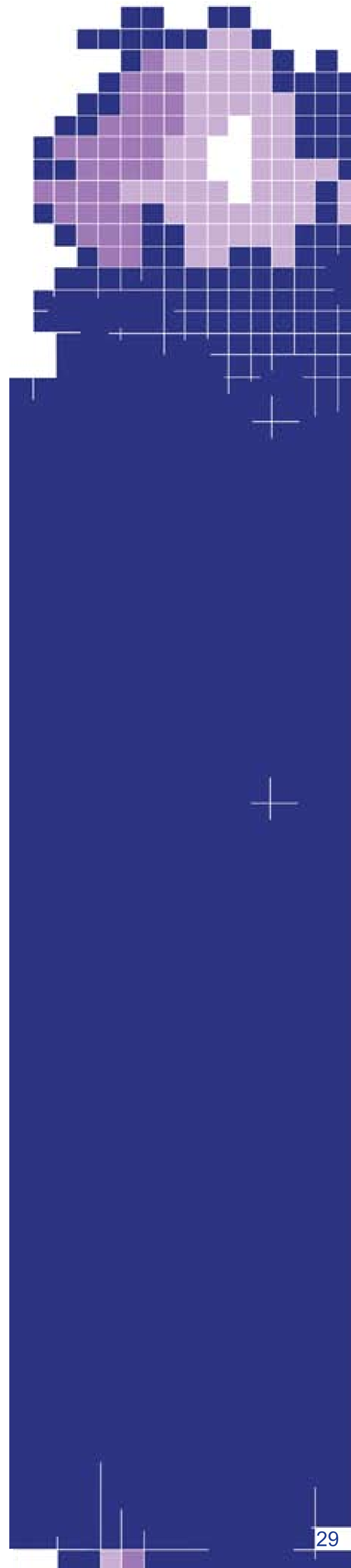
## Self-Harm Behaviour in Young People (under 18 years)

Self-harm attendances by those under 18 contributed to 9.0% (n=241) of all self-harm presentations to A&E in 2007 and 2008. There was a 41% increase in self-harm attendances individuals under the age of 18 in the second year.

Females made up 74.7% of all these episodes. Only one in four episodes were male.

Alcohol was a major contributing factor in self-harm amongst males with half (50.8%) of the self-harm episodes involving alcohol. However, this was not the case for young females where 27.2% of self-harm episodes recorded involved alcohol.

Drug overdose was the most common method of self-harm for both genders but more common method of self-harm used by females (84.4%) than males (65.6%). Self-cutting was the second most common method of self-harm for both genders but more common amongst males (19.7%) than females (15.0%). Males had a significantly high percentage of attempted drowning (8.2%) compared to females (1.1%).



## Month of Attendance

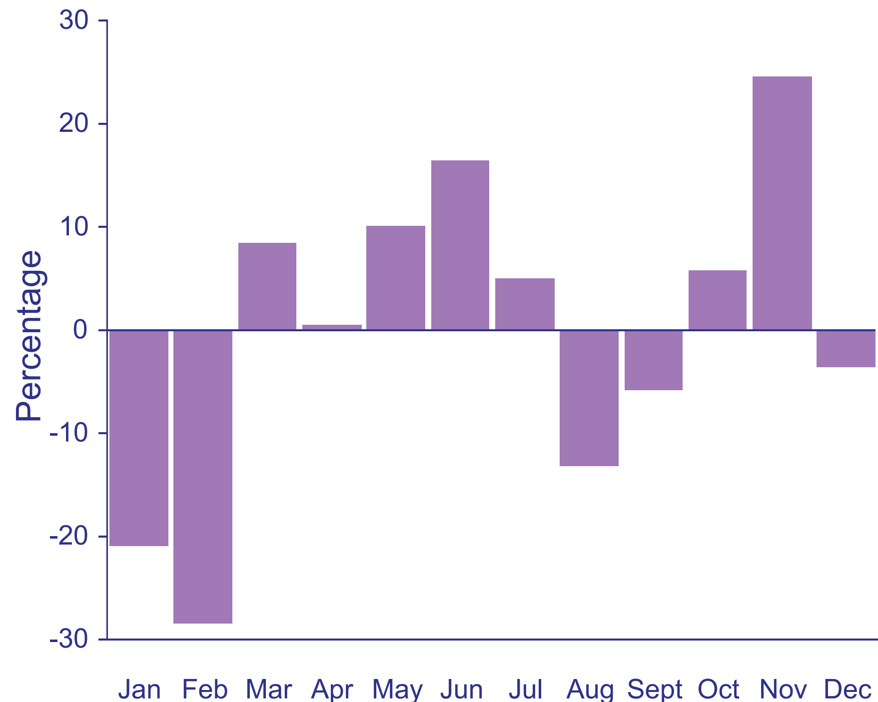
**Table 2: Breakdown of self-harm episodes by gender and month within the Western area, 2007 and 2008.**

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Males | 91 | 94 | 121 | 89 | 109 | 125 | 101 | 102 | 101 | 93 | 125 | 112 | 1263 |
| Females | 131 | 90 | 139 | 123 | 124 | 110 | 128 | 101 | 109 | 114 | 137 | 123 | 1429 |
| Total | 222 | 184 | 260 | 212 | 233 | 235 | 229 | 203 | 210 | 207 | 262 | 235 | 2692 |

There was some variation in the number of self-harm presentations to hospitals over the course of the two years.

- In 2007 (figure 4), January and February saw fewer presentations than expected (21% and 29% below average respectively).

**Figure 4: Percentage difference between the observed and expected number of self-harm presentations by month in the Western area, 2007.**




- The peak month for self-harm presentations in 2007 was November (24% above average) with a secondary peak in June (16% above average).

- The lower than average figures for January and February in 2007 were most evident for males whereas the November peak was most evident for females.

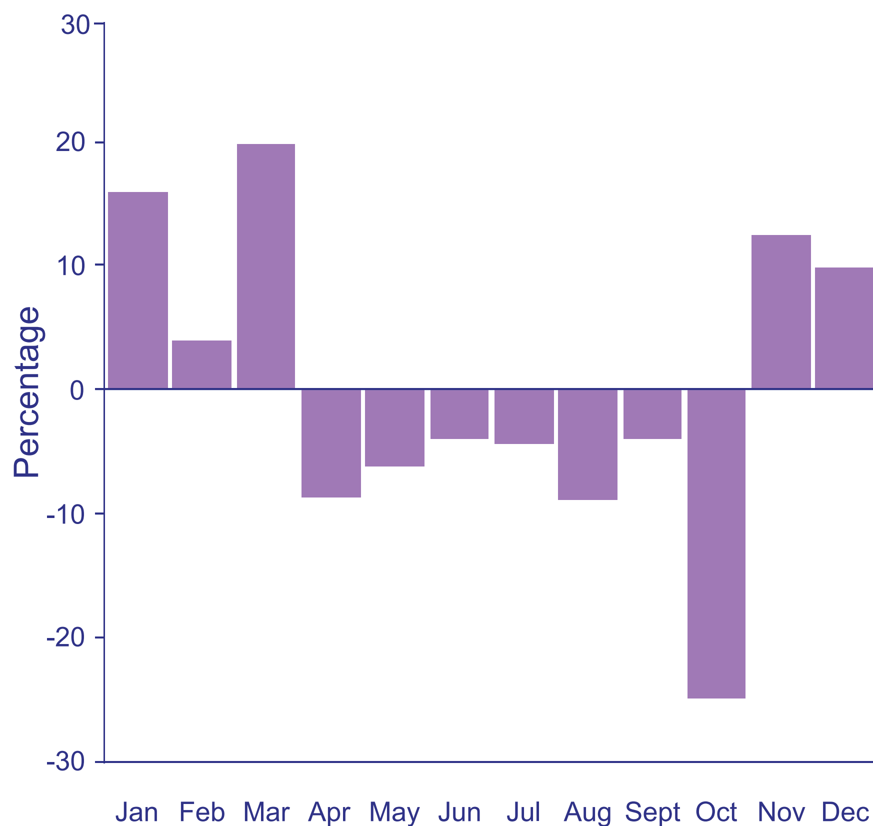
- The June peak in 2007 was solely due to males. The monthly pattern in self-harm presentations was evident irrespective of age.

- 2008 showed a different pattern to that of 2007 with the peak months in January and March (figure 5).

- In 2008, October showed a 25% lower than average figure for self-harm attendance.

- The peak month for self-harm presentations in 2008 was March (20% above average).

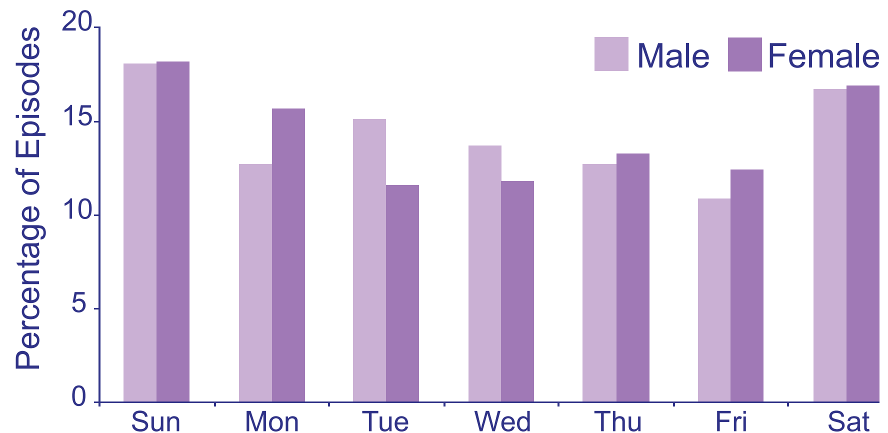
**Figure 5: Percentage difference between the observed and expected number of self-harm presentations by month in the Western area, 2008.**



## Day of Attendance

There was some variation in the percentage of episodes and the day of the week for both genders (figure 6).

**Figure 6: Episodes of self-harm by day and gender, Western area 2007 and 2008.**




### Summary of Findings for Weekday and Gender

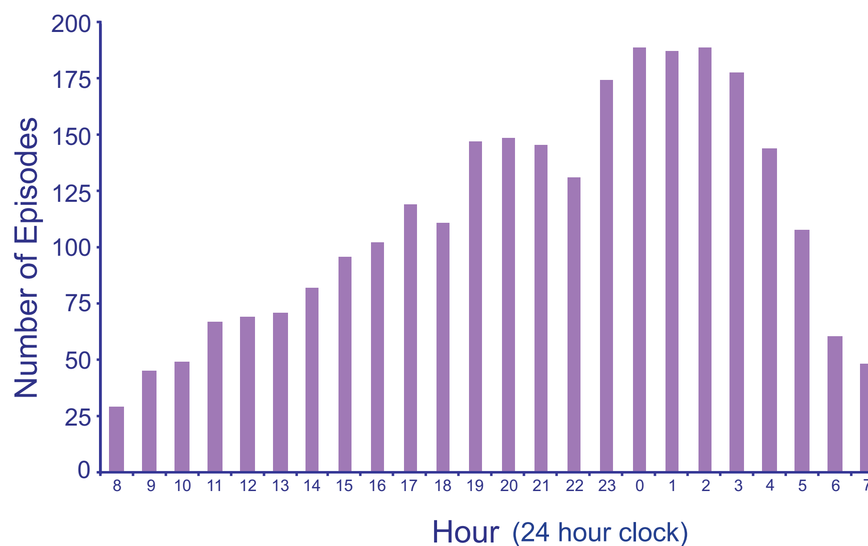
- There was a clear pattern of attendance for females over the course of the week. Both genders peaked at the weekend.

- The increase in self-harm presentations at the weekend and the decrease during the week was most pronounced for individuals aged 15-34. Of the 1,354 self-harm presentations by individuals in this age group, 37.6% occurred on Saturday or Sunday.

# Time of Attendance

Figure 7 illustrates the variation between the number of self-harm episodes and the hour of attendance.

**Figure 7: Hour of Presentation, Western area, 2007 and 2008.**




## Summary of Findings for Hour of Attendance

- There was an increase in frequency of attendance over the course of the day with a peak in the early hours of the morning. (this is discussed in more detail in the 'Next Care' section)
- In the Western area 50.0% of all cases presented between 8pm and 4am. In contrast, 21.6% of cases presented between 9am and 5pm.
- There was a dip in presentations at 10pm which was evident for both genders and at two of the three hospitals (Tyrone County and Erne Hospitals).
- The pattern of presentations over the course of the day was similar for males and females.
- One gender difference that was evident was that female self-harm presentations peaked at midnight, whereas, male self-harm presentations continued to increase until 2am.
- Most striking were the very high rates of presentations in the period from 11pm to 3am.

## Incidence Rates

The overall crude and age-standardised rates in the Western area were 372 and 373 per 100,000 respectively. The rates for males and females can be seen in Table 3. The female rate of self-harm is considerably higher than the male rate of self-harm.

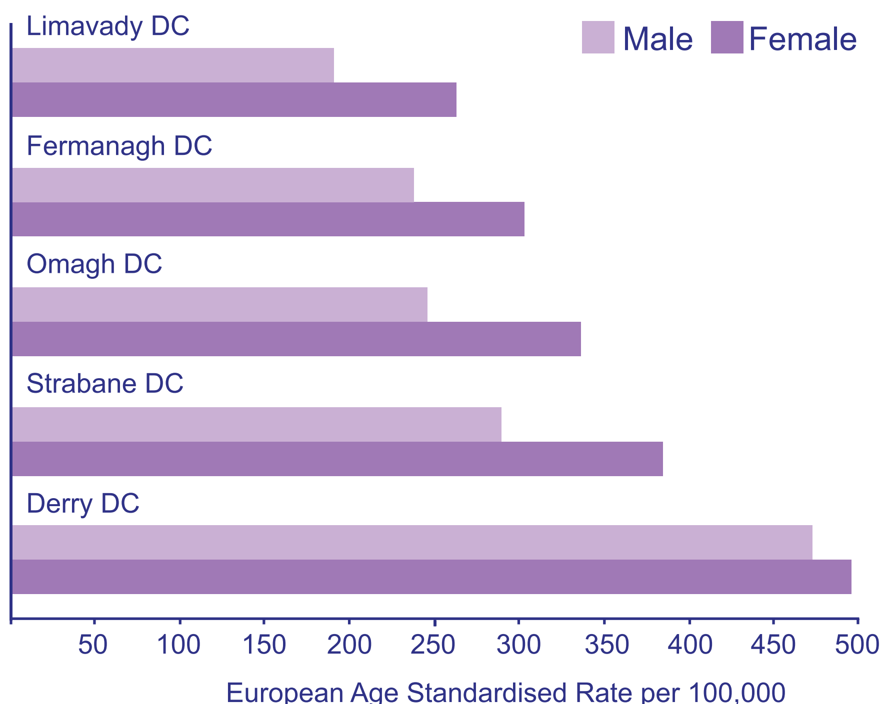
**Table 3: Average incidence rates of persons presenting to hospital following DSH in 2007 and 2008.**

| | Males | Females | All |
|---|---|---|---|
| Crude Rate Per 100,000 | 340 | 403 | 372 |
| European Age Standardised Rate per 100,000 | 339 | 408 | 373 |

# Incidence Rates – Western Area

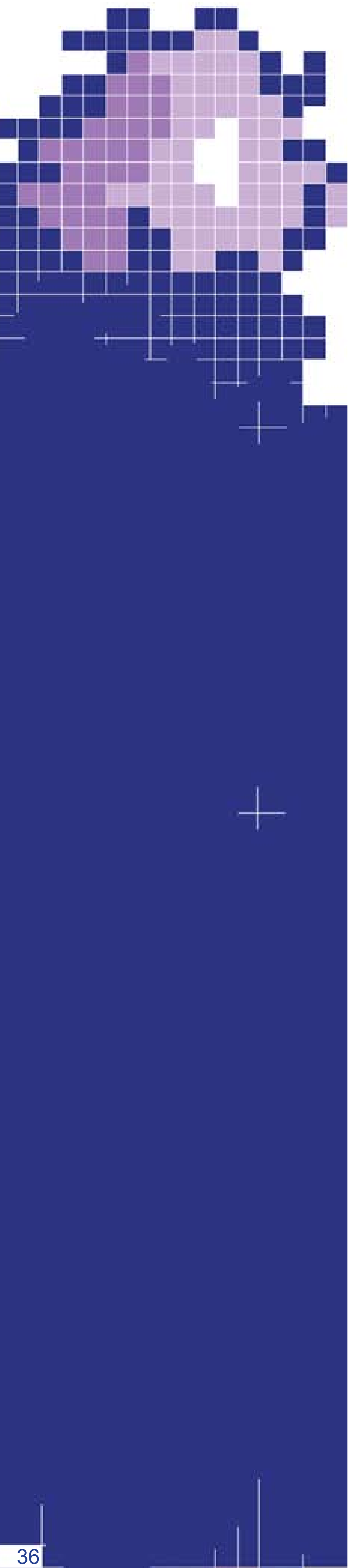
There was significant variation in the incidence of self-harm when examined at council area level. Figure 8 illustrates that the highest rate was in Derry CC area, followed by Strabane DC, Omagh DC, Fermanagh DC and Limavady DC.

**Figure 8: Person based European aged standardised rate of self-harm by council area and gender in the Western area, 2007 and 2008.**

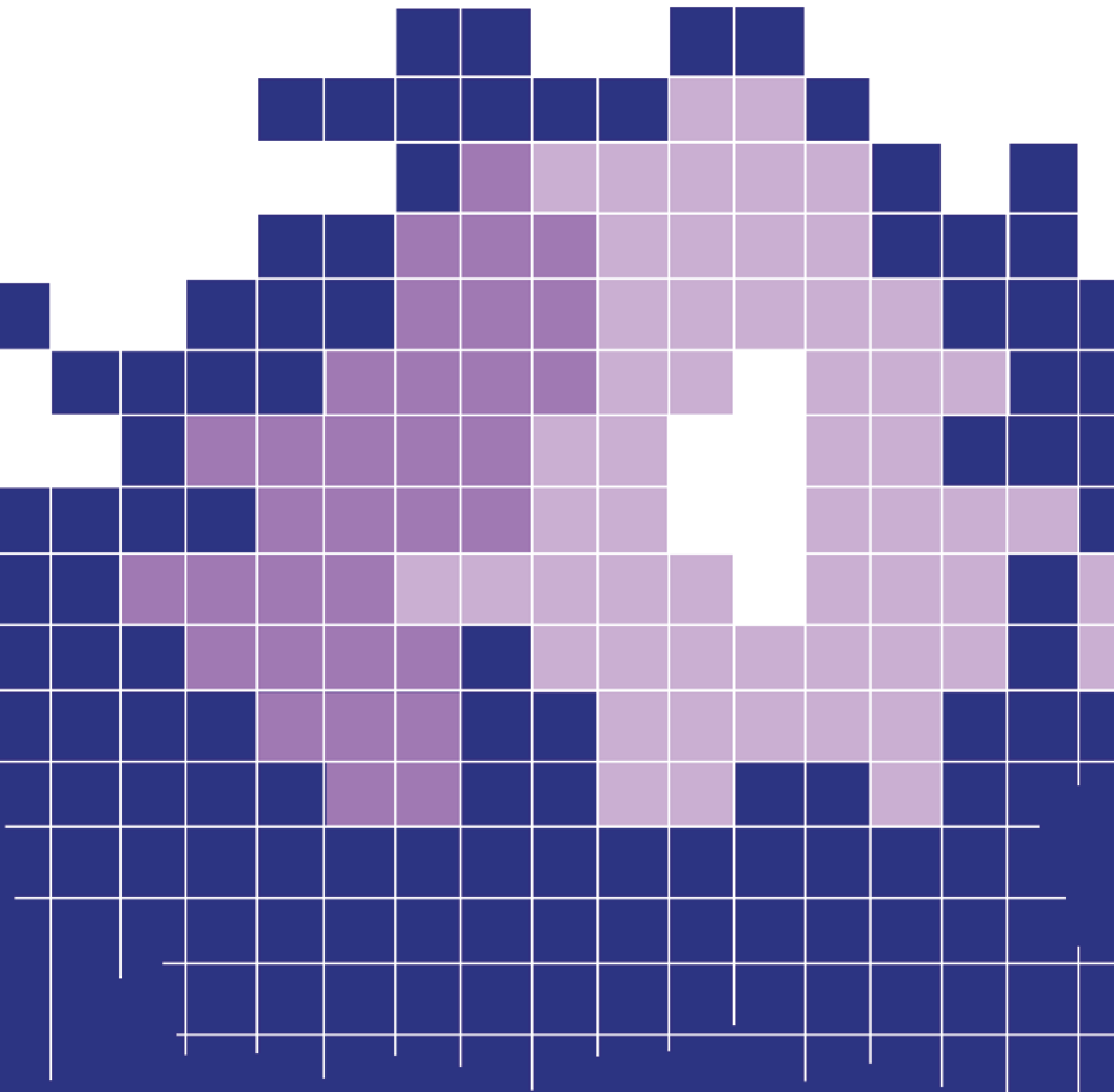



## Summary of Incidence Rates within the Western Area 2007-08

- Average person-based (per 100,000) rates of self-harm in the Western area for 2007 and 2008 were 340 for males and 403 for females.
- The rate in Derry CC was 29% higher than the average rate in the Western area as a whole.
- In contrast, rates in Strabane DC, Omagh DC, Fermanagh DC and Limavady DC were 10%, 22%, 28%, and 39% lower respectively than the average rate in the Western area.
- The self-harm rates for males in Derry CC was more than double that of males in Limavady DC, and almost double that of males within Fermanagh DC and Omagh DC.
- The self-harm rate for females in Derry CC was almost double that of the female rate in Limavady DC.



# Rates of Self-Harm in the Western area Compared with Republic of Ireland and United Kingdom



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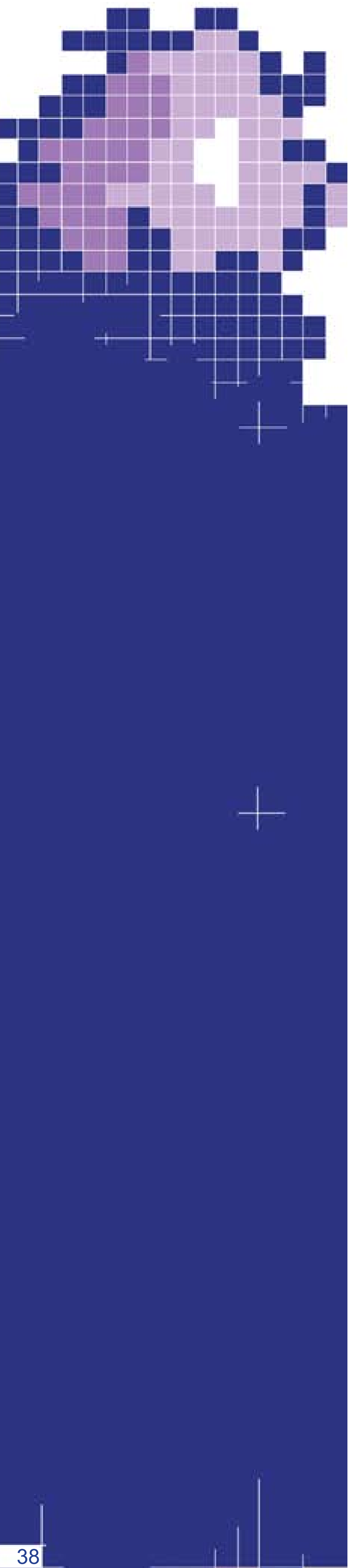


# Incidence Rates – All-island of Ireland Comparison

Derry CC rates were compared with those of five cities in Ireland (figure 9) for the two year period 2007 and 2008.

- Derry CC had the highest rates for both genders, with higher rates than in Limerick City which has the highest rates in RoI.
- The male rate in Derry CC was between 40-86% higher than the male rates in the other four cities (Cork, Dublin, Galway and Waterford) of the Republic of Ireland.
- The female rate in Derry CC was between 65-80% higher than the female rate in the other four cities of the Republic of Ireland.

**Figure 9: Person based EASR of self-harm in Derry CC by gender compared to RoI cities in 2007-08.**

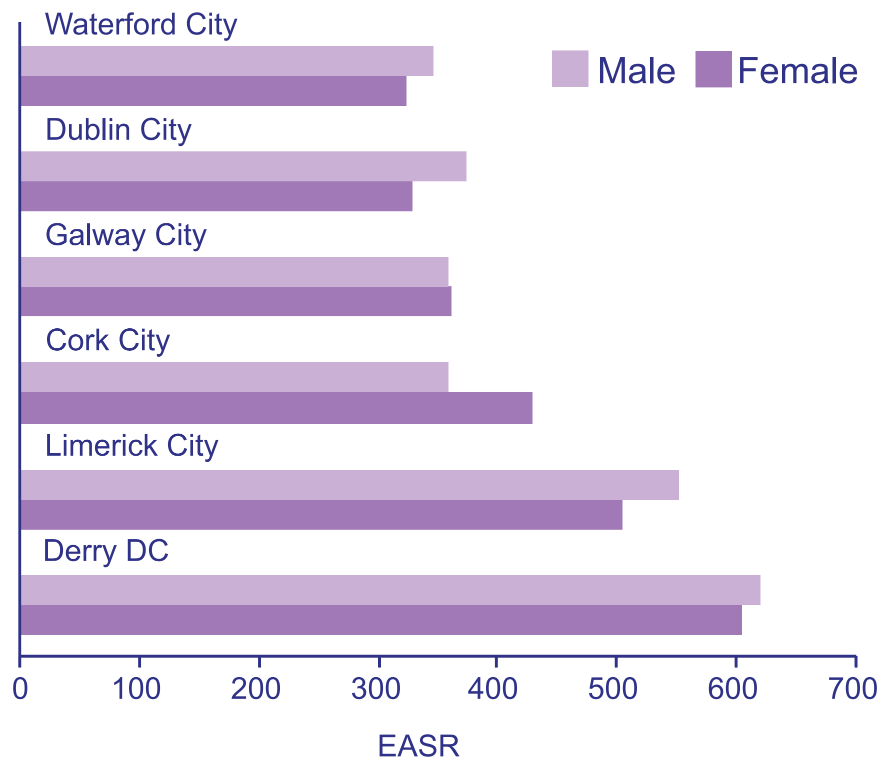


Table 4 compares the European Aged Standardised Rate of Self-Harm attendances in the Western area with the Republic of Ireland. The Western area rate is almost double the rate for the Republic of Ireland.

**Table 4: Person-based European Age-Standardised rate per 100,000 of the population in the Western area and in the Republic of Ireland.**

| | Males | Females | All |
|---|---|---|---|
| Western area, NI | 339 | 408 | 373 |
| Republic of Ireland | 171 | 219 | 194 |

## Incidence Rates - NI, RoI and UK Cities

A NI/RoI/UK comparison of cities shows the highest incidence rates were in Derry CC and the lowest rates in Oxford. Table 5 illustrates the person-based European Age-Standardised (EASR) rate of deliberate self-harm for those aged 15 years and above to allow for comparison with other studies.

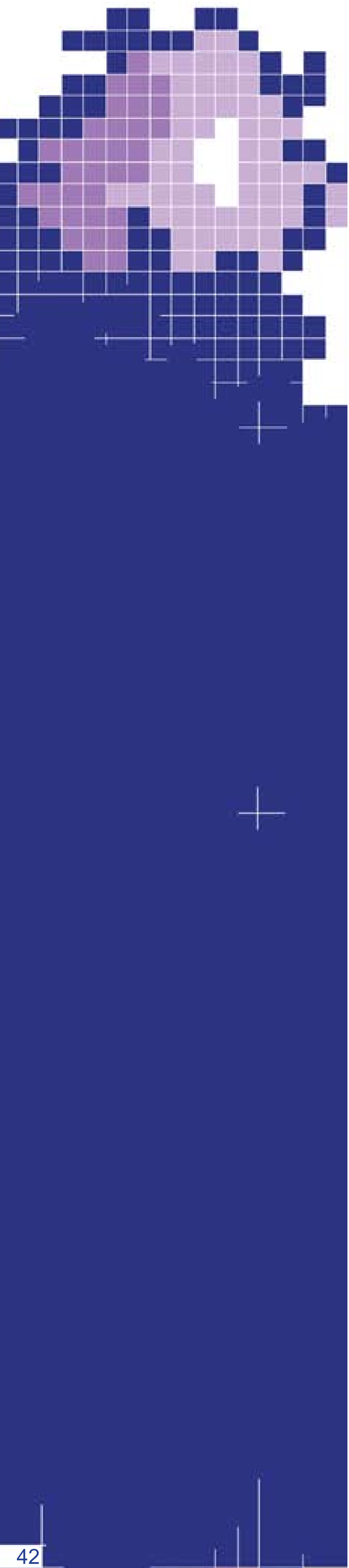
**Table 5: Incidence rates per 100,000 in the Western area compared to RoI and UK Cities.**

| | Males | Females | Total |
|---|---|---|---|
| Derry CC | 604 | 620 | 611 |
| Limerick** | 505 | 523 | 529 |
| Manchester* | 460 | 587 | 527 |
| Cork** | 430 | 359 | 394 |
| Galway** | 361 | 385 | 361 |
| Dublin** | 329 | 375 | 352 |
| Waterford** | 324 | 345 | 335 |
| Leeds* | 291 | 374 | 333 |
| Oxford* | 285 | 342 | 314 |

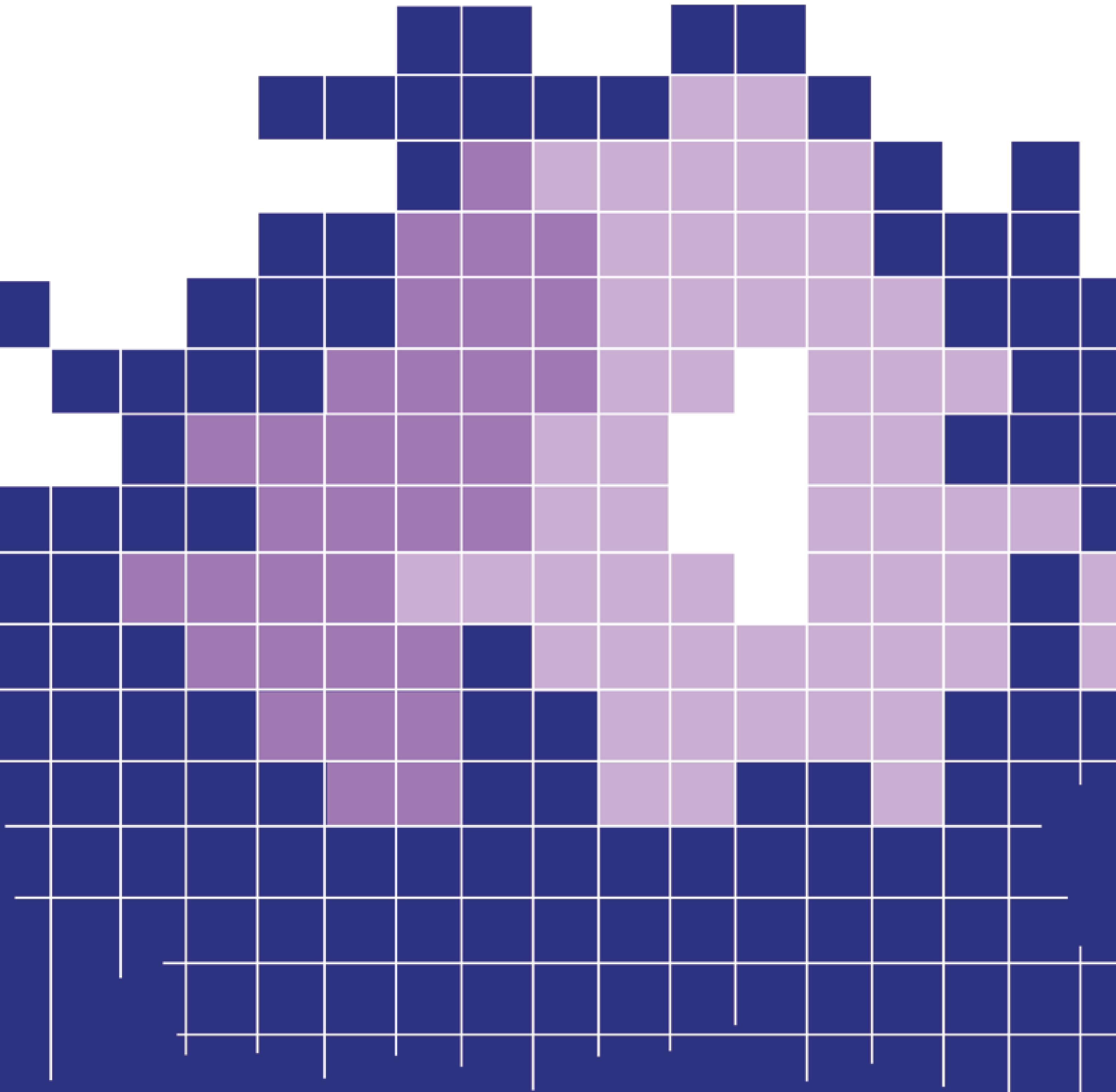
Rates presented are age-standardised for those aged over 15 years.

**Source – (2007) Self-Harm in England: a tale of three cities. Multicentre study of self-harm. Social Psychiatry and Psychiatric Epidemiology, 42, 513-521. Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., Kapur, N., Horrocks, J., House, A., Lilley, R., Noble, R., Owens, D. (2007) Self-harm in England: a tale of three cities.*

***Source – 2006-2007 Report on Deliberate Self-Harm, and 2008 Annual Report on Deliberate Self-Harm, National Suicide Research Foundation. Corcoran, P. Perry, I, Reulbach, U, Arensman, E.*



# Rates of Self-Harm: Comparison between Local Council areas in Northern Ireland



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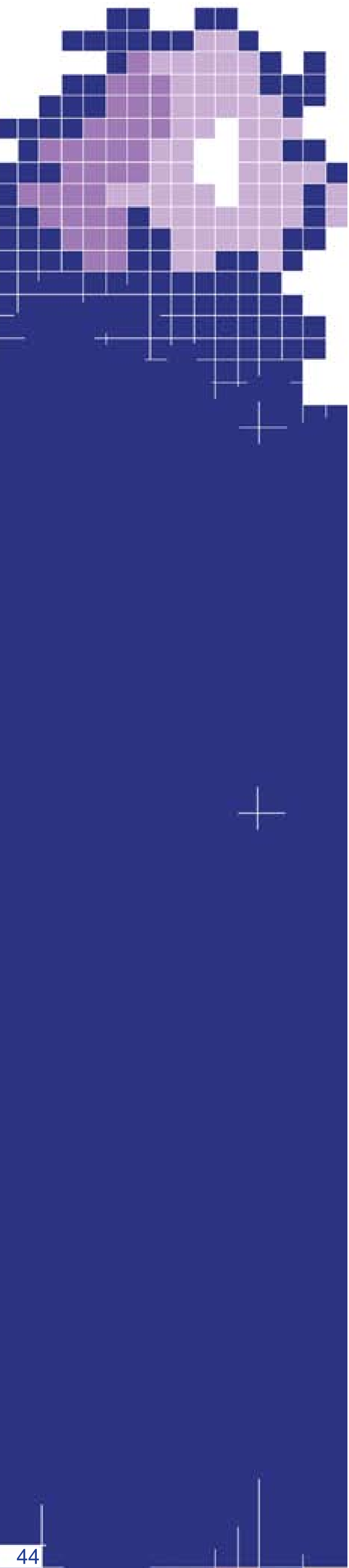


# Incidence Rates – Local Council Area Comparison

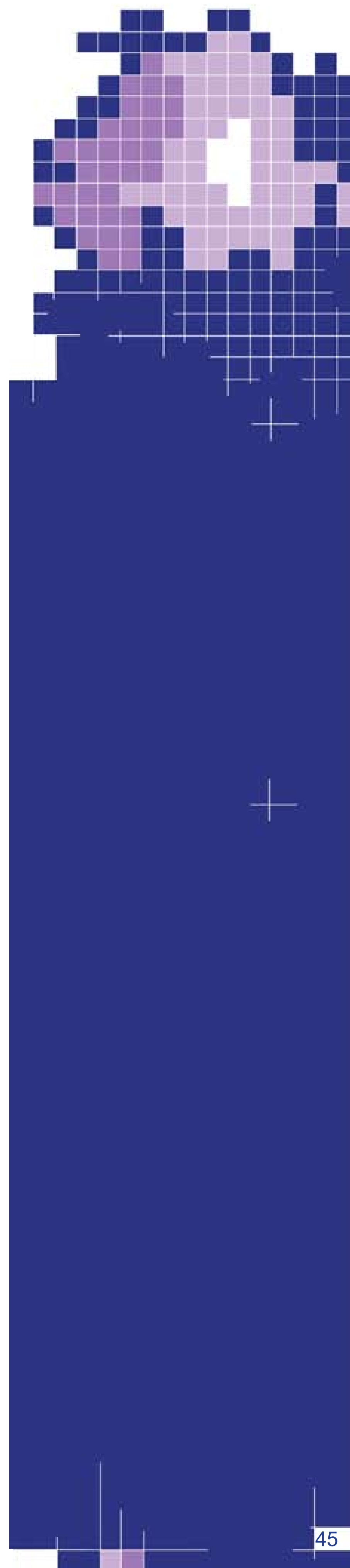
There were some variations in the incidence rates of self-harm within each council area across the two years (2007 – 2008). This section looks at each council area individually and compares age-groups and genders across the two years.

## Derry City Council Area

The Derry City Council area is the largest of all council areas in the study with a population of 108,535 (NISRA, 2007 MYE). Altnagelvin Hospital is located in the Derry City Council area which has seen the highest number of attendances to the A&E department due to self-harm.

### Summary of Findings from Derry City Council area

- There was no significant change to the overall rate of self-harm within the Derry City Council area between 2007 and 2008.
- In 2007, the incidence of self-harm among people living in the Derry City Council area was 31 per cent higher than in the Western area as a whole.
- In 2008, the incidence of self-harm among people living in the Derry City Council area was 27 per cent higher than in the Western area as a whole, which showed a drop by 4 per cent from the previous year.
- Figure 10 illustrates the incidence rates of self-harm within the Derry City Council area in 2007 showing that the highest rates of self-harm for both genders were in 20-24 year olds.
- In 2007, males had a slight second peak in the 45-54 years age-group and females had a very evident second peak in the 35-45 year age-group.
- Figure 11 illustrates the incidence rates of self-harm within the Derry City Council area in 2008, showing the highest rates in 15-19 and 45-54 year old females.
- In 2008, the highest self-harm rate for males within the Derry City Council area was in 20-24 year olds. The self-harm rate for males had a secondary peak in 35-44 year olds.



- In 2007, there were no self-harm episodes recorded for males under 15 years.
- There was a significant increase in the rates of self-harm among 55-64 year old females within the Derry City Council area in 2008 compared with 2007.

**Figure 10: Person based EASR rate of self-harm by age group and gender in Derry CC in 2007.**

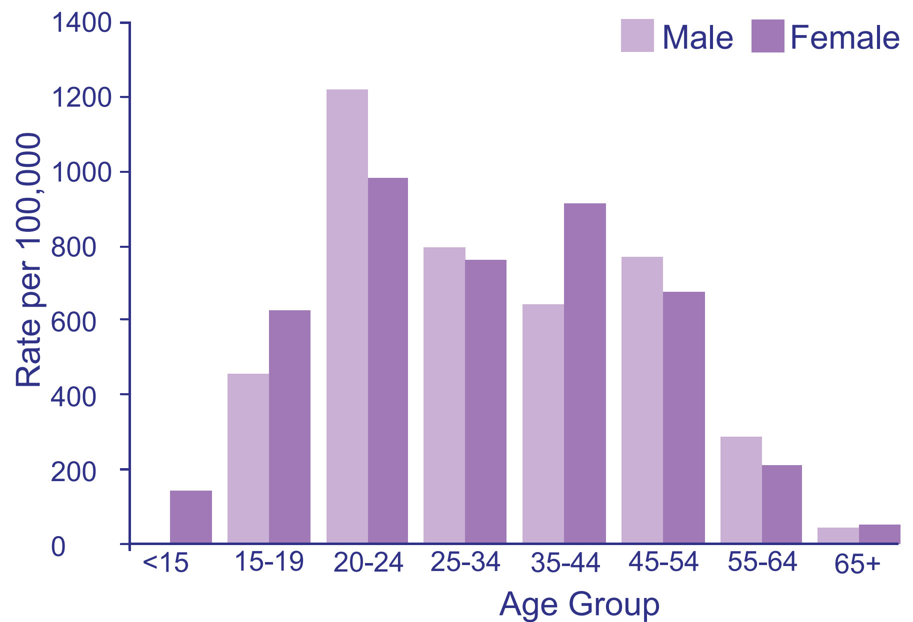
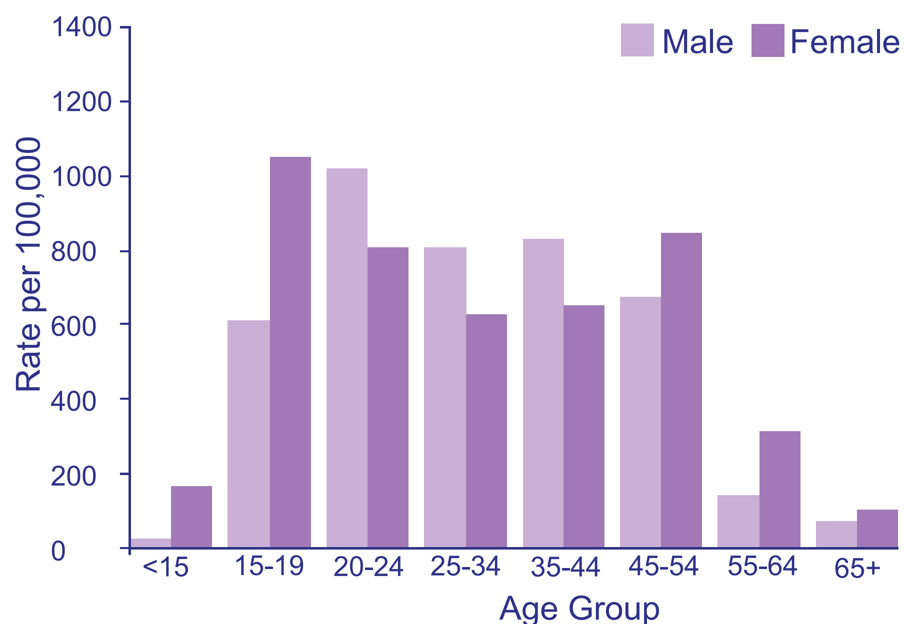



**Figure 11: Person based EASR rate of self-harm by age group and gender in Derry CC in 2008.**



## Limavady District Council Area

Limavady District Council area is the smallest of all areas involved in the study with a population of 34,428 (NISRA, 2007 MYE). Limavady DC borders Derry CC, Strabane DC and also council areas within the Northern Health & Social Care Trust.

## Summary of Findings from Limavady District Council area

- The highest rate of self-harm for females within the Limavady DC area was in 15-19 year olds.
- There was almost a 50% increase in the overall rate of self-harm in age-groups 15-19 and also 20-24 in 2008 when compared with 2007.
- There was a 83% increase in the rate of self-harm in 15-19 year old females within the Limavady DC area in 2008 compared with 2007.
- There was no change in the rate of self-harm for females under 15 years across the two years 2007 and 2008. There were no reported episodes for males under 15 in these two years from the Limavady DC area.
- The self-harm rate for females aged 20-24 more than doubled in 2008 when compared to 2007.
- There was a decrease in the rate of self-harm in males within the 45-54, 55-64 and 65+ age groups.
- The 45-54 year age group showed a 28% decrease in the overall rate of self-harm within the Limavady DC area, due entirely to a decrease in males.

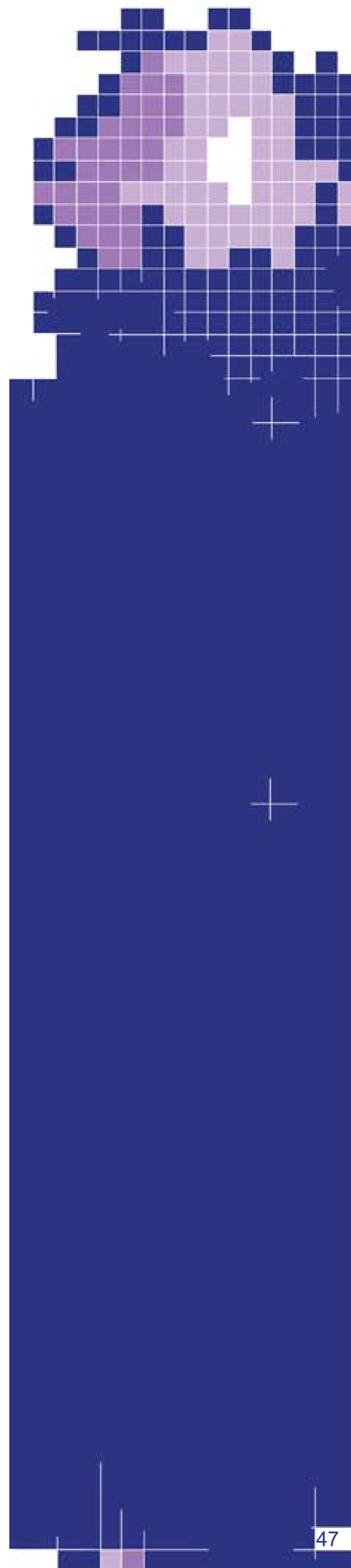


Figure 12: Person based EASR rates of self-harm by age group and gender in Limavady DC in 2007.

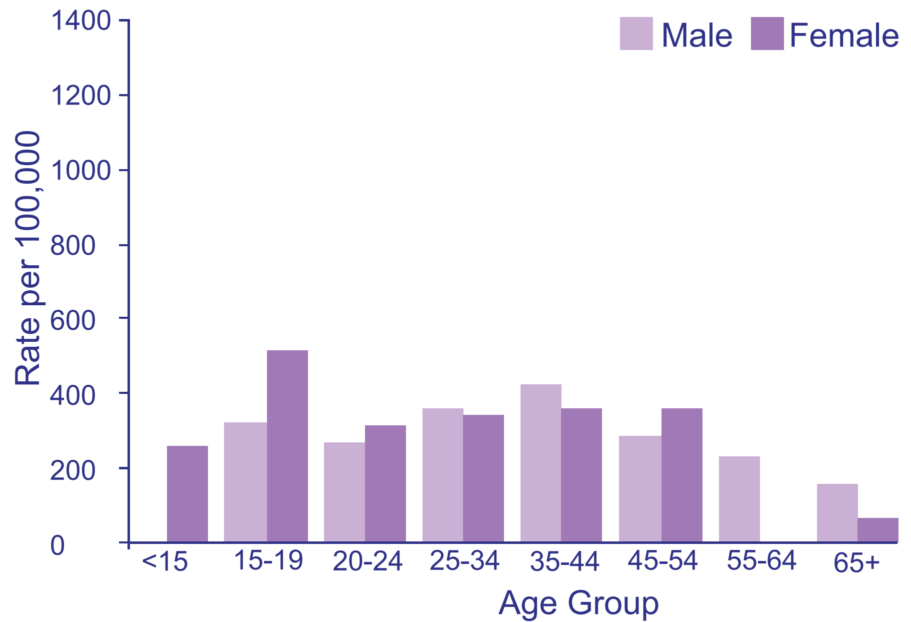
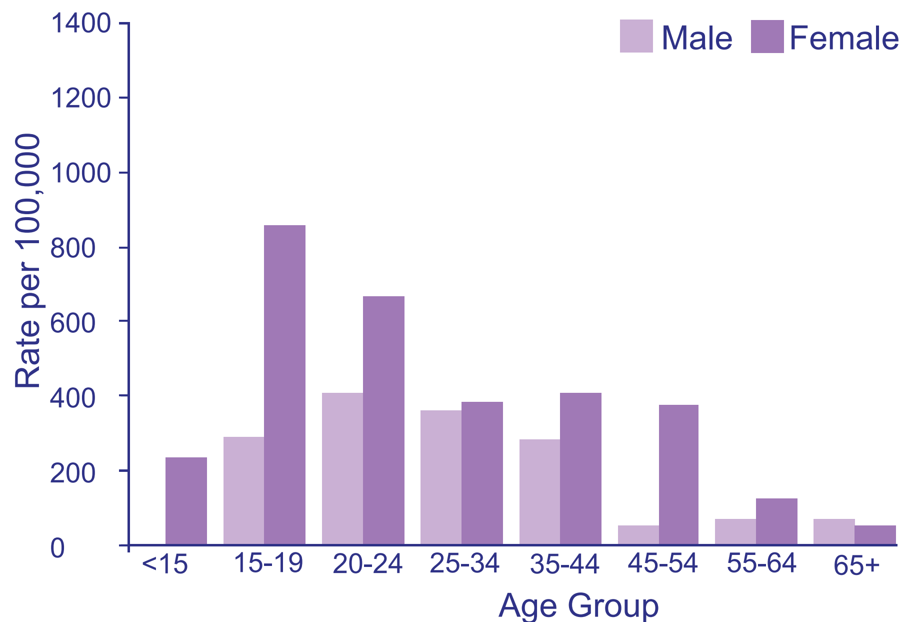



Figure 13: Person based EASR rates of self-harm by age group and gender in Limavady DC in 2008.



## Strabane District Council Area

Strabane District Council area is the second smallest council area in the study with a population of 39,430 (NISRA, 2007 MYE). Strabane DC borders Derry CC and Omagh DC and also borders County Donegal in the Republic of Ireland.

### Summary of Findings from Strabane District Council area

- There were no reported episodes for males under 15 and over 65 during the two years from the Strabane District Council area.
- The self-harm rate for males within the 20-24 year age-group doubled in 2008 compared with 2007.
- There was a decrease in the rate of self-harm for both genders within the 25-34 year age-group, with 2008 showing a drop of 26% overall compared with 2007.
- The female rate of self-harm within the 35-44 year age-group dropped by one third in the 2008 compared with 2007.

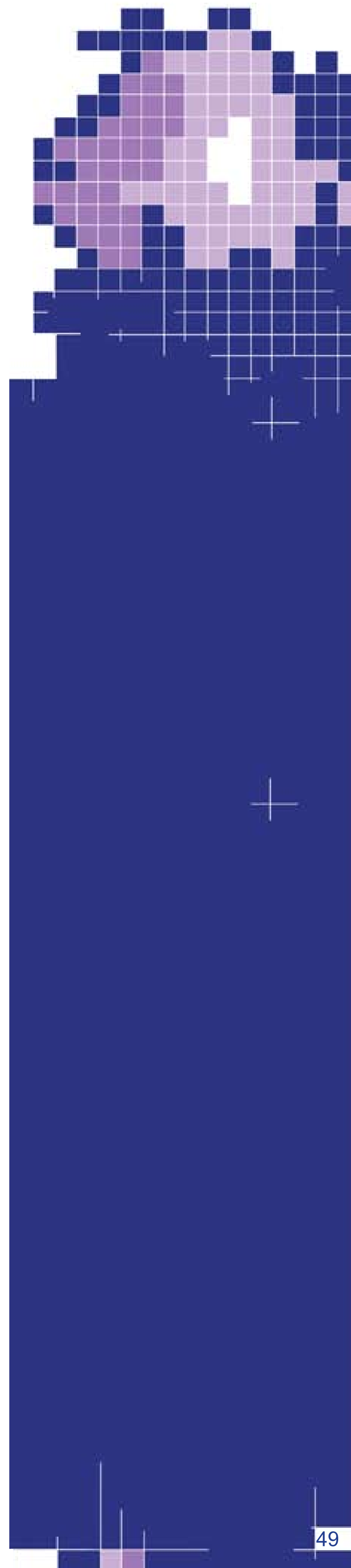


**Figure 14: Person based EASR rate of self-harm by age group and gender in Strabane DC in 2007.**

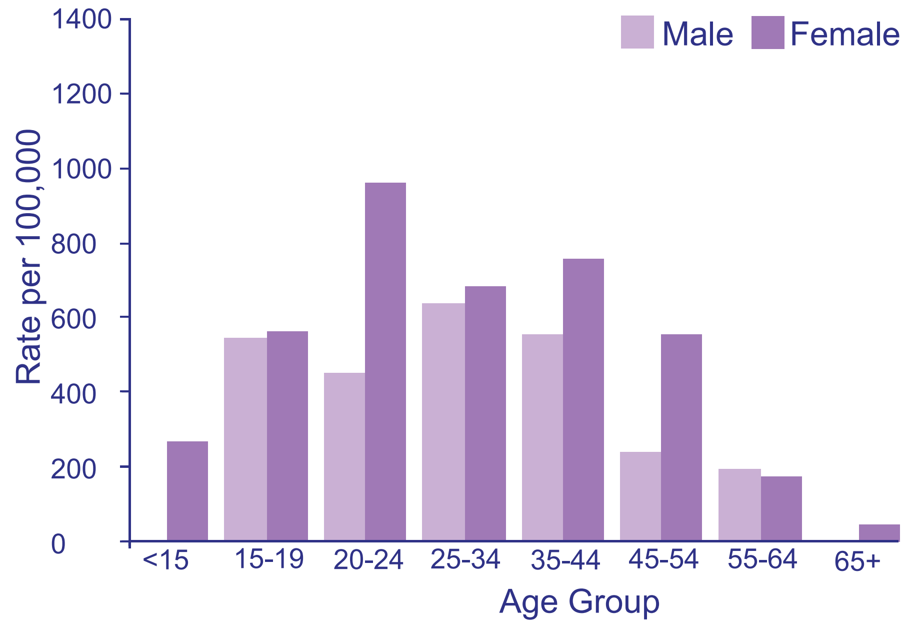
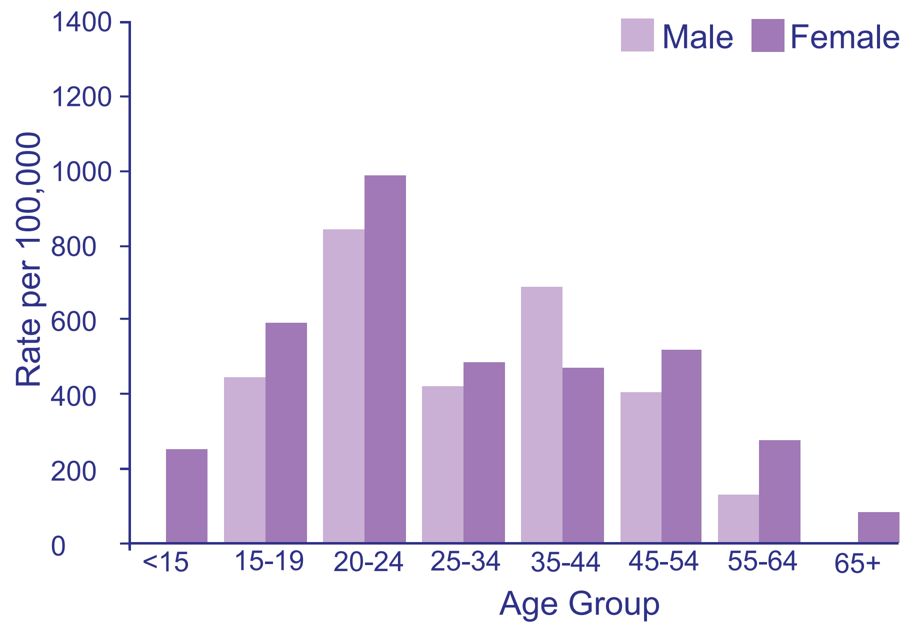



**Figure 15: Person based EASR rate of self-harm by age group and gender in Strabane DC in 2008**



## Omagh District Council Area

Omagh District Council area has a population of 53,508 (NISRA,2007 MYE) and borders Strabane DC, Fermanagh DC and also council areas within the Northern and Southern Health and Social Care Trust areas of Northern Ireland. The Tyrone County Hospital is located within Omagh District Council area.

## Summary of Findings from Omagh District Council area

- There was a decrease in the rate of self-harm in 15-19 year old females with a reduction of almost 40% in 2008 compared to 2007.
- This was accompanied by an increased rate of self-harm amongst females aged 20-24, with a 42% rise in 2008 compared with 2007.
- There were no significant changes to the rate of self-harm for males in 2008 compared with 2007.
- There was a decrease in the male rate of self-harm within the 55-64 year age group.
- There were no recorded episodes of self-harm for males aged over 65 in 2008.

**Figure 16: Person based EASR rate of self-harm by age group and gender in Omagh DC in 2007.**

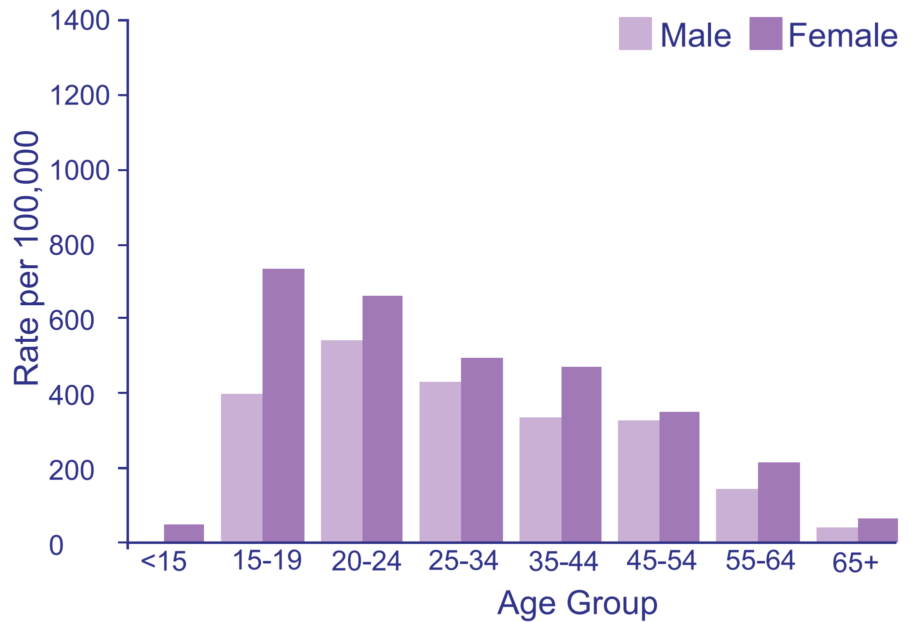
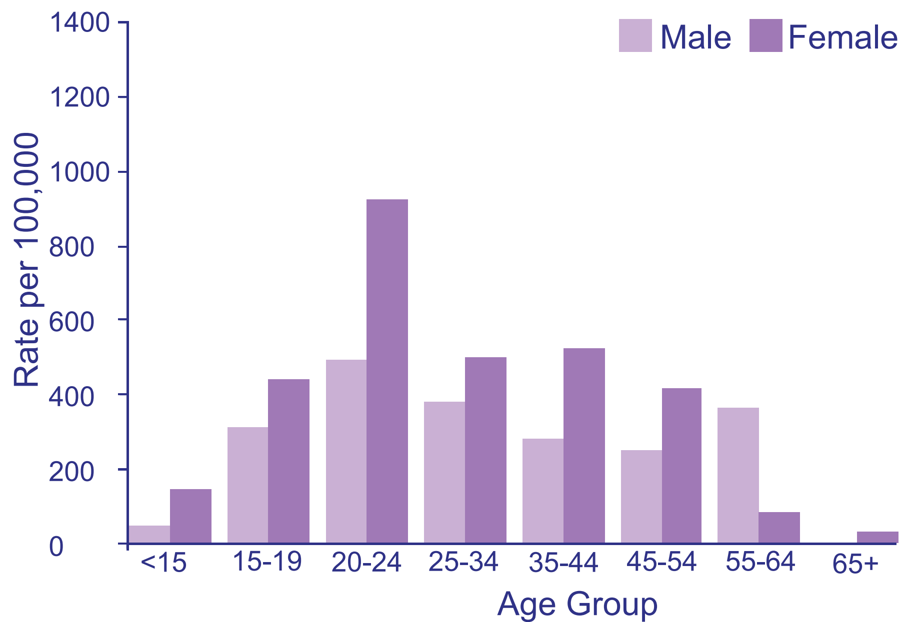
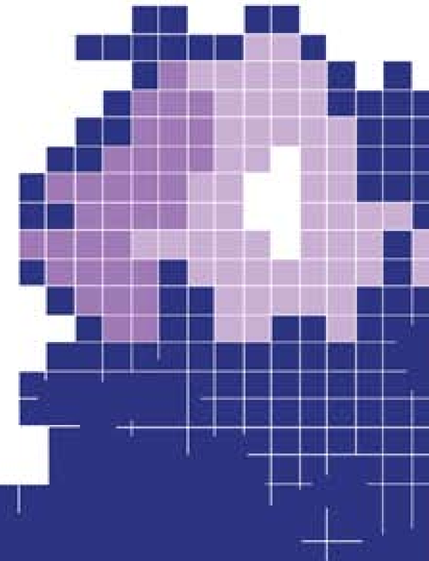



**Figure 17: Person based EASR rate of self-harm by age group and gender in Omagh DC in 2008.**



## Fermanagh District Council Area

Fermanagh District Council area is the second largest council area in the study, with a population of 61,291 (NISRA, 2007 MYE). Fermanagh borders Omagh District Council and council areas from the Southern Health and Social Care area of Northern Ireland. Fermanagh DC also borders the Republic of Ireland counties of Donegal, Leitrim, Cavan and Monaghan. The Erne Hospital is located within Fermanagh District Council.



## Summary of Findings from Fermanagh Disfrict Council area

- There was a decrease in the rate of self-harm in 15-19 year old males, with 2008 showing almost half the rate of that recorded in 2007.
- There was an increase in the rate of self-harm in 15-19 year old females, with a 50% rise in 2008 from 2007.
- The rate of self-harm for males within the 35-44 year age group decreased by 22% in 2008.
- There was a decrease of 40% in the rate of self-harm in 35-44 year old females in 2008.

**Figure 18: Person based EASR rate of self-harm by age group and gender in Fermanagh DC in 2007.**

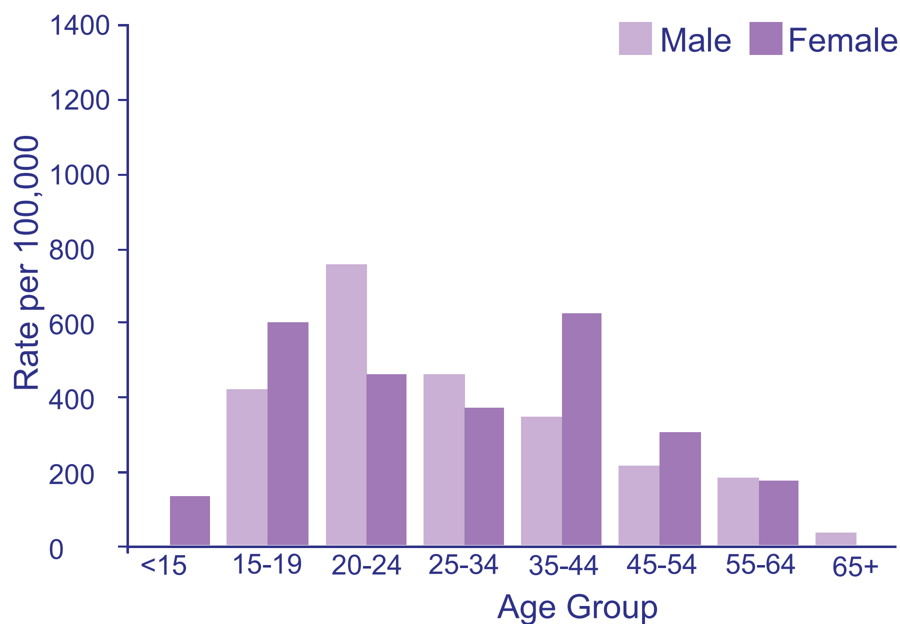
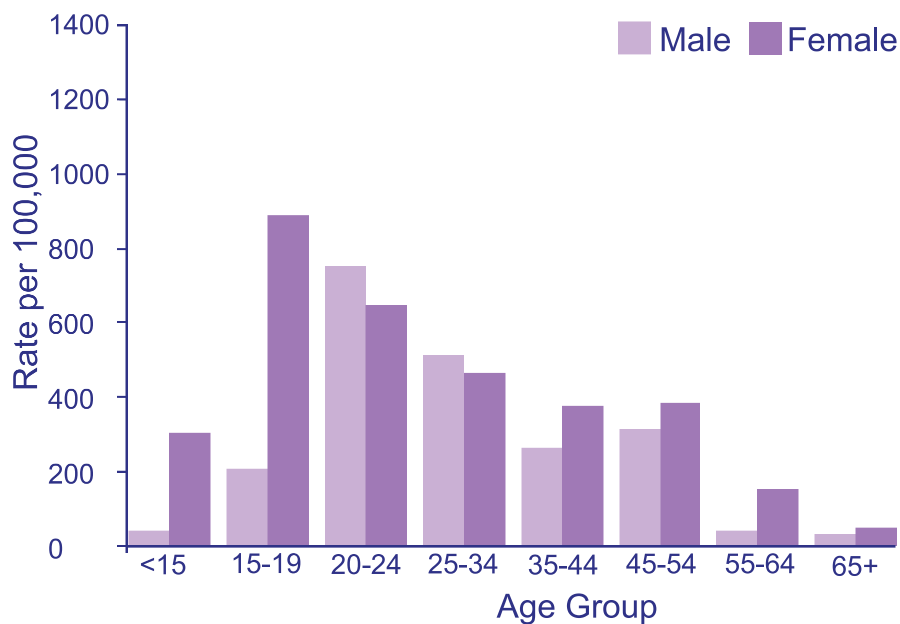
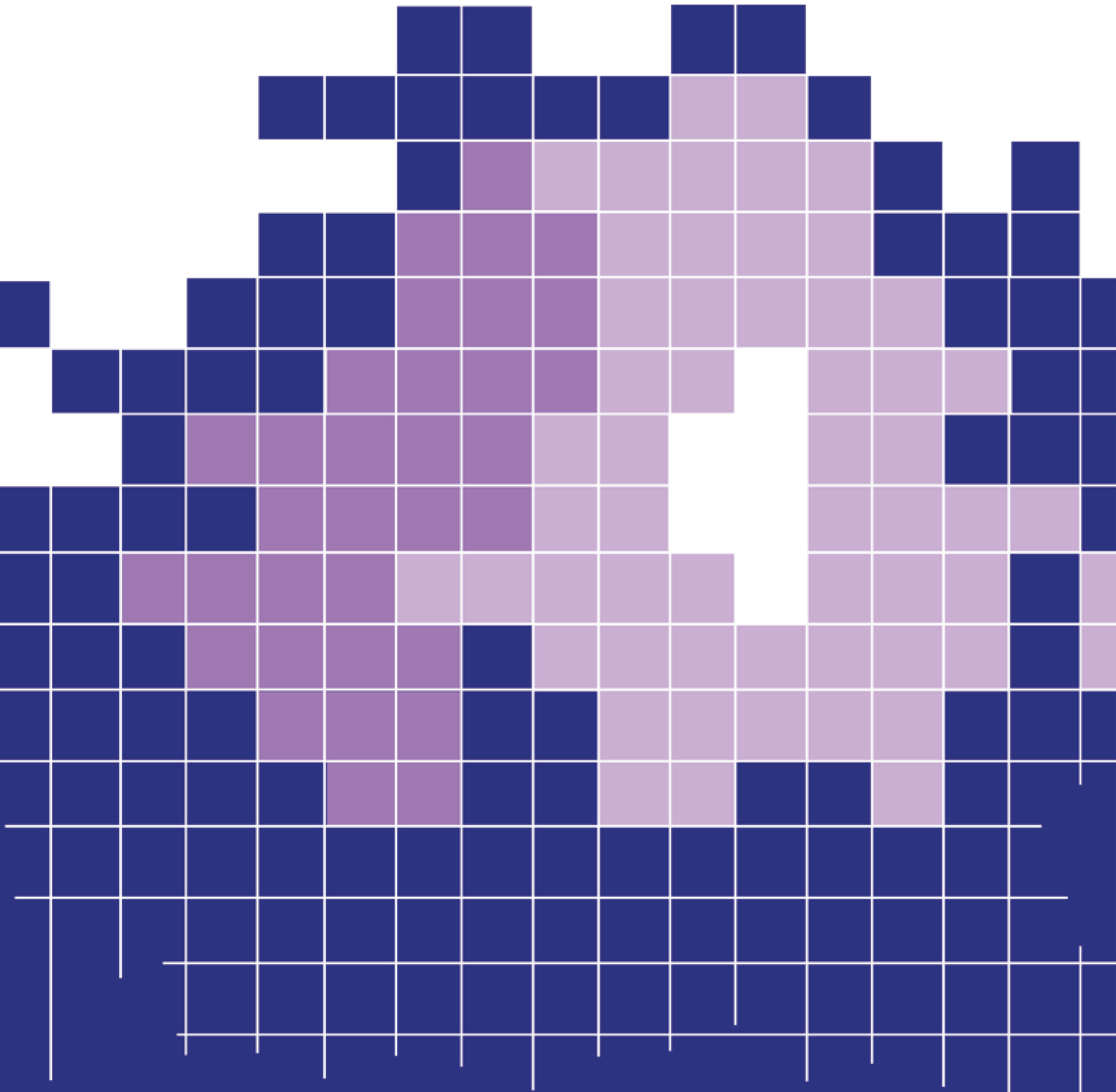



**Figure 19: Person based EASR rate of self-harm by age group and gender in Fermanagh DC in 2008.**



# Method of Deliberate Self-harm



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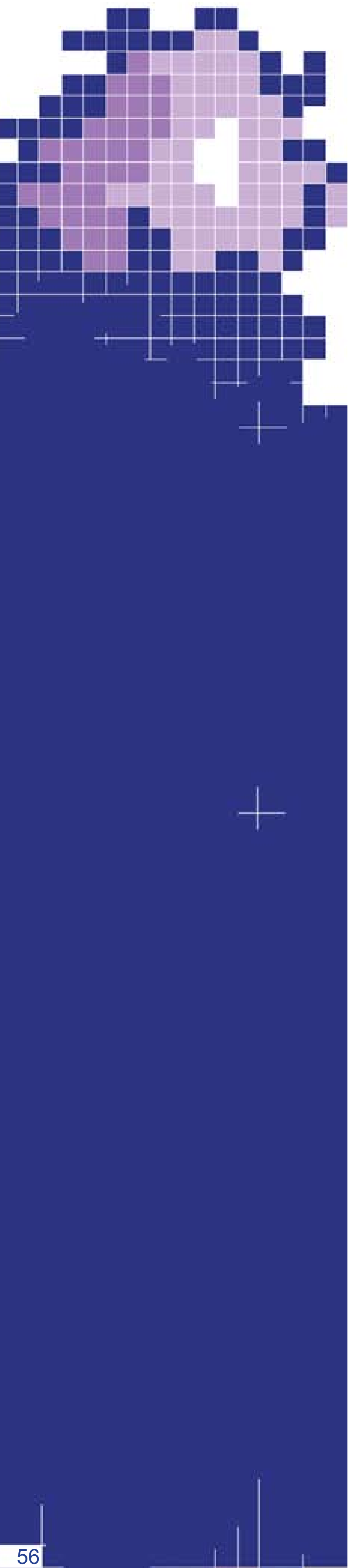


## Methods

Table 6 shows the methods of self-harm used. Patients may have engaged in one or more of these methods.

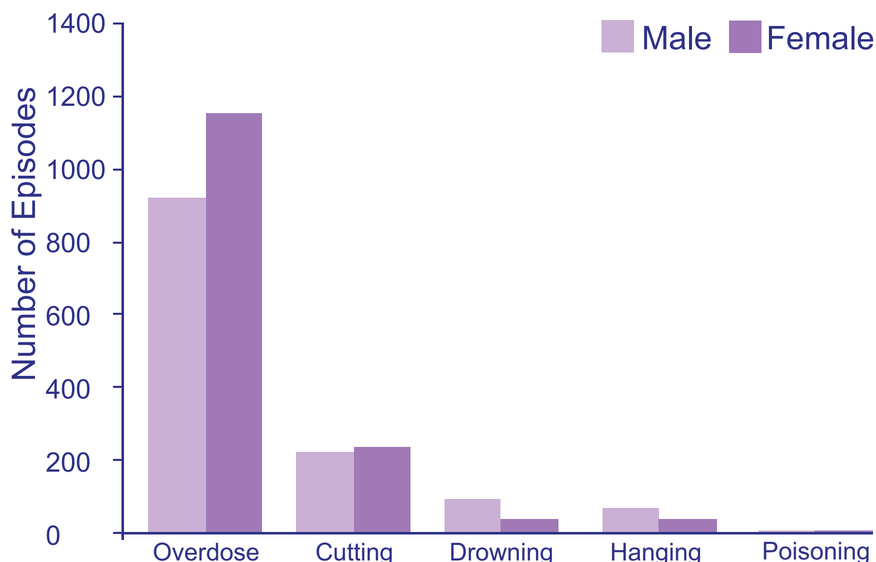
**Table 6: Number of episodes by method and gender, Western area, 2007 and 2008.**

| | Overdose | Cutting | Drowning | Hanging | Poisoning | Alcohol involvement |
|---|---|---|---|---|---|---|
| Total | 2076 (77.1%) | 459 (17.1%) | 128 (4.8%) | 104 (3.9%) | 13 (0.5%) | 1717 (63.8%) |

### Summary of Methods

- Overdose was the most commonly used method of self-harm in the Western area in 2007 and 2008, used in 77.1% of episodes. Self-cutting was the second most commonly used method involved in 17.1% of all episodes.
- Attempted drowning accounted for 4.8% of all self-harm attendances. There were more male attendances due to attempted drowning than female attendances with 72.7% of all attempted drowning being among males.
- The majority (79.7%) of all attempted drownings occurred among residents within the Derry CC area.
- Attempted hanging accounted for 3.9% of all self-harm attendances. There were more male attendances due to attempted hanging than female attendances with 64.4% of all attempted hanging being among males.
- Alcohol, whilst rare as a main method, was involved in 63.8% of all episodes.

**Figure 20: Breakdown of methods by gender, Western area, 2007 and 2008.**



# Methods of Self Harm - Drug Overdose

Drug overdose was the most common method of self-harm, recorded in over three quarters (77.1%) of all self-harm episodes in 2007 and 2008.

## Summary of Drug Overdose Findings

- Drug overdose was more commonly used as a method of self-harm by females than males (80.9% of all female episodes and 72.8% of male episodes).
- These figures were slightly higher than those for the Republic of Ireland. The NSRF figure show 72.5% of all deliberate self-harm episodes in the Republic of Ireland involved an overdose.  It was more commonly used as a method of self-harm by females than males (79.2% of female episodes and 64.2% of male episodes).
- The study in Oxford showed a similar percentage of drug overdoses (77.5%) when compared to the Western area (77.1%).
- There was some variation in the use of drug overdose as a method of self-harm when examined by age (figure 21)

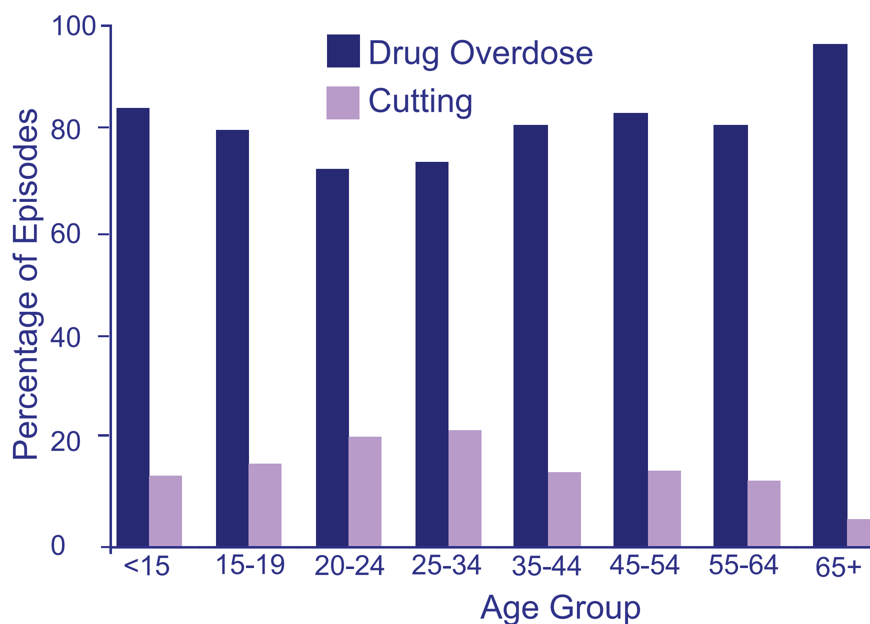
# Methods of Self-harm - Cutting

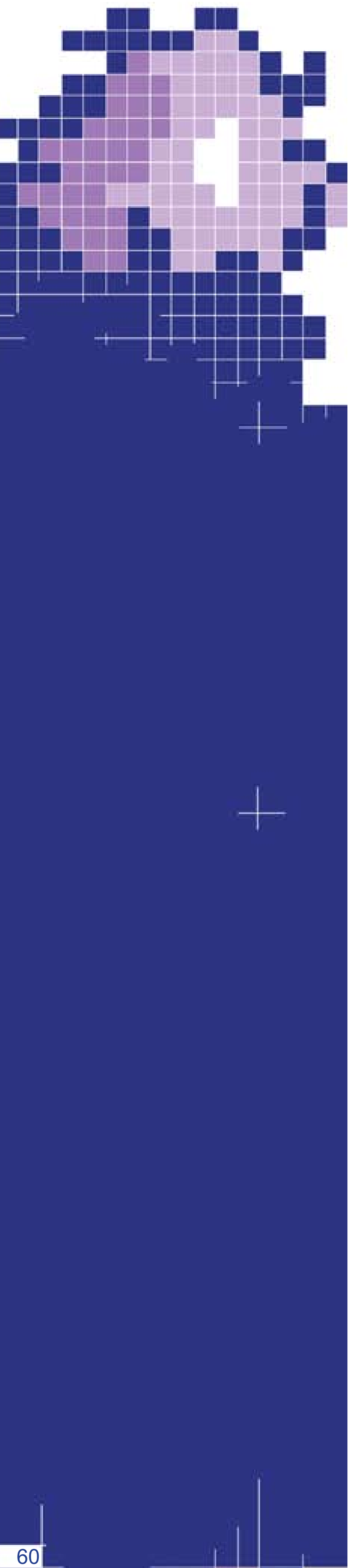
Cutting was the second most common method of self-harm, being used in 17.1% of all self-harm episodes.

## Summary of Cutting Findings

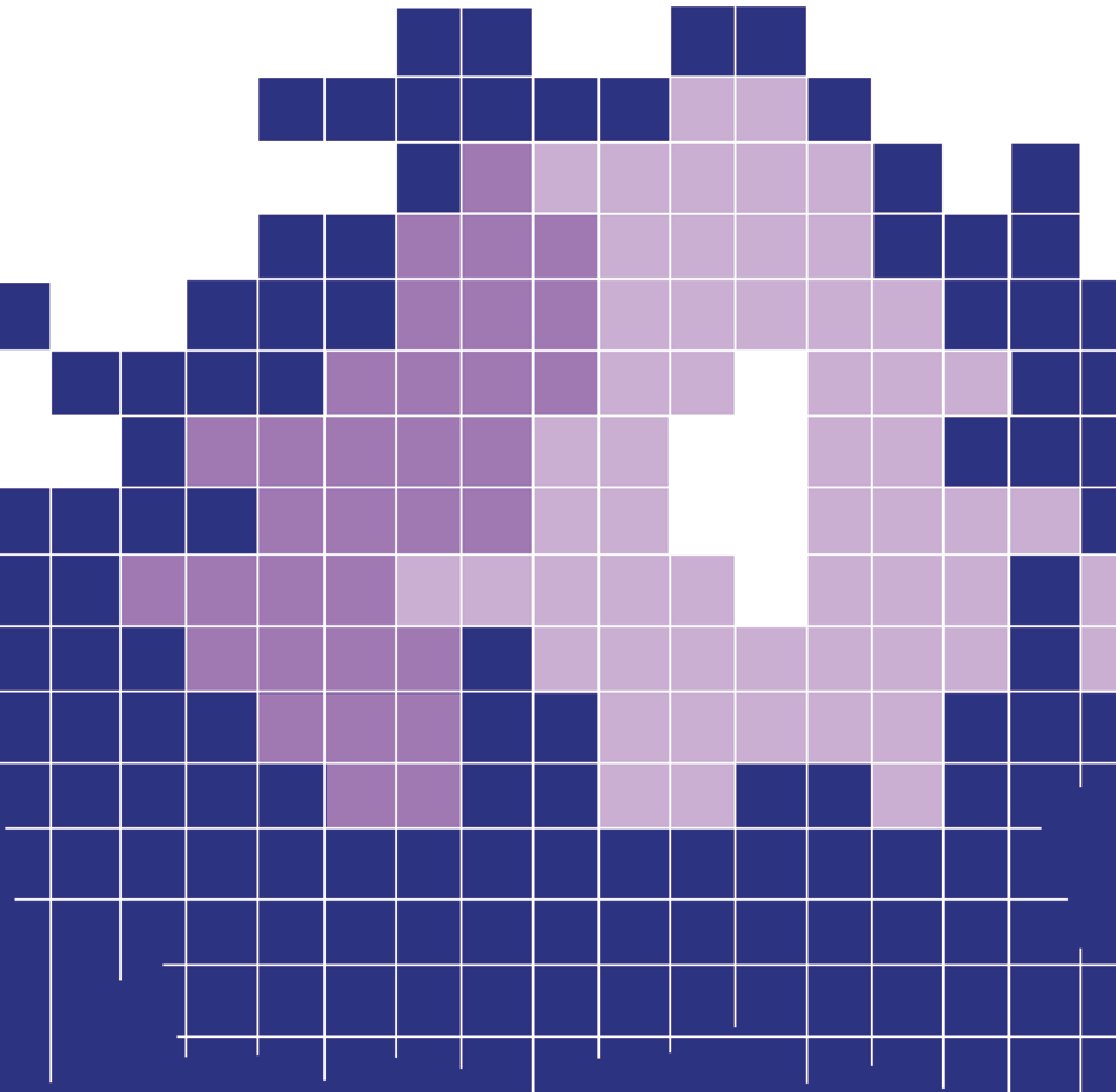
- Cutting was a method of self-harm in 17.7% of male episodes and 16.4% of female episodes.
- This was slightly lower than the Republic of Ireland figure where self-cutting was the method used in more than one fifth (21.7%) of all episodes and was used significantly more by males (26.3%) than by females (18.1%).
- There was some variation in the use of drug overdose and self-cutting as a method of self-harm when examined by age (figure 21).
- Drug overdose was most common in the under 15's and the over 65's and least common in the 25-34 year olds.
- In contrast, self-cutting was least common in the under 15's and over 65's and most common in the 25-54 year olds.

**Figure 21: Variation in drug overdose and cutting by age group in the Western area, 2007 and 2008.**





# Involvement of Alcohol in Deliberate Self-harm



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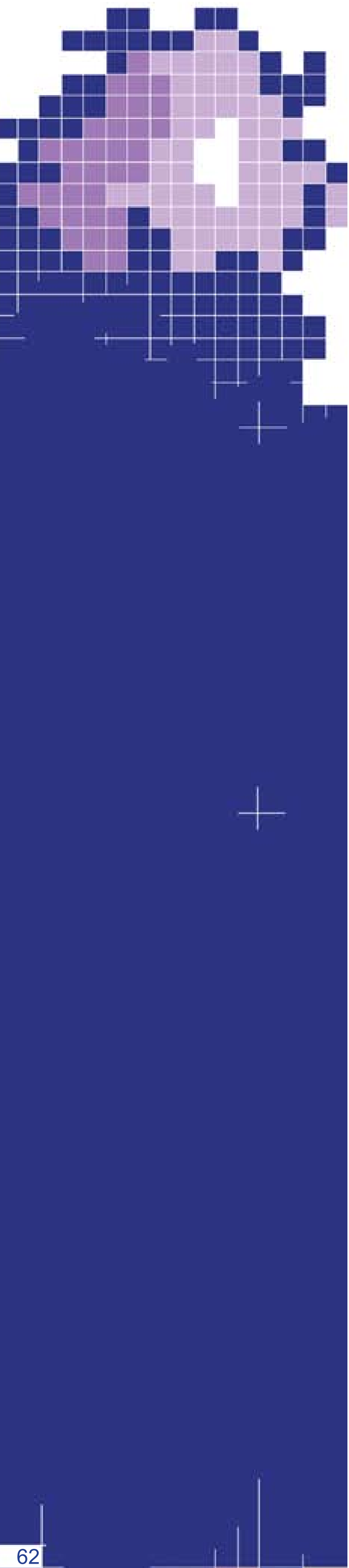


# Alcohol

## Alcohol - Method

The study did not highlight alcohol as main method of self-harm but as a major contributing factor. The level of alcohol was not recorded. Alcohol was only recorded if a person was intoxicated or used alcohol as part of the self-harm act when the episode took place.

### Summary of Alcohol Findings (By Method)

- There was a 10% increase in the number of self-harm episodes involving alcohol in 2008 (68.5%) compared to 2007 (59.2%).
- Alcohol was involved more often in male deliberate self-harm episodes (69.9%) than in female episodes (58.4%).
- This was higher than the Republic of Ireland where alcohol was involved in 45.3% of male episodes and 38.1% of female episodes.
- Compared with Oxford, the Western area had a somewhat higher overall percentage (63.8%) of episodes involving alcohol than Oxford (52.9%).
- The frequency of alcohol involvement varied to some extent with method of self-harm.
- Alcohol involvement was more common if the self-harm act involved attempted drowning (76.6%) and attempted hanging (72.1%) but less common in acts involving a drug overdose (63.3%) of self-cutting (60.6%). (Figure 22).
- There was a variation in the self-harm method and alcohol involvement when compared by gender (Figure 23). Males had a higher percentage of alcohol involvement with attempted hanging (80.6%) than females (56.8%).
- Males had also a higher percentage of alcohol involvement with attempted drowning than females (79.6% and 68.6% respectively).

**Figure 22: Average percentage of episodes involving alcohol by method in the Western area in 2007 and 2008.**

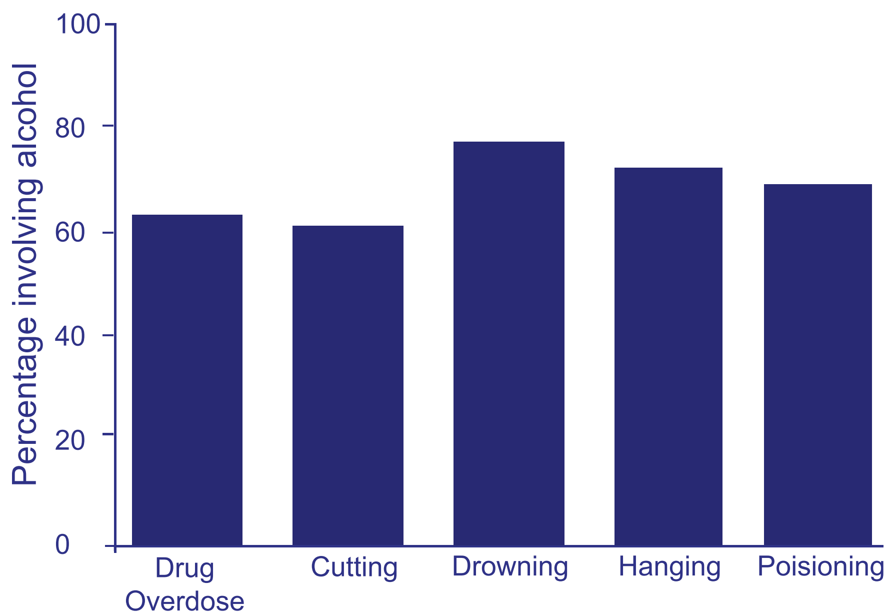
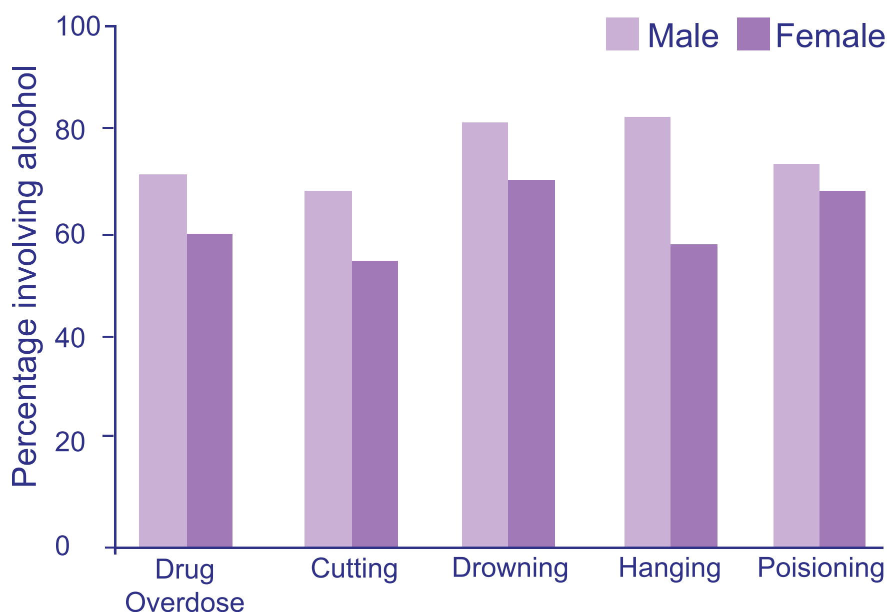



**Figure 23: Average percentage of episodes involving alcohol by gender and method in the Western area in 2007 and 2008.**

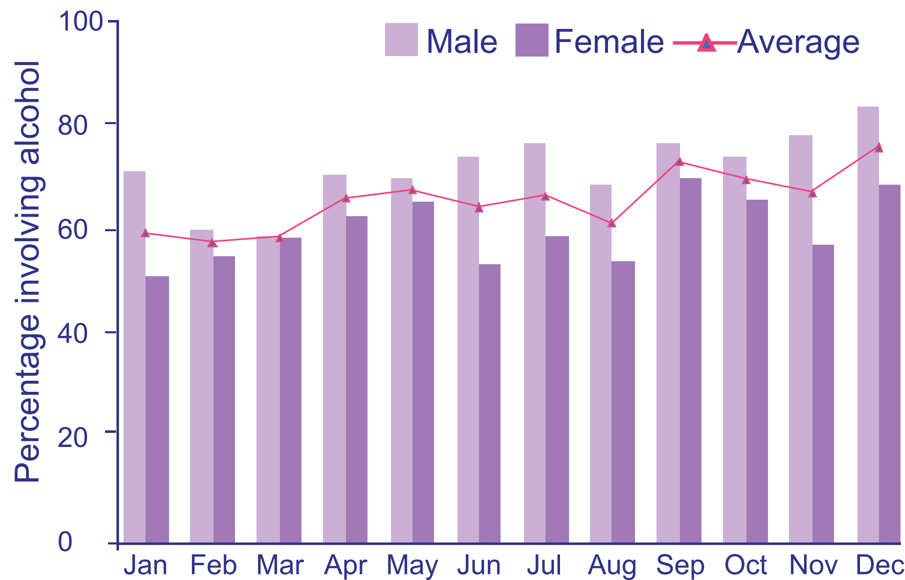


## Alcohol – Month / Day / Hour

### Summary of Alcohol Findings by Month (figure 24)

- Males had a higher percentage of self-harm episodes involving alcohol in every month than females.
- February had the lowest percentage of self-harm episodes involving alcohol (56.0%) regardless of gender.
- January had the lowest number of episodes involving alcohol for females (49.6%); March had the lowest percentage of episodes involving alcohol for males (57.0%)
- Almost three quarters (73.6%) of the self-harm presentations made in December involved alcohol.

**Figure 24: Average percentage of episodes involving alcohol by gender and month in the Western area in 2007 and 2008.**

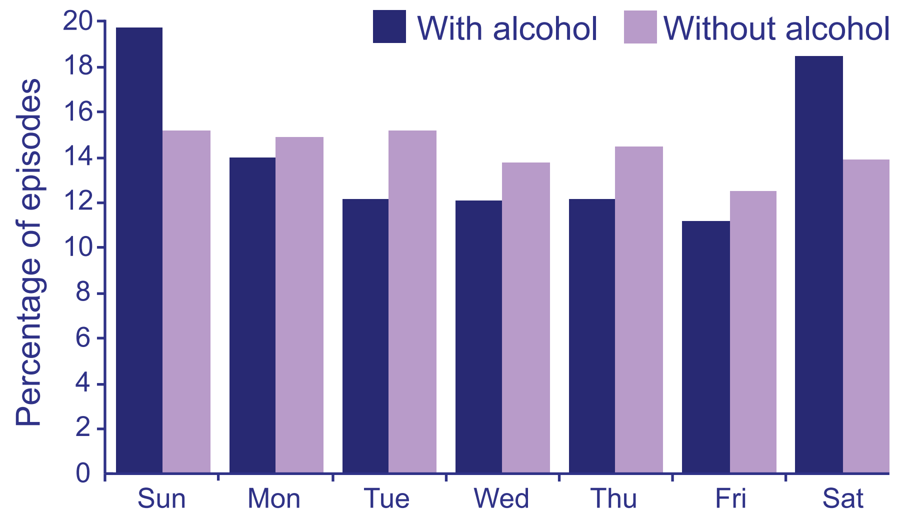


## Summary of Alcohol Findings by Day

Figure 25 presents the association between the percentage of self-harm episodes with and without alcohol and the day of presentation to hospital.

- 38.3% of self-harm episodes involving alcohol presented at the weekend.
- There was no clear association between self-harm episodes not involving alcohol and the day of attendance.

**Figure 25: Average percentage of self-harm episodes with and without alcohol involvement in the Western area in 2007 and 2008.**

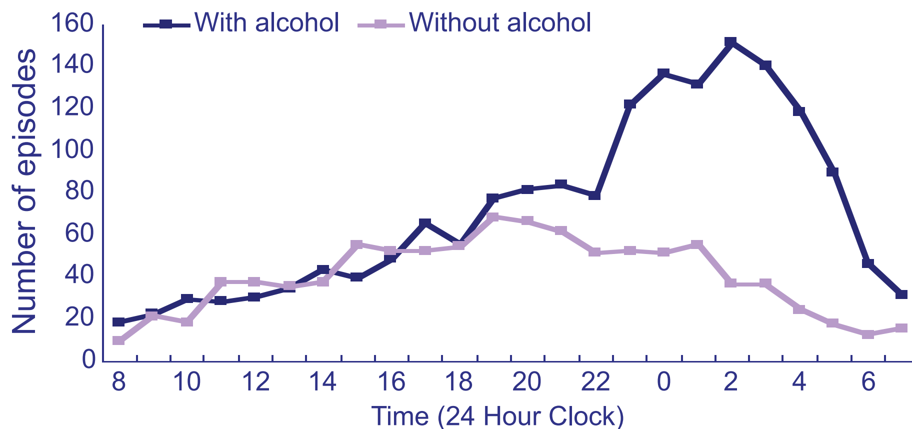


## Summary of Outcomes for Alcohol by Hour of Presentation

Figure 26 looks at the pattern of self-harm episodes with and without alcohol and the hour of presentation to hospital.

- The pattern of self-harm presentations over the course of the day was influenced by whether alcohol was involved in the act.
- The increase in self-harm presentations over the course of the day was more evident for cases involving alcohol.
- Over half (52.0%) of self-harm episodes involving alcohol attended hospital between 11pm and 6am.
- Self-harm episodes involving alcohol increased from 11pm and continued to increase until 2am.
- Self-harm episodes not involving alcohol peaked at 7pm.

**Figure 26: Pattern of self-harm episodes with and without alcohol involvement by hour in the Western area in 2007 and 2008.**



# Alcohol – Age Group & Gender

There was some variation in self-harm episodes involving alcohol when broken down by age-group and gender.

## Summary of Outcomes for Alcohol (By Age Group & Gender)

- There was a clear pattern in the use of alcohol with age for both genders (figure 27). Its frequency increased with age, peaking for both genders at 35-44 (77.2% for males and 70.8% for females). After these age groups the frequency decreased for each gender.

- Males had a higher percentage of self-harm episodes involving alcohol than females in all age-groups from 15-54 years.

- Females had a higher proportion of self-harm episodes involving alcohol than males in over 55 age-groups.

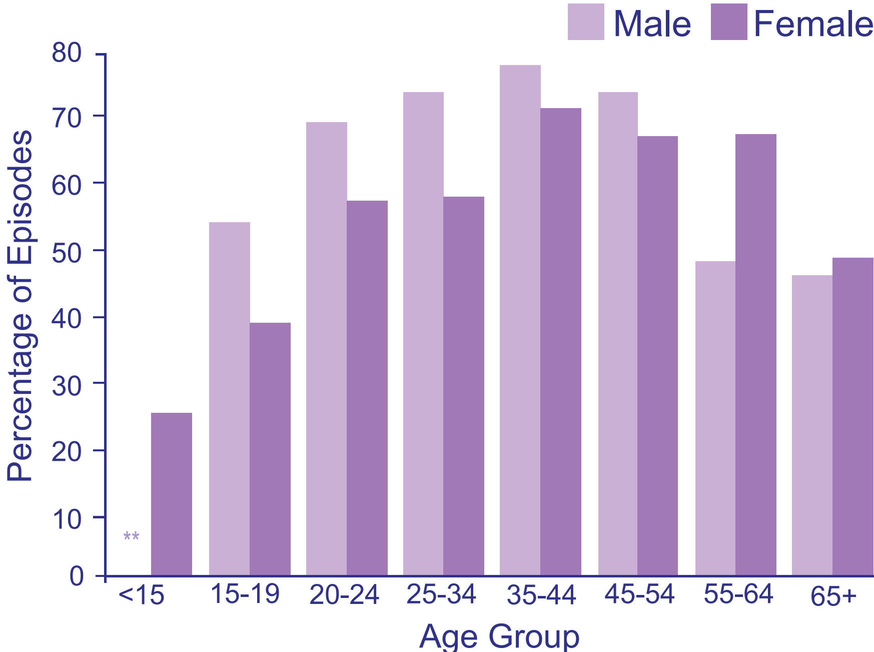
- In the 15-19 year age group, Limavady DC had the highest percentage of self-harm episodes involving alcohol (62.5%) followed by Derry CC (54.3%).

- In the 20-24 year age group, Fermanagh DC and Derry CC both had high percentages of episodes of self-harm involving alcohol with 78.3% and 74.7% respectively.

- Derry CC and Fermanagh DC had also relatively high percentages of self-harm episodes involving alcohol in the 25-34 (81.3% and 73.9% respectively) and in the 35-44 year age groups (89.4% and 83.3% respectively).

- Limavady DC had the highest percentage of episodes involving alcohol within the 45-54 and 55-64 year age groups (91.7% and 80.0% respectively).

**Figure 27: Percentage of episodes with alcohol involved by age group and gender, Western area, 2007 and 2008.**

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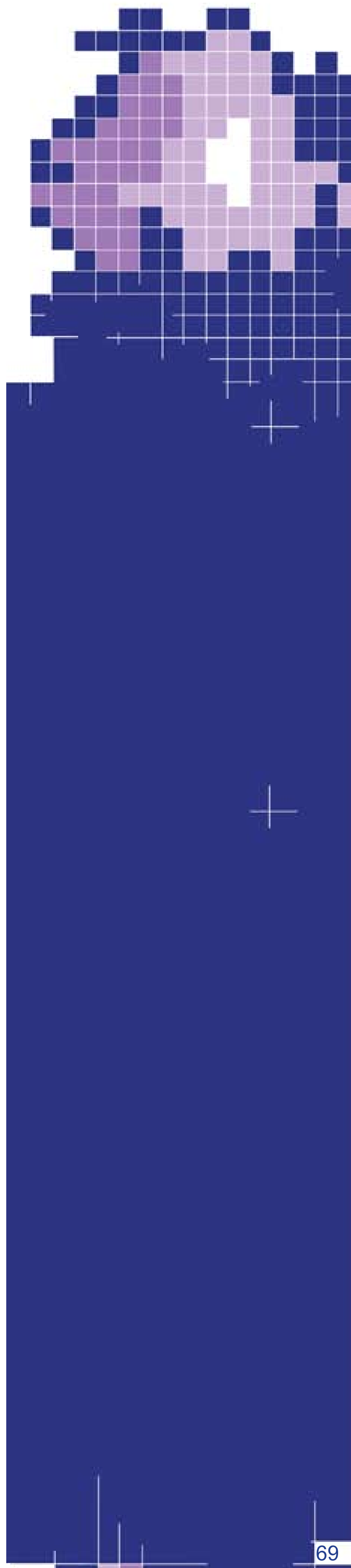


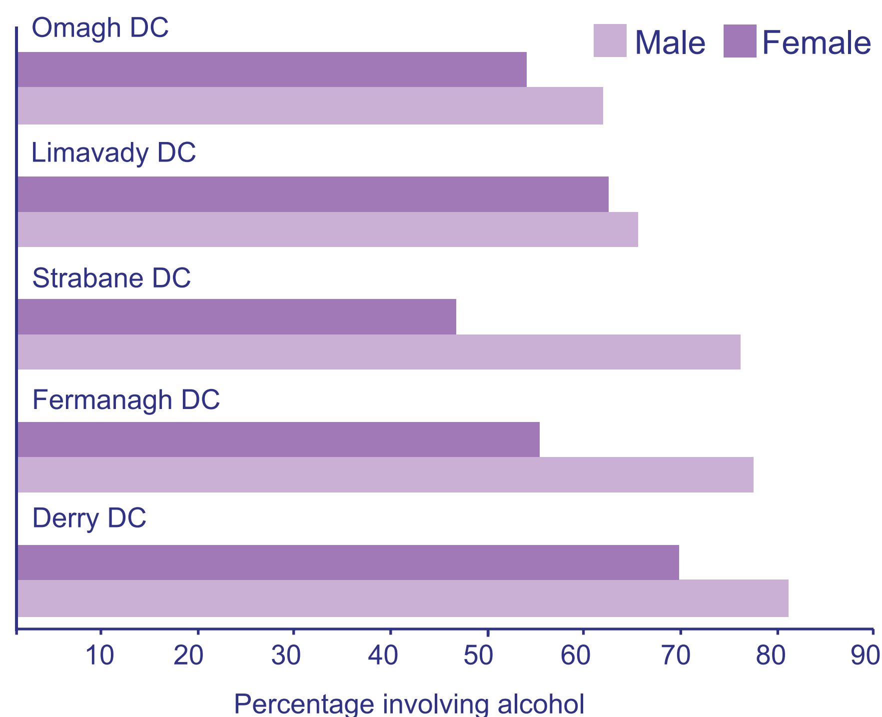
# Alcohol – Local Area Comparison

Figure 28 shows a breakdown of council areas within the Western area and the episodes of self-harm involving alcohol within each area.

## Self-harm involving alcohol by age group and local council area

- Derry CC had the highest overall percentage of episodes of self-harm involving alcohol (76.0%), followed closely by Fermanagh DC (65.2%), Limavady DC (63.6%), Strabane DC (61.3%) and Omagh DC (56.9%).
- Males had a higher percentage of episodes involving alcohol across all of the council areas.
- Derry CC had the highest percentage of self-harm episodes involving alcohol for both genders (81.6% for males and 70.1% for females).
- Strabane had the lowest percentage of self-harm episodes involving alcohol for females (46.3%).
- Omagh had the lowest percentage of self-harm episodes involving alcohol for males (61.9%).

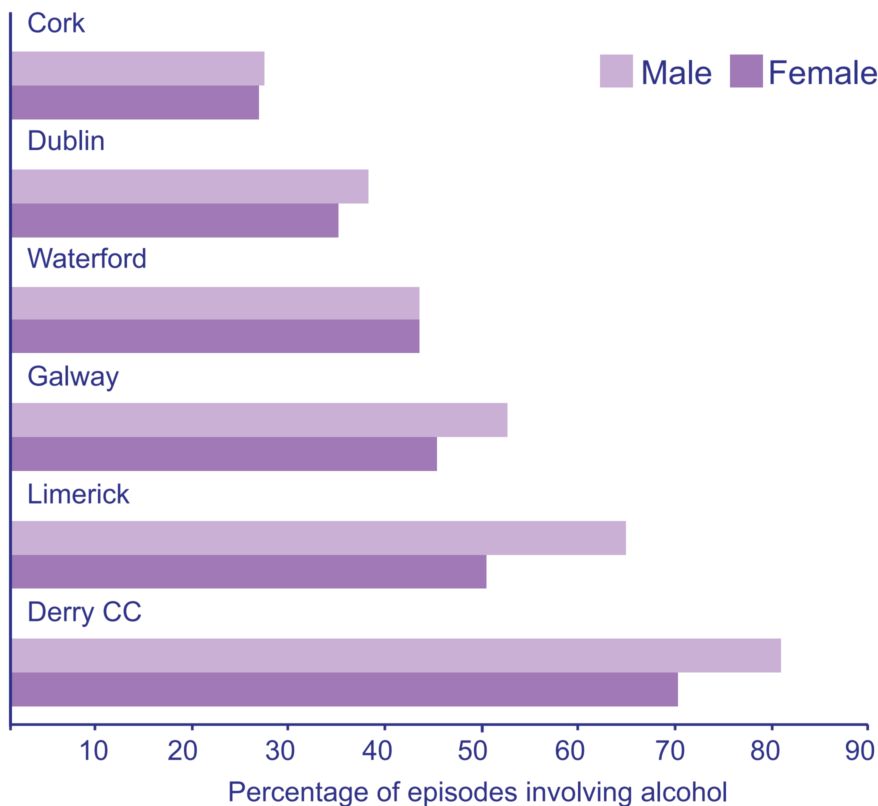
**Figure 28: Council areas within the Western area showing percentage of episodes which involved alcohol by gender, 2007 and 2008.**



# Alcohol – All-island

- An all-island comparison of cities (figure 29) shows Derry CC had the highest percentage of self-harm episodes involving alcohol in both genders.
- Episodes of self-harm involving alcohol were lower in females in Republic of Ireland cities (26.4-50.5%) than in Derry CC (70.1%).
- The percentage of self-harm episodes involving alcohol for males was high within Derry CC, Limerick City and Galway City (52.6-81.6%).

**Figure 29: Average percentage of self-harm episodes involving alcohol by gender in cities (all-island). 2007 and 2008.**

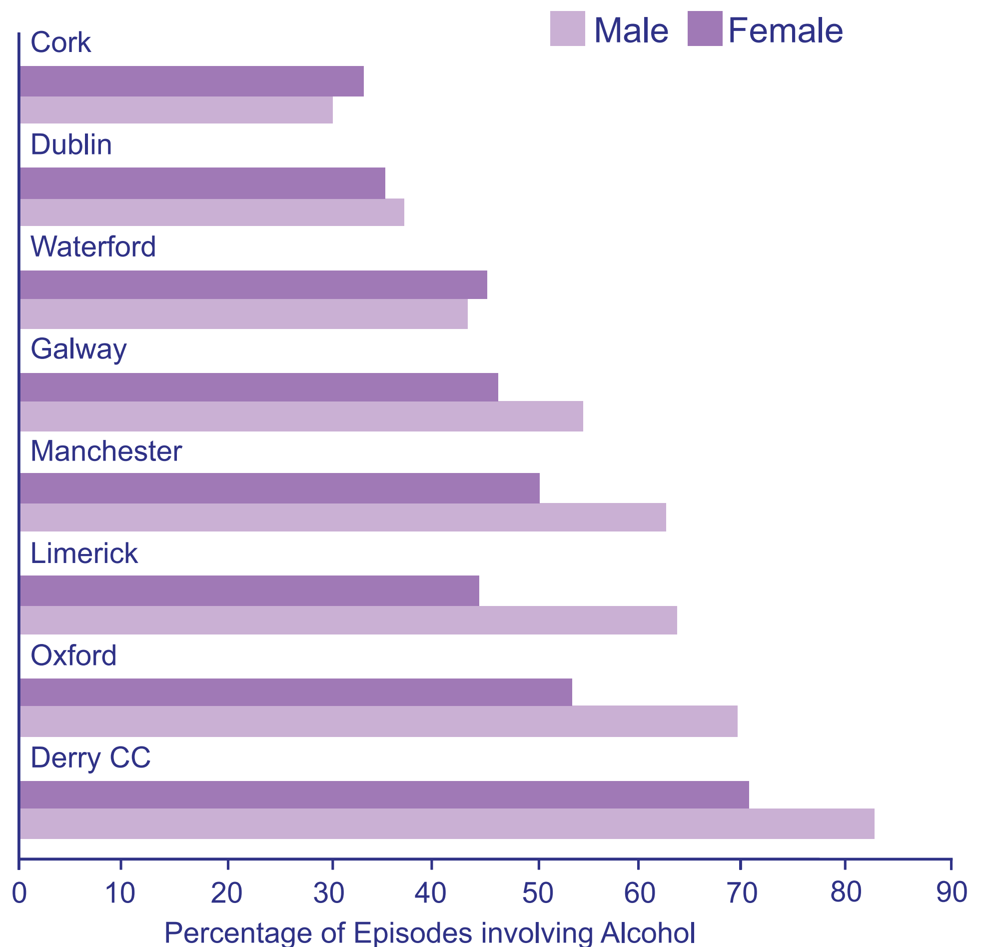


## Alcohol – NI / RoI / UK

Figure 30 presents the percentages of self-harm episodes involving alcohol in cities across England, Northern Ireland and Republic of Ireland.

- Derry CC had the highest percentage for both genders with 71.6% for males and 70.1% for females.

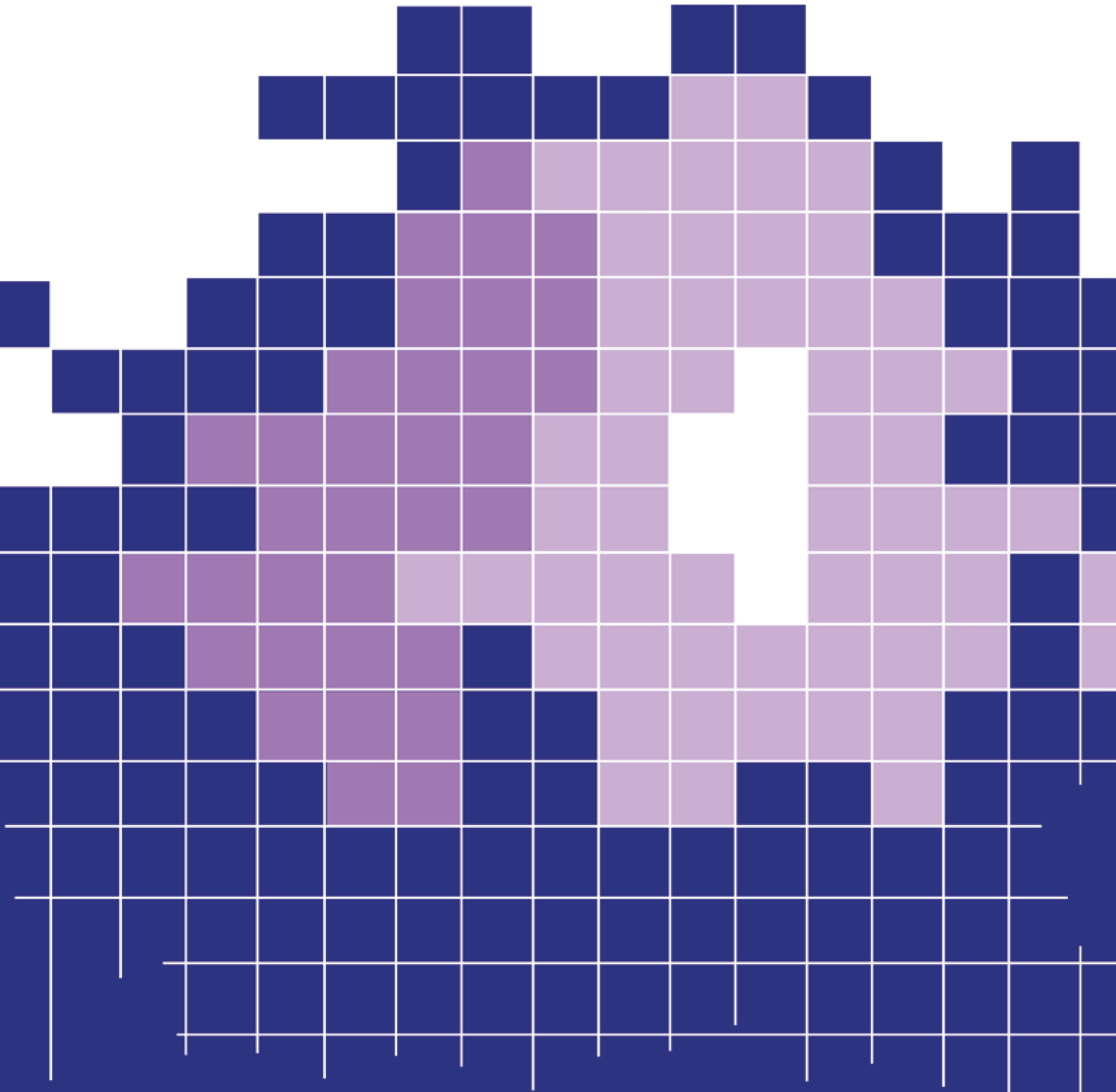
**Figure 30: Percentage of self-harm episodes involving alcohol by gender, NI, RoI, UK.**




## Episodes of Self-harm Involving Alcohol by Age-group NI/RoI/UK

There were similarities in percentages of self-harm episodes involving alcohol in Oxford, Derry CC and Limerick across all age groups.

Next Care
Following A&E Attendance



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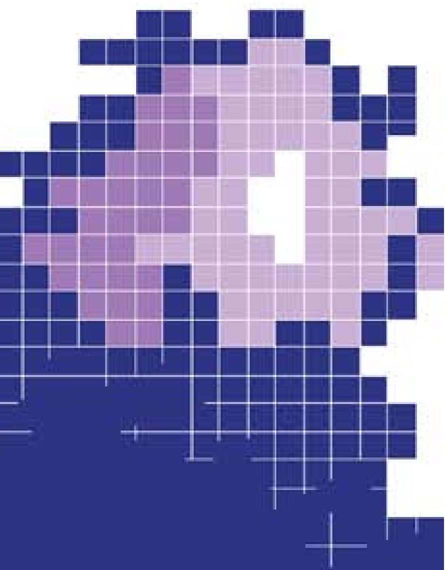


# Next Care Following A&E Attendance

Following attendance at A&E for self-harm, the A&E staff must make an assessment of:

a) the patient's physical health needs and

b) the patient's mental health needs.

In some cases the patient's physical condition may mean that admission to the acute general hospital is required. In other cases the physical health issues may be relatively easily treated by A&E staff and hospital admission for physical health reasons is not required.

With respect to the patient's mental health needs, A&E staff make an assessment of the patient's mental state and if there are concerns a referral is made to the mental health team for either an immediate assessment to be carried out in the A&E department or if a mental health practitioner is not available the patient may be admitted to the acute general hospital until a mental health practitioner is available (usually the next morning) to carry out an assessment. In some cases the A&E doctor may determine that a referral to the mental health team is not required based on their assessment of the patient's mental health state. The A&E doctor may signpost to other services or discharge the patient back into the care of their GP.

The table below indicates the outcome for the patient following attendance at A&E.

**Table 7: Next care following self-harm attendance to A&E in the Western area in 2007 and 2008.**

| Outcome following attendance at A&E | Number | % |
|---|---|---|
| Admitted to general hospital | 1582 | 58.8% |
| Admitted to psychiatric hospital | 228 | 8.5% |
| Patient left contrary to medical advice | 138 | 5.1% |
| Discharged from A&E | 592 | 22.0% |
| Patient left without being seen by A&E doctor | 74 | 2.7% |
| Patient left prior to decision | 78 | 2.9% |
| Total | 2692 | 100% |

## Patients Admitted to Hospital from A&E

In total, 67.2% (n=1810) of self-harm presentations to the A&E department resulted in admission to either an acute or psychiatric hospital. Of those, 5.9% (n=106) received a psychiatric assessment by a member of the mental health team prior to admission. The Registry does not record psychiatric assessments carried out by the mental health team within acute and psychiatric wards.

In general, admission patterns following emergency treatment were similar for males and females with the exception that males were more often admitted directly to psychiatric care (10.4%) compared to females (6.8%). Females were more often discharged from A&E following emergency care (23.9%) compared to males (19.8%).

## Admission to General Hospital

- Of the 2,692 self-harm presentations, 58.8% (n=1582) resulted in an admission to the general acute hospital. There was some variation across the three sites. Almost two thirds (63.7%) of self-harm presentations to Altnagelvin Hospital resulted in an admission to the general acute hospital, compared to approximately half of those who presented to Tyrone County Hospital (52.1%) and Erne Hospital (43.8%).

## Admission to Psychiatric Hospital

- Direct admission to a psychiatric hospital after emergency care at A&E followed 8.5% (n=228) of all self-harm attendances. Direct psychiatric admission was lowest at 4.7% in Altnagelvin Hospital compared to 17.4% and 16.2% in Tyrone County Hospital and Erne Hospital respectively. This may be an underestimate of the total proportion admitted for psychiatric care given that some patients admitted initially to an acute ward may have been subsequently admitted for psychiatric care.

## Patients Not Admitted to Hospital from A&E

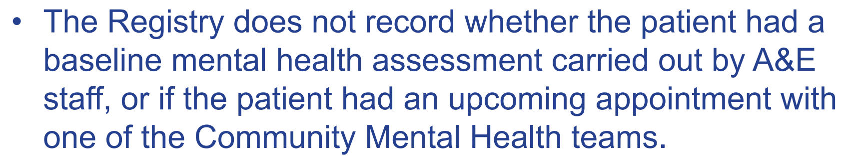
- In total, 32.8% (n=882) of self-harm presentations to the A&E department did not result in admission to acute or psychiatric hospital. There were a number of reasons for a patient not being admitted to an acute or a psychiatric ward.

These included:

- Patient leaving the A&E department before receiving treatment (2.7%, n=74);
- Patient leaving the A&E department after receiving treatment but before a decision was made regarding their next care (2.9%, n= 78);
- Patient being advised to stay for further assessment or admission but refusing to do so (5.1%, n=138);
- A health professional making the decision that admission was not required (22.0%, n=592).

- Of those attendances that did not result in admission to either an acute or psychiatric hospital, the majority (79.0%, n=697) did not receive a psychiatric assessment by a member of the mental health team within the A&E department prior to leaving the A&E department. In some cases this may be partly explained by the current availability of mental health staff to carry out assessments. Just over 35% (n=1439) of all self-harm attendances to A&E presented outside the hours of current mental health service provision. The current hours of provision are set out below.

    - At Altnagelvin Hospital A&E department a mental health practitioner is available to perform assessments between the hours of 9am and 1am, seven days a week. However, 35.9% (n=663) of all self-harm presentations to the A&E department within Altnagelvin occurred between the hours of 1am and 9am when no mental health service was available.
    - At the Erne Hospital A&E department a mental health practitioner is available to carry out assessments until 10pm, seven days a week. Over half (51.7% n=217) of all self-harm presentations occurred between the hours of 10pm and 9am when no mental health service was available.
    - Similarly at Tyrone County Hospital, a mental health practitioner is available to carry out assessments until 10pm, seven days a week. Almost half (49.3% n=210) of all self-harm presentations occurred between the hours of 10pm and 9am when no mental health service was available.



- The Registry does not record whether the patient had a baseline mental health assessment carried out by A&E staff, or if the patient had an upcoming appointment with one of the Community Mental Health teams.

## Patients Discharged Home from A&E

- Table 7 indicates that in 22.0% (n=592) of cases the patient was discharged home following A&E attendance. This varied across the three sites. The Erne Hospital had a higher percentage of patients who were discharged following emergency treatment (31.4%) than both Altnagelvin Hospital and Tyrone County Hospital (20.4% and 19.7% respectively).

- Of the 592 patients discharged home from A&E, 70.6% (n= 418) did not have an assessment by a mental health practitioner prior to discharge from A&E/Urgent Care Unit. Of these 42.8% (n= 179) presented outside the current hours of mental health service provision.

## Patients Leaving A&E Contrary to Medical Advice

- Table 7 indicates that 5.1% of patients (n=138) left the A&E department contrary to medical advice. This includes those who were advised to wait for further mental health assessment and/or admission. Only a minority of these (n=8) had an assessment by a mental health practitioner prior to leaving the department. The remaining 130 patients did not have a formal mental health assessment prior to leaving the department. Over a third (n=50) presented after 1am. Alcohol was involved in the self harm act in 43 of these 50 cases presenting after 1am.

## Patients Leaving Without Being Seen by A&E Doctor

- Table 7 indicates that 2.7% of patients left the department before being seen by an A&E doctor.

## Patients Leaving the Department Prior to a Decision Being Made

- Table 7 indicates that 2.9% were seen by the doctor but left the department of their own accord prior the A&E doctor making a decision about their further management.

## Relationship Between Method of Self-harm and Next Care

Next care of the patient following A&E attendance varied depending on the main method involved in the self-harm act (table 8).

- Two thirds (68.6%) of drug overdose acts resulted in acute ward admission compared to 39.4% of attempted hangings, 46.9% of attempted drowning and 25.1% of self-cuttings.
- Direct psychiatric admission followed 29.8% of attempted hanging episodes and 25.8% of attempted drowning episodes.
- Almost half (46.8%) of self-harm patients who had used self-cutting were discharged from A&E after emergency treatment.
- Almost two thirds (61.6%) of self-harm episodes involving alcohol resulted in an acute ward admission. In addition to facilitating treatment of any physical health needs, admission is sometimes arranged so that a formal mental health assessment can be carried out the following day.

**Table 8: Number and percentage of recommended next care by method and alcohol involvement, Western area, 2007 and 2008**

| Method | | General admission | Psychiatric admission | Not admitted | Patient refused | Left before decision | Left without being seen | Total |
|---|---|---|---|---|---|---|---|---|
| **Overdose** | Count | 1424 | 97 | 332 | 119 | 54 | 50 | 2076 |
| | % | 68.6% | 4.7% | 16.0% | 5.7% | 2.6% | 2.4% | 100% |
| Alcohol involvement | | 65.1% | 57.7% | 55.4% | 68.9% | 70.4% | 56.0% | 63.3% |
| **Cutting** | Count | 115 | 74 | 215 | 18 | 19 | 18 | 459 |
| | % | 25.1% | 16.1% | 46.8% | 3.9% | 4.1% | 3.9% | 100% |
| Alcohol involvement | | 64.3% | 66.2% | 57.2% | 72.2% | 78.9% | 22.2% | 60.6% |
| **Hanging** | Count | 41 | 31 | 21 | 2 | 4 | 5 | 104 |
| | % | 39.4% | 29.8% | 20.2% | 1.9% | 3.8% | 4.8% | 100% |
| Alcohol involvement | | 78.0% | 74.2% | 66.7% | 50.0% | 75.0% | 40.0% | 72.1% |
| **Drowning** | Count | 60 | 33 | 25 | 5 | 4 | 1 | 128 |
| | % | 46.9% | 25.8% | 19.5% | 3.9% | 3.1% | 0.8% | 100% |
| Alcohol involvement | | 90% | 51.5% | 76.0% | 80.0% | 75.0% | 100% | 76.6% |
| **Poisoning** | Count | 9 | - | 3 | - | - | 1 | 13 |
| | % | 69.2% | - | 23.1% | - | - | 7.7% | 100% |
| Alcohol involvement | | 77.8% | - | 66.7% | - | - | - | 69.2% |

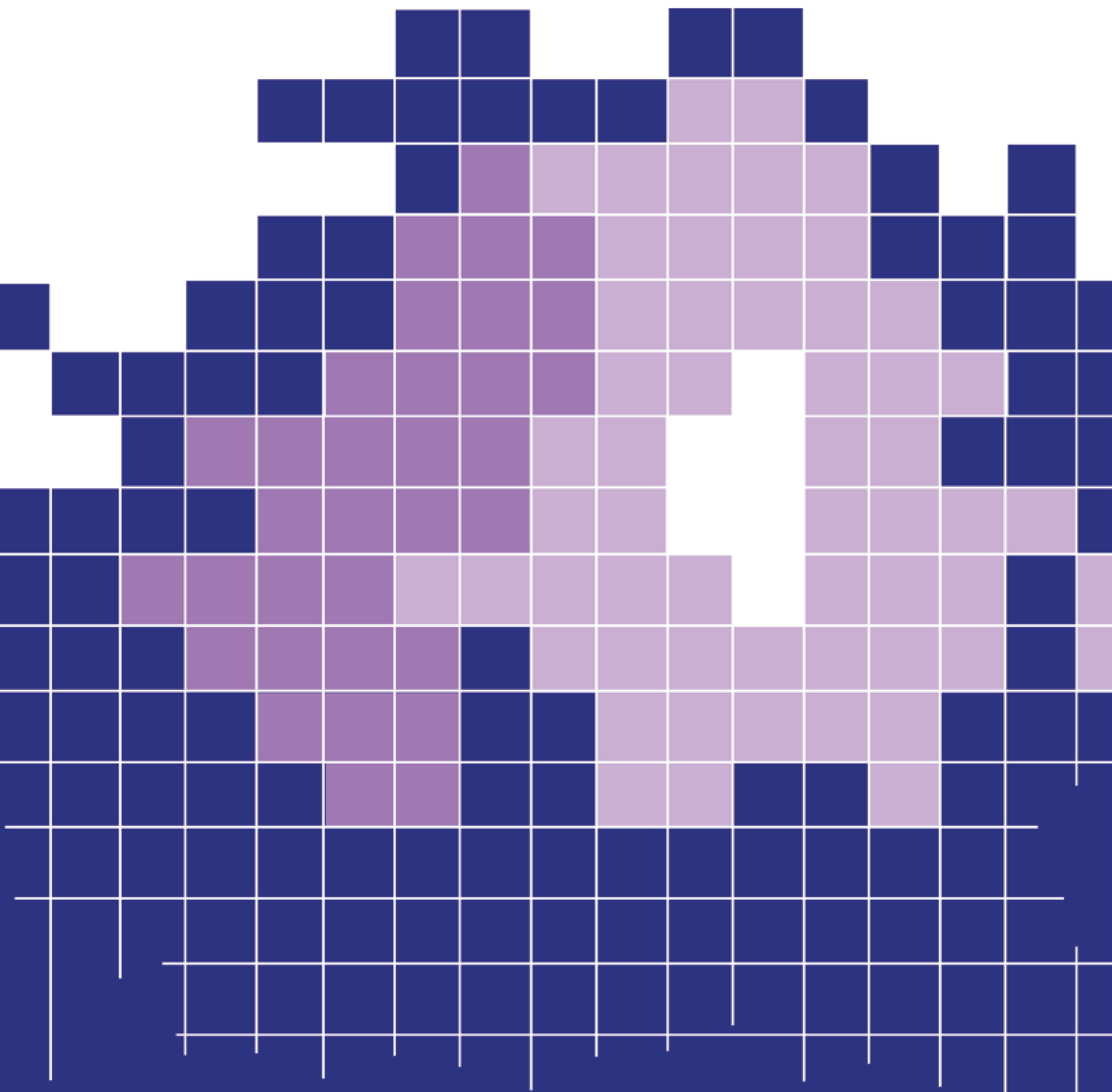
## Alcohol Involvement

As noted previously in the report, a large proportion (63.8%) of self harm episodes involved alcohol as part of the self harm act or as a contributory factor. This makes carrying out a mental health assessment difficult and in some cases impossible if the patient is heavily intoxicated.

At Altnagelvin A&E department, mental health services are currently not available between 1am and 9am. Over one third, 35.9% (n=663) of all self-harm attendances to Altnagelvin A&E department occurred between these hours. Of these, 79.8% (n=529) involved alcohol.

At the Erne Hospital and Tyrone County Hospital, mental health services are currently not available between 10pm and 9am. Half of all self-harm presentations (50.5% n=427) to these units occurred between these hours. Of these, 69.8% (n=298) involved alcohol.

Repetition
Ideation Cases



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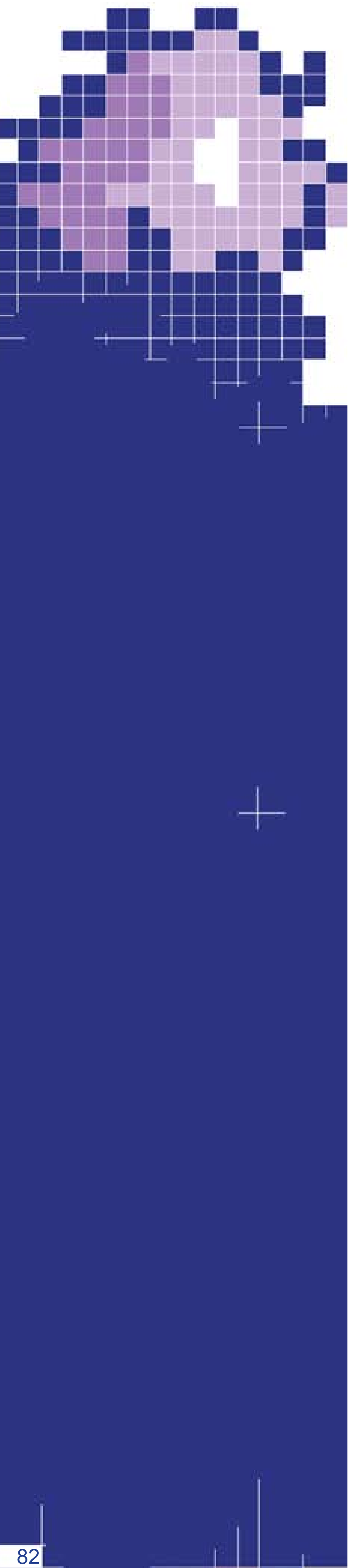


## Repetition

An episode was considered to be a repeat episode if the person had previously attended A&E due to self-harm in that calendar year.

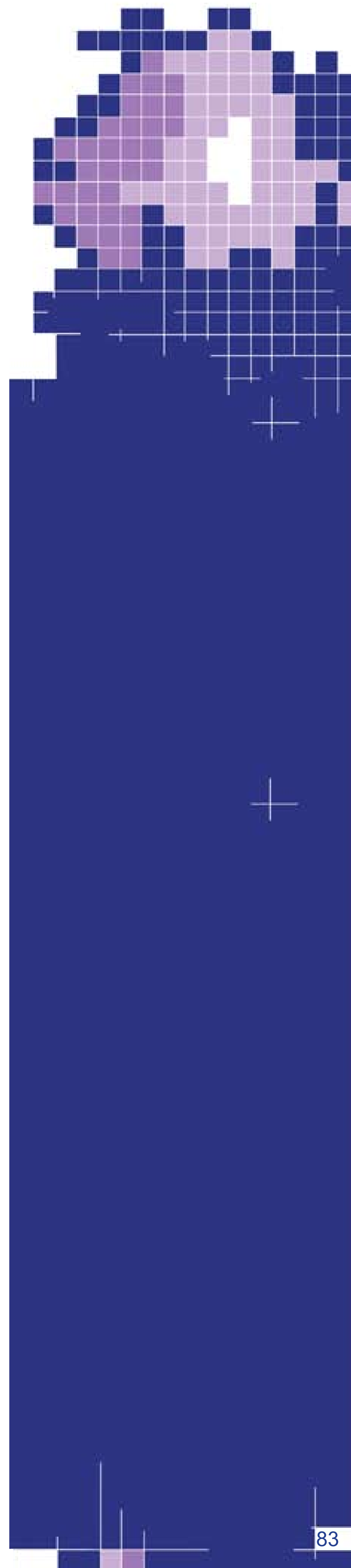
There were 1,043 people treated for 1,369 episodes of self-harm in 2007 and 1,048 people treated for 1,323 episodes of self-harm in 2008. One in four (24%) of all self-harm presentations in 2007 were repeat presentations. This decreased to one in five (21%) in 2008. There was some variation in repetition within gender, age-group, method and hospital:

### 2007

- Repetition varied by gender with 17% of the males repeating compared to 14% of the females.
- Repetition increased with increasing age up to the 45-54 year old age group which had the highest rate of repetition at 23%.
- There was a difference in the rate of repetition between those who primarily engaged in drug overdose (15%) and those who primarily engaged in self-cutting (18%).
- There were fairly similar percentages of episodes being repeats at Tyrone County 14%; Altnagelvin Hospital, 16%; Erne Hospital 17%.

### 2008

- Repetition varied by gender with 22% of all episodes by males being repeats compared to 19% of all episodes by females.
- Repetition increased with increasing age up to the 45-54 year old age group which had the highest rate of repetition at 28% of self-harm episodes being repeats within this age-group.
- There was a difference in the rate of repetition of self-harm episodes involving drug overdose (18%) and self-cutting (33%).
- There were fairly similar percentages of episodes being repeats at Tyrone County Hospital 20%; Altnagelvin Hospital, 22%; Erne Hospital 17%.



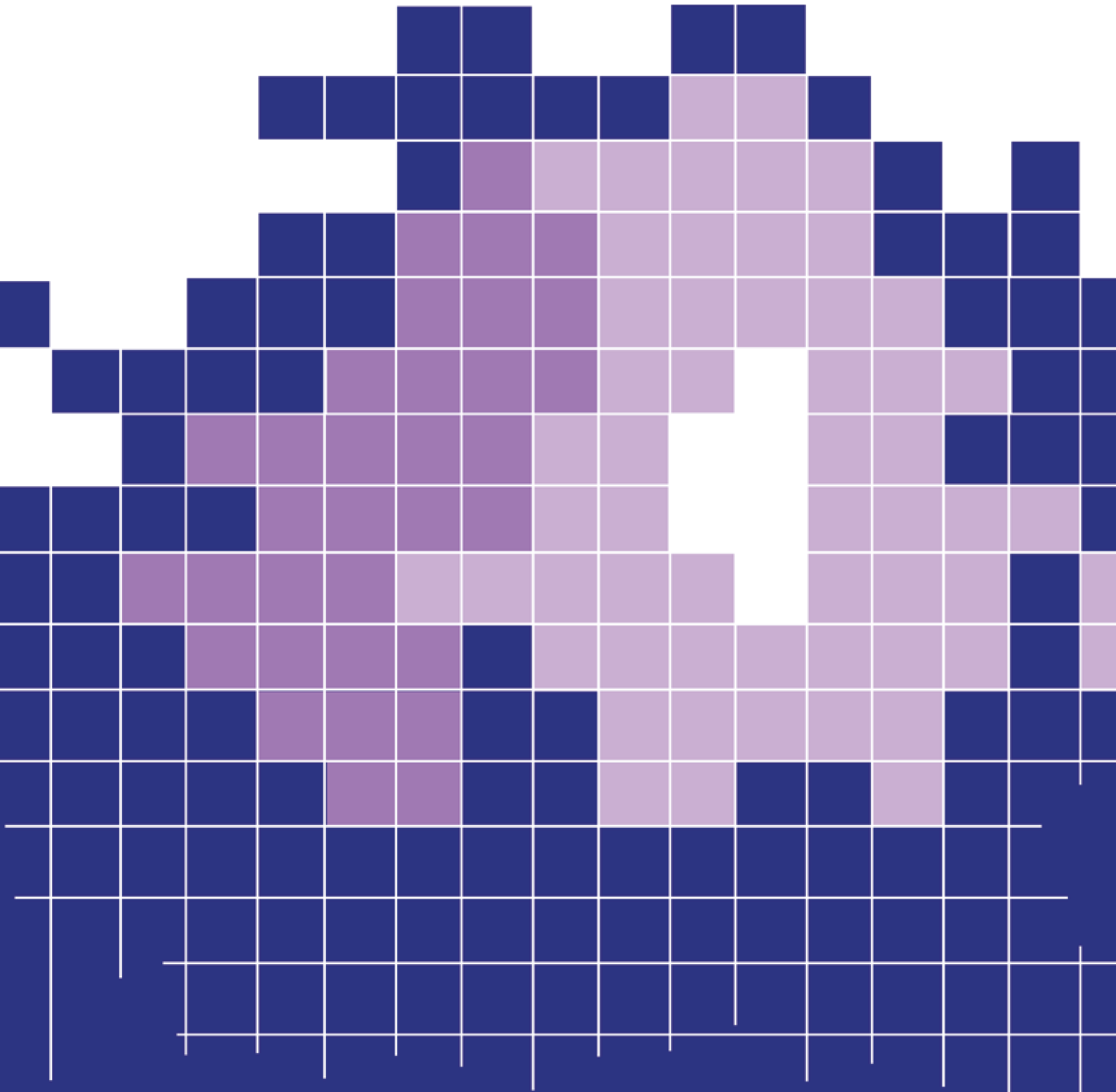
# Ideation Cases

In the Western area data was collected on cases of suicidal or self-harm ideation. This data is not collected by the National Registry of Self-Harm in the Republic of Ireland but was felt to be useful locally.

Ideation cases involve presentations to Accident and Emergency Department due to thoughts of self-harm and/or suicide where no act has taken place. Information on ideation cases was collected alongside actual DSH cases but is reported separately.

## Summary of Findings from Ideation Cases:

- There were 148 ideation cases recorded in 2007 and 207 ideation cases recorded in 2008
- Ideation cases comprised 10.6% of all recorded cases (DSH and ideation) in 2007: 9% in Altnagelvin and Erne hospital and 18% in Tyrone County Hospital
- In 2008, ideation cases comprised 14% of all recorded cases (DSH and Ideation): 12% in Altnagelvin, 15% in the Erne Hospital and 20% in Tyrone County Hospital
- Patients presenting with ideation were marginally older in age than the actual self-harm cases
- More than two thirds (69.3%) of ideation cases were male, in contrast to 47% of self-harm cases being male.



# Two Year Report • 1 January 2007 – 31 December 2008

HSC Western Health and Social Care Trust

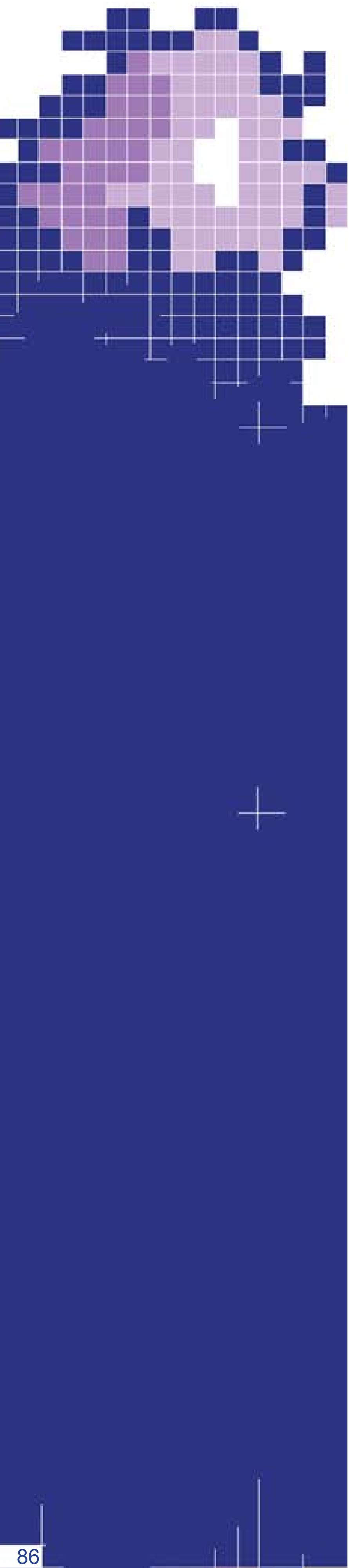
HSC Public Health Agency

HSC Health and Social Care Board

CAWT

NATIONAL SUICIDE RESEARCH FOUNDATION

Health, Social Services and Public Safety



## Key Issues for Consideration

This report has highlighted a number of important issues that may require further attention.

The scale of self-harming behaviour outlined in this report highlights the importance of maintaining close working relationships between the A&E department and mental health services and ensuring appropriate protocols are in place.

Almost one quarter of all self-harm attendances to A&E were repeat attendances and consideration should be given to whether any additional support can be provided to this group in order to reduce repetition.

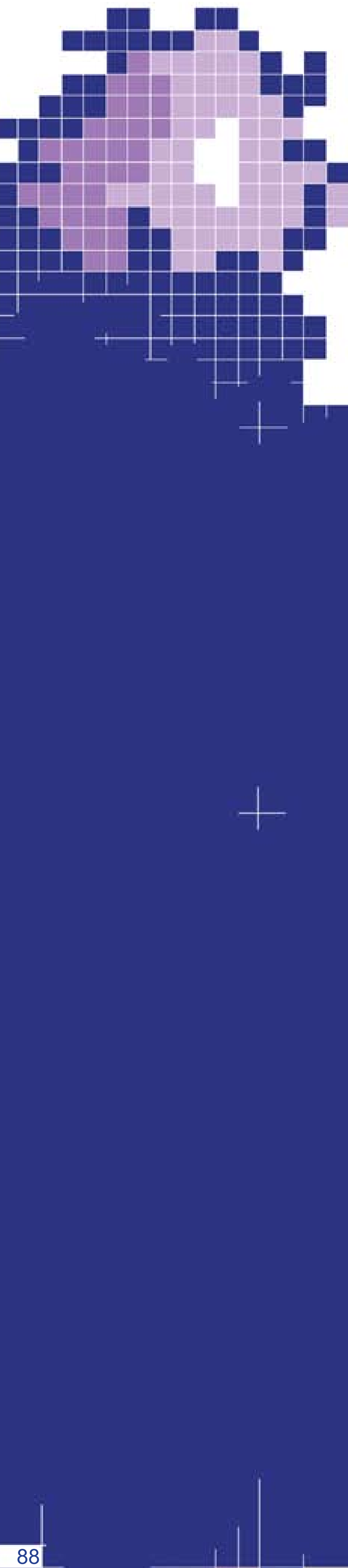
There are clear peaks in attendance around midnight and at weekends and health services may wish to consider how best to respond to this pattern of demand.

The Registry recorded 241 attendances over the two year period among people aged under 18 years. This presents a challenge for the health service in providing mental health practitioners skilled in the area of assessing young people's mental health.  It also highlights a need for mental health promotion and preventative work with young people.

The Registry is planning to include an additional data collection field to monitor the implementation of the 'Card Before You Leave Scheme'. This scheme will be introduced over coming months and involves patients who leave A&E without having had an assessment by a member of the mental health team being provided with a card by A&E staff indicating how they can receive a mental health assessment over the next few days.

The report has highlighted high rates of self harm within the Western area generally but particularly in the Derry City Council area. A strong relationship with alcohol has also been identified. This information will be of interest to regional and local government and also to people working in the area of health promotion and prevention of alcohol misuse.

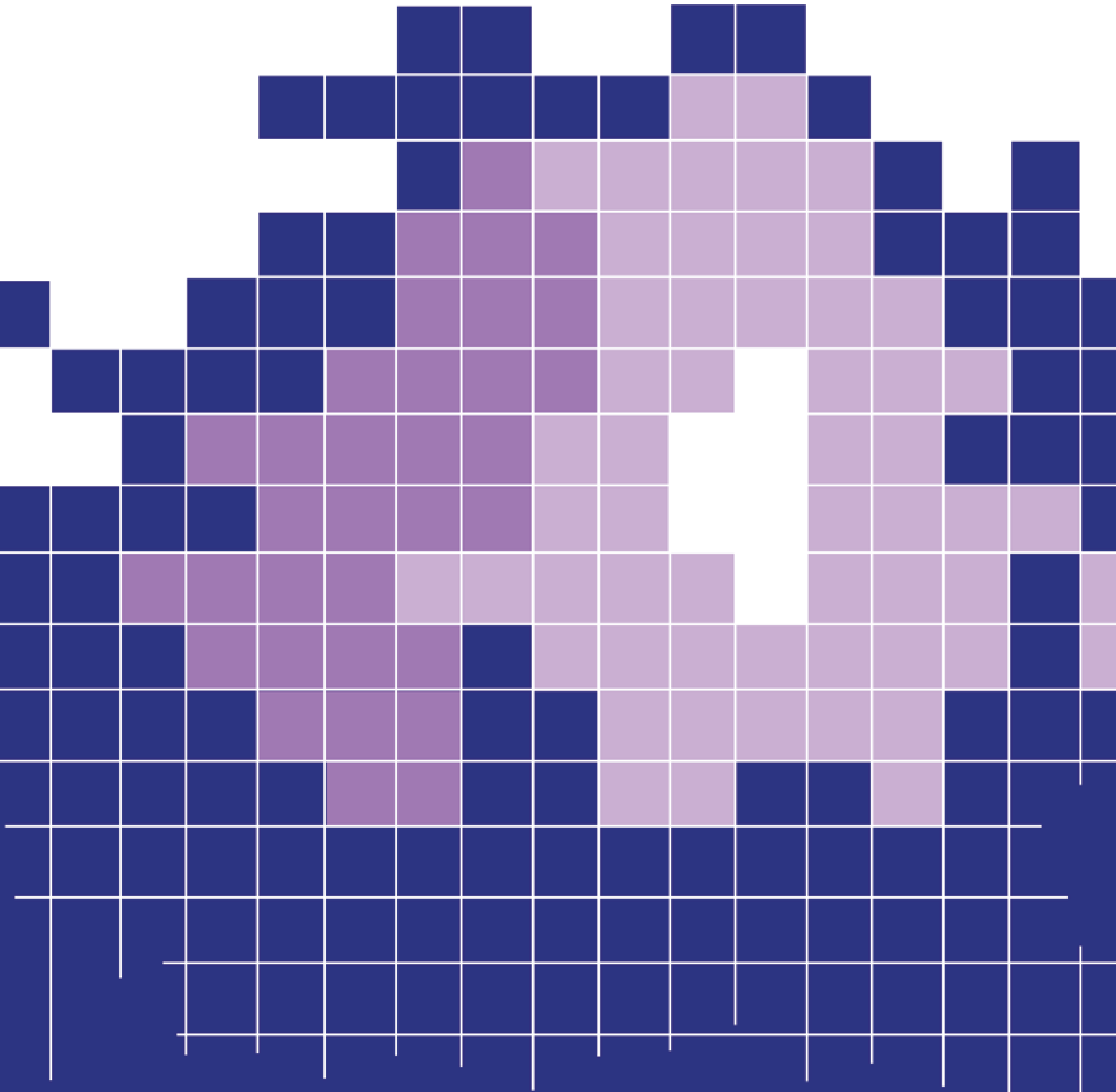
The majority (79.7%) of episodes recorded as attempted drowning were by individuals within the Derry City Council area.  Although the Registry did not record the specific location of the self harm act, relative ease of access to the bridges in the Derry City Council area may be a contributing factor making this an option for people considering taking



their lives. Consideration should be given to means of making the bridges more secure in order to prevent fatalities.

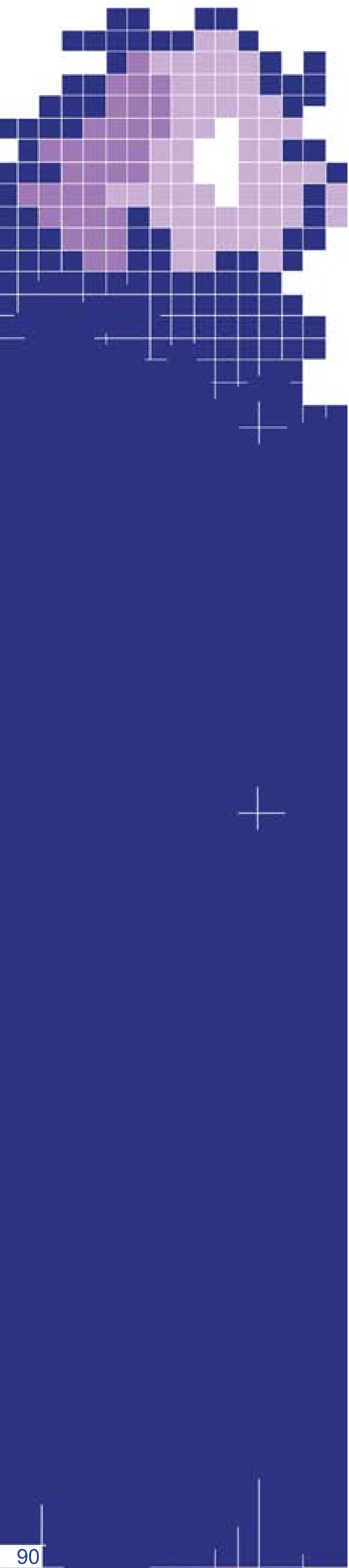
Plans are in place to extend this Registry pilot project to the Belfast Trust area in the near future.  In the longer term, coverage across Northern Ireland would bring great benefits in terms of informing service and policy developments and also in ensuring availability of comparable data across the island of Ireland.

# Project Evaluation



## Two Year Report • 1 January 2007 – 31 December 2008

Western Health and Social Care Trust
Public Health Agency
Health and Social Care Board
CAWT
National Suicide Research Foundation
Department of Health, Social Services and Public Safety



# Project Evaluation

The Self-Harm Registry project was independently evaluated by an evaluation team and a report was released in December 2008. The evaluation report listed some key recommendations based on the 2007 Interim Report released in September 2008.

Key recommendations from the report were:

1. A decision should be taken to extend the pilot beyond March 2009.

2. Given the limitations associated with the catchment area for the pilot, consideration is given to extending the availability and use of the Registry to at least one other Trust area within N. Ireland during 2009. Should a decision be taken to extend the Registry to one other geographical area, the evaluation team suggested that consideration should be given to introducing its use within the Belfast HSC Trust for the following reasons:

   - The Belfast HSC Trust is responsible for the management of three acute hospitals, (the Royal Victoria, Belfast City and Mater Hospitals) all of which currently provide A&E services and serve a local population of circa. 340,000.

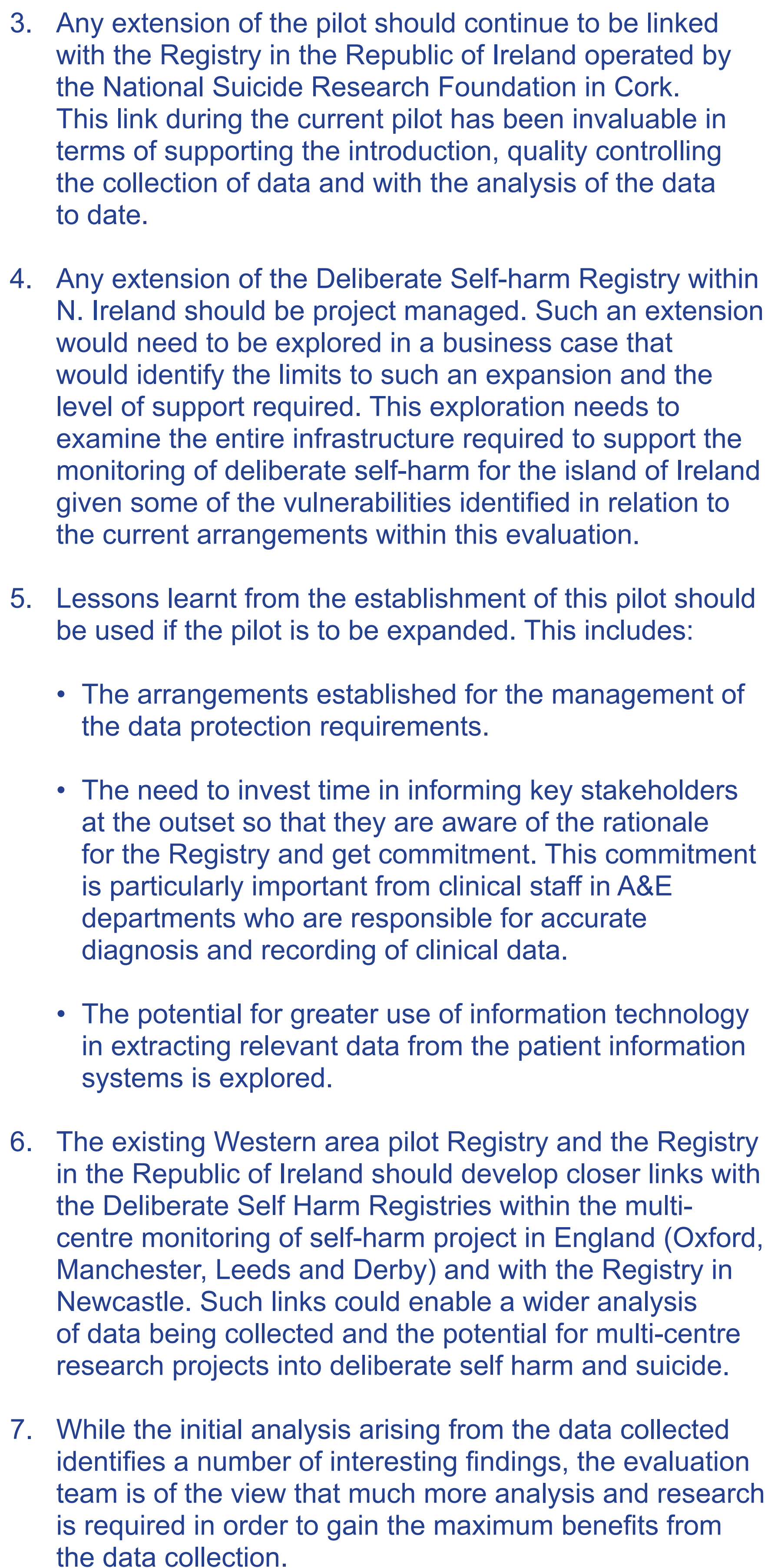
   - This would increase the total resident population covered by the Registry to about 36.3% of the total population of N. Ireland. i.e. Western HSC Trust = 16.8% & Belfast HSC Trust = 19.54%.

   - The Belfast HSC Trust catchment area is urban, while the Western HSC Trust contains a mix of urban and rural areas.

   - Such an extension would create a balance in the collection of data from the East and West of the province which would facilitate analysis and comparison in patterns of deliberate self harm.

   - The Belfast HSC Trust area contains a number of areas in North and West Belfast that are considered to experience relatively high levels of social deprivation and areas in South Belfast with relative affluence.

   - There is a high density of young people who reside in the university area of South Belfast. Deliberate self harm peaks in the 20 -24 year age group.



3. Any extension of the pilot should continue to be linked with the Registry in the Republic of Ireland operated by the National Suicide Research Foundation in Cork. This link during the current pilot has been invaluable in terms of supporting the introduction, quality controlling the collection of data and with the analysis of the data to date.

4. Any extension of the Deliberate Self-harm Registry within N. Ireland should be project managed. Such an extension would need to be explored in a business case that would identify the limits to such an expansion and the level of support required. This exploration needs to examine the entire infrastructure required to support the monitoring of deliberate self-harm for the island of Ireland given some of the vulnerabilities identified in relation to the current arrangements within this evaluation.

5. Lessons learnt from the establishment of this pilot should be used if the pilot is to be expanded. This includes:

   - The arrangements established for the management of the data protection requirements.

   - The need to invest time in informing key stakeholders at the outset so that they are aware of the rationale for the Registry and get commitment. This commitment is particularly important from clinical staff in A&E departments who are responsible for accurate diagnosis and recording of clinical data.

   - The potential for greater use of information technology in extracting relevant data from the patient information systems is explored.

6. The existing Western area pilot Registry and the Registry in the Republic of Ireland should develop closer links with the Deliberate Self Harm Registries within the multi-centre monitoring of self-harm project in England (Oxford, Manchester, Leeds and Derby) and with the Registry in Newcastle. Such links could enable a wider analysis of data being collected and the potential for multi-centre research projects into deliberate self harm and suicide.

7. While the initial analysis arising from the data collected identifies a number of interesting findings, the evaluation team is of the view that much more analysis and research is required in order to gain the maximum benefits from the data collection.

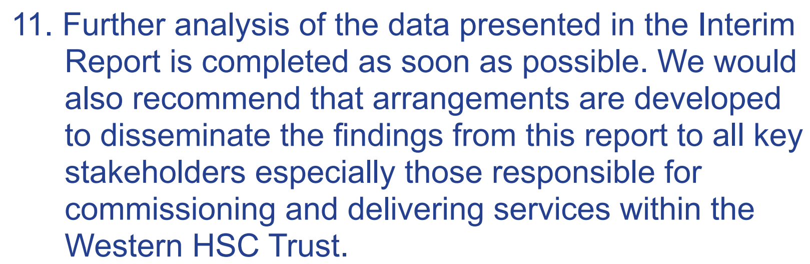
The team recommend that:

- There is a need to collect data over a longer period of time and over a greater catchment area in order to generate data that could be analysed to track trends.
- Further research is conducted to establish the factors that contribute to deliberate self harm.
- Further research is conducted to try and establish the most appropriate service response to various groups of individuals who engage in deliberate self harm.
- Further research should be considered into the relationship between deliberate self-harm and completed suicides.

8. A process and protocol is developed to manage requests and the release of data arising out of the Deliberate Self-harm Registry. Such an arrangement could be adopted from the approach developed for the management of such requests by the N. Ireland Cancer Registry.

9. The length of any extension or expansion of the Deliberate Self-Harm Registry needs to be considered at the outset, given the need for a greater volume of data and a longer history of data to gain a more comprehensive analysis. It is recommended that any extension should be for a further four years in the first instance. This would result in a Registry with five years data for the existing area and up to four years for any extended area. Further evaluation of the Registry to include the cost – benefits associated with the continuation of it after that stage.

10. Given the planned change within Health and Social Services structures from April 2009 the future ownership of any Deliberate Self-Harm Registry needs to be agreed. Having reviewed the DHSSPSNI Consultation Report September 2008 and the proposed responsibilities to be undertaken by the various bodies, the team suggested that any future Registry should be managed by the Public Health Agency. However given the management involved in such organisational change the evaluation team would consider it prudent that the Agency should commission CAWT to project manage the extended Registry at least in the interim.



11. Further analysis of the data presented in the Interim Report is completed as soon as possible. We would also recommend that arrangements are developed to disseminate the findings from this report to all key stakeholders especially those responsible for commissioning and delivering services within the Western HSC Trust.

The recommendations from the evaluation of the project have been considered and the Self-Harm Registry is currently being expanded to include Emergency Departments within the Belfast Health & Social Care Trust.

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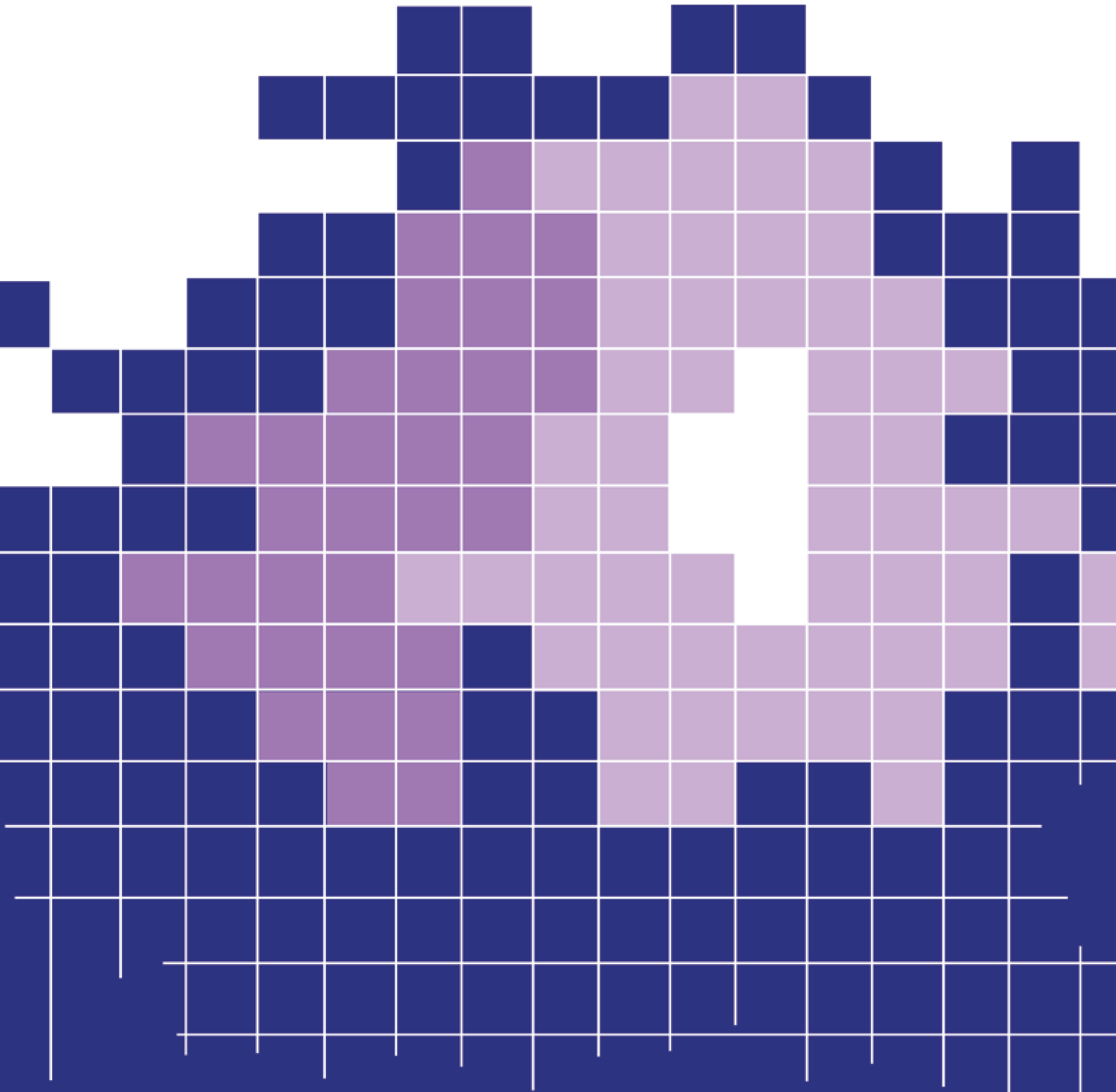

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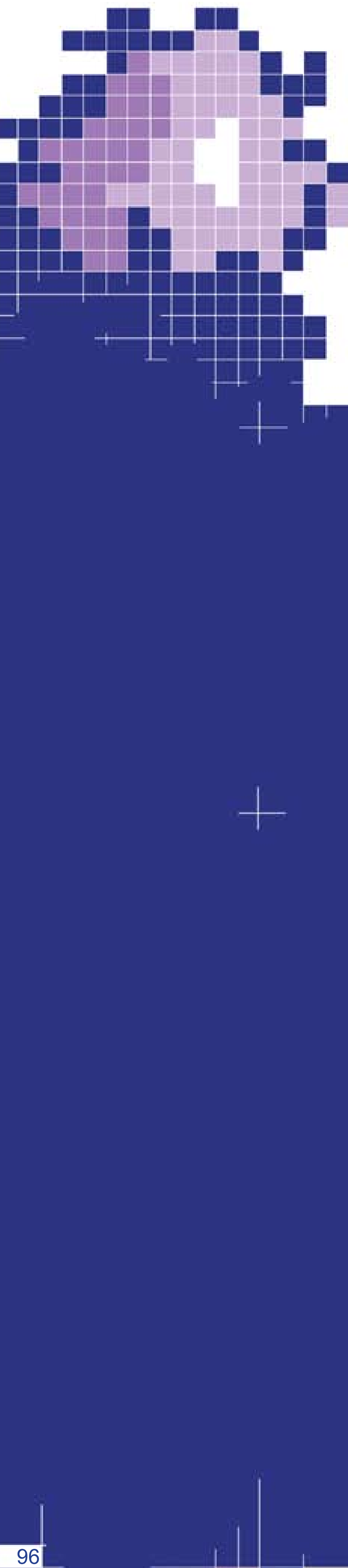

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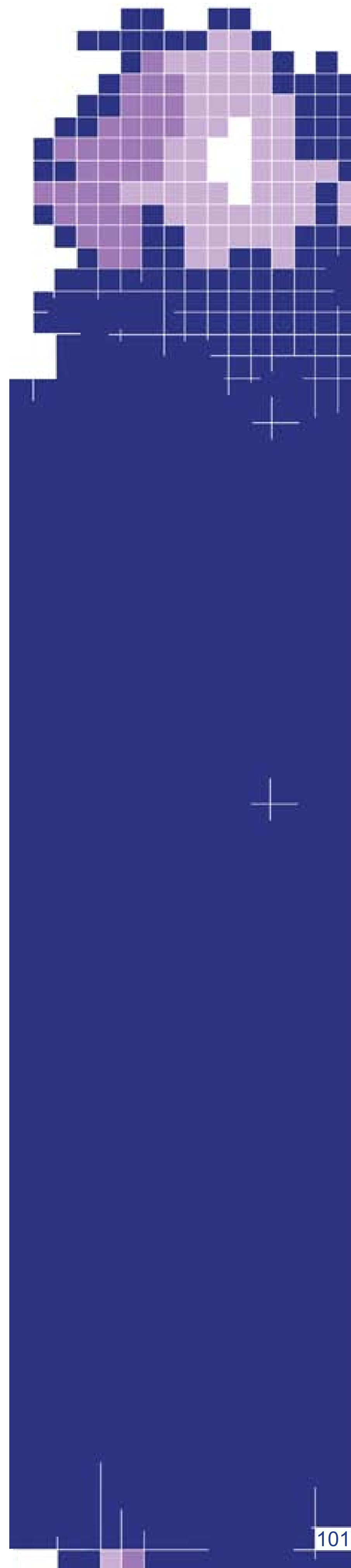

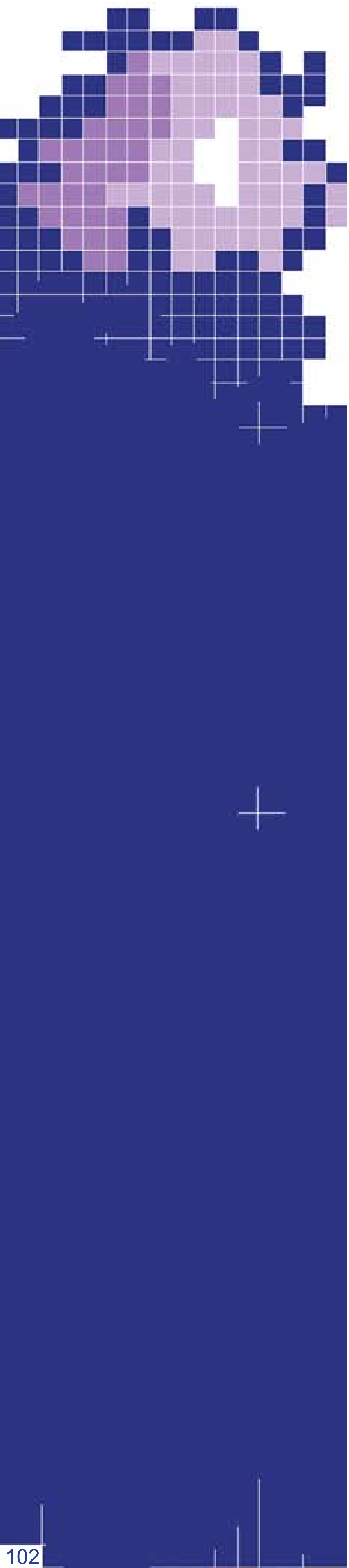

# Northern Ireland Registry of Deliberate Self-Harm
## Western Area

Two Year Report • 1 January 2007 – 31 December 2008