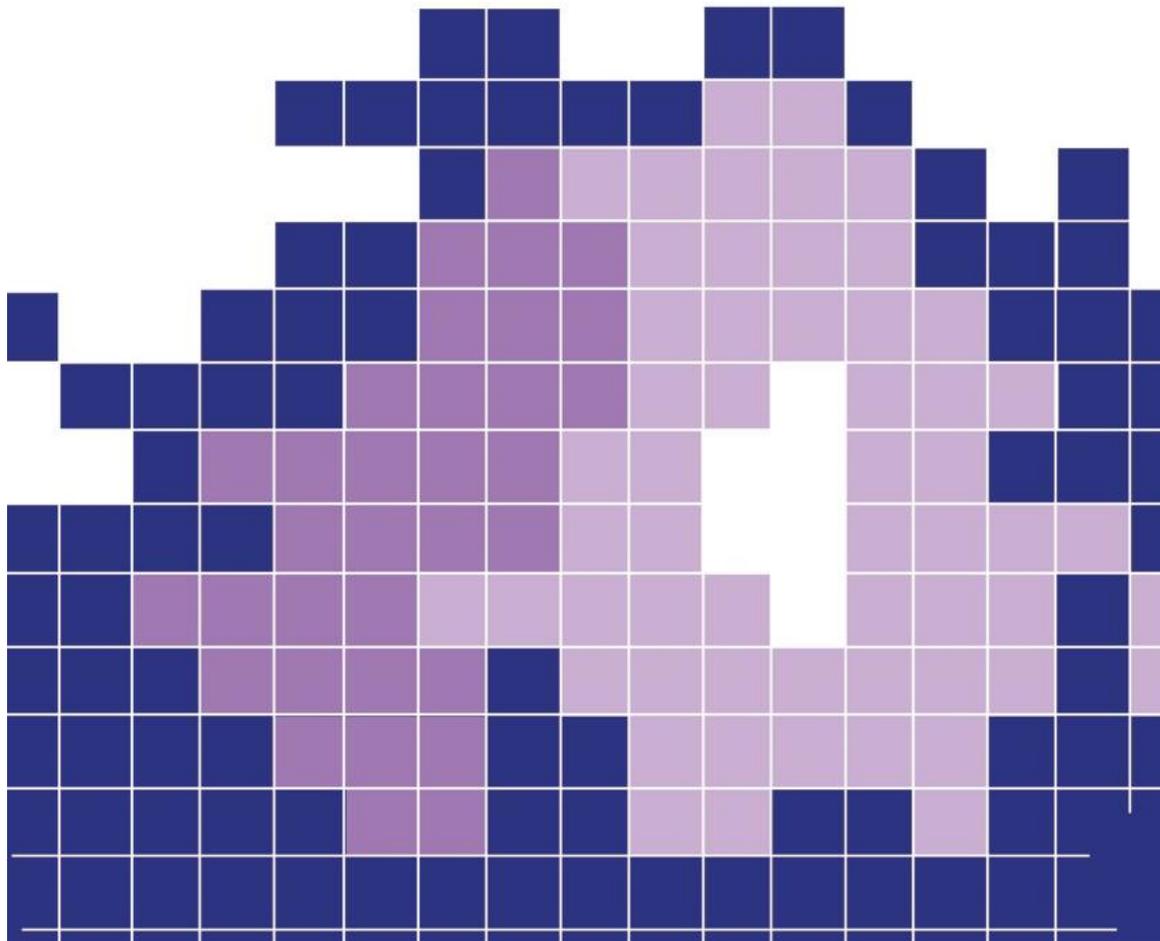


# Northern Ireland Registry of Deliberate Self-Harm

## Western Area

Annual Report 2010





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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 Age 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
WHST	Western Health and Social Care Trust
PFA	Priority for Action

## Executive Summary

This is the fourth report from the Northern Ireland Registry of Deliberate Self-Harm since its pilot stage in 2007. The NI Registry is part of the Northern Ireland Suicide Prevention Strategy 'Protect Life – A Shared Vision'. The NI Registry is a collaboration with the National Registry of Deliberate Self-harm in the Republic of Ireland which has been operating since 2000.

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 report represents data obtained over the 2010 calendar year.

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 four years of data collection to date, a considerable amount of useful information has been obtained to help initiate discussion, guide service provision and inform policy development. The findings from the first two years of the Registry have been used to highlight awareness of self-harm issues within the health and social care setting and to influence the redesign of services. In some cases however, four 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

There were 1,402 presentations to three Accident & Emergency / Urgent Care departments from 1st January 2010 to 31st December 2010. This is 10.7% higher than 2009, 5.9% higher than 2008 and 2.4% higher than 2007.

### Repeat attendances

People who engage in self-harm may do so repeatedly and therefore may present to A&E on more than one occasion.

There were 1,086 people treated for 1,402 episodes of self-harm in 2010. One in five (22.5%) of all self-harm presentations in 2010 were repeat presentations. This was similar to previous findings (22% in 2009, 21% in 2008 and 24% in 2007).



## Age groups and gender

Data for 2010 show the highest rates of self-harm were among 20-24 year olds for both genders.

Females represented a higher percentage of attendances, accounting for 55% (n=771) of the 1,402 presentations. This is consistent with the findings in previous years.

There were 102 attendances among those aged under 18 years which accounted for 7.3% of all episodes in 2010. This is slightly lower than the findings in previous years (8.4% in 2009 and 9% in 2007-08)

The majority of self-harm episodes among those aged under 18 years (68.6%) were female.

## Day and time of presentation

There was a clear pattern of attendance for females over the course of the week but no clear pattern for males. This is consistent with the previous three years. Presentations by both genders peaked at weekends.

Over one quarter (28.2%) of all self-harm attendances at A&E occurred during normal working hours i.e. 9am-5pm.

Attendances peaked after midnight and over one third (34.9%) of attendances occurred after 1am until 9am. This presents a challenge for health services in responding to this issue.

## Public Holidays / Annual Events

There was some correlation between self-harm attendances and certain public holidays/annual events. In February, 11.4% of attendances occurred on St Valentine's Day, 14<sup>th</sup>, and the following day, 15<sup>th</sup>. In March, 7.7% of attendances occurred on St Patrick's Day.

## Incidence rates

The incidence rate of self-harm presentation to hospital was considerably higher in the Western area (355 per 100,000) than in the Republic of Ireland (217 per 100,000). The rate in the Western area increased by 12.3% in 2010 compared to 2009 (316 per 100,000) but is lower than the rate in 2007-08 (373 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 most cities in the Republic of Ireland but lower than the rate for Limerick City.

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 receiving 69.8% (n= 978) of the overall total of 1,402 self-harm episodes recorded in 2010.

At 990 per 100,000, the peak rate for females was among 20-24 year-olds. This was highest within Omagh DC (1,112 per 100,000) and lowest within Limavady DC (686 per 100,000). The number of female self-harm episodes in this age group for Omagh DC was 20 which is an increase of 10 (100%) compared to the previous year.

The peak rate for males was 870 per 100,000 among 20-24 year-olds. This was highest within Fermanagh DC (1,158 per 100,000) and lowest within Omagh DC (540 per 100,000). The number of male self-harm episodes in this age group for Fermanagh DC was 23 which is an increase of 10 (77%) compared to the previous year.

### Method of self-harm

In many self-harm attendances more than one method of self-harm was used. In 2010, and as seen in previous years (2007 to 2009), drug overdose was the predominant method of self-harm particularly among females, and was used in 72.8% of all self-harm episodes. Self-cutting was the second most common form of self-harm, used in 18.4% of all self-harm episodes. Almost one in ten attendances involved attempted drowning or attempted hanging, methods which often indicate a high degree of suicidal intent.

### Alcohol

Alcohol, whilst rare as a main method of self-harm, was involved in 55.8% of all episodes. This was similar to 2009 (56.3%) and lower than 2008 findings (68.5%).

Alcohol was more likely to be involved in cases of self-harm among males (60.4%) than females (52.1%). This is similar to 2009 findings.

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 1,402 self-harm presentations, 49.9% (n=700) 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. One half (50.1%) of self-harm presentations to Altnagelvin Hospital resulted in an admission to the general acute hospital, compared to 52.0% of those who presented to Erne Hospital and less than one fifth (16.7%) at Tyrone County Hospital. These figures varied slightly from 2009 findings for Altnagelvin (54.3%), Erne Hospital (44.5%) and Tyrone County Hospital (27.9%).

Direct admission to a psychiatric hospital after emergency care at A&E followed 7.3% (n=102) of all self-harm attendances (7.6% in 2009 and 8.5% in 2007-08). Direct psychiatric admission was highest at 12.2% in the Erne Hospital compared to 5.5% Altnagelvin Hospital.

Direct psychiatric admission in Tyrone County Hospital decreased significantly over the four year period with no direct psychiatric admissions in 2010 compared to 9.8% in 2009 and 17.4% in 2007-2008.

These figures will be underestimates 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.



In total, 42.8% (n=600) 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 (0.9%, n=12);
- Patient leaving the A&E department after receiving treatment but before a decision was made regarding their next care (2.9%, n= 41);
- Patient being advised to stay for further assessment or admission but refusing to do so (3.8%, n=53);
- A health professional making the decision that admission was not required (35.2%, n= 494).

Of those attendances that did not result in admission to either an acute or psychiatric hospital, the majority (71.5%, n=429) 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. This is similar to 2009 findings (72.9%)

In some cases this may be partly explained by the current availability of mental health staff to carry out assessments. Just over 40% (n=575) of all self-harm attendances to A&E presented outside the hours of current mental health service provision compared to 17% (n=224) in 2009.

Tyrone County Hospital had a higher percentage of patients who were discharged following emergency treatment (83.3%) than both Altnagelvin Hospital and Erne Hospital (35.8% and 30.2% respectively).

Next care of the patient following A&E attendance varied depending on the main method involved in the self-harm act. Over half (58.5%) 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 323 ideation cases recorded in 2010 which is an increase of 86.7% (n=150) compared to 173 ideation cases in 2009.

These data were 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 Arising

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

The scale and pattern 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.

This report has highlighted the changes in self-harm behaviour over the past four years and has reinforced the importance of self-harm data collection/analysis, and it's potential to target resources and develop services to meet the needs of patients.

Numerous studies have found that engagement in deliberate self-harm is the strongest predictor of future suicidal behaviour, both fatal and non-fatal. There is therefore the need to develop a mechanism which ensures that the self-harm patterns identified by the Registry are feeding into the development of both the local suicide prevention action plans and the wider delivery of the mental health services.

The Registry demonstrates use of recreational and prescription drugs in overdose cases. The impact of these drugs needs to be monitored and this data should be used when considering restricting certain drugs.

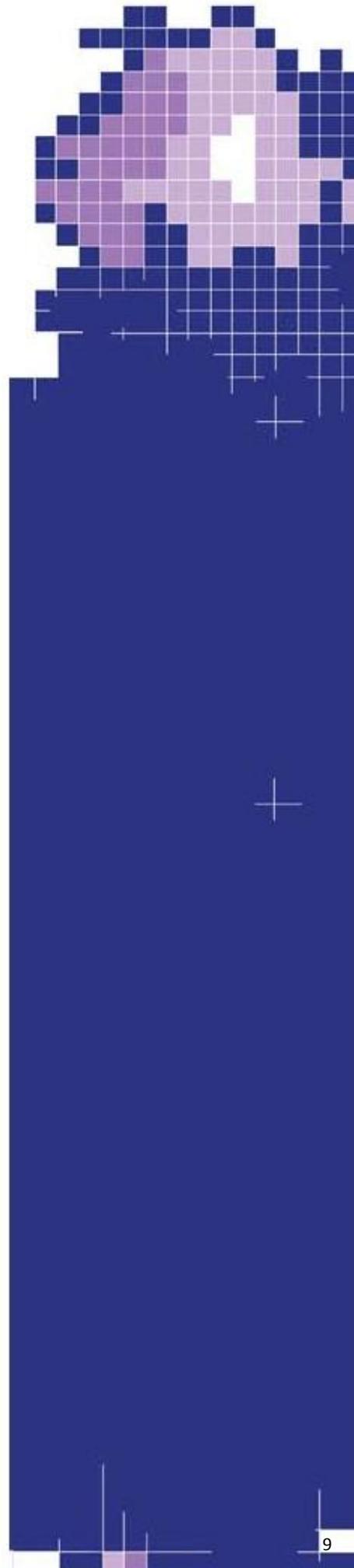
The Registry highlights the importance of maintaining close working relationships with statutory, community and voluntary sectors as well as the need to maintain cross-border working relationships.

The Registry has been altered to include an additional data collection field to monitor the implementation of the 'Card Before You Leave Scheme'. This scheme was introduced in January 2010 and provides an information card to patients leaving A&E who have not had an assessment by a member of the mental health team giving details of contact numbers for support, and of how follow up care will progress including a follow-up appointment for patients being discharged from in-patients.

The Self-Harm Registry has been expanded to include the 4 Emergency Departments in the Belfast Trust (Royal Victoria Hospital, Royal Hospital for Sick Children, Mater Infirmorum Hospital and Belfast City Hospital). The Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI) has also developed a specific Priorities for Action (PFA) target to support the roll-out of the work of the Registry across Northern Ireland.

***PFA Target 1.3: The PHA and HSCB should ensure that by the month March 2012, the details of 100% of people presenting at A&E Departments who have self harmed are being added onto the Deliberate Self Harm Registry.***

The data outlined in this report demonstrates that implementation of a Registry on a province-wide basis provides intelligence to enhance service provision and contribute to policy development, and it also provides for comparison of data across these islands.





## 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.

- . Accident and Emergency Department, Altnagelvin Area Hospital, Londonderry
- . Accident and Emergency Department, Erne Hospital, Enniskillen
- . 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 mechanisms 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.

- Card Before You Leave

The Registry has been modified to record Card Before You Leave. This initiative commenced on 1st January 2010 therefore is not included in this report.

## Study Period

To date, information for the Registry has been collected for four full calendar years (1st January 2007 – 31st December 2010). The information within this report is mainly based on data collected within the 2010 calendar year but makes references to the 2007, 2008 and 2009 calendar years.

## 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 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.

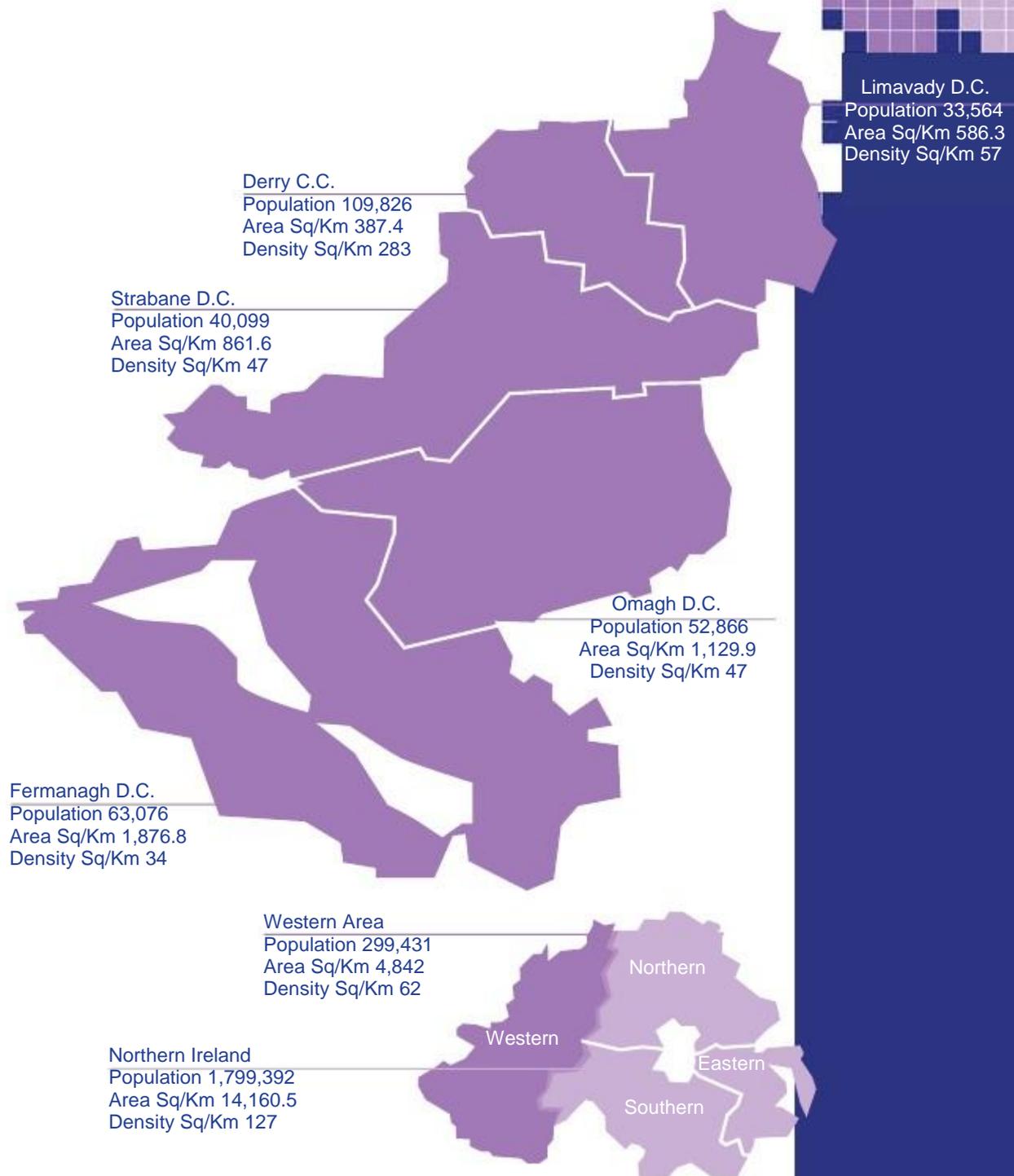
## Quality Assurance

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 299,431 (2010 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.

## Acute Services at Tyrone County Hospital

Reconfiguration of services at the Tyrone County Hospital site resulted in acute medicine being removed as of 2nd March 2009.

## 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.  $(n/p) \times 100,000$ . Calculation of rates has been based on 2010 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:

- National Registry of Deliberate Self-Harm Annual Report 2010, National Suicide Research Foundation.
- NI Registry of Deliberate Self-Harm 2009 Annual Report &, 2-Year Report, 2007-2008.

## Acknowledgements

This report has been compiled by Linda Cassidy, Project Manager, with input from Paul Corcoran, Deputy Director/Senior Statistician, NSRF and Brendan Bonner, Head of Health Improvement and Social Wellbeing (West), PHA.

The data which forms the basis of this report was collected by Mary P. McDermott. All input and efforts are greatly appreciated.

We would like to acknowledge the assistance of the staff from the Accident & Emergency / Urgent Care Departments within Altnagelvin, Tyrone County and Erne Hospitals and also staff from the IT/Communications team within the Western Health & Social Care Trust, in particular that of Mr Neville McChesney, Senior ICT Project Manager.

We would also like to acknowledge the input from the Western Self-Harm Registry Steering Group which includes:

Bernard McAnaney	Assistant Director of Mental Health, WHSCT
Dr Sophie Graber	Accident & Emergency Doctor, WHSCT
Diane Brennan	Assistant Director Emergency Care Medicine, WHSCT
Isobel McClintock	Accident and Emergency Dept, WHSCT
Barry McGale	Suicide Liaison Officer, WHSCT
Dermot Lynch	Suicide Liaison Officer, WHSCT
John Mullan	Primary Care Liaison Manager, WHSCT
Gerry McHugh	Head of Service for Recovery (Adult Mental Health Southern Sector) WHSCT
Siobhan Sweeney	Health Improvement, PHA
Hilary Parke	Health Improvement, PHA
Connor McCafferty	SHINE
Dr Ella Arensman	Director, NSRF

We would also like to acknowledge the assistance of:

Eve Griffin	Research Psychologist / Registry Co-ordinator, NSRF
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## Number of Presentations

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

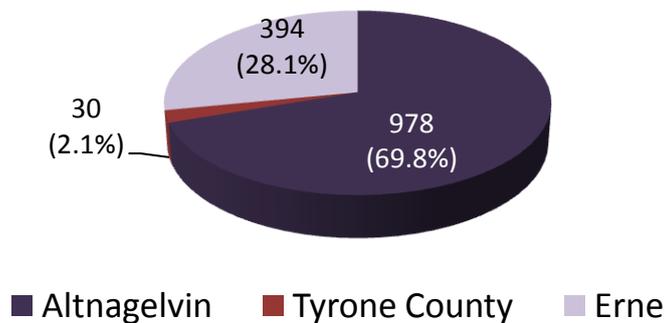
There were 1,402 presentations to three Accident & Emergency / Urgent Care departments from 1st January 2010 to 31st December 2010. This is 10.7% higher than 2009, 6.0% higher than 2008 and 2.4% higher than 2007.

The three departments were:

- . Accident and Emergency Department, Altnagelvin Area Hospital, Londonderry
- . Accident and Emergency Department, Erne Hospital, Enniskillen
- . 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 the Western area, 2010



Altnagelvin Hospital had a total of 57,324 attendances to A&E in 2010 and 978 (1.7%) of these were due to deliberate self-harm. This is the same percentage as 2009. The number of self harm attendances at Altnagelvin Hospital has increased by 5.7% (n=53) since 2007.

Erne Hospital had a total of 27,471 attendances to A&E in 2010; 394 (1.4%) attended due to deliberate self-harm. This is similar to 2009 (1.3%). Since 2007, the number of self harm attendances at the Erne Hospital have increased by 84.9% (n=181).

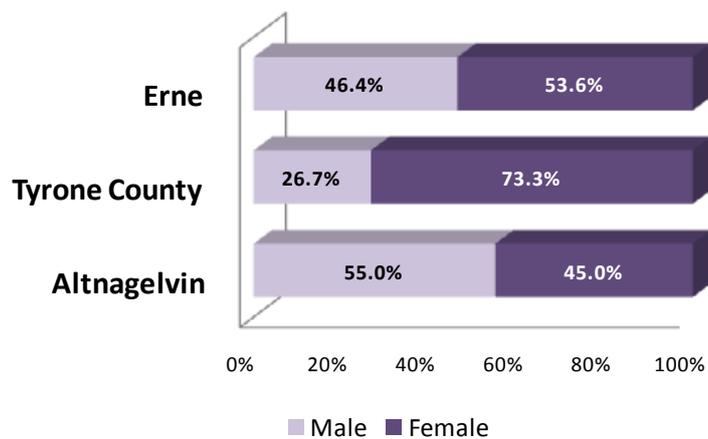
Tyrone County Hospital had a total of 15,401 attendances to the Urgent Care Department in 2010 of which 30 (0.2%) attended due to deliberate self-harm. This is slightly lower than 2009 (0.5%). Self harm attendances at Tyrone County Hospital have decreased by 87.0% (n=201) since 2007.

The significant increase in numbers within the Erne Hospital and decrease in Tyrone Hospital could be the result of the removal of acute services at Tyrone County Hospital on 2<sup>nd</sup> March 2009. Since then, all Emergency Service call out in the Tyrone area would be taken to Erne Hospital.

### Gender Distribution

The distribution of episodes (figure 2) showed that the female percentage rate was higher in all three hospitals. This is consistent with the findings from the previous three years.

Figure 2: Gender balance of self-harm episodes in the Western Area in 2010



## Persons and Episodes

During 2010, there were 1,402 presentations to an Accident & Emergency Department / Urgent Care Centre in the Western area. These are referred to as episodes. One individual may have had multiple episodes.

- The 1,402 episodes of self-harm in 2010 were made by 1,086 individuals. This was an increase of 10.7% (n=136) in episodes and an increase of 9.9% (n=98) individuals when compared to the previous year.
- Repeat attendances accounted for one in five (22.5%) of all self-harm attendances in 2010.

Table 1: Person & Episode figures of self-harm in the Western Area, 2007 to 2010.

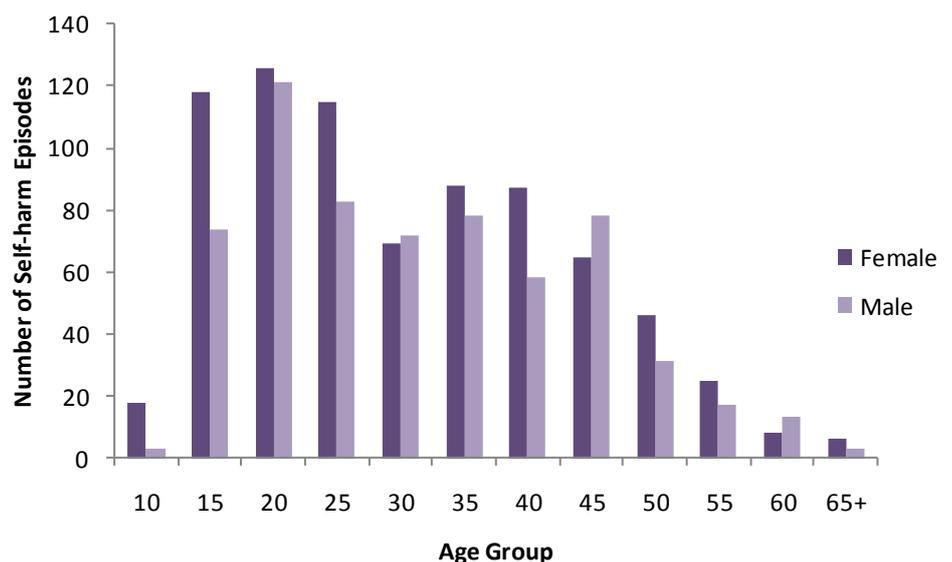
Episodes	2007	2008	2009	2010
Male	652	611	575	631
<i>Difference</i>		-41	-36	+56
Female	717	712	691	771
<i>Difference</i>		-5	-21	+80
<b>Total</b>	<b>1369</b>	<b>1323</b>	<b>1266</b>	<b>1402</b>

Persons	2007	2008	2009	2010
Male	472	474	463	490
<i>Difference</i>		+2	-11	+27
Female	567	574	525	596
<i>Difference</i>		+7	-49	+71
<b>Total</b>	<b>1039</b>	<b>1048</b>	<b>988</b>	<b>1086</b>

## Age and Gender

- Females represented a higher percentage of attendances, accounting for 55% (n=771) of the 1,402 presentations. This is consistent with the findings in previous years (2007 to 2009).
- Figure 3 illustrates the age and gender distribution of attendances. More than half (57.0%) of all Accident & Emergency / Urgent Care attendances due to self-harm in 2010 were under 35 years of age. This was consistent across all hospitals. The majority (89.4%) of episodes were by persons aged less than 50 years. This is consistent with the findings from the previous three years.
- Among the younger attenders, female episodes were considerably higher than male episodes, particularly within the 10-14 and 15-19 year age groups. This is consistent with the findings from 2009 and 2007-08 reports.
- The majority (85.7%) of self-harm presentations under the age of 15 years were female. This is higher than 2009 (76.5%) but lower than findings in 2007-08 (94.2%)
- Figure 3 demonstrates that the highest number of episodes of self-harm were among 20-24 year olds for both males and females. Self-harm attendances were also high among the 15-19 and 25-29 year old females. Findings from the previous three years have shown that highest number of self-harm episodes were among the 25-44 year age group for both genders.

Figure 3: Number of self-harm by age group in the Western Area in 2010



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

- Self-harm attendances by those under 18 contributed to 7.3% (n=102) of all self-harm presentations to A&E in 2010. This is slightly lower than the findings in 2009 (8.4%) and 2007-08 (9.0%)
- Females made up 68.6% of all these episodes. One in three episodes under 18 years were male.
- Alcohol was a contributing factor in self-harm amongst one in three episodes of self-harm by males (31.3%) and females (31.5%). This is a decrease of 2% for males and an increase of 8.9% for females when compared to 2009.
- Drug overdose was the most common method of self-harm for both genders but more common among females (77.1%) than males (53.1%). Compared to last year this is a decrease of 7% for females but an increase of 7.3% for males.
- Self-cutting was the second most common method of self-harm for both genders but more common amongst males (28.1%) than females (11.4%). This is a decrease of 9.4% for males compared to last year but still remains higher than the figure of 19.7% in 2007-08. Figures are consistent for females compared to the previous three years.
- Males had a significantly higher percentage of attempted drowning (12.5%) compared to females (5.7%). There has been no percentage change compared to last year for males however there has been an increase of 3.3% for females.



## Month of Attendance

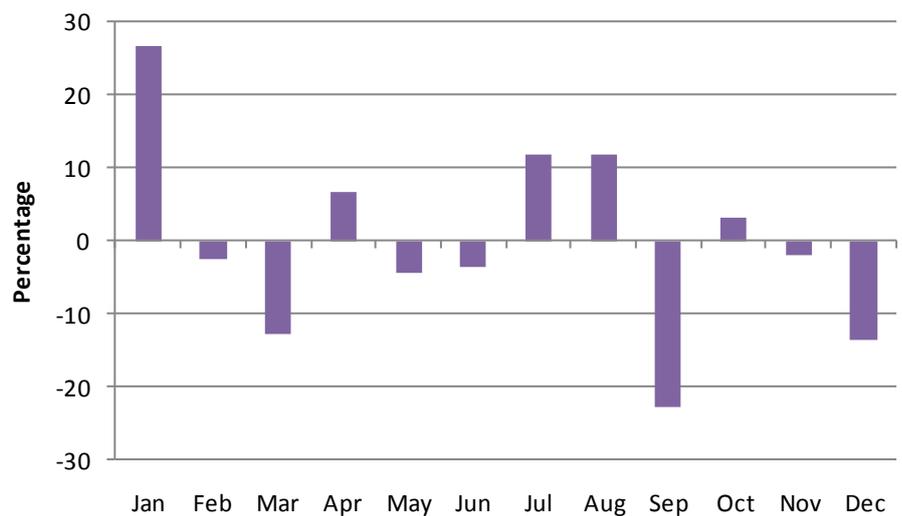
Table 2: Breakdown of self-harm episodes by gender and month within the Western area, 2010.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>Males</b>	74	47	38	57	55	45	54	59	43	64	51	44
<b>Females</b>	77	58	66	66	59	66	79	74	46	59	62	59
<b>Total</b>	<b>151</b>	<b>105</b>	<b>104</b>	<b>123</b>	<b>114</b>	<b>111</b>	<b>133</b>	<b>133</b>	<b>89</b>	<b>123</b>	<b>113</b>	<b>103</b>

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

- The pattern shown in 2010 does not reflect the patterns seen in previous years. This indicates that there is no clear pattern in self-harm attendances by month of the year.

Figure 4: Percentage difference between the observed and expected number of self-harm presentations by month in the Western area, 2010

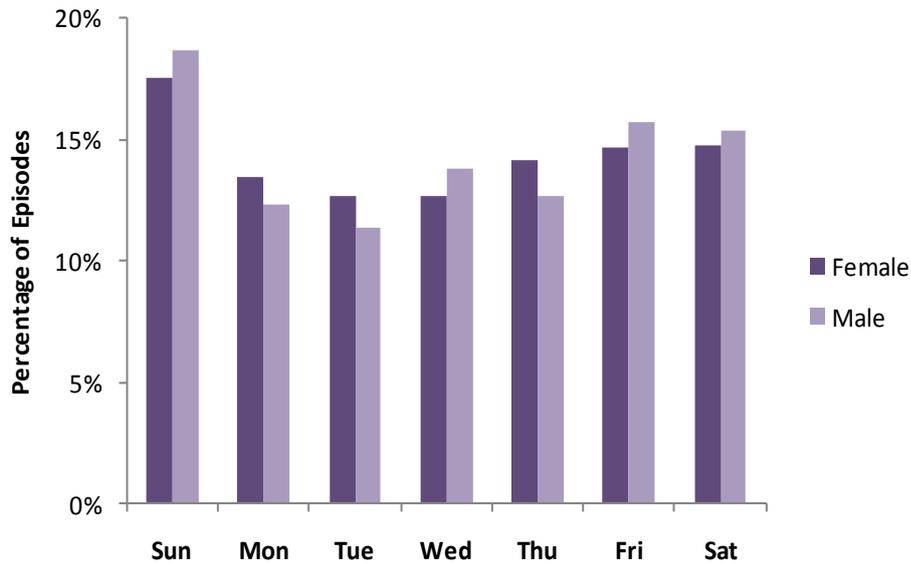


- In 2010 (figure 4), March, September and December months saw fewer presentations than expected (12.7%, 22.8% and 13.5% below average respectively).
- The peak month for self-harm presentations in 2010 was January (26.8% above average) with a secondary peak in July and August (both 11.7% above average).

## Day of Attendance

There was some variation in the percentage of episodes and the day of the week for both genders (figure 5).

Figure 5: Episodes of self-harm by day and gender, Western area, 2010.



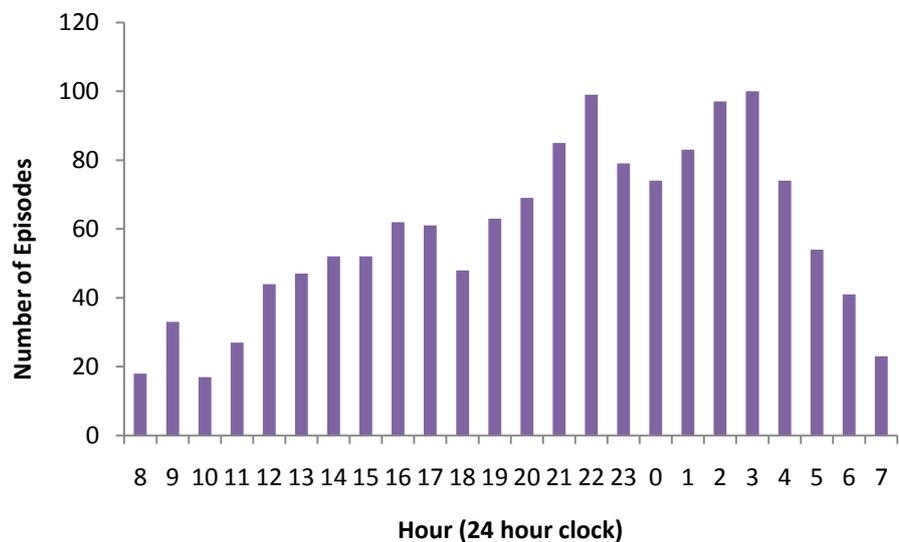
### Summary of Findings for Weekday and Gender

- There was a clear pattern of attendance for females over the course of the week but no clear pattern for males. This is consistent with the previous three years (2007 to 2009).
- Both genders peaked at the weekend. This pattern is also reflected in the previous three years.

## Time of Attendance

Figure 6 illustrates the variation between the number of self-harm episodes and the hour of attendance.

Figure 6: Hour of Presentation, Western area in 2010



### Summary of Findings for Hour of Attendance

- There was an increase in frequency of attendance over the course of the day with peaks around 10pm and in the early hours of the morning. This is discussed in more detail in the 'Next Care' section.
- In the Western area 54% of all cases presented between 8pm and 4am. In contrast, 28% of cases presented between 9am and 5pm. This is a similar pattern to the findings in the previous four years.
- The pattern of presentations over the course of the day was similar for males and females. This is also similar to the findings in the previous three years.
- As in previous years, most striking were the very high rates of presentations in the period from 10pm to 3am.

### Self-Harm and Public Holidays

There was some correlation between self-harm attendances and certain public holidays:

- In February, 11.4% of attendances occurred on St Valentine's Day, 14<sup>th</sup>, and the following day, 15<sup>th</sup>.
- In March, 7.7% of attendances occurred on St Patrick's Day.



## Incidence Rates

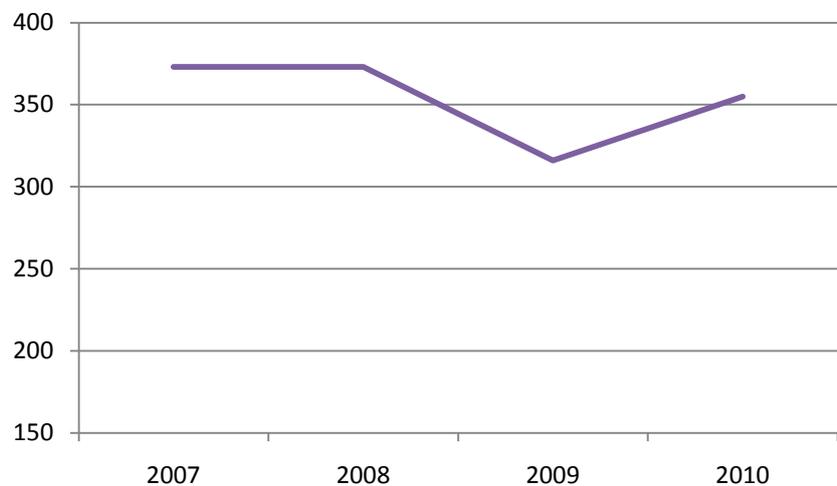
The overall crude and age-standardised rates in the Western Area in 2010 were 354 and 355 per 100,000 respectively. The rates for males and females can be seen in Table 3. This is 12.3% higher than the previous year.

Figure 7 shows the rate of self-harm in the Western area over the course of the previous four years

Table 3: Average incidence rates of persons presenting to hospital following DSH in 2010.

	Males	Females	All
Crude Rate Per 100,000	318	389	354
European Age Standardised Rate per 100,000	316	395	355

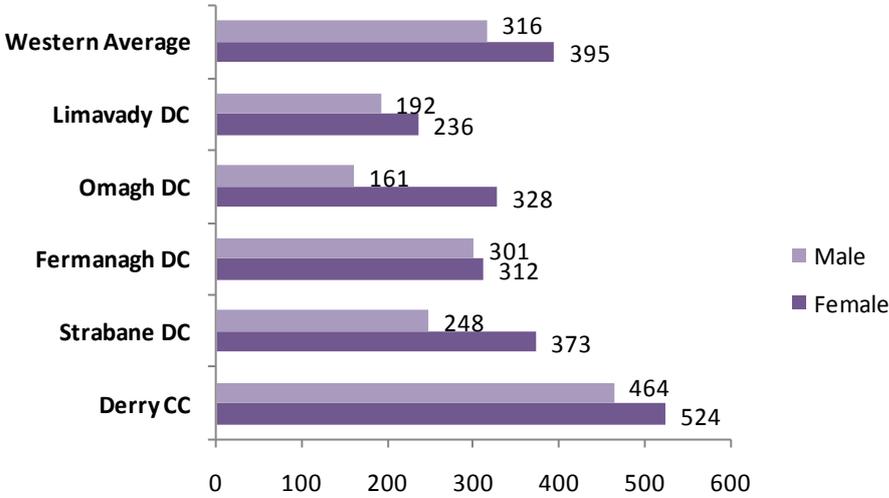
Figure 7: European Age Standardised Rate per 100,000 in the Western Area from 2007 to 2010.



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, Fermanagh DC, Omagh DC and Limavady DC.

The average EASR for females in the Western area was 395 for females and 316 for males as outlined in figure 8.

Figure 8: Person based European Age Standardised Rate (EASR) of self-harm by council area and gender in the Western area in 2010



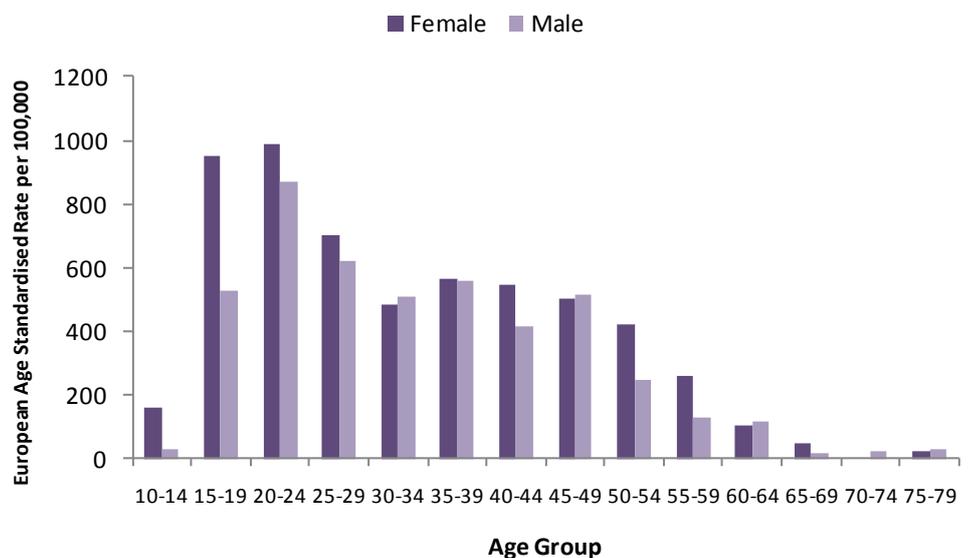
Summary of Incidence Rates within the Western Area 2010

- Average person-based (per 100,000) rates of self-harm in the Western area for 2010 was 316 for males and 395 for females. This was an increase of 7.1% for males and 16.9% for females when compared to 2009.
- The rate in Derry CC was 39% higher than the average rate in the Western area as a whole. This is higher than the findings from 2009 (38%) and 2007-08 (29%).
- In contrast, rates in Strabane DC, Fermanagh DC, Omagh DC and Limavady DC were 13%, 14%, 31% and 40% lower respectively than the average rate in the Western area. This is similar to the findings from the previous three years.
- The self-harm rates for males in Derry CC was more than double that of males in Limavady DC and Omagh DC, and almost double that of males within Strabane DC. This is similar to previous years' findings.
- The self-harm rate for females in Derry CC was more than double that of females in Limavady DC and 40% higher than the female rate in Fermanagh DC. This is higher than previous years.

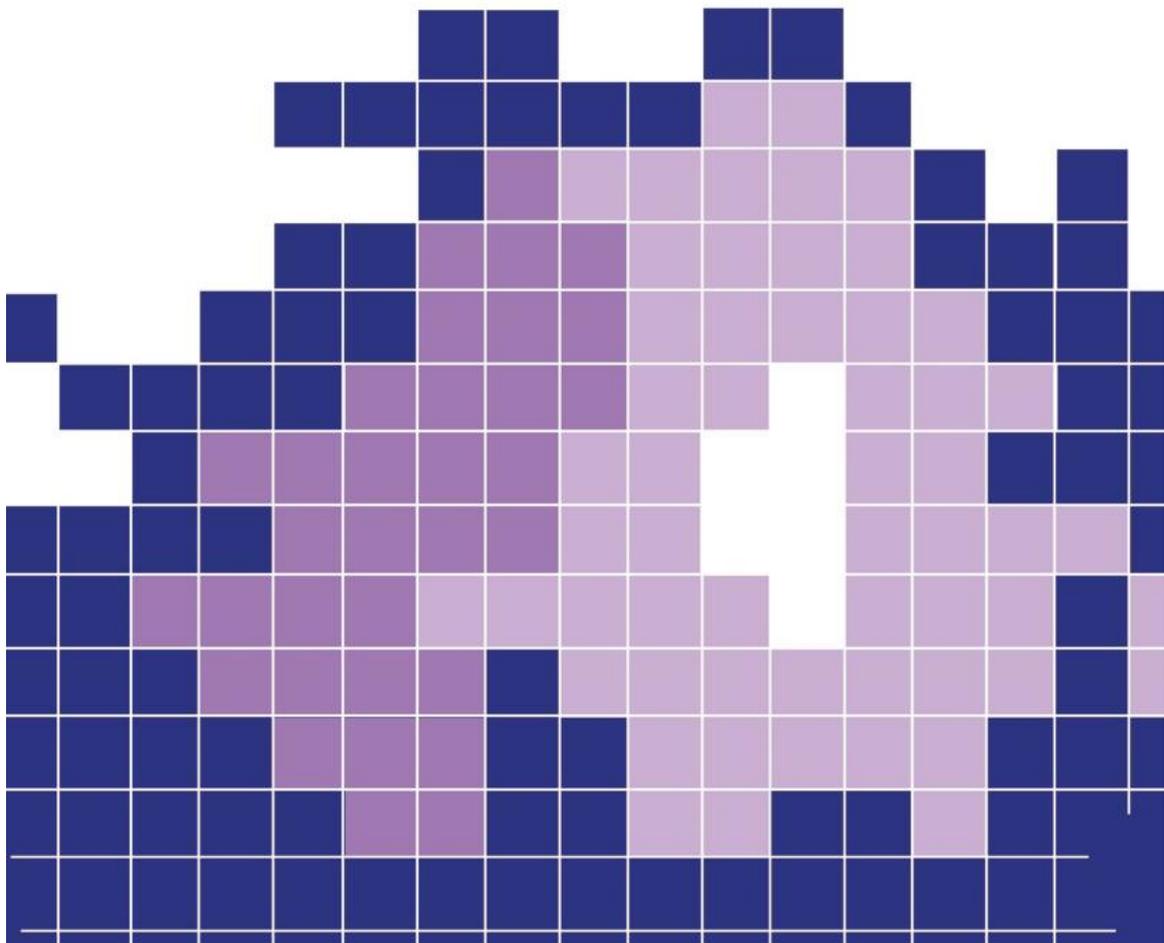
## Deliberate self harm by gender and age 2010

- Deliberate self harm rates show a striking age pattern with the highest rates among the 20-24 year olds.
- At 990 per 100,000, the peak rate for females was among 20-24 year-olds in the Western area. This was highest within Omagh DC (1,112 per 100,000) and lowest within Limavady DC (686 per 100,000) for this age group. Female incidence rates were also high among 15 – 19 year-olds in Derry CC (1,176 per 100,000) and Strabane DC (1162 per 100,000).
- The peak rate for males in the Western area was 870 per 100,000 among 20-24 year-olds. This was highest within Fermanagh DC (1,158 per 100,000) and lowest within Omagh DC (540 per 100,000). Male incidence rates were highest in the 20-24 year age groups for all council areas in the West with the exception of Omagh DC where the highest rate was among 35-39 year-olds (585 per 100,000).
- The deliberate self harm rate for both genders decreased after the 20-24 year age group with a secondary peak among 35 - 39 year olds. Males peaked for a third time among 45-49 year olds (figure 9).
- The extent of gender differences in the incidence of deliberate self harm varied with age.

Figure 9: Annual person-based rate of deliberate self harm in the Western area of Northern Ireland in 2010 by age and gender.



# Incidence Rates of Self-Harm in the Western area of NI Compared with Republic of Ireland





## National Suicide Research Foundation

The National Suicide Research Foundation consists of a multidisciplinary team with contributions from epidemiology, psychology, psychiatry, sociology and public health. The Foundation has been recognised by the Irish government's Department of Health and Children as an official research unit to contribute to the prevention of suicidal behaviour in Ireland. The National Suicide Research Foundation's aims are to produce a nationally and internationally recognised body of reliable knowledge from a multidisciplinary perspective on the risk and protective factors associated with suicidal behaviour and to provide a solid evidence base for policy development and intervention in the prevention of suicide and the management of patients presenting with deliberate self harm. At the request of the Department of Health and Children the Foundation established the Irish National Registry of Deliberate Self Harm funded by the Health Service Executive's National Office for Suicide Prevention. The Registry records all deliberate self harm presentations made to all general hospital emergency departments in the country.

The next section of this report compares the findings from the Western Area in 2010 to the NSRF 2010 Annual Report.

# Incidence Rates – All-island of Ireland Comparison

Derry CC rates were compared with those of five cities in Ireland (figure 10) for 2010.

- In 2007-08, Derry CC had the highest rates for both genders, with higher rates than in Limerick City which had the highest rates in RoI in 2008.
- In 2009 and 2010, the rate of self-harm in Derry CC has fallen below the rate for Limerick but remains higher than the other four cities in RoI.
- The female rate for 2010 in Derry CC is 8.4% lower than the female rate in Limerick City but 54.6% to 98.5% higher than the other four cities in RoI

Figure 10: Person-based EASR of self-harm in Derry CC by gender compared to RoI cities in 2010.

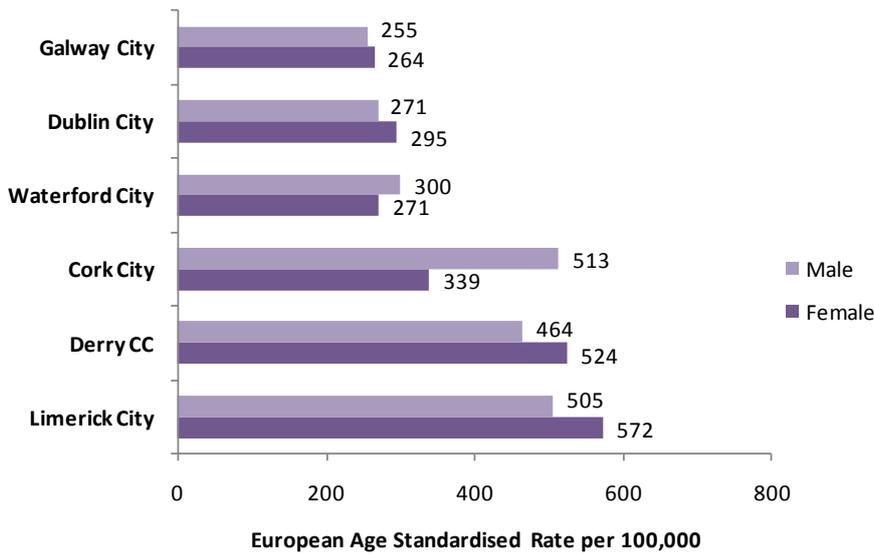


Table 4 compares the European Age Standardised Rate of Self-Harm attendances in the Western area with the Republic of Ireland. The Western area rate is higher than the rate for the Republic of Ireland.

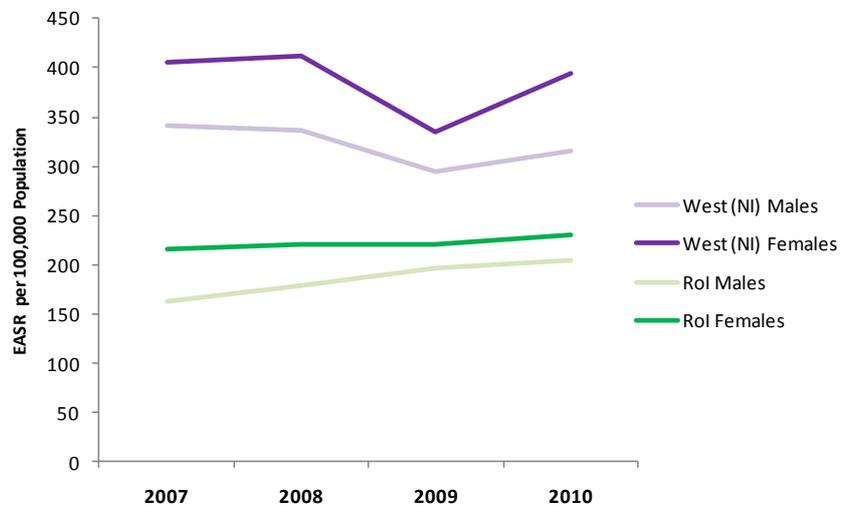
Table 4: Person-based European Age-Standardised rate per 100,000 of the population in the Western area and in the RoI in 2010.

	Males	Females	All
Western area, NI	316	395	355
Republic of Ireland	205	231	217

Figure 11 illustrates the EASR of self-harm in the Western area of NI and in the RoI from 2007 to 2010.

The rate in the Western area dipped in 2009 but has shown an increase in 2010 while the rate in the RoI has increased steadily over the four year period.

Figure 11: EASR for males and females in NI and RoI, 2007 to 2010







# Methods of Self-harm

Table 5 shows the methods of self-harm used. Patients may have engaged in one or more of these methods.

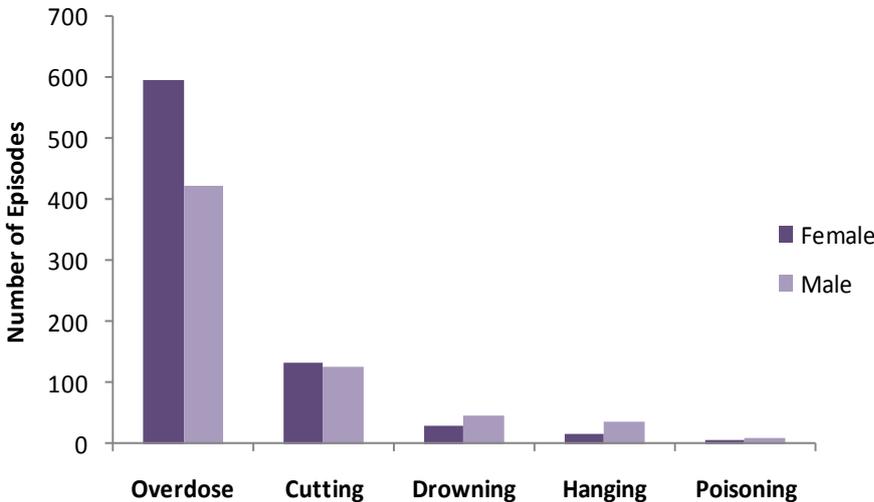
Table 5: Number of episodes by method, Western area, 2010

	Overdose	Cutting	Drowning	Hanging	Poisoning	Alcohol Involvement
<b>Total</b>	<b>1021</b> (72.8%)	<b>258</b> (18.4%)	<b>74</b> (5.3%)	<b>53</b> (3.8%)	<b>14</b> (1%)	<b>783</b> (55.8%)

### Summary of Methods of self-harm

- Similar to the previous three years, overdose was the most commonly used method of self-harm in the Western area in 2010, used in 72.8% of episodes. Self-cutting was the second most commonly used method involved in 18.4% of all episodes.
- Attempted drowning accounted for 5.3% of all self-harm attendances. This was slightly lower than 2009 (6.4%). There were more male attendances due to attempted drowning than female attendances with 62.2% of all attempted drowning being among males.
- The majority (82.4%) of all attempted drownings occurred among residents within the Derry CC area. This is slightly lower than the findings from 2009 (84%). Attempted drowning accounted for 8.3% of all methods within the Derry CC area compared to 1.1% to 2.6% of episodes in the other council areas.
- Attempted hanging accounted for 3.8 % of all self-harm attendances. There were more male attendances due to attempted hanging than female attendances with 67.9% of all attempted hanging being among males. This is similar to previous findings.
- Alcohol, whilst rare as a main method, was involved in 55.8% of all episodes. This is similar to findings in the previous three years.

Figure 12: Breakdown of methods by gender, Western area in 2010





## Methods of Self-Harm - Drug Overdose

Drug overdose was the most common method of self-harm, recorded in almost three quarters (72.8%) of all self-harm episodes in 2010. This is a slight decrease than the previous three years (73.9% in 2009 and 77.1% in 2007-08).

### Summary of Drug Overdose Findings

- Drug overdose was more commonly used as a method of self-harm by females than males (77.4% of all female episodes and 67.2% of male episodes).
- These figures were slightly higher than those for the RoI. The NSRF findings show 71.4% 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 (77.0% of female episodes and 65.1% of male episodes).

## Methods of Self-Harm – Cutting

Cutting was the second most common method of self-harm, being used in 18.4% of all self-harm episodes. This is a slight increase compared to previous years (17.2% in 2009 and 17.1% in 2007-08).

### Summary of Cutting Findings

- Cutting was a method of self-harm in 19.9% of male episodes and 17.1% of female episodes. The percentage of male episodes is similar to 2009 while there has been an increase in the percentage of female episodes (19.5% and 15.3% respectively).
- The findings in 2010 were slightly lower than the RoI figure where self-cutting was the method used in more than one fifth (22.6%) of all episodes and was used significantly more by males (25.8%) than by females (19.7%).





# 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 has been a decreasing trend in the number of self-harm episodes involving alcohol from 2007-08 (68.5%) to 2010 (55.8%).
- In line with previous findings, alcohol was involved more often in male deliberate self-harm episodes (60.4%) than in female episodes (52.1%).
- This was higher than the RoI where alcohol was involved in 44.3% of male episodes and 37.3% of female episodes.
- 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 (68.9%), attempted hanging (58.5%), self-cutting (55.8%) and drug overdose (54.9%) but less common in acts involving self-poisoning (35.7%) (figure 13). Since 2009, there has been an increase in alcohol involvement in self-harm acts involving attempted hanging and attempted drowning.
- There was a variation in the self-harm method and alcohol involvement when compared by gender (Figure 14). In 2010 males had a higher percentage of alcohol involvement with all methods of self-harm. In previous years males have had a higher percentage of alcohol involvement with all methods except for drowning.



Figure 13: Average percentage of episodes involving alcohol by method in the Western area in 2010.

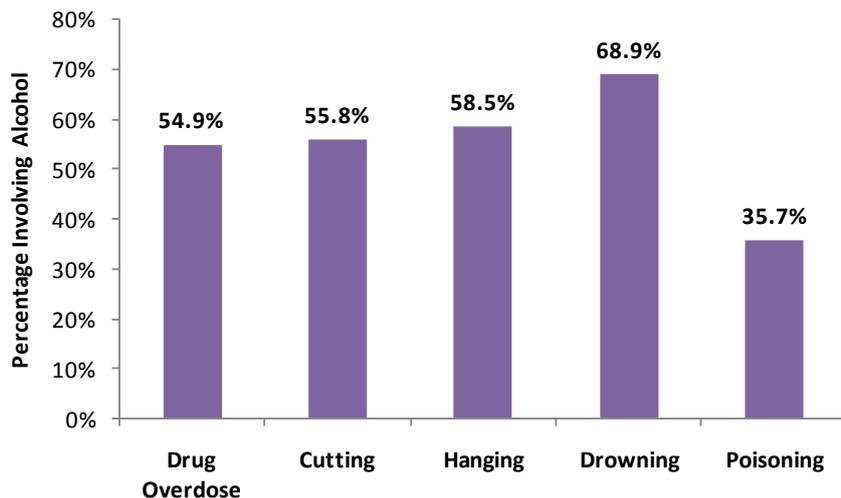
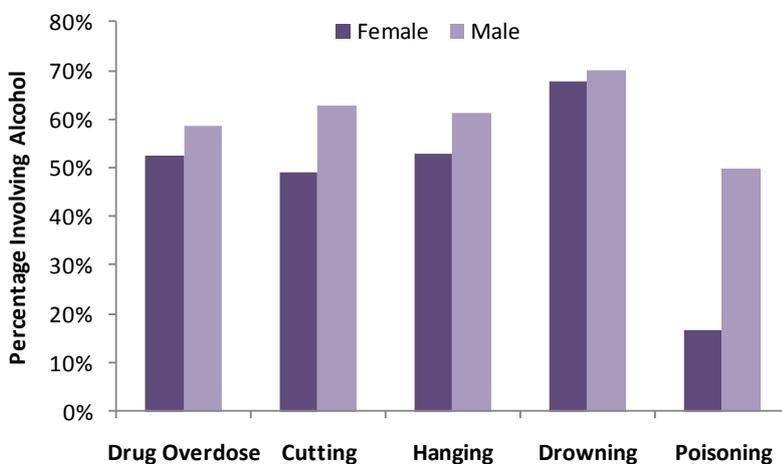


Figure 14: Average percentage of episodes involving alcohol by gender and method in the Western area in 2010.

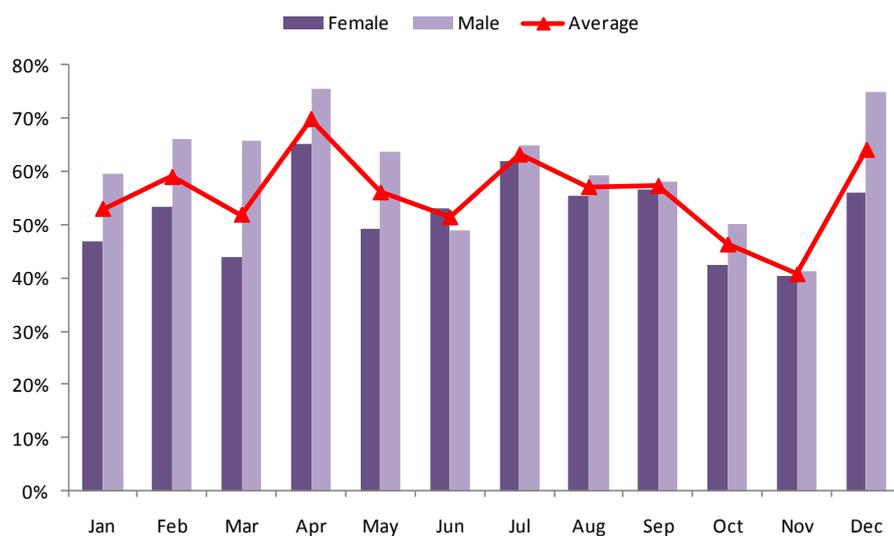


## Alcohol – Month / Day / Hour

Summary of Alcohol Findings by Month (figure 15)

- Males had a higher percentage of self-harm episodes involving alcohol than females in every month of the year in 2010 with the exception of June.
- April had the highest percentage of self-harm episodes involving alcohol for both males (75.4%) and females (65.2%).
- November had the lowest percentage of episodes involving alcohol for both males and females (41.2% and 40.3% respectively).
- Three quarters of the self-harm presentations made by males in April and December involved alcohol.

Figure 15: Average percentage of episodes involving alcohol by gender and month in the Western area in 2010.

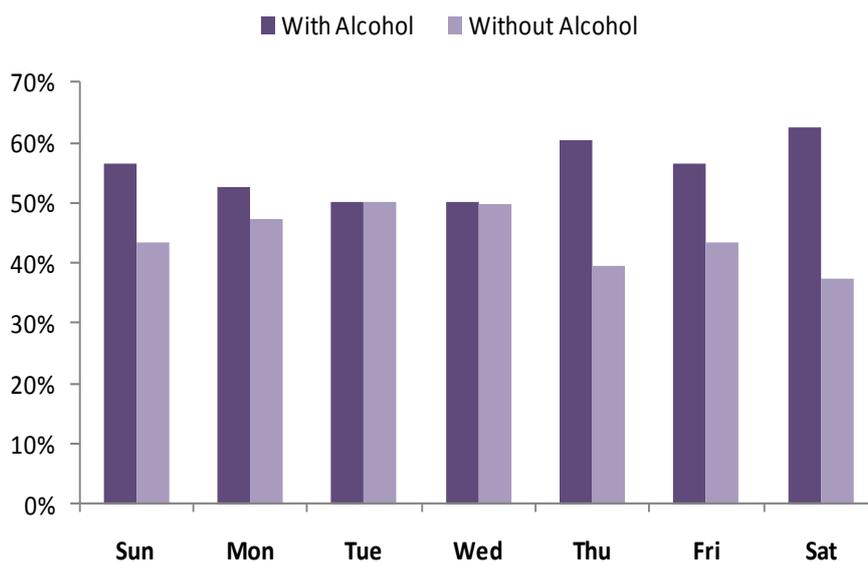


### Summary of Alcohol Findings by Day

Figure 16 presents the association between the percentage of self-harm episodes with and without alcohol and the day of presentation to hospital.

- 35.1% of self-harm episodes involving alcohol presented at the weekend. This is similar to findings in previous years (35.2% in 2009 and 38.3% in 2007-08)
- There was no clear association between self-harm episodes not involving alcohol and the day of attendance. This pattern is consistent with previous years.

Figure 16: Average percentage of self-harm episodes with and without alcohol involvement in the Western area in 2010.



## Summary of Outcomes for Alcohol by Hour of Presentation

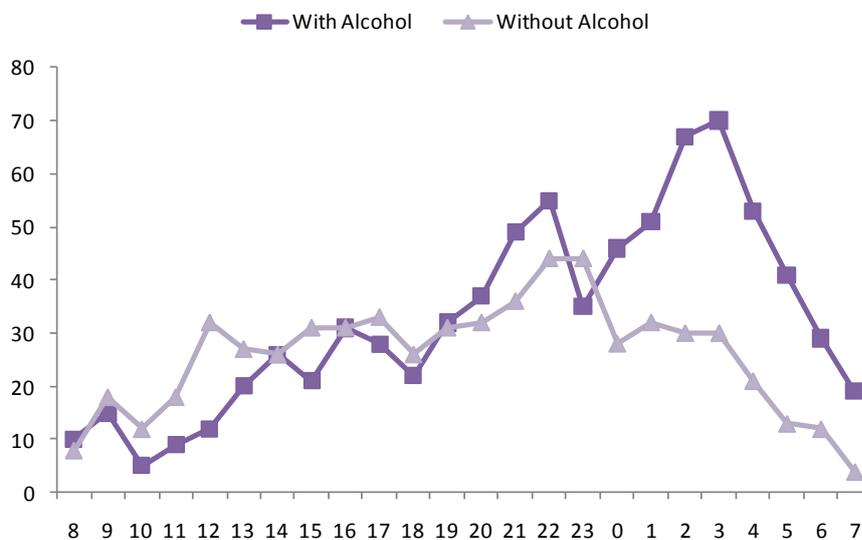
Figure 17 looks at the pattern of self-harm episodes with and without alcohol and the hour of presentation to hospital.

- 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 (59.6%) of self-harm episodes involving alcohol attended hospital between 9pm and 5am.

All of the above findings are consistent with previous years.

- Self-harm episodes involving alcohol increased from 8pm until 3am with a dip in attendances at 11pm. In 2009 the increase started at 10pm and continued to 3am.
- Self-harm episodes not involving alcohol peaked between the hours of 10pm and 11pm. This is later than previous years with peaks at 9pm in 2009 and 7pm in 2007-08.

Figure 17: Pattern of self-harm episodes with and without alcohol involvement by hour in the Western area in 2010.



## Alcohol – Age Group & Gender

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

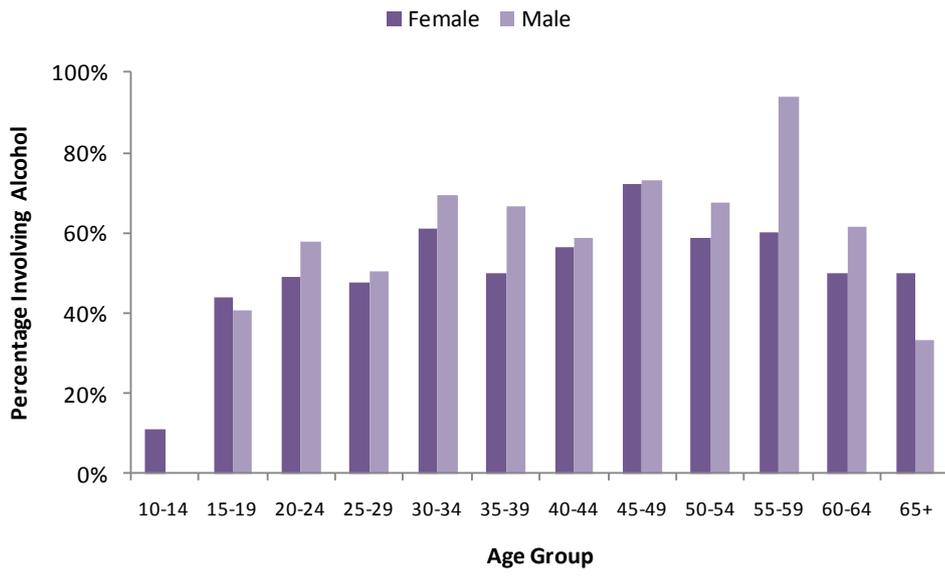
### Summary of Outcomes for Alcohol (By Age Group & Gender)

- There was some variation in the use of alcohol with age for both genders (figure 18).
- Males had a higher percentage of self-harm episodes involving alcohol than females from age 20 to 64 years.
- Females had a higher percentage of self-harm episodes involving alcohol than males in the 10-14, 15-19 and over 65 year age groups. In the previous three years 15-19 year old males had a higher percentage of alcohol involvement than females.
- 94% of male self harm attendances in the 55-59 year age group involved alcohol.

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

- In the 15-19 year age group, Derry CC had the highest percentage of self-harm episodes involving alcohol (51.0%) followed by Strabane DC (50.0%). In 2009, Strabane DC had the highest percentage of self-harm episodes involving alcohol in this age group (54.5%) followed by Limavady DC (50.0%). Limavady DC (22.2%) has seen a decrease in alcohol involvement in this age group in 2010 compared to previous years.
- In the 20-24 year age group, Limavady DC had the highest percentage of self-harm episodes involving alcohol at 69.2%, followed by Derry (56.1%). In 2009, Omagh DC had the highest percentage of episodes involving alcohol (66.7%) in this age group.
- Limavady DC and Derry CC had the highest percentage of self-harm episodes involving alcohol among 25-34 year olds at 60.7% and 59.3% respectively. In 2009 Derry CC had the highest percentage of alcohol involvement (67.4%) followed by Limavady DC (65.0%) in the 25-34 year age group. Findings in 2007-08 showed Fermanagh to have the highest percentage of alcohol involvement in this age group (78.3%).
- In 2010 Fermanagh DC and Strabane had high percentages of self-harm episodes involving alcohol in the 35-44 year age group (63.2% and 61.8% respectively), while Limavady DC and Derry CC had the highest percentages of self-harm episodes with alcohol involvement among the 45-54 year olds (78.6% and 75.9% respectively).
- Derry CC had the highest percentage of episodes involving alcohol within the 55-64 year age group (84.0%). In 2009, Fermanagh DC had the highest percentage of episodes involving alcohol in this age group (75.0%).

Figure 18: Percentage of episodes with alcohol involved by age group and gender, Western area, 2010



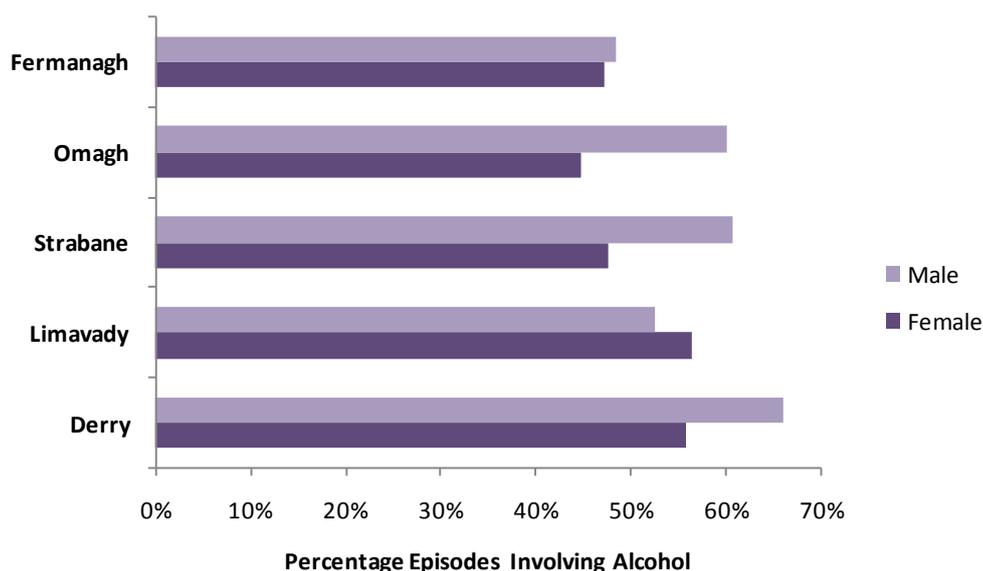
## Alcohol – Local Area Comparison

Figure 19 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 self-harm episodes involving alcohol (60.5%), followed by Limavady DC (54.7%), Strabane DC (52.8%), Omagh DC (49.7%) and Fermanagh DC (47.8%).
- Males had a higher percentage of episodes involving alcohol across most of the council areas with the exception of Limavady DC where females had a higher percentage of self-harm episodes involving alcohol than males (56.4% and 52.5% respectively). This is similar to findings in 2009, however in 2007-08, males had a higher percentage of episodes involving alcohol in all council areas.
- Limavady DC had the highest percentage of self-harm episodes involving alcohol for females (56.4%) and Derry CC had the highest percentage for males (66%). In 2009 Derry CC had the highest percentage of self-harm episodes involving alcohol for females (57.8%) and Omagh CC had the highest percentage for male (65.5%). Derry CC had the highest percentage self-harm episodes involving alcohol for both genders in 2007-08.
- Omagh DC had the lowest percentage of self-harm episodes involving alcohol for females (44.7%). In previous years (2007 to 2009) Strabane DC had the lowest percentage of self-harm episodes with alcohol involvement for females.
- Fermanagh DC had the lowest percentage of self-harm episodes involving alcohol for males (48.3%). In 2009, Limavady DC had the lowest percentage of self-harm episodes involving alcohol for males (43.2%) while Omagh DC had the lowest percentage for males (61.9%) in 2007-08.

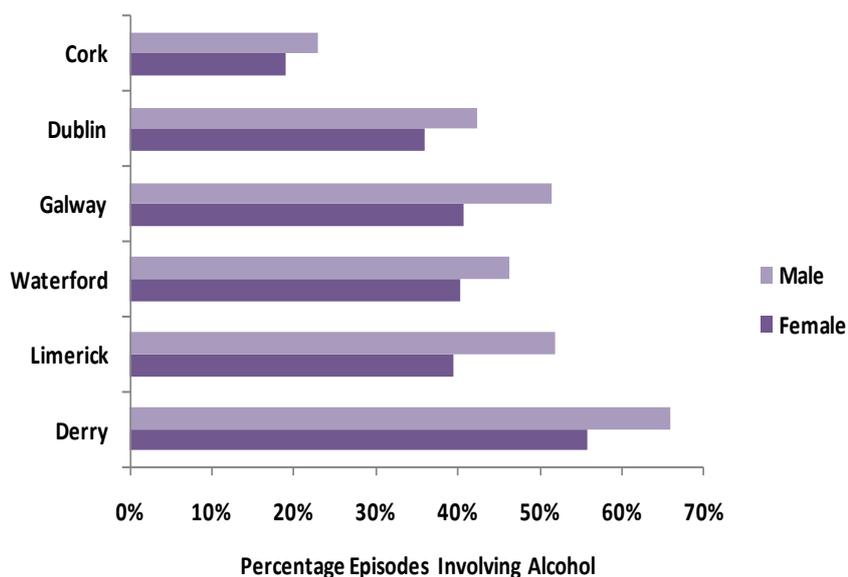
Figure 19: Council areas within the Western area showing percentage of episodes which involved alcohol by gender, 2010.



## Alcohol – All-island

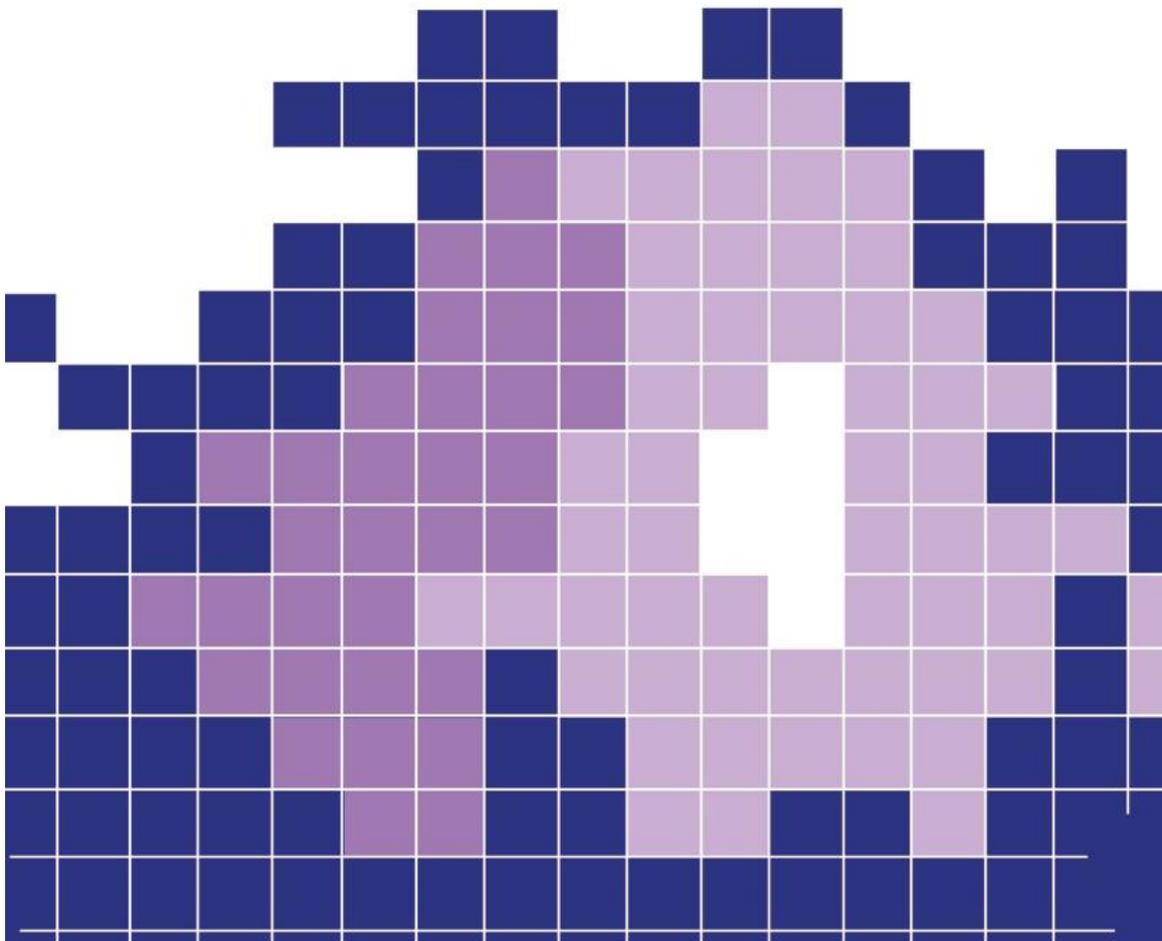
- An all-island comparison of cities (figure 20) shows Derry CC had the highest percentage of self-harm episodes involving alcohol in both genders. This is consistent with the findings from previous years (2007 to 2009).
- Episodes of self-harm involving alcohol were lower in females in Rol cities (19.0% - 40.7%) than in Derry CC (55.8%). This is also consistent with the findings from previous years (2007 to 2009).
- Male episodes of self-harm involving alcohol in Rol cities were also lower than Derry CC (66.0%) ranging from 22.9% in Cork to 51.8% in Limerick. This is also consistent with the findings from previous years (2007 to 2009).

Figure 20: Average percentage of self-harm episodes involving alcohol by gender in cities (all-island) 2010.





## Next Care Following A&E Attendance





## 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 6: Next care following self-harm attendance to A&E in the Western area in 2010

Outcome Following Attendance at A&E	Number	%
Admitted to General Hospital	700	49.9%
Admitted to Psychiatric Hospital	102	7.3%
Discharged from A&E	494	35.2%
Patient left without being seen by A&E doctor	53	3.8%
Patient left prior to decision	41	2.9%
Patient left contrary to medical advice	12	0.9%



## Patients Admitted to Hospital from A&E

There has been a decrease in the percentage of patients being admitted to hospital over the past four years.

In total, 57.2% (n=802) of self-harm presentations to the A&E department resulted in admission to either an acute or psychiatric hospital (58.1% in 2009 and 67.2% in 2007-08). Of those, 7.9% (n=63) received a psychiatric assessment by a member of the mental health team prior to admission. This was below the level recorded in 2009 (10.6%) and above findings in 2007-08 (5.9%).

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 almost identical for both genders.

### Admission to General Hospital

- Of the 1,402 self-harm presentations in 2010, 49.9% (n=700) resulted in an admission to the general acute hospital. This was slightly lower than 2009 (50.5%) and 9% lower than 2007-08 findings (58.8%).

There was some variation across the three sites. One half (50.1%) of self-harm presentations to Altnagelvin resulted in admission to the general acute hospital, compared to 52.0% of those who presented to Erne Hospital and 16.7% at Tyrone County Hospital. These figures varied slightly from 2009 findings for Altnagelvin (54.3%), Erne Hospital (44.5%) and Tyrone County Hospital (27.9%).

### Admission to Psychiatric Hospital

Direct admission to a psychiatric hospital after emergency care at A&E followed 7.3% (n=102) of all self-harm attendances (7.6% in 2009 & 8.5% in 2007-08).

Direct psychiatric admission was highest at 12.2% in the Erne Hospital (16.2% in 2009) compared to 5.5% in Altnagelvin (4.2% in 2009).

Direct psychiatric admission in Tyrone County Hospital decreased significantly over the previous three years with no direct psychiatric admissions in 2010 compared to 9.8% in 2009 and 17.4% in 2007-2008.

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, 42.8% (n= 600) of self-harm presentations to the A&E departments did not result in admission to acute or psychiatric hospital. This is similar to last year (42.1%) but an increase of 10% compared to 32.8% in 2007-08.

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 (0.9%, n=12);
  - Patient leaving the A&E department after receiving treatment but before a decision was made regarding their next care (2.9%, n= 41);
  - Patient being advised to stay for further assessment or admission but refusing to do so (3.8%, n=53);
  - A health professional making the decision that admission was not required (35.2%, n=494).
- Of those attendances that did not result in admission to either an acute or psychiatric hospital, the majority (71.5%, n=429) 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. This is a slight decrease from previous findings (72.9% in 2009 and 79.0% in 2007-08)

In some cases this may be partly explained by the current availability of mental health staff to carry out assessments. Just over 40% (n=575) 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, 34.4% (n=336) 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. This is slightly lower than 2009 (38.7%) and 2007-08 (35.9%) findings.
- 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 (56.3% n=222) of all self-harm presentations occurred between the hours of 10pm and 9am when no mental health service was available. This is slightly higher than 2009 (55.2%) and 2007-08 (51.7%) findings.
- At Tyrone County Hospital, patients have access to a mental health practitioner available to carry out assessments at Lissan House from 9am to 6pm and then at GP Out of Hours between 6pm and 10.30pm seven days a week. Over half (56.6% n=17) of all self-harm presentations occurred between the hours of 10.30pm and 9am when no mental health service was available. This is lower than 2009 (70.5%) and higher than the 2007-08 findings (49.3%).

- 
- 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. From 1<sup>st</sup> January 2010, the Registry records episodes where Card Before You Leave was issued.

### Patients Discharged Home from A&E

- Table 6 indicates that in 35.2% (n=494) of cases the patient was discharged home following A&E attendance. This is slightly higher than 2009 (33.8%) and 15.2% higher than the 2007-08 findings (22.0%).

This varied across the three sites. Tyrone County Hospital had a higher percentage of patients who were discharged following emergency treatment (83.3%) than both Altnagelvin Hospital and Erne Hospital (35.8% and 30.2% respectively).

- Of the 494 patients discharged home from A&E, 66.6% (n= 329) did not have an assessment by a mental health practitioner prior to discharge from A&E/Urgent Care Unit. This is similar to 2009 and slightly lower than the 2007-08 findings (70.6%). Of these, 44.1% (n= 145) presented outside the current hours of mental health service provision.

### Patients Leaving A&E Contrary to Medical Advice

- Table 6 indicates that 0.9% of patients (n=12) 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. None of these had a formal mental health assessment prior to leaving the department. Almost half (n=5) presented after 1am.

This is almost a 50% decrease compared to 2009 (1.7%) and a significant decrease to the 2007-08 findings where 5.1% of patients left contrary to medical advice.

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

- Table 6 indicates that 3.8% of patients left the department before being seen by an A&E doctor. This is an increase compared to 2.1% in 2009 and 2.7% in 2007-08 findings.

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

- Table 6 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. This is lower than 2009 (4.7%) but the same as findings in 2007-08 (2.9%).

## Card Before You Leave

The “Card Before You Leave” scheme was launched on 13 January 2010, and it ensures that any patient being discharged from an in-patient, or an A&E setting, who requires ongoing attention from Mental Health teams, will now receive a card prior to discharge, giving details of contact numbers for support, and of how follow up care will progress.

For those being discharged from in-patients, this includes a follow-up appointment. Anyone being discharged from A&E will be contacted by their local Mental Health team within 24 hours to arrange an appointment. The card therefore provides additional reassurance and support for some of our most vulnerable people who are at risk of suicide and self-harm.

The Registry has been altered to record when the Card Before You Leave has been issued. During 2010, there were 470 patients discharged home following A&E attendance, of which 27.6% (n=130) were issued with a “Card Before You Leave”.

## 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.

- Over half (59.7%) of drug overdose acts resulted in acute ward admission compared to 35.8% of attempted hangings, 35.1% of attempted drowning episodes and 16.7% of self-cuttings. This is similar to findings in the previous three years.
- Direct psychiatric admission followed 17.0% of attempted hanging episodes compared to 12.1% in 2009. 14.9% of attempted drowning episodes were directly admitted to a psychiatric ward which was similar to 2009 (14.8%). These figures are much lower than the 2007-08 findings where direct psychiatric admission followed 29.8% and 25.8% of attempted hanging and attempted drowning episodes respectively.
- Over half (58.5%) of self-harm patients who had used self-cutting were discharged from A&E after emergency treatment. This is higher than previous findings (55.0% in 2009 and 46.8% in 2007-08 findings).
- Over half (52.5%) of self-harm episodes involving alcohol resulted in an acute ward admission. This is similar to 2009 (53.6%) and lower than the 2007-08 findings (61.6%).

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.



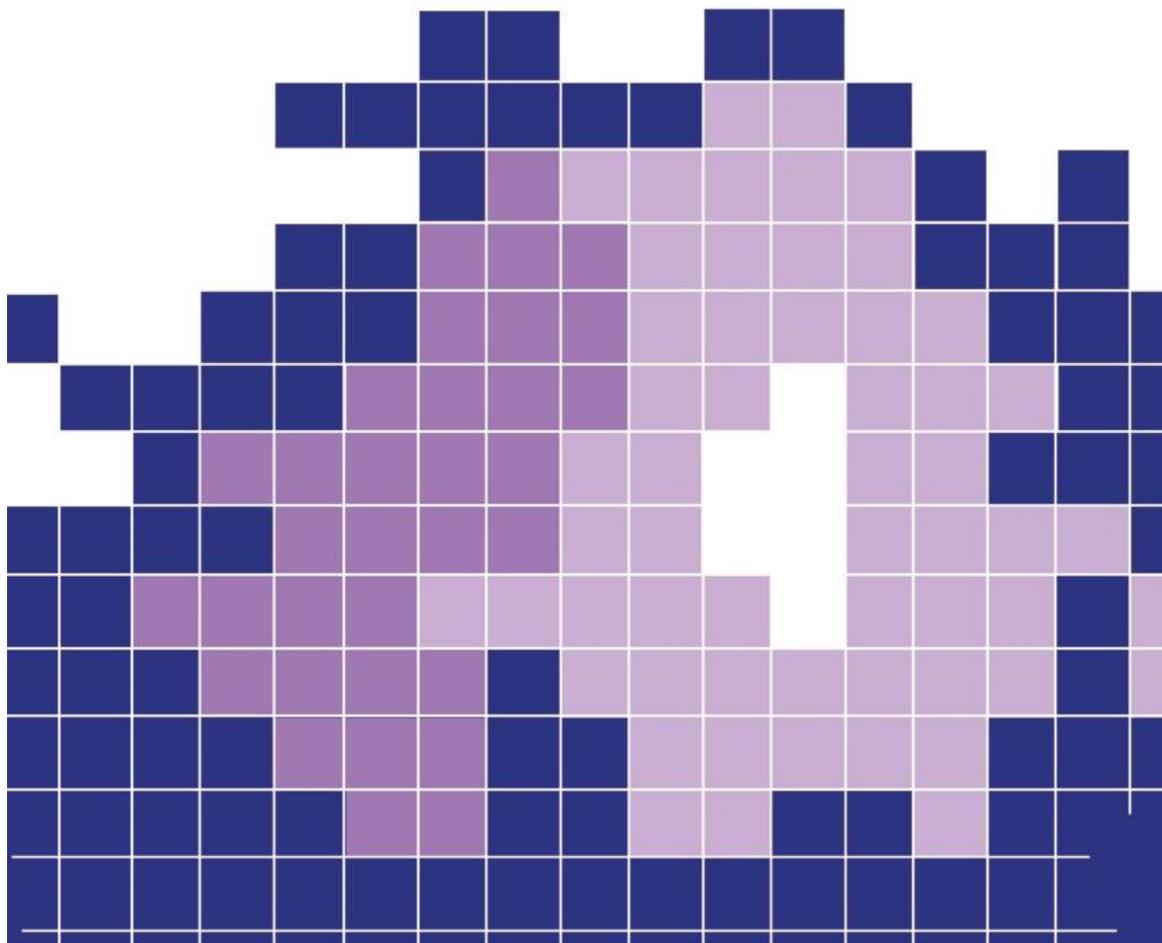
## +Alcohol Involvement

As noted previously in the report, a large proportion (55.8%) 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, 34.4% (n=336), of all self-harm attendances to Altnagelvin A&E department occurred between these hours. Of these, 71.1% (n=239) involved alcohol. This is very similar to the findings in previous years 2007 to 2009.

Mental health services are currently not available between 10.00pm and 9am at the Erne Hospital and 10.30pm and 9am at Tyrone County Hospital. Over half of all self-harm presentations (56.4% n=239) to these units occurred between these hours. Of these, 56.9% (n=136) involved alcohol. This is similar to 2009 but varies slightly to the 2007-08 findings where 50.5% of all self-harm attendances occurred outside of the hours of the provision of mental health services and 69.8% of those involved alcohol.

# Repetition and Ideation





## 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 1086 people treated for 1,402 episodes of self-harm in 2010. A One in five (22.5%) of all self-harm presentations in 2010 were repeat presentations. This was similar to 2009 (22.0%) and 2007-08 (21.0%). There was some variation in repetition within gender, age group, method and hospital:

### Summary of repetition in 2010

- There was virtually no difference in repetition between male (15.3%) and female (15.6%) attendances.
- 168 of the 1,086 people (15.5%) made at least one repeat self-harm presentation.
- There was no clear pattern with repetition and increasing age. The highest repetition was among the 30-34 year age group (20.0%) followed by the 35-39 year age group (18.7%).
- There was a difference in the rate of repetition between those who primarily engaged in drug overdose (14.2%), those who primarily engaged in self-cutting (25.1%) and those who primarily engaged in attempted hanging (12.2%).

## Ideation Cases

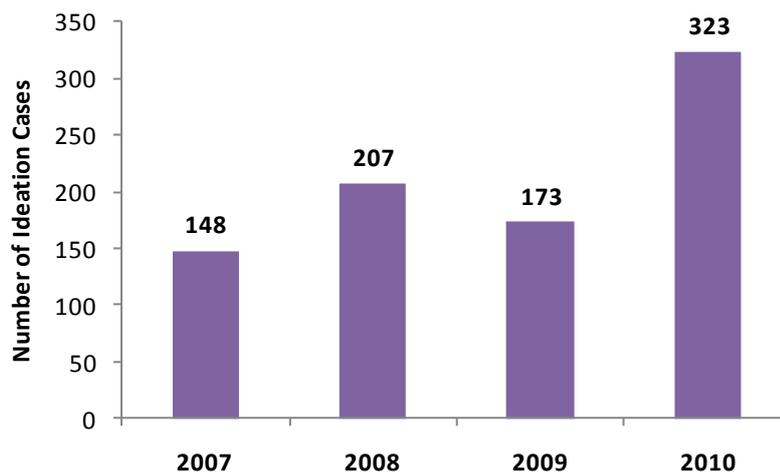
In the Western area data was collected on cases of suicidal or self-harm ideation. This data is not collected by the National Registry of Self-Harm in the Republic of Ireland but was felt to be useful locally.

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 were collected alongside actual self-harm cases but is reported separately.

### Summary of Findings from Ideation Cases:

- There were 323 ideation cases recorded in 2010, an increase of 86.7% (n=150) compared to 2009. There were 207 ideation cases recorded in the Western area in 2008 and 148 ideation cases in 2007.

Figure 21: Number of Ideation Cases Recorded, 2007 to 2010



- Ideation cases comprised 18.7% of all recorded cases (self-harm and ideation) in 2010. This was higher than previous years (12% in 2009, 14% in 2008 and 10.6% in 2007).

There was some variation when compared to each hospital site:

- Ideation cases comprised 18.4% of all recorded episodes (self-harm and Ideation) at Altnagelvin Hospital in 2010. This was higher than previous years (10.4% in 2009, 12% in 2008 and 9% in 2007).
- Ideation cases comprised 18.9% of all recorded episodes (self-harm and Ideation) at Tyrone County Hospital in 2010. This was higher than 2009 (11.8%) and similar to 2007 and 2008 (18% and 20% respectively).
- Ideation cases comprised 19.4% of all recorded episodes (self-harm and Ideation) at Erne Hospital in 2010. This was higher than previous findings (16.1% in 2009, 15% in 2008 and 9% in 2007).
- Patients presenting with ideation were marginally older in age than the actual self-harm cases
- Almost two thirds (61.3%) of ideation cases were male, in contrast to 45.0% of self-harm cases being male. This is similar to the findings in the previous three years.





## Key Issues Arising

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

The scale and pattern 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.

This report has highlighted the changes in self-harm behaviour over the past four years and has reinforced the importance of self-harm data collection/analysis, and it's potential to target resources and develop services to meet the needs of patients.

Numerous studies have found that engagement in deliberate self-harm is the strongest predictor of future suicidal behaviour, both fatal and non-fatal. There is therefore the need to develop a mechanism which ensures that the self-harm patterns identified by the Registry are feeding into the development of both the local suicide prevention action plans and the wider delivery of the mental health services.

The Registry demonstrates use of recreational and prescription drugs in overdose cases. The impact of these drugs needs to be monitored and this data should be used when considering restricting certain drugs.

The Registry highlights the importance of maintaining close working relationships with statutory, community and voluntary sectors as well as the need to maintain cross-border working relationships.

The Registry has been altered to include an additional data collection field to monitor the implementation of the 'Card Before You Leave Scheme'. This scheme was introduced in January 2010 and provides an information card to patients leaving A&E who have not had an assessment by a member of the mental health team giving details of contact numbers for support, and of how follow up care will progress including a follow-up appointment for patients being discharged from in-patients.

The Self-Harm Registry has been expanded to include the 4 Emergency Departments in the Belfast Trust (Royal Victoria Hospital, Royal Hospital for Sick Children, Mater Infirmorum Hospital and Belfast City Hospital).

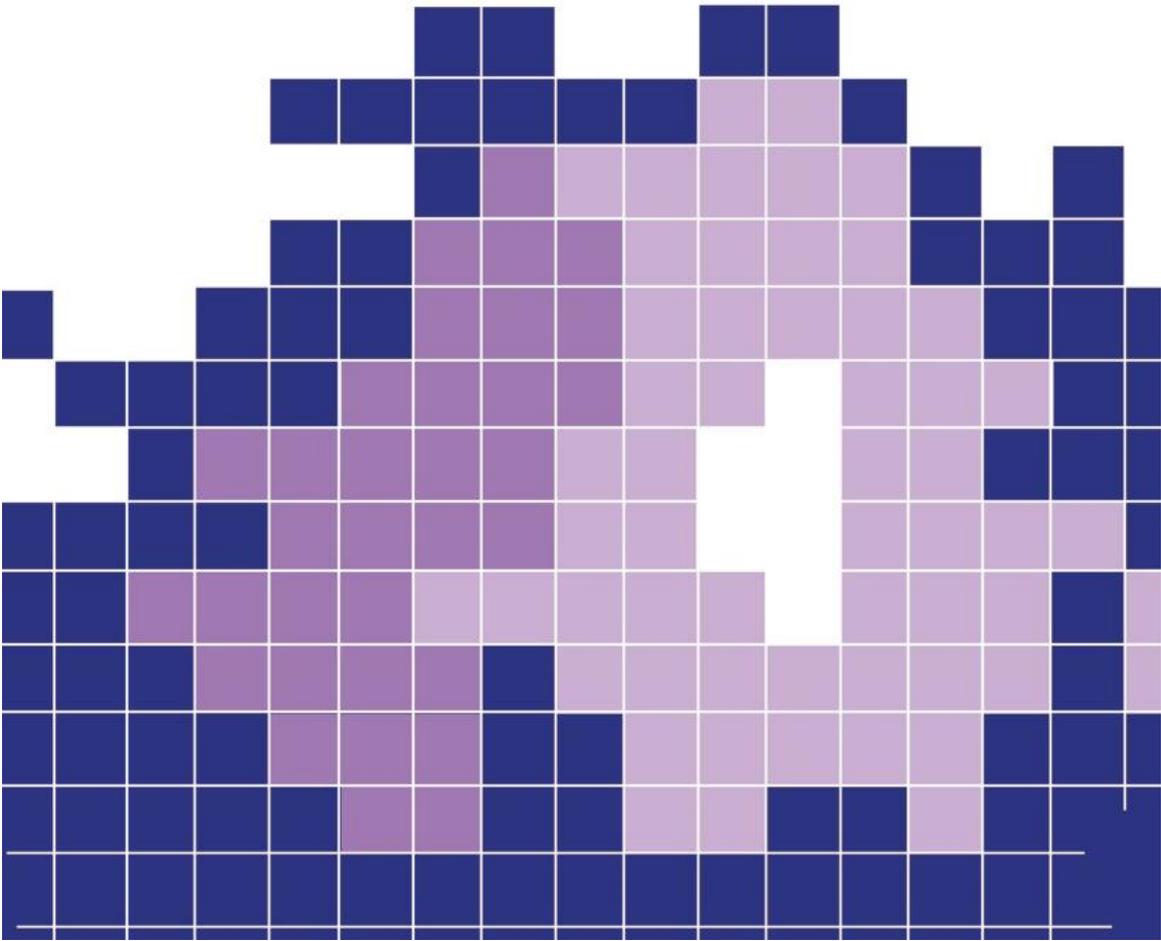
The Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI) has identified the Registry as a Ministerial Priority for Action (PFA) Target for 2011/12 and Self-Harm Registry will be rolled out across the whole of Northern Ireland by March 2012.

The data outlined in this report demonstrates that implementation of a Registry on a province-wide basis provides intelligence to enhance service provision and contribute to policy development, and it also provides for comparison of data across these islands.





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