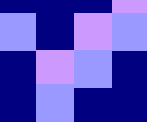




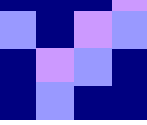
# WHSSB Registry of Deliberate Self-Harm Pilot Study (2007 – 2009)

*Interim Report for January – December 2007*



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## BACKGROUND

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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 Health and Social Services Board area of Northern Ireland.

The Registry in the Republic of Ireland, operated by the National Suicide Research Foundation (NSRF) in Cork, has collected data from a number of general hospitals in the country since 2002.

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 Board Area. Co-operation and Working Together (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 Health and Social Services Boards and Trusts in Northern Ireland. CAWT manages a range of cross border health and social care programmes.

For this pilot project, information was collated on the incidence of hospital attendance due to self-harm behaviour at the Accident & Emergency Departments in Altnagelvin, Tyrone County and Erne Hospitals.

The pilot will identify trends and patterns of self-harm and the information will be used to inform and target resources effectively to enhance existing services and plan for future service delivery.



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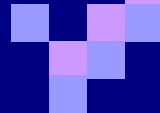
## SUMMARY OF KEY FINDINGS

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The study of the incidence of attendances at Accident & Emergency / Urgent Care departments across the WHSSB reveals a number of trends. Whilst each case is highly individual and requires further analysis, these trends may point to a specific requirement for support for both genders at various stages of the life-cycle.

- There was a significantly 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% (n 925) of the overall total of 1,369 self-harm episodes in 2007.
- In 2007, 1,369 presentations due to self-harm were made by 1,043 individuals; repeat attendances account for one in four (24%) of all attendances to the Emergency Departments in the Western Board area.
- Females represented a higher percentage of attendance, accounting for 52.4% of the 1,369 presentations and 54.4% of the 1,043 individuals involved. Age-standardised rates for females were also 19% higher than males.
- Statistics for self-harm for both genders peaked in the 20-24 year age group. Males revealed a very slight secondary peak at 45-49 years and females showed an evident secondary peak at 35-44 years.
- Alcohol, whilst rare as a main form of self-harm, featured as a major factor and was involved in 59% of all episodes.
- Alcohol was in significantly more male self-harm episodes (64%) than female episodes (55%) which was considerably higher than the Republic of Ireland where alcohol was involved in 44% of male and 38% of female episodes in 2007.
- There was an association between alcohol and the month in which the self-harm act took place. In February, only 35% of self-harm episodes involved alcohol. This figure doubled to 70% by May and almost three quarters (73%) of the self-harm presentations in December involved alcohol.
- In 2007, Emergency Department attendances due to self-harm were spread fairly evenly throughout the year, with a slight increase over the summer months and a peak in November. January, February and December showed the lowest rates of presentations to hospitals.

- There was a clear pattern in self-harm attendance over the course of the week with Saturday and Sunday experiencing the higher number of incidents. The higher rate of presentations on Saturday and Sunday and the decrease during the week was evident in the self-harm cases with and without alcohol.
- Drug overdose was a predominant method in 72.2% of all self-harm episodes, particularly among females.
- Self-cutting was a common form of self-harm, used in 17% of all self-harm episodes in both genders.



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## **PROJECT MANAGEMENT**

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The WHSSB Self-harm Registry's Project Steering Group oversees the strategic management and provides expertise on the direction and implementation of the project. The Group monitors the progress of the project and ensure adherence to the project plan. They oversee the budget and will consider recommendations when the project has been concluded.

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 (WHSCCT), The Western Health & Social Services Board (WHSSB), 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 Project Manager oversees the day-to-day running of the project, ensuring all key milestones are met and informs the 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 methodology.

The Steering Group members are:

Mr Martin Bell	Suicide Prevention Secretariat, DHSSPSNI (Chair)
Dr Sophie Graber	Accident & Emergency Doctor, WHSCCT
Mr Barry McGale	Suicide Liaison Officer, WHSCCT
Mrs Dorothy Hutchinson	Strategic Commissioning Team Lead, WHSSB
Dr Denise O'Hagan	Public Health Registrar, WHSSB
Mr Peter Moran	Information Governance Manager, WHSSB
Mr Bernard McAnaney	Assistant Director of Mental Health Services, WHSCCT
Dr Paul Corcoran	Deputy Director / Senior Statistician, NSRF, Cork
Mrs Edel O'Doherty	Deputy Chief Officer, CAWT
Miss Amanda O'Carroll	Project Manager, CAWT
Prof. Keith Hawton	Consultant Psychiatrist, Oxford and Buckinghamshire Mental Health NHS Foundation Trust and Professor of Psychiatry at Oxford University

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## **PURPOSE OF THE REGISTRY**

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The aim of the Registry is to identify the issue and extent of self-harming behaviour by collecting data from hospital accident and emergency departments on specific trends in deliberate self-harm. The analysis of this information will inform the development of policies and shape the implementation of measures aimed at preventing suicide and self-harm.

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

### INCLUSION CRITERIA

- All methods of self-harm are included 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 admission to hospital following a deliberate self-harm act are included.

### EXCLUSION CRITERIA

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

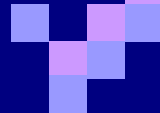
- Accidental overdoses e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm.
- Alcohol overdoses alone where the intention was not to self-harm.
- Accidental overdoses of street drugs i.e. drugs used for recreational purposes, without the intention to self-harm.
- Individuals who are dead on arrival at hospital as a result of suicide.

### IDEATION CASES

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 on separately.

#### *Summary of Findings:*

- Comprised 10.6% of all recorded cases (DSH and ideation)  
9% in Altnagelvin and Erne hospital and 18% in Tyrone County Hospital
- Were marginally older in age than the actual self-harm cases
- More than two thirds were male



## HOSPITALS

The project is based on anonymised information collected from the three Accident & Emergency / Urgent Care departments of Altnagelvin Hospital, Tyrone County Hospital and the Erne Hospital.

## DATA RECORDING

Two of the three Accident and Emergency Departments in the hospitals within the WHSSB area use the same computer system. A basic report was designed using a key word search to define the number of possible self-harm cases. The data collector then checked each of the potential cases and, using the inclusion / exclusion criteria, identified the actual self-harm cases. Anonymised information on these cases was then entered onto a data entry system for analysis.

## 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 were 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 were 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 were encrypted prior to entry and can only be decrypted by the data recorder.

- ***Gender***

- ***Age***

- ***Date And Time 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 were recorded to identify those requiring a general admission, psychiatric admission, not admitted and those who abscond from the accident & emergency department against medical advice.

- **Method(S) Of Self-Harm**

The method(s) of self-harm were recorded according to the Tenth Revision of the WHO's International Classification of Diseases codes for intentional injury (X60-X84). The main methods were 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. In this report, results generally relate to the 'primary method' of self-harm. In keeping with standards recommended by the WHO/Euro Study on Suicidal Behaviour, this is taken as the most lethal method employed.

- **Drugs Taken**

Where applicable, the name and quantity of the drugs taken were recorded.

- **Area Code**

The post / area code was recorded. Once entered, the postcode was replaced by a ward name so to remove the identity of the exact area. This is non-reversible.

- **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 will be collected for 2 full years (1<sup>st</sup> January 2007 – 31<sup>st</sup> December 2008). Information in this report was from data collected from 1<sup>st</sup> January 2007 – 31<sup>st</sup> December 2007.

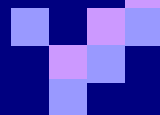
## **CONFIDENTIALITY**

Confidentiality was strictly maintained. The data collector 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 Services Board. No identifiable client information is recorded or used in reports. The data collector was monitored by an appropriately qualified Western Board Officer.

## **QUALITY ASSURANCE**

A number of audits were carried out to check the accuracy of the data collection method. The outcome of the audits showed that the process used was both effective and efficient.

A quality assurance exercise was completed involving the data collector applying the same process to another hospital which linked to the Register. Comparisons were made to the records collated with the records identified by another data collector. The outcome of this provides assurance that both data collectors were working to the same level and applying the correct criteria.



## **REGISTRY COVERAGE**

Self-harm information was collected from the three hospitals within the Western Health & Social Services Board area which is made up 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 Board is 295,192 (MYEs).

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 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.  $(n/p) \times 100,000$ . Calculation of rates have been based on 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 ensures 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 were made throughout this report with:

- 2007 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., 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.

## FINDINGS

### HOSPITALS IN THE WESTERN BOARD AREA

There were 1,369 presentations to Accident & Emergency / Urgent Care departments in 2007. The distribution of presentations between the three is shown in figure 2:

Figure 1 below shows the percentage of cases in each hospital:

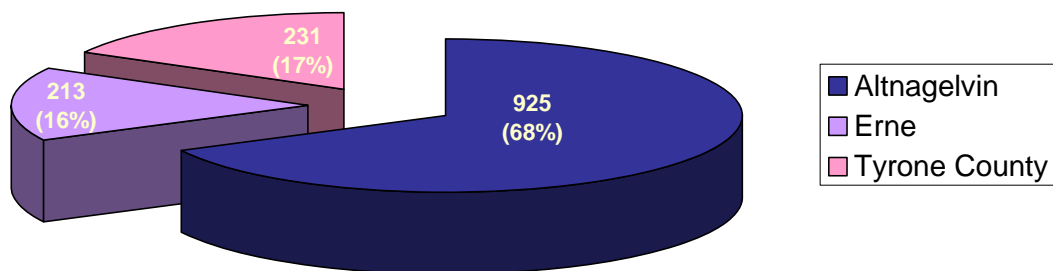
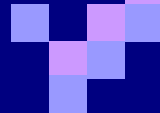


Figure 1: Breakdown of numbers of DSH episodes in the three hospitals in Western Board, 2007.

**Altnagelvin Hospital** had a total of 48,863 attendances to A&E in 2007; 925 (2%) of these were due to deliberate self-harm.

**Erne Hospital** had a total of 23,074 attendances to A&E; 213 (1%) attended due to deliberate self-harm.

**Tyrone County Hospital** had a total of 22,943 attendances to A&E; 231 (1%) attended due to deliberate self-harm.



## PERSONS AND EPISODES

During the one year study period (2007) there were 1,369 presentations made by 1,043 individuals. Therefore, in 2007, one in four (24%) self-harm presentations was due to repetition.

Table 1: person, episodes and rates of self-harm in the Western Board in 2007

	Males	Females	All
Episodes	652	717	1,369
Persons	476	567	1,043

- Females accounted for 52.4% of the 1,369 self-harm presentations and 54.4% of the 1,043 individuals involved (table 1).
- More than half (51.5%) of all Accident & Emergency / Urgent Care attendances due to self-harm in 2007 were under 35 years of age. This was more the case in Tyrone County (54.5%) and Altnagelvin (51.7%) than in the Erne Hospital (47.4%). 87% of episodes were by persons aged less than 50 years.
- All self-harm presentations under the age of 15 years were female.
- The distribution of episodes across the three hospitals (figure 2) showed that the female rate was higher in Altnagelvin (52.4%) and Tyrone County (55.4%) Hospitals but males had a higher percentage rate in the Erne Hospital (51.2%).

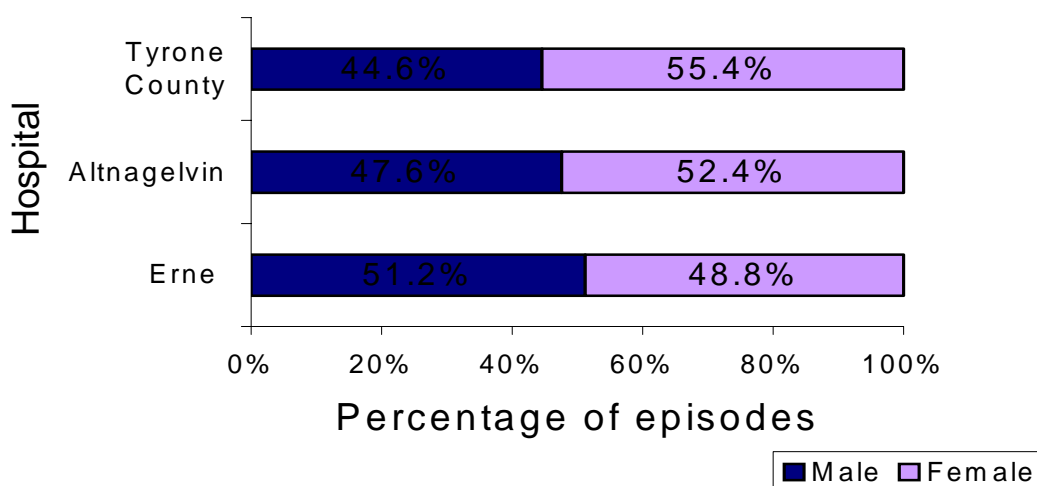


Figure 2: Gender balance of self-harm episodes in the Western Board in 2007.

## INCIDENCE RATES

Table 2 Incidence rates of persons presenting to hospital following DSH in 2007.

	Males	Females	All
Crude rate per 100,000	341	401	371
Age Standardised Rate per 100,000	341	405	373

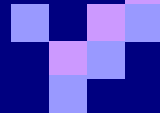
- The overall crude and age-standardised rates in the Western Board were 371 and 373 per 100,000 respectively.
- Crude and age-standardised rates for males were identical at 341 per 100,000 whereas for females the rates were 401 and 405 respectively. Thus the female age-standardised rate was 19% higher than the male rate.

## AGE

- Figure 3 demonstrates that the highest rates of self-harm were among 20-24 year old males and females.
- There was a clear secondary peak in incidence of self-harm for females aged 35-44 years.
- Self-harm rates were significantly lower among the elderly (over 65 years).
- Among the young, female rates were considerably higher than male rates particularly within the 10-14 and 15-19 age groups.
- Male and female rates were both high in the 20-34 age groups, whereas females had the higher rate in those aged 35-44 years.

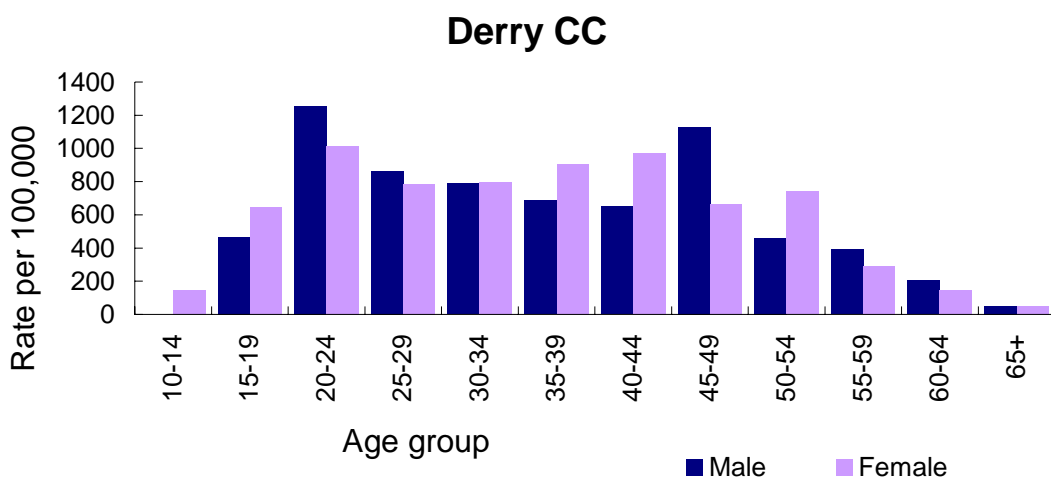


Figure 3: Rates of self-harm by age group in the Western Board area in 2007

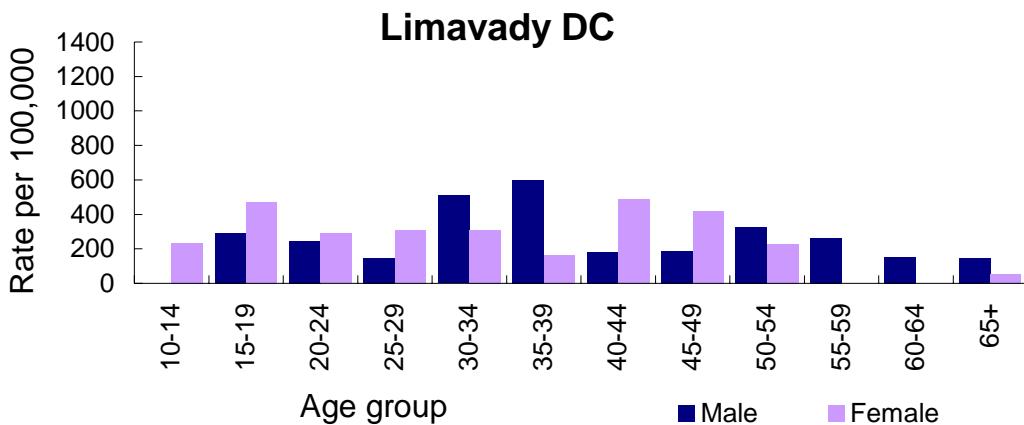


## INCIDENCE RATES OF SELF-HARM BY COUNCIL AREA (PER 100,000)

- In Derry CC, males had 2 very evident peaks at the 20-24 and 45-59 year age groups (figure 4).
- Males in Limavady DC peaked between 30-39 years (figure 5).
- Females in Strabane DC peaked at 20-24 and had a slight secondary peak at 40-44 (figure 6).
- Females in Omagh DC peaked from 15-29 years and had a secondary peak at 40-44 (figure 7).
- Males in Fermanagh DC peaked at 20-24 years; females had a significant peak at 35-39 years (figure 8).



*Figure 4: Rates of self-harm by age group in Derry CC in 2007*



*Figure 5: Rates of self-harm by age group in Limavady DC in 2007*

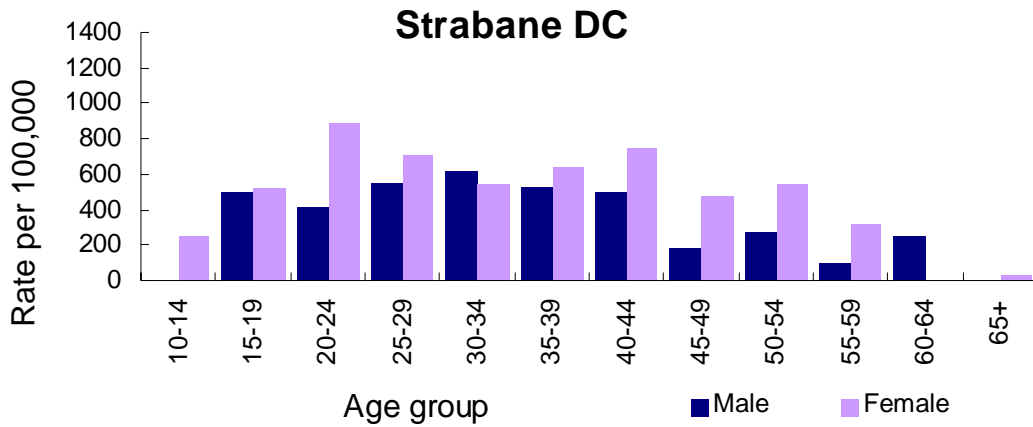


Figure 6: Rates of self-harm by age group in Strabane DC in 2007

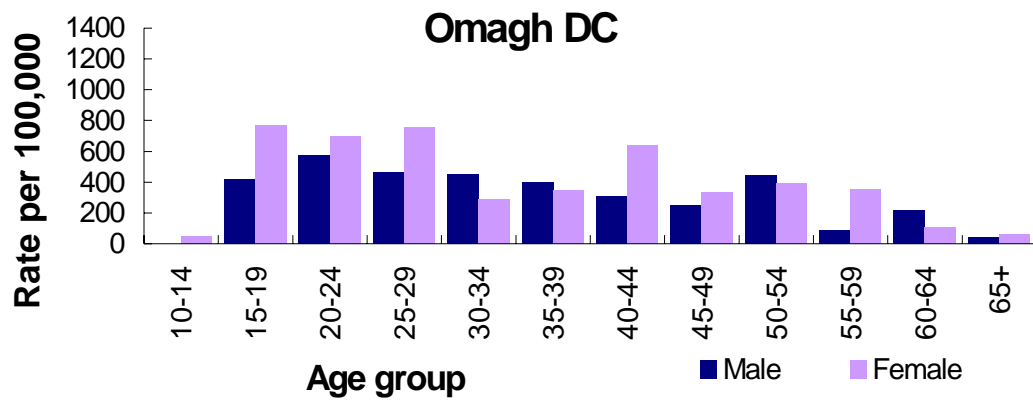


Figure 7: Rates of self-harm by age group in Omagh DC in 2007

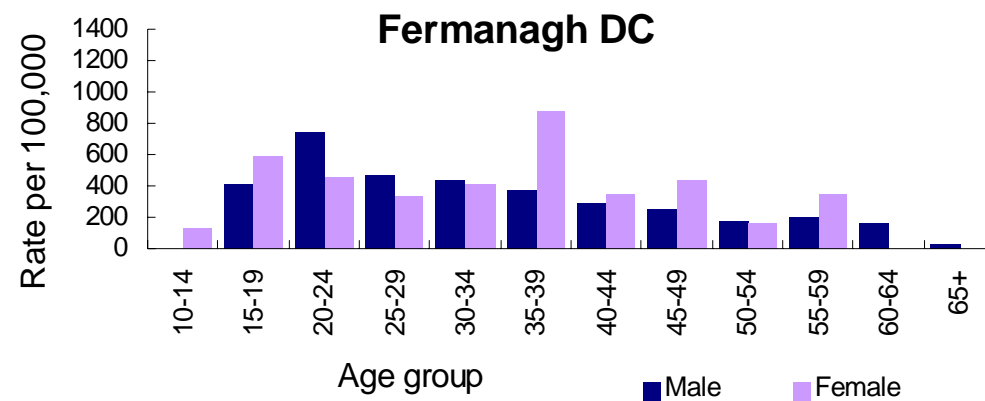
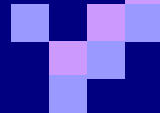


Figure 8: Rates of self-harm by age group in Fermanagh DC in 2007



## INCIDENCE RATES - WHSSB

- There was significant variation in the incidence of self-harm when examined at council area level. Figure 9 illustrates that the highest rate was in Derry CC area, followed by Strabane DC, Omagh DC, Fermanagh DC and Limavady DC.
- The rate in Derry CC was 31% higher than in the Western Board as a whole.
- In contrast, rates in Strabane DC, Omagh DC, Fermanagh DC and Limavady DC were 11%, 22%, 29%, and 43% lower respectively than that of the Western Board.
- Males and females had almost identical rates in Derry CC and Limavady DC area.
- The female rate was 15% higher in Fermanagh DC, 33% higher in Omagh DC and 48% higher in Strabane DC.

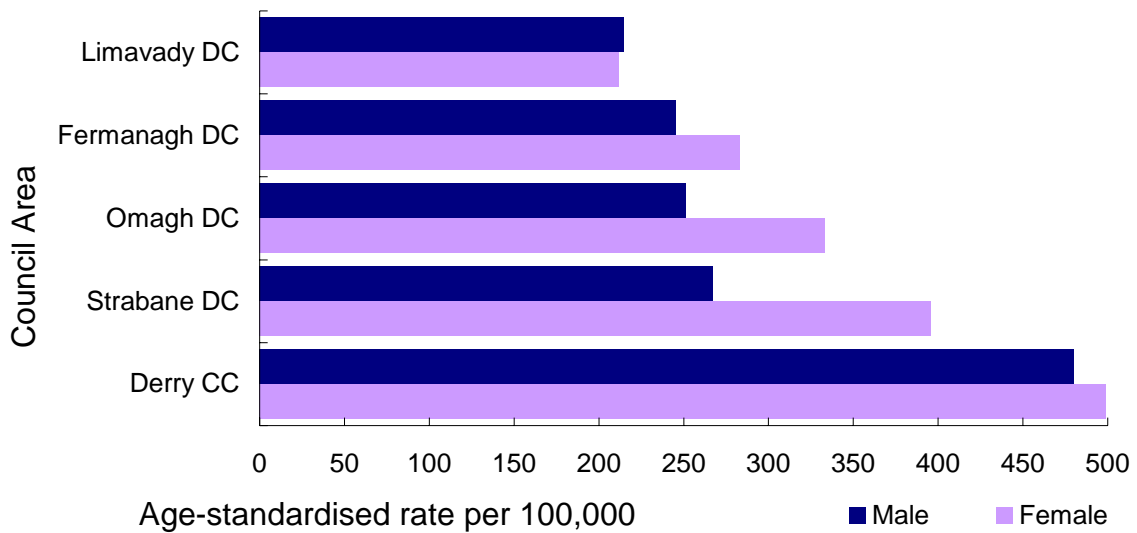


Figure 9: rates of self-harm by council area in the Western Board, 2007.

## INCIDENCE RATES – ALL-ISLAND (Cities)

Derry CC rates were compared with those of the five cities in Ireland (figure 10).

- The highest rates were in Derry CC for both genders though not significantly higher than in Limerick for males (+6%) or females (+9%).
- The male rate in Derry CC was 81-92% higher than the male rates in the other cities of the Republic of Ireland.
- The female rate in Derry CC was 56-99% higher than the female rate in the other cities.

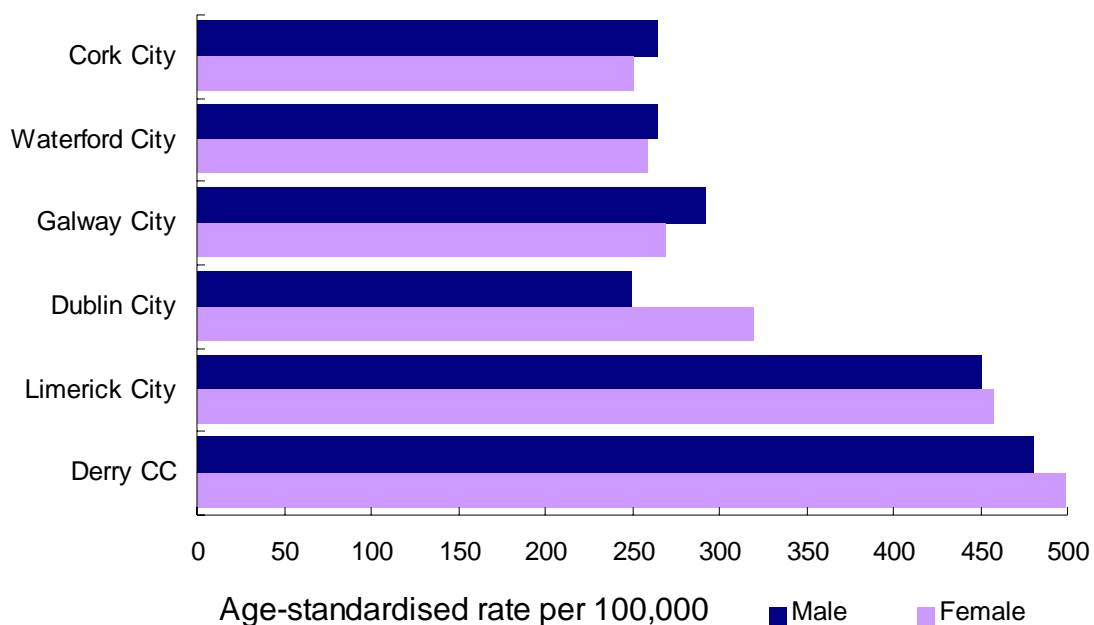
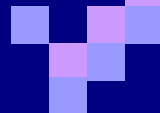


Figure 10: Rates of self-harm in Derry CC in 2007 compared to ROI cities



## INCIDENCE RATES – GB / NI / RoI

The table below illustrates the incidence rates in the Western Board (471) compared to the Republic of Ireland (236).

Table 3: Incidence rates per 100,000 in the Western Board and Republic of Ireland.

	Males	Females	Total
<b>Western Board</b>	<b>437</b>	<b>505</b>	<b>471</b>
<b>R.O.I.</b>	<b>205</b>	<b>267</b>	<b>236</b>

A GB / NI / RoI comparison of cities shows the highest incidence rates were in Derry CC and the lowest rates in Oxford. (Table 4)

Table 4: Incidence rates per 100,000 in the Western Board compared to RoI and UK Cities.

	Males	Females	Total
<b>Derry CC</b>	<b>616</b>	<b>626</b>	<b>621</b>
<b>Limerick**</b>	<b>573</b>	<b>543</b>	<b>556</b>
<b>Manchester*</b>	<b>460</b>	<b>587</b>	<b>527</b>
<b>Dublin**</b>	<b>313</b>	<b>396</b>	<b>354</b>
<b>Galway**</b>	<b>369</b>	<b>333</b>	<b>351</b>
<b>Leeds*</b>	<b>291</b>	<b>374</b>	<b>333</b>
<b>Waterford**</b>	<b>338</b>	<b>323</b>	<b>332</b>
<b>Cork**</b>	<b>330</b>	<b>313</b>	<b>322</b>
<b>Oxford*</b>	<b>285</b>	<b>342</b>	<b>314</b>

**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, National Suicide Research Foundation.* Corcoran, P. Perry, I.

## MONTH OF ATTENDANCE

Table 5: Breakdown of self-harm episodes by gender and month in 2007 within the Western Board

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Males	37	33	63	43	62	72	62	50	55	51	64	60	652
Females	55	42	63	70	66	59	60	51	51	72	76	52	717
Total	91	75	126	113	128	131	122	101	106	123	140	112	1369

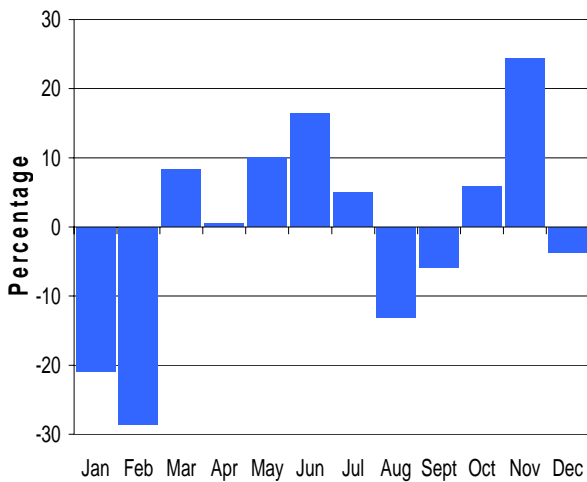


Figure 11: Percentage difference between the observed and expected number of self-harm presentations by month in the Western Board, 2007.

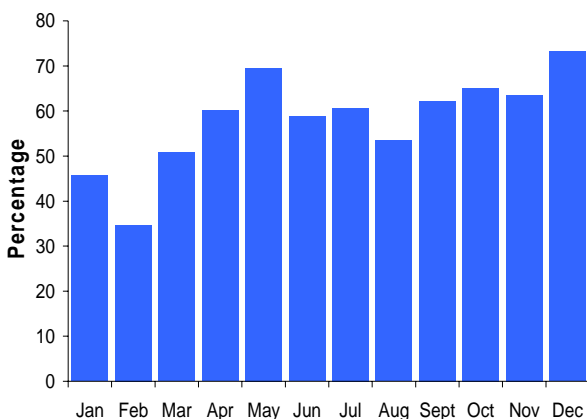
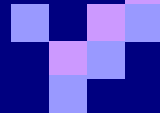


Figure 12: percentage of episodes involving alcohol by month in the Western Board in 2007.

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

- January and February saw fewer presentations than expected (21% and 29% below average respectively).
- The peak month for self-harm presentations was November (24% above average) with a secondary peak in June (16% above average).
- The lower than average figures for January and February was most evident for males whereas the November peak was most evident for females.
- The June peak was solely due to males. The monthly pattern in self-harm presentations was evident irrespective of age.

- Alcohol was involved in 59% of the self-harm presentations made in 2007 (method of self-harm is described in detail in a later section).
- Figure 12 illustrates that alcohol was involved in only 35% of the self-harm presentations in February.
- February was also the month that saw the lowest rate of presentations to hospital.
- The involvement of alcohol in self-harm presentations doubled from 35% in February to 70% in May.
- Almost three quarters (73%) of the self-harm presentations made in December involved alcohol.



## DAY OF ATTENDANCE

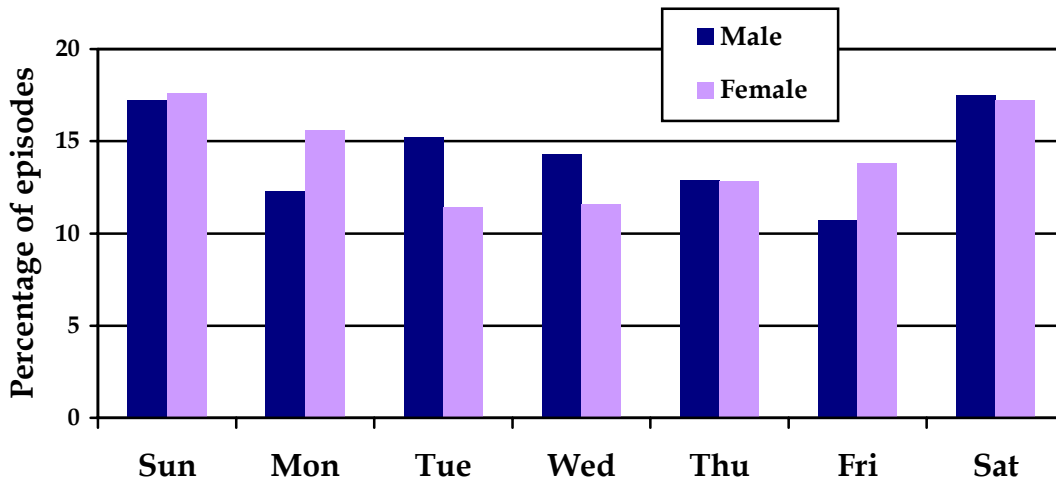


Figure 13: Episodes of self-harm by day, Western Board, 2007.

- There was a clear pattern of female attendance over the course of the week. Both genders peak at the weekend.
- The weekend increase in self-harm presentations and the decrease during the week was most pronounced for individuals aged 15-34.
- Of the 686 self-harm presentations by individuals in this age group, 39% were made on Saturday or Sunday.
- Figure 14 illustrates the higher rate of presentations on Saturday and Sunday and the decrease during the week which was evident in the self-harm cases with and without alcohol.

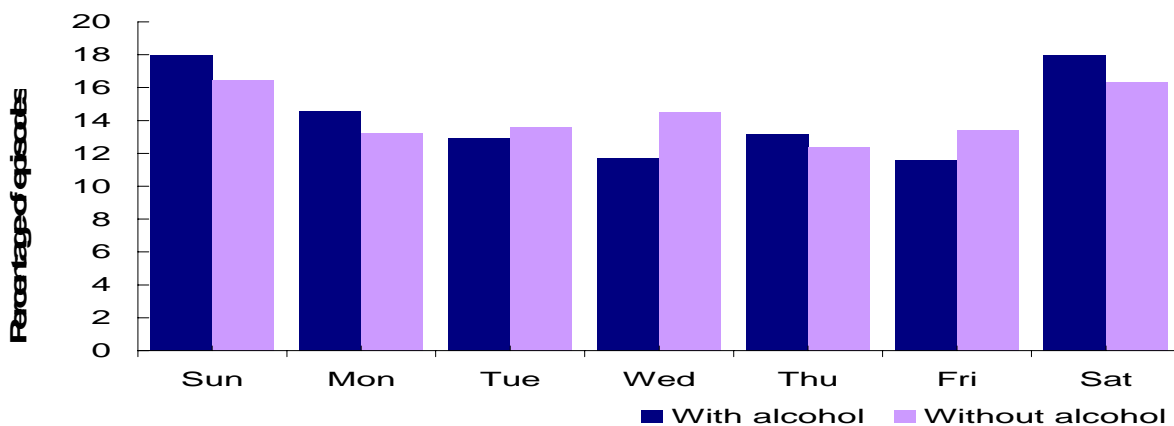


Figure 14: percentage of self-harm episodes with and without alcohol involvement in the Western Board in 2007.

## TIME 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.
- In the Western Board 50% of all cases presented between 8pm and 4am. In contrast, 22% of cases presented between 9am and 5pm.
- There was a dip in presentations at 10pm which was evident at each of the three hospitals and for both genders.

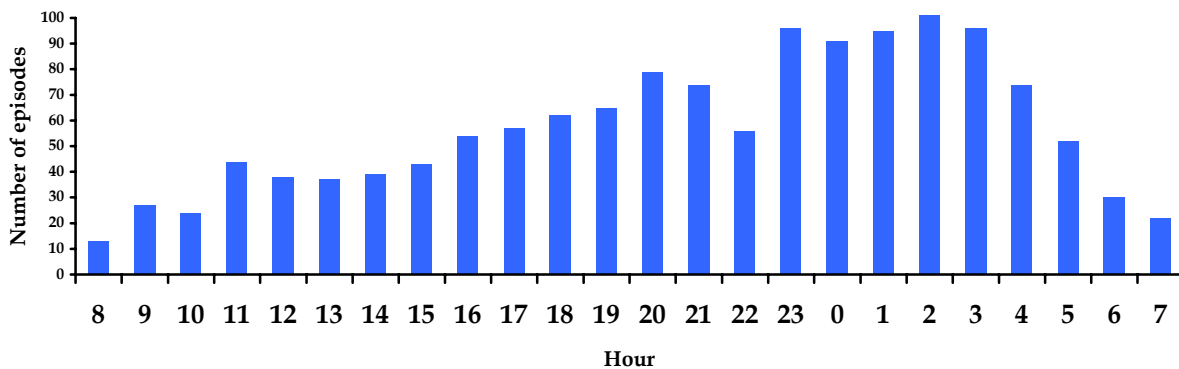


Figure 15: hour of presentation, Western Board, 2007.

- 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 the hour before midnight, whereas, male self-harm presentations continued to increase until 3am.
- The pattern of presentation over the course of the day was influenced by whether alcohol was involved in the act (figure 16).
- The increase in rate of presentation over the course of the day was more evident for cases involving alcohol.
- These cases largely accounted for the dip in presentations at 10:00 pm.
- Most striking was the very high rates of presentation in the period from 11pm to 5am.

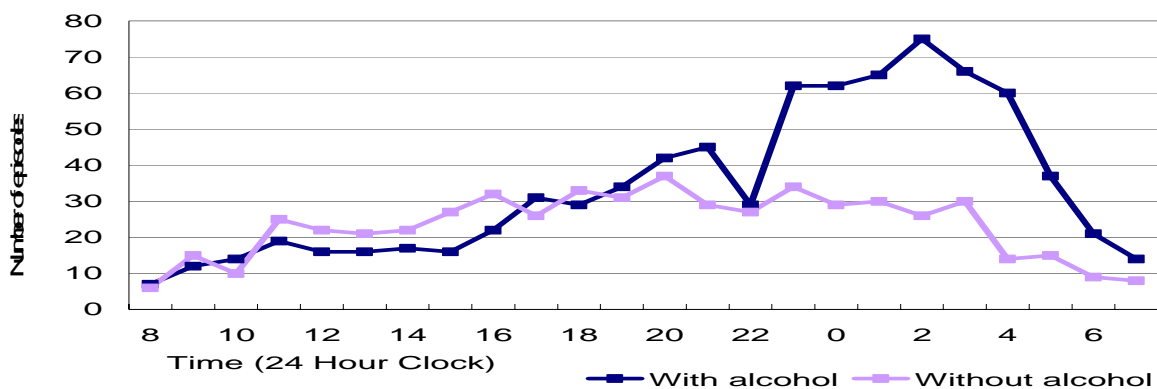
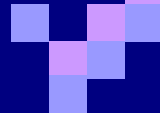


Figure 16: Pattern of self-harm episodes with and without alcohol involvement by hour in the Western Board in 2007.



## METHODS

Table 6: Number of episodes by primary and most lethal method, Western Board, 2007.

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	Total
Males	443 (67.9%)	1 (0.2%)	7 (1.1%)	35 (5.4%)	37 (5.7%)	113 (17.3%)	16 (2.5%)	652 (100%)
Females	552 (77%)	0 (0%)	5 (0.7%)	15 (2.1%)	14 (2%)	118 (16.5%)	13 (1.8%)	717 (100%)
Total	995 (72.7%)	1 (1%)	12 (0.9%)	50 (3.7%)	51 (3.7%)	231 (16.9%)	29 (2.1%)	1369 (100%)

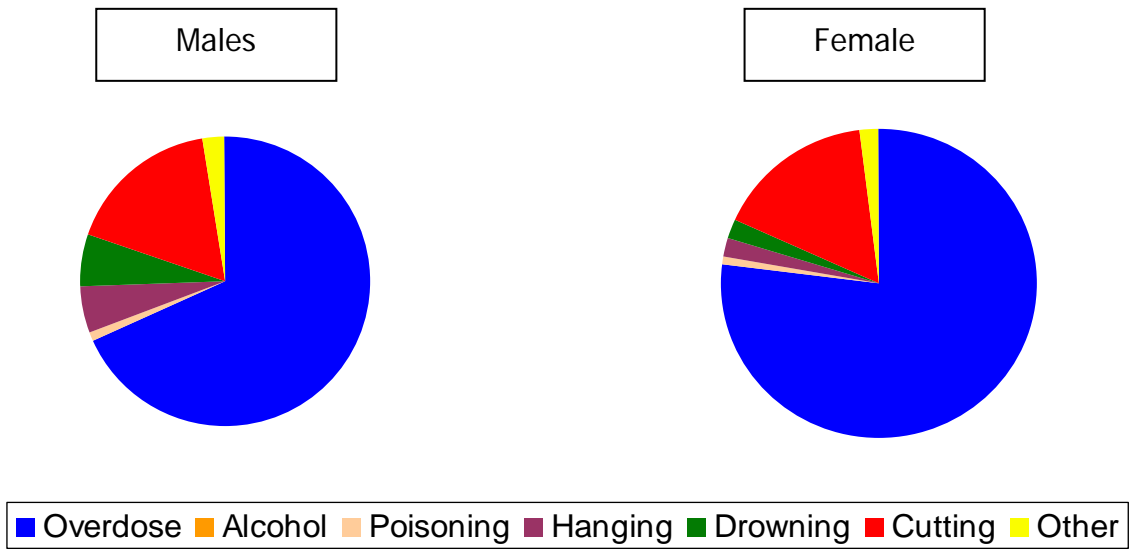


Figure 17: Most lethal and primary episode by gender, Western Board, 2007

- Overdose and cutting was the most common used primary method of self-harm in the Western Board in 2007, used in 72.7% and 16.9% of self-harm episodes respectively.
- Hanging and drowning are methods often associated with suicide. In the Western Board in 2007, 7.4% of all self-harm episodes involved hanging or drowning (3.7% each).

## METHODS OF SELF HARM - DRUG OVERDOSE

- Almost three quarters (72.7%) of all deliberate self-harm episodes involved an overdose of medication.
- Drug overdose was more commonly used as a method of self-harm by females than males (77% of female episodes and 68% male episodes).
- These figures were slightly higher than those for the Republic of Ireland. The NSRF figure show two thirds (66%) of all deliberate self-harm episodes in the republic of Ireland involved an overdose and drug overdose was more commonly used as a method of self-harm by females than males (73% of female episodes and 57% of male episodes).
- The study in Oxford showed a higher percentage of drug overdoses in all episodes (77.5%) than the Western Board (72.7%) and Republic of Ireland (66%).
- When consideration was given to drug overdose as a secondary method, its frequency increased to 77% (80% for females, 73% for males).

## METHODS OF SELF-HARM - CUTTING

- Cutting was the other common method of self-harm, being used in 16.9% of all cases.
- Cutting was the main method of self-harm in 17% of male episodes and 16% 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%) of all episodes and was used significantly more in males (26%) than in females (18%).
- There was significant variation in the use of drug overdose and self-cutting as the primary method of self-harm when examined by age (figure 18).
- 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.

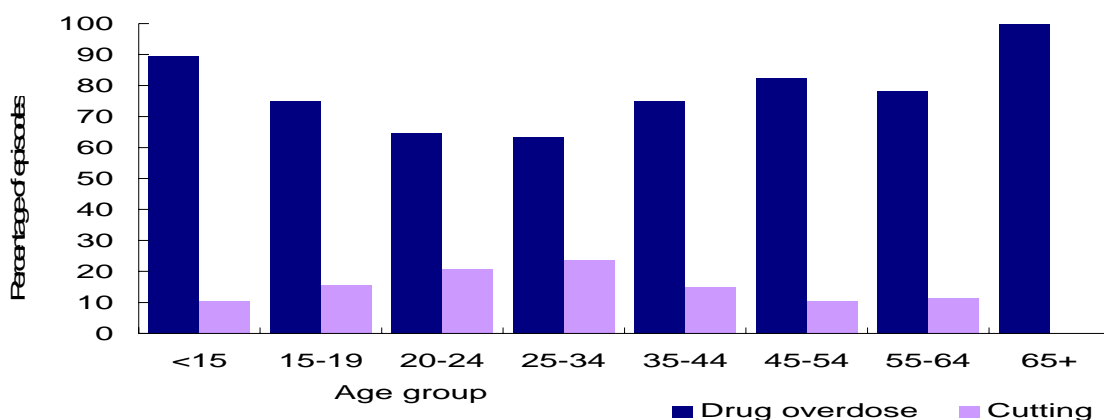
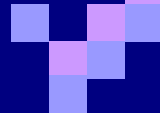


Figure 18: Variation in drug overdose and cutting by age group in the Western Board, 2007.



## ALCOHOL - WHSSB

- The study did not highlight alcohol as a main method of self-harm but alcohol was involved in 59% of all cases.
- Alcohol was involved significantly more often in male deliberate self-harm episodes (64%) than in female episodes (55%).
- This was higher than the Republic of Ireland where alcohol was involved in 44% of male episodes and 38% of female episodes.
- Compared with Oxford, the Western Board had a somewhat higher overall percentage (59%) of episodes involving alcohol than Oxford (52.9%).
- The frequency of which alcohol was involved varied to some extent with method of self-harm.
- Alcohol was more common if the self-harm act involved a drug overdose (61%), attempted hanging (64%) and attempted drowning (64%) but less common in acts involving self-cutting (53%).
- There was a clear pattern in the use of alcohol with age for both genders (figure 19). Its frequency increased with age, peaking for males at 73% in 45-54 year olds and for females at 67% in 35-44 year olds. After these age groups the frequency decreased for each gender.

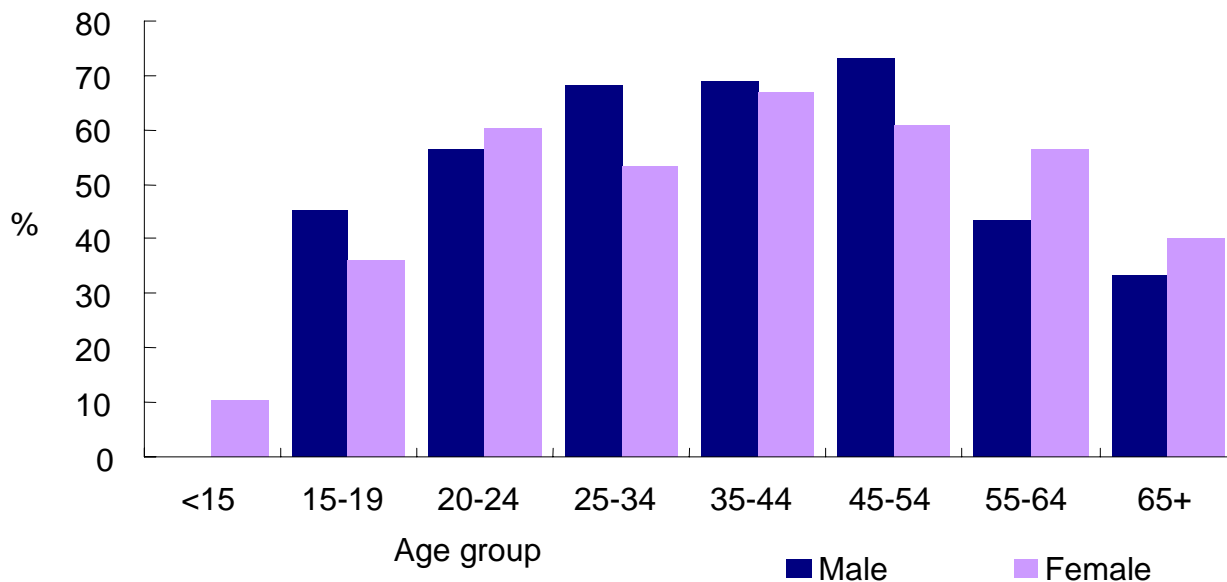


Figure 19: Percentage of episodes with alcohol involved by age group, Western Board, 2007.

## ALCOHOL – WHSSB COUNCIL AREAS

Figure 20 shows a breakdown of council areas within the Western Board and the episodes of self-harm involving alcohol within each area.

- Males had a higher percentage of episodes involving alcohol across most of the council areas with the exception of Omagh DC where females had a higher percentage than males (62% for females v 54% for males).
- Strabane DC had the highest rate for males (70%) and Omagh DC had the highest rate for females (62%).

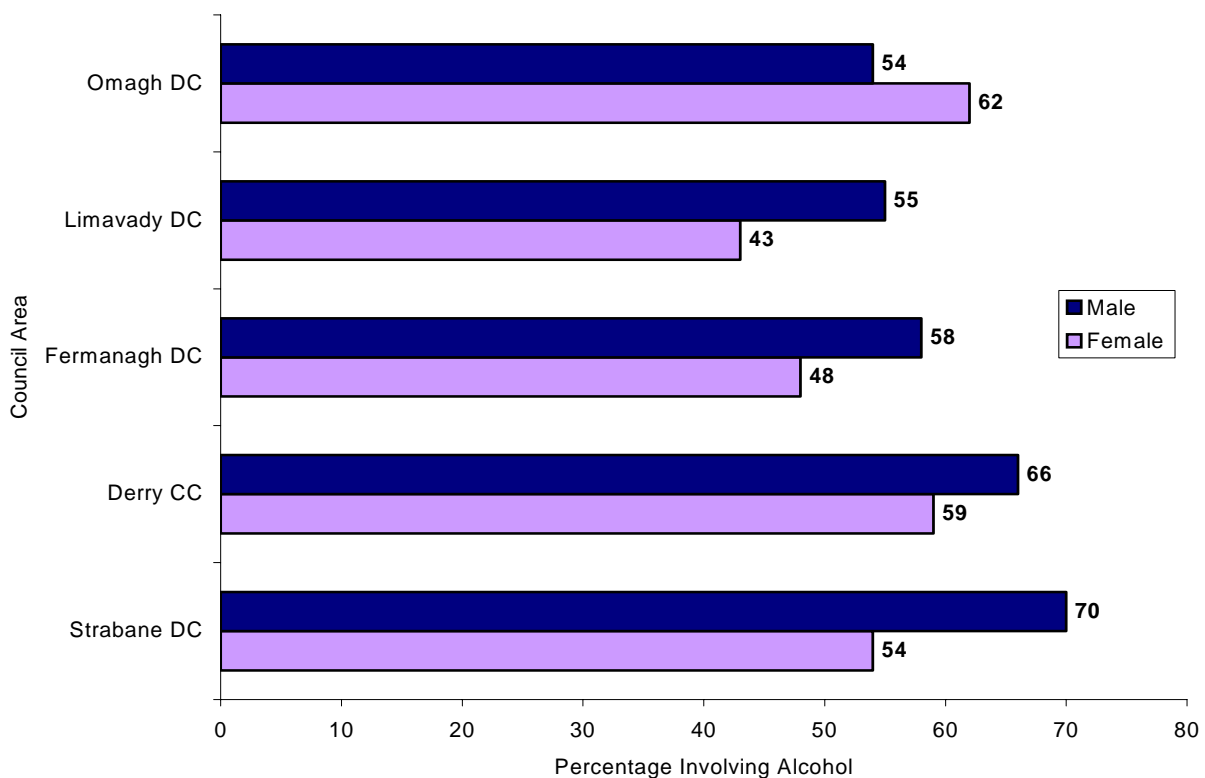
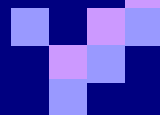


Figure 20: Council areas within the Western board showing percentage of episodes which involved alcohol by gender:

- Derry CC had the highest overall percentage of episodes of self-harm involving alcohol (63%), followed closely by Strabane DC (61%), Omagh DC (61%), Fermanagh DC (53%) and Limavady DC (49%).



## **EPIISODES OF SELF-HARM INVOLVING ALCOHOL BY AGE-GROUP IN THE WESTERN BOARD**

- In the 15-19 year age group, Derry CC had the highest percentage of self-harm episodes involving alcohol (52%).
- In the 20-24 year age group, Strabane and Omagh both had high percentages of episodes of self-harm involving alcohol with 69% and 64% respectively.
- Derry CC and Strabane DC had relatively high percentages of self-harm episodes involving alcohol in the 25-34 (63% and 62% respectively) and in the 35-44 year age groups (70% and 75% respectively).
- The percentage figures for self-harm episodes involving alcohol were similar across the whole of the Western Board for the 45-54 year age group ranging from 56% to 69%.
- Omagh had a significantly high percentage of self-harm episodes involving alcohol in the 55-64 year age group (77%).
- In contrast, Limavady DC showed relatively low percentage of self-harm episodes involving alcohol in the 15-19 year age group.
- Fermanagh also showed a significantly low percentage of self-harm episodes involving alcohol in the 20-24 year age group (38%).

## ALCOHOL – ALL-ISLAND

- An all-island comparison of cities (figure 21) shows Derry CC had the highest percentage of self-harm episodes involving alcohol in both genders.
- Cork and Waterford were the only cities where females had a higher percentage of self-harm episodes involving alcohol than males.
- Episodes of self-harm involving alcohol were relatively low in females in Republic of Ireland cities (30-46%) than in Derry CC (59%).
- The percentage of self-harm episodes involving alcohol for males was high within Derry CC, Limerick and Galway (54-66%).

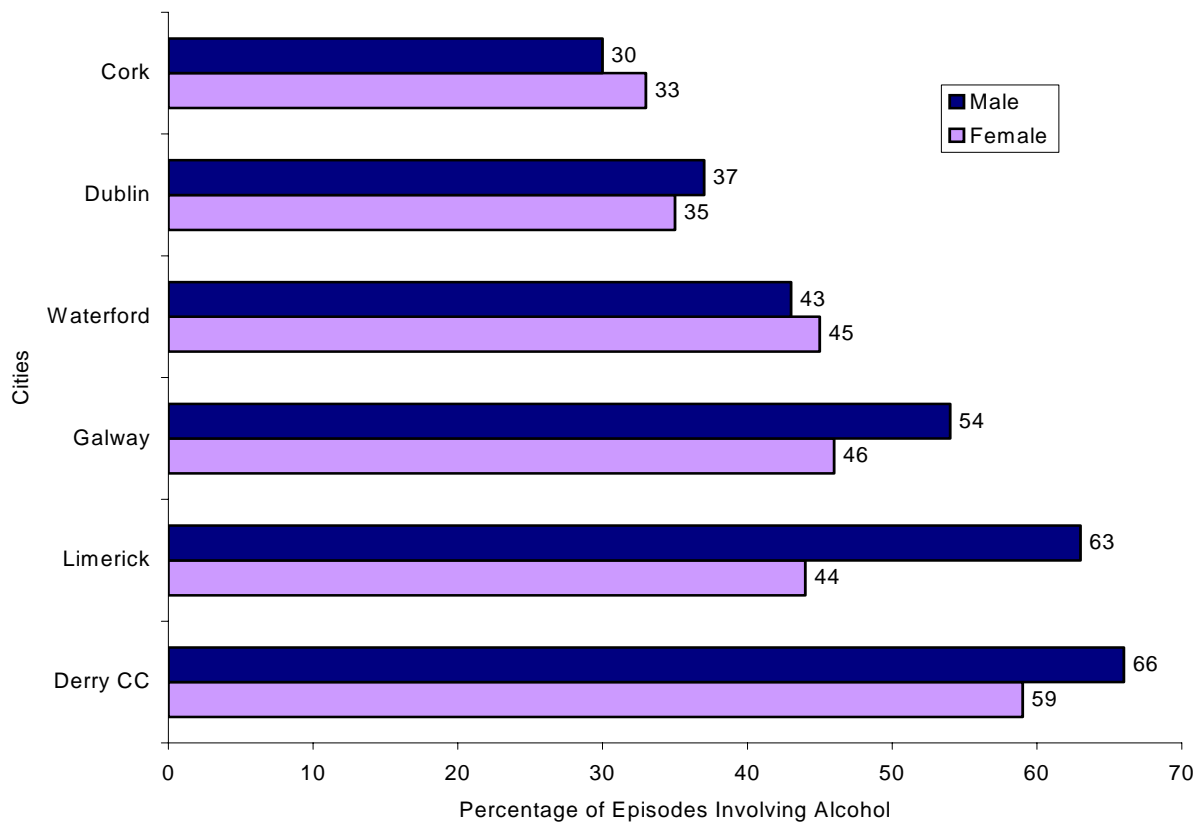
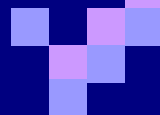


Figure 21: Percentage of self-harm episodes involving alcohol by gender in cities (all-island).



## **EPIISODES OF SELF-HARM INVOLVING ALCOHOL BY AGE-GROUP ALL-ISLAND COMPARISON**

- Comparisons were be made in the percentage of self-harm episodes involving alcohol between Derry CC and Limerick in a number of age groups i.e. 20-24 year age group (61% and 60% respectively), 25-34 year age group (63% and 50% respectively), the 35-44 year age group (70% and 68% respectively), and in the 45-54 year age group (66% and 83% respectively).
- This pattern was reflected again in the overall percentage of self-harm episodes involving alcohol where Derry CC and Limerick had the highest percentage rate of 63% and 54% respectively.
- Galway and Waterford had a particularly high percentage rate in two of the age groups. In the 45-54 year age group, 69% of self-harm episodes in both Galway and Waterford involved alcohol, and in the 55-64 year age-group 58% of self-harm episodes in both Galway and Waterford involved alcohol.
- In contrast, Dublin and Cork had the lowest percentages of self-harm episodes involving alcohol throughout all age-groups.
- Dublin had a fairly low percentage rate among the 15-19 year age group with 24% of self-harm episodes involving alcohol.
- Cork had the lowest percentage rate of self-harm episodes involving alcohol within the 20-24 year age-group (25%).

## ALCOHOL – GB / NI / RoI

Figure 22 below highlights the percentage rates of self-harm episodes involving alcohol in cities across England, Northern Ireland and Republic of Ireland.

- Oxford had the highest percentage rates for males (69%) and Derry CC had the highest percentage rate for females (59%).
- The lowest percentage rate for males was in Cork (30%).
- The lowest percentage rate for females was in Cork (33%).

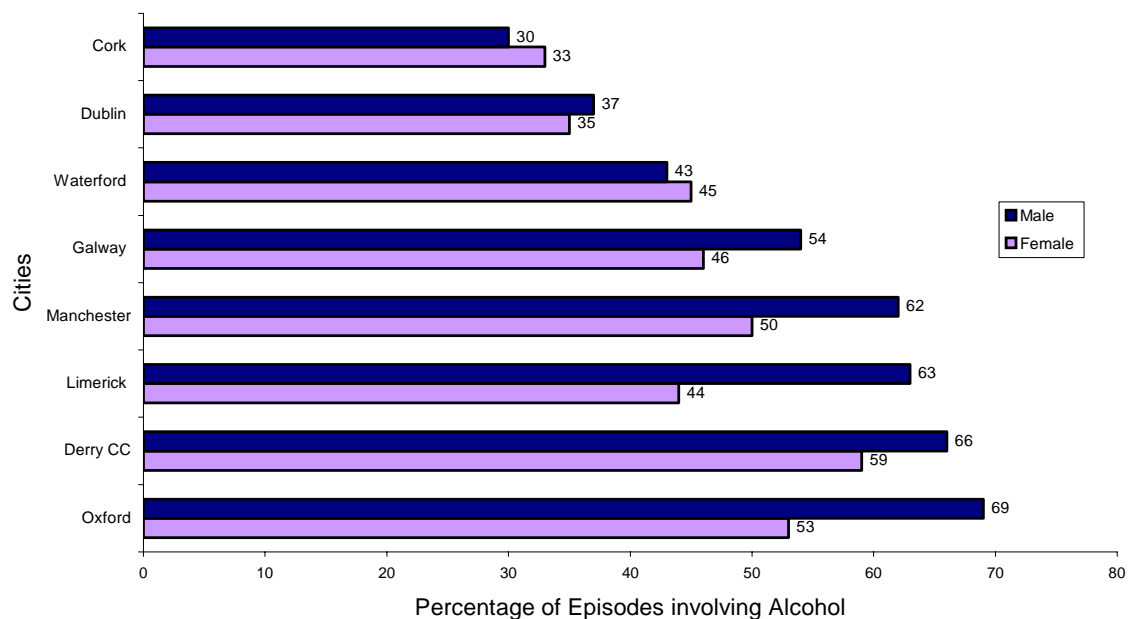
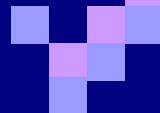


Figure 22: Percentage of self-harm episodes involving alcohol by gender, GB, NI, RoI.

## EPIISODES OF SELF-HARM INVOLVING ALCOHOL BY AGE-GROUP GB/NI/RoI

- There was a similarity in self-harm episodes involving alcohol in Oxford, Derry CC and Limerick across all age groups.
- Oxford had the highest percentage rate in the 55-64 year age group than any of the cities investigated (65%).
- Manchester had a relatively high percentage rate of self-harm episodes involving alcohol in all age-groups over 25 years.
- In contrast, Manchester had a relatively low percentage rate of self-harm episodes involving alcohol within the 15-19 year age group.
- Manchester also had the highest rate of self-harm episodes involving alcohol in all cities within the 45-54 year age group (68%).



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## RECOMMENDED NEXT CARE

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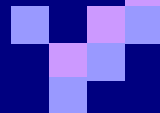
- Of the 1,369 self-harm presentations, 59% resulted in a general admission to hospital.
- Admission to a psychiatric hospital directly after emergency care followed 10% of all episodes. This is an underestimate of the total proportion admitted for psychiatric care given that some patients admitted initially to a general ward were subsequently admitted for psychiatric care.
- Almost one in five (19%) were not admitted after emergency care. These patients generally receive a referral to other services such as out-patient appointment or GP/Community Psychiatric Nurse (CPN).
- Patients refusing, leaving before a decision was made and leaving without being seen accounted for 6%, 3% and 4% of all other episodes respectively.
- Recommended next care showed some variations across the three hospitals.
- Almost two thirds (63%) of self-harm presentations to Altnagelvin Hospital resulted in general admission, compared to approximately half of those who presented to Tyrone County Hospital (53%) and Erne Hospital (46%).
- Direct psychiatric admission was lowest at 6% in Altnagelvin Hospital compared to 18% and 16% in Tyrone County Hospital and Erne Hospital respectively.
- One in four (26%) patients was discharged following emergency treatment in Erne Hospital compared to 18% at both Altnagelvin Hospital and Tyrone County Hospital.
- 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 (13%) compared to females (7%).
- Admission patterns varied significantly depending on the main method involved in the self-harm act.
- More than two thirds (70%) of drug overdose acts resulted in general ward admission compared to 28% of attempted hangings, 41% of attempted drowning and 22% of self-cuttings.
- Direct psychiatric admission followed one in three cases of attempted hanging (34%) and attempted drowning (31%).
  - Almost half (46%) of self-harm patients who had used self-cutting were not admitted after emergency treatment.

Table 7: number and percentage of recommended next care by primary method, Western Board, 2007

Primary Method		General admission	Psychiatric admission	Not admitted	Patient refused	Left before decision	Left without being seen	Total
Overdose	Count	699	44	124	70	22	36	995
	%	70.3%	4.4%	12.5%	7.0%	2.2%	3.6%	100.0%
Alcohol	Count	0	0	0	0	0	1	1
	%	.0%	.0%	.0%	.0%	.0%	100.0%	100.0%
Poisoning	Count	9	1	1	0	0	1	12
	%	75.0%	8.3%	8.3%	.0%	.0%	8.3%	100.0%
Hanging	Count	14	17	10	2	3	4	50
	%	28.0%	34.0%	20.0%	4.0%	6.0%	8.0%	100.0%
Drowning	Count	21	16	11	2	1	0	51
	%	41.2%	31.4%	21.6%	3.9%	2.0%	.0%	100.0%
Cutting	Count	51	41	106	10	10	13	231
	%	22.1%	17.7%	45.9%	4.3%	4.3%	5.6%	100.0%
Other	Count	10	12	6	0	1	0	29
	%	34.5%	41.4%	20.7%	.0%	3.4%	.0%	100.0%
Total	Count	804	131	258	84	37	55	1369
	%	58.7%	9.6%	18.8%	6.1%	2.7%	4.0%	100.0%

## REPETITION

- There were 1,043 people treated for 1,369 episodes of self-harm in 2007.
- One in four (24%) of all self-harm presentations in 2007 were repeat presentations.
- Of these 1,043 individuals, 162 (15.5%) re-attended hospital in 2007 as a result of self-harm.
- 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 was a similar rate of repetition among the three hospitals – Tyrone County 14%; Altnagelvin Hospital, 16%; Erne Hospital 17%.



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