Self-harm in Ireland:

Priority groups and opportunities for intervention

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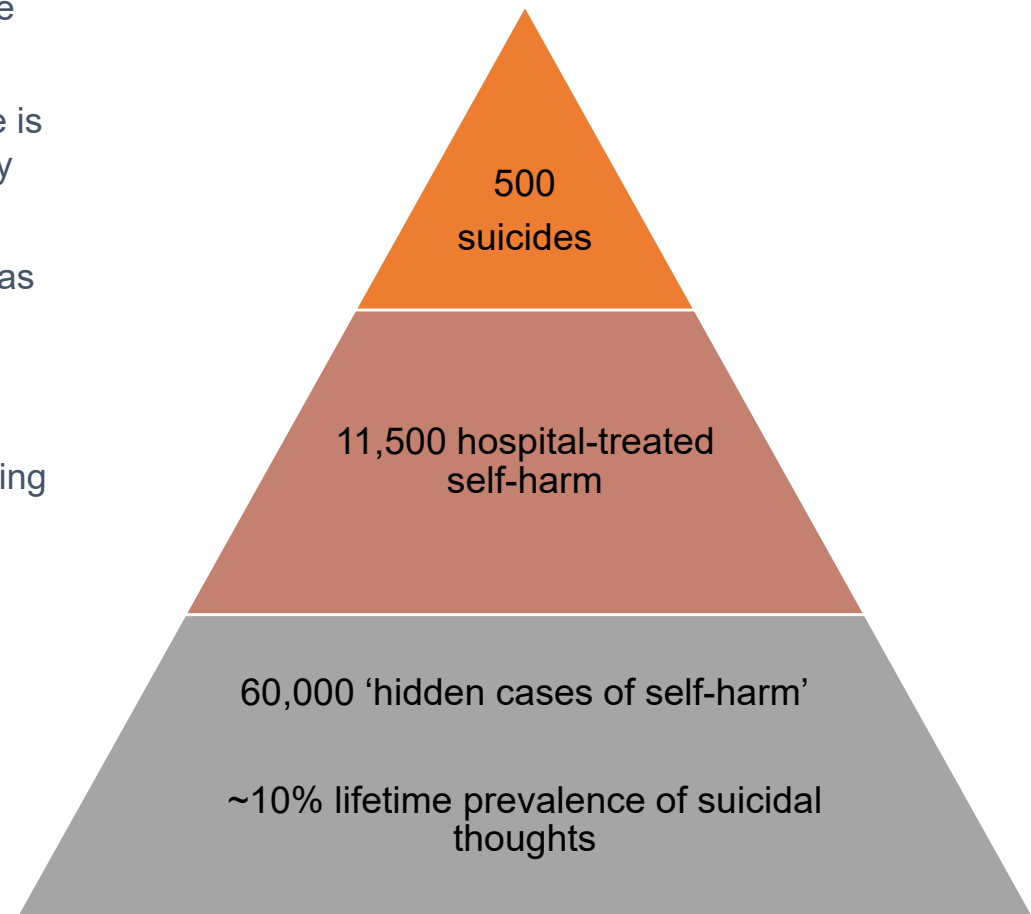
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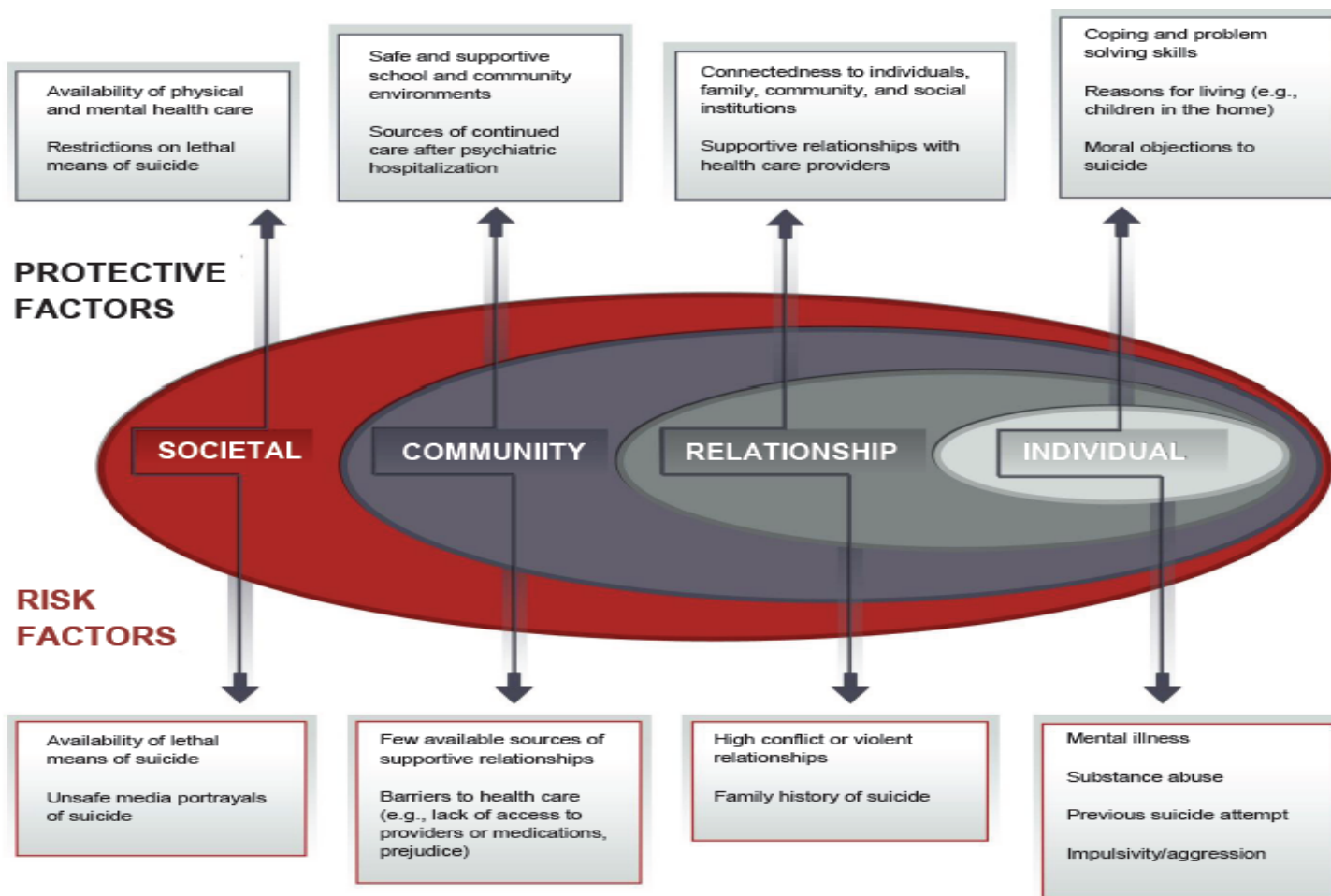National Suicide
Research Foundation

Suicidal behaviour as a public health issue

- ▶ Every 40 seconds a person dies by suicide

- ▶ Among people 15-29 years of age, suicide is the second leading cause of death globally

- ▶ In 61% of responding countries, suicide was perceived to be a significant public health concern

- ▶ By 2030, mental disorders will be the leading cause of burden of disease globally
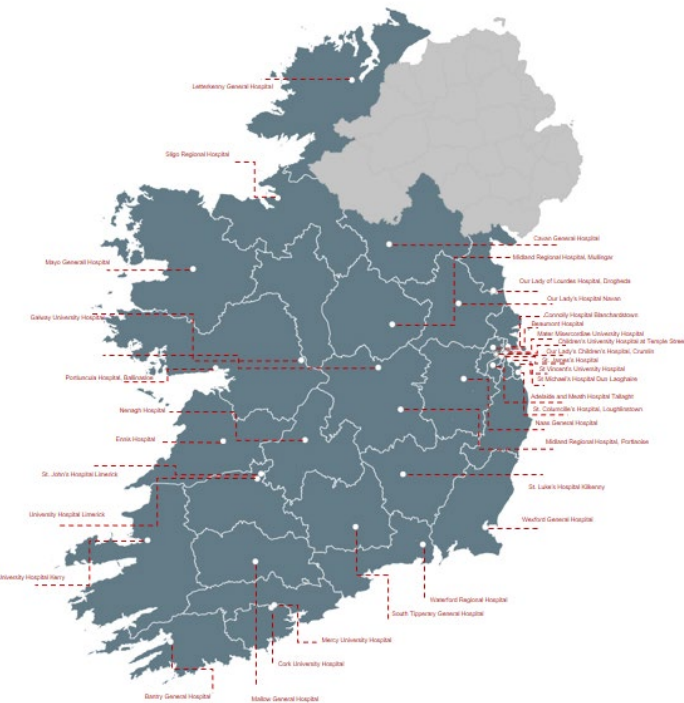
500 suicides

11,500 hospital-treated self-harm

60,000 'hidden cases of self-harm'

~10% lifetime prevalence of suicidal thoughts

Risk factors for suicidal behaviour

PROTECTIVE FACTORS

Availability of physical and mental health care

Restrictions on lethal means of suicide

Safe and supportive school and community environments

Sources of continued care after psychiatric hospitalization

Connectedness to individuals, family, community, and social institutions

Supportive relationships with health care providers

Coping and problem solving skills

Reasons for living (e.g., children in the home)

Moral objections to suicide

SOCIETAL   **COMMUNIITY**   **RELATIONSHIP**   **INDIVIDUAL**

RISK FACTORS

Availability of lethal means of suicide

Unsafe media portrayals of suicide

Few available sources of supportive relationships

Barriers to health care (e.g., lack of access to providers or medications, prejudice)

High conflict or violent relationships

Family history of suicide

Mental illness

Substance abuse

Previous suicide attempt

Impulsivity/aggression

National Self-Harm Registry Ireland

The National Self-Harm Registry Ireland team

To **establish the extent and nature** of hospital-treated self-harm;

To **monitor trends over time** and also by **area**;

To **contribute to policy and development**;

To **inform** the progress of **research and prevention**.

Definition of self-harm

'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'.

(Schmidtke et al, 2006)

NATIONAL SELF-HARM REGISTRY IRELAND

ANNUAL REPORT 2017

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2017 statistics at a glance

Presentations
11,600

Persons
9,103

+21%

2007 — 2017

Rates in young people 10-24 years increased by 21% between 2007-2017

RATES:

199
per 100,000

1 in every 503
had a self-harm act

Male: 20-24 year-olds
(505 per 100,000)
1 in every 198

Female: 15-19 year-olds
(758 per 100,000)
1 in every 132

PEAK RATES WERE AMONG YOUNG PEOPLE

TIME:

Peak time

10pm

3am
7pm

Almost **half** of presentations were made between 7pm-3am

M T W T F S S

Monday, Tuesday and **Sunday** had the highest number of self-harm presentations

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METHOD:

2 in every 3
involved **overdose**

65%

3 in every 10
involved **alcohol**

33% Men

29% Women

1 in every 4
involved **self-cutting**

27%

TREATMENT:

72%
received an assessment in the ED
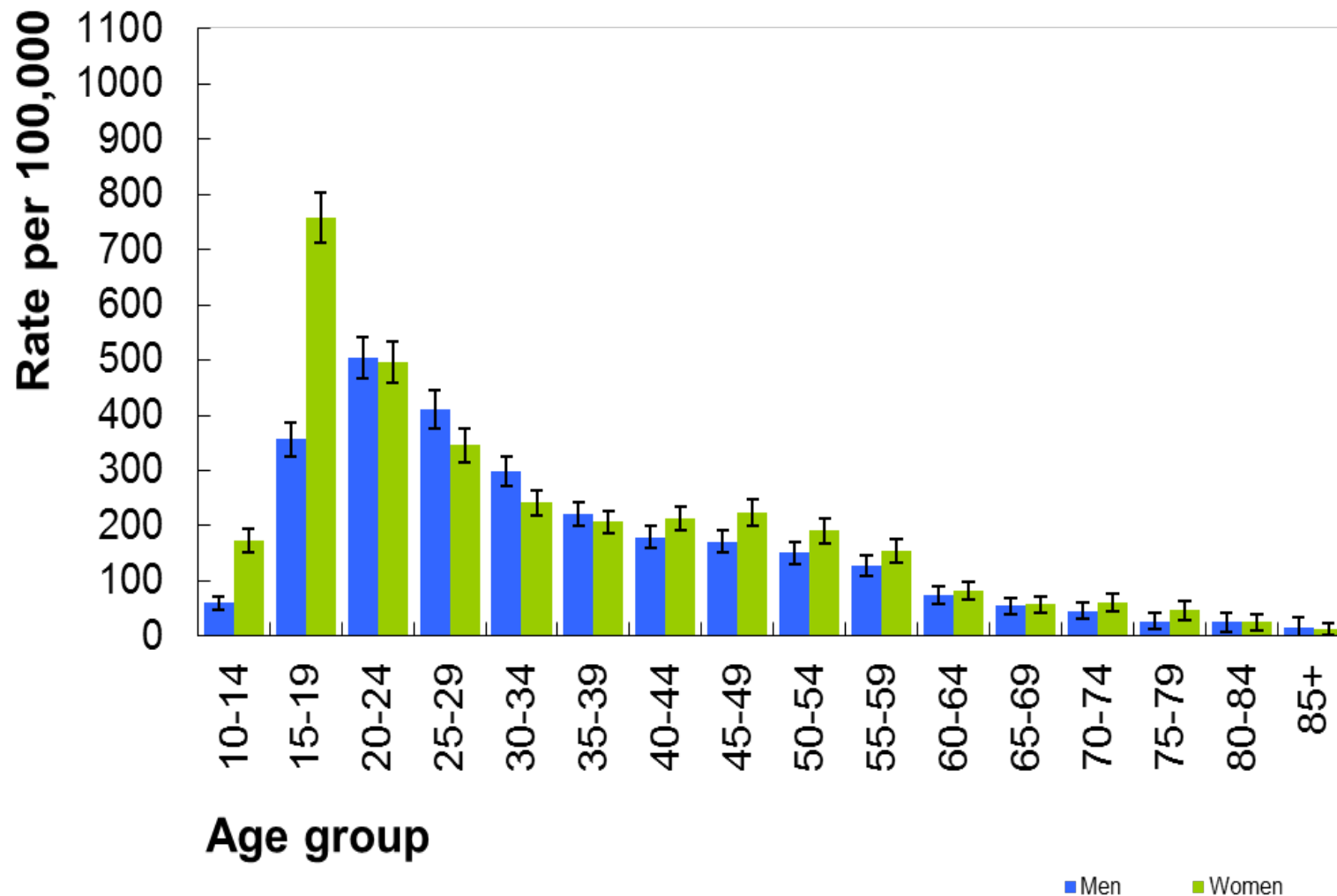
80% received a follow-up recommendation after discharge

12% left ED before a recommendation was made
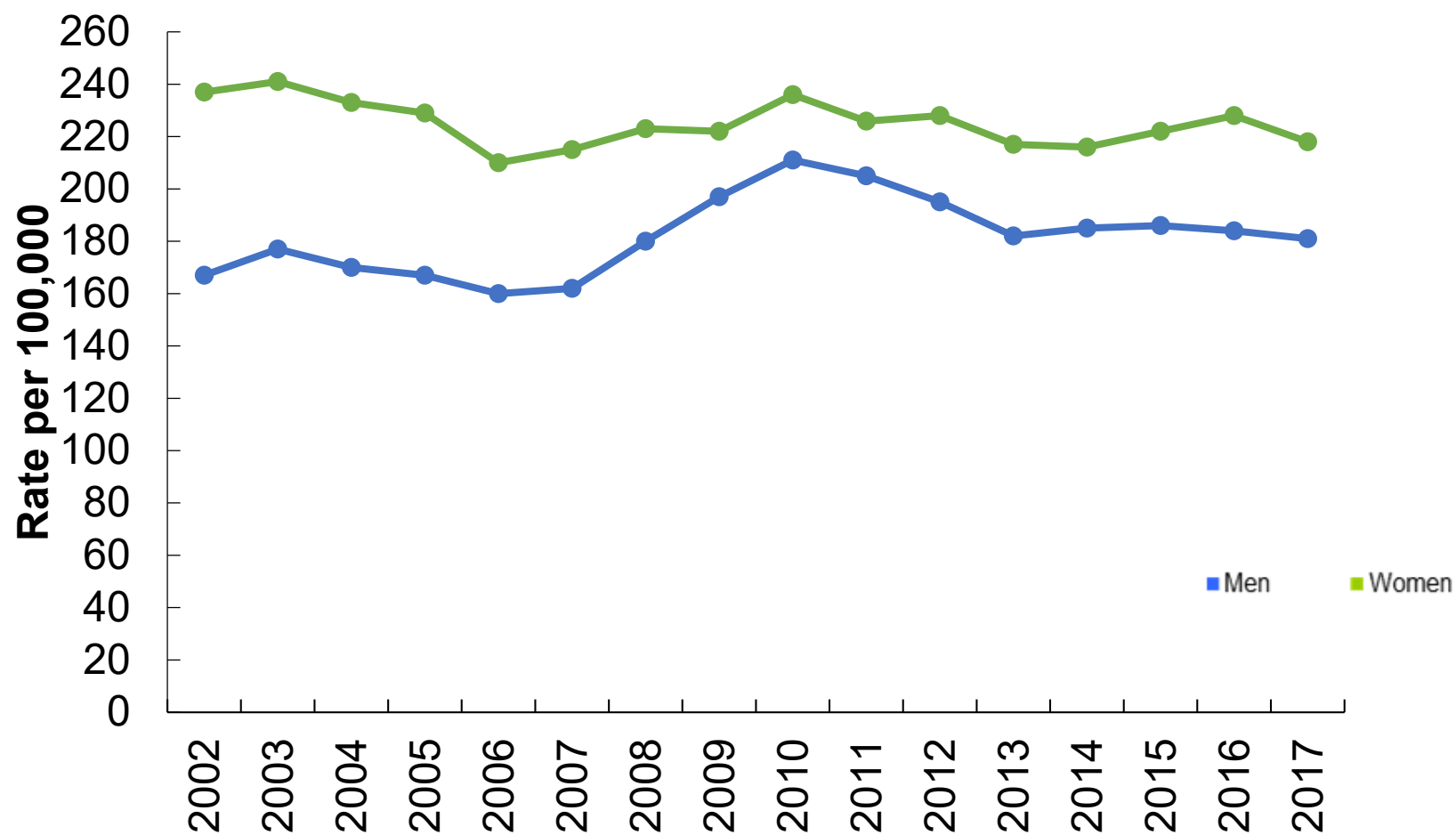
1 in 7
persons had a repeat attendance in 2017

Self-harm by age and gender, 2017

Irish rate of self-harm, 2002-2017

Trends in highly lethal methods of self-harm

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Men	316	349	408	405	523	573	503	536	545	530	577
Women	126	164	200	208	211	203	229	250	245	232	281

Y-axis: Number of self-harm presentations

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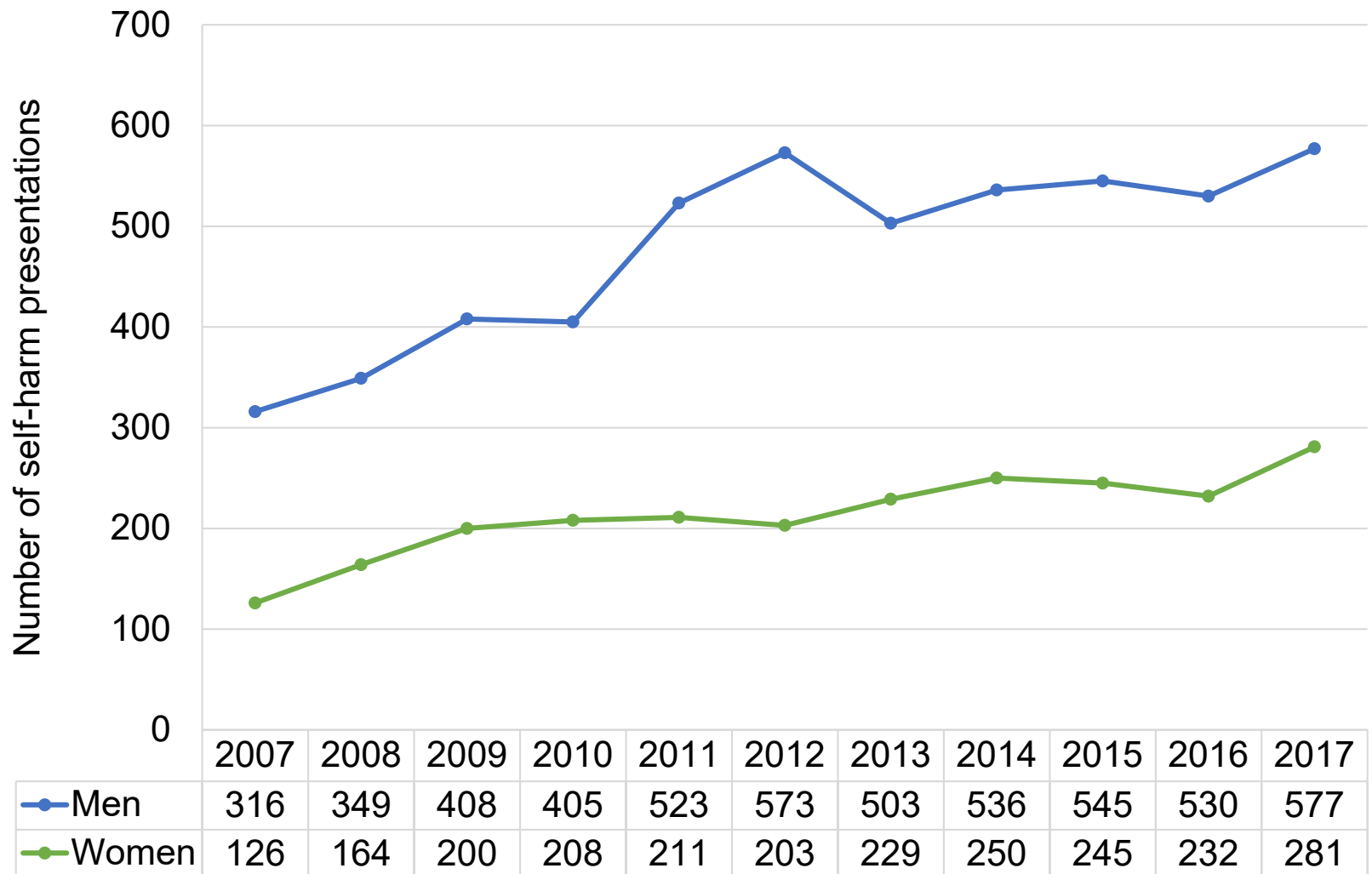
➢ Rate of self-harm **x30 times higher**

➢ Male, older in age, self-cutting or more lethal methods

➢ More likely to involve minor tranquilisers, street drugs, opiates

➢ Factors associated with repetition: Self-cutting, no psychiatric review

ARTICLE INFO

Keywords:
Self-harm
Homeless
Overdose
Self-cutting
Incidence
Epidemiology

ABSTRACT

Background: Self-harm is a strong predictor of future suicide, but little is known about self-harm among the homeless population. The study aim was to estimate the incidence of self-harm among the homeless population and to assess factors associated with self-harm.
Methods: Data on self-harm presentations to 34 hospital emergency departments in Ireland were collected by the National Self-Harm Registry Ireland (NSHRI). Index presentations between 2010 and 2014 were included for the homeless and fixed residence populations. Incidence rates of self-harm were calculated using NSHRI data and census estimates. Factors associated with self-harm and repeated self-harm were analysed by multivariable-adjusted logistic regression.
Results: The age-standardised incidence rate of self-harm was 30 times higher among the homeless (5572 presentations per 100,000) compared with those with a fixed residence (187 presentations per 100,000). Homeless people had significantly higher odds of being male (OR 1.86, 95%CI 1.56–2.23), presenting with self-cutting (vs. overdose, OR 2.15, 95%CI 1.74–2.66) and having psychiatric admission (vs. general admission, OR 2.43, 95%CI 1.66–3.57). Homeless people had higher odds of self-harm repetition within 12 months (vs. fixed residence, OR 1.46, 95%CI 1.21–1.77). The odds of repetition were significantly increased among homeless who engaged in self-cutting (vs. overdose, OR 1.76, 95%CI 1.17–2.65) and did not receive psychiatric review at index presentation (vs. reviewed, OR 1.54, 95%CI 1.05–2.26).
Limitations: The study only reflects self-harm presenting to hospital, and assumes no change in homelessness status after index presentation. Residual confounding may affect the results.
Conclusion: There is a disproportionate burden of self-harm among the homeless. Targeted preventive actions are warranted.

Risk of suicide and external causes of death following self-harm, 2009-2011

	All External Cause Mortality % (95% CI)	Suicide Mortality % (95% CI)	Non-Suicide Mortality % (95% CI)
Males	2.0 (1.7-2.3)	1.3 (1.1-1.5)	0.7 (0.6-0.9)
Females	0.7 (0.6-0.9)	0.4 (0.3-0.6)	0.3 (0.2-0.4)
All Persons	1.3 (1.2-1.5)	0.8 (0.7-1)	0.5 (0.4-0.6)

O'Farrell et al (unpublished)
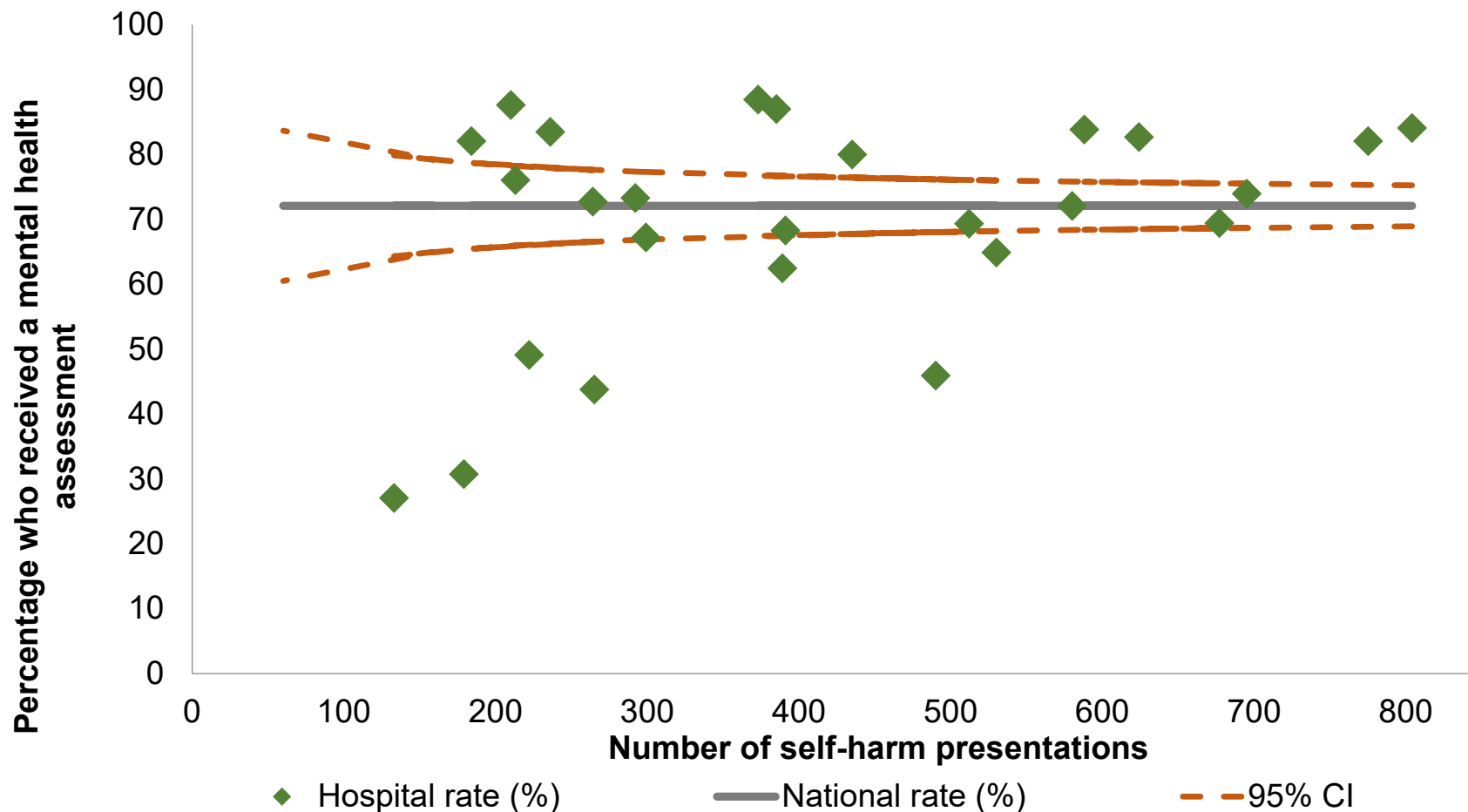
Opportunity for intervention:

Clinical settings

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Fig 2. Instrumental variable estimates* of the risk difference in repeat self-harm between those who did, and did not receive a psychosocial assessment.* The overall estimate in this figure is the overall instrumental variable estimate, not the pooled estimate from a meta-analysis of the three individual centre estimates.

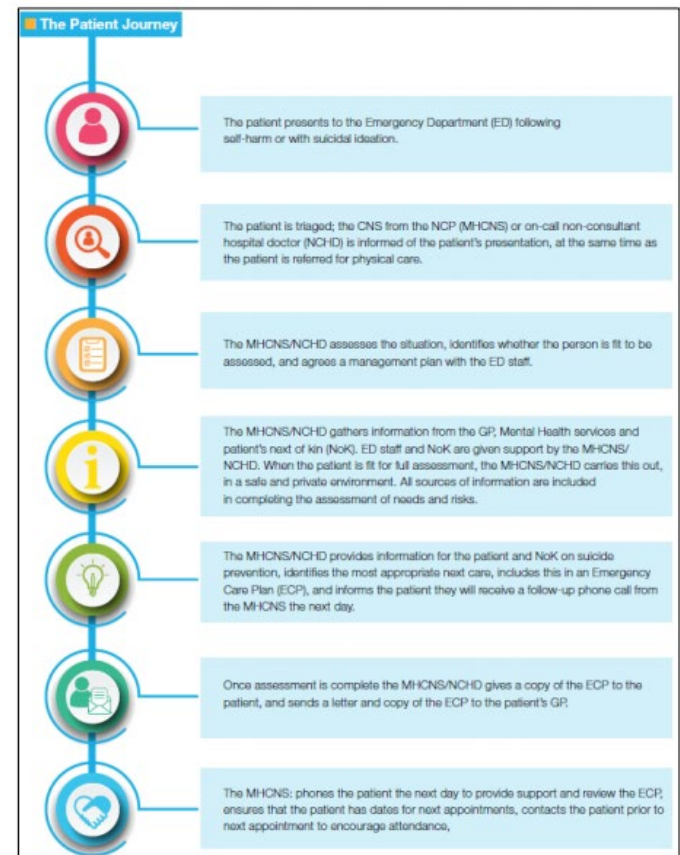**Provision of mental health assessments by hospital**

Leaving before recommendation following self-harm

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% left before recommendation

Number of self-harm presentations

Hospital rate (%)   National rate (%)   95% CI
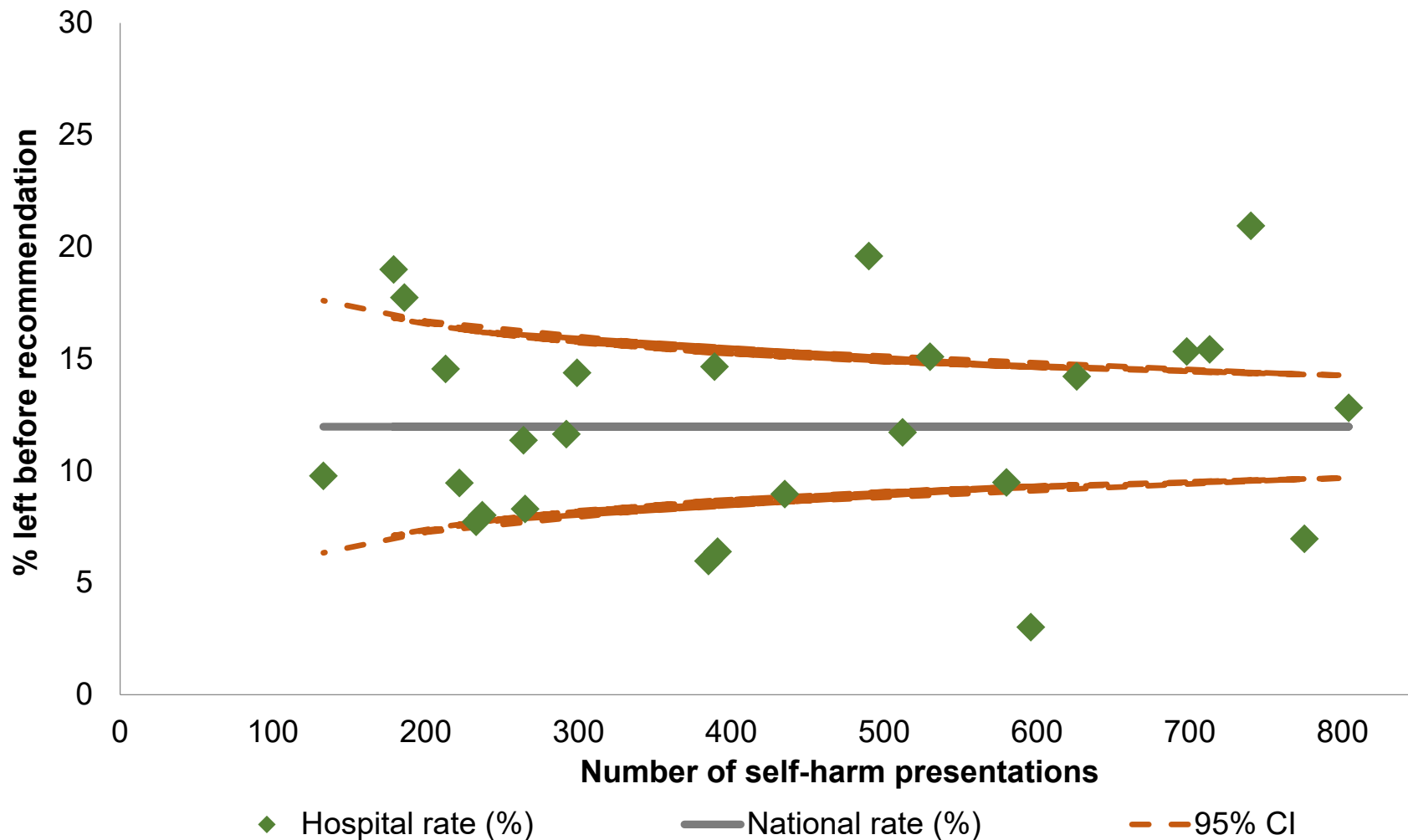
Hospital management of self-harm – Ireland's National Clinical Programme (HSE, 2017)

- ▶ Mental health assessment conducted, including needs and risk

- ▶ Emergency Care Plan provided

- ▶ Involvement of NOK

- ▶ Follow-up phone call (24 hours)

- ▶ Letter to GP

The Patient Journey

The patient presents to the Emergency Department (ED) following self-harm or with suicidal ideation.

The patient is triaged; the CNS from the NCP (MHCNS) or on-call non-consultant hospital doctor (NCHD) is informed of the patient's presentation, at the same time as the patient is referred for physical care.

The MHCNS/NCHD assesses the situation, identifies whether the person is fit to be assessed, and agrees a management plan with the ED staff.

The MHCNS/NCHD gathers information from the GP, Mental Health services and patient's next of kin (NoK). ED staff and NoK are given support by the MHCNS/NCHD. When the patient is fit for full assessment, the MHCNS/NCHD carries this out, in a safe and private environment. All sources of information are included in completing the assessment of needs and risks.

The MHCNS/NCHD provides information for the patient and NoK on suicide prevention, identifies the most appropriate next care, includes this in an Emergency Care Plan (ECP), and informs the patient they will receive a follow-up phone call from the MHCNS the next day.

Once assessment is complete the MHCNS/NCHD gives a copy of the ECP to the patient, and sends a letter and copy of the ECP to the patient's GP.

The MHCNS: phones the patient the next day to provide support and review the ECP; ensures that the patient has dates for next appointments, contacts the patient prior to next appointment to encourage attendance,

Repetition of self-harm (2007-2015)

- Approximately **15% of patients** will represent with a further act of self-harm within 12 months

Number of presentations	Individual persons	% persons	Presentations	% presentations
1	49,788	77%	49,788	48%
2	8,307	13%	16,614	16%
3	2,911	5%	8,733	8%
4	1,358	2%	5,432	5%
5 or more	2,548	4%	23,804	23%
Total	64,912		10,4371	

Factors associated with repetition of self-harm

- Self-cutting as first presentation

- Leaving before a recommendation

- Self-harm history

- Methods of high lethality (method escalation)

- People who present with thoughts of self-harm or suicide are more likely to repeat with self-harm (~20%)

Self-harm and suicide ideation presenters to hospital in Northern Ireland: a registry-based study

Eve Griffin, Brendan Bonner, Denise O'Hagan, Paul Corcoran

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DBT PROJECT
IRELAND

REPORT

PLANNING, IMPLEMENTATION AND EVALUATION
OUTCOMES FOR DIALECTICAL BEHAVIOUR THERAPY
IN THE IRISH COMMUNITY MENTAL HEALTH SERVICE

2013
2018

National Office for
Suicide Prevention

National Suicide Research Foundation

HSE

National
DBT Project
Ireland

JUNE 2013 - MAY 2015

16 Teams
Selected

9 Adult (AMHS)

7 Child (CAMHS)

124 Therapists trained

INTENSIVE TRAINING

July 2014

May 2015

1st Cohort

2nd Cohort

8 Teams completed
Intensive Training

8 Teams completed
Intensive Training

National Dialectical Behaviour Therapy Project
(Flynn et al, 2018)

**Frequency of self-harm
6 months pre-intervention**

**Frequency of self-harm
6 months post-intervention**

Daily
8%

Not
self-
harming
12%

Weekly
32%

Less than once
a month
24%

Monthly
20%

Weekly
1%

Daily
0%

Monthly
7%

Less than
once a month
17%

Not
self-harming
75%
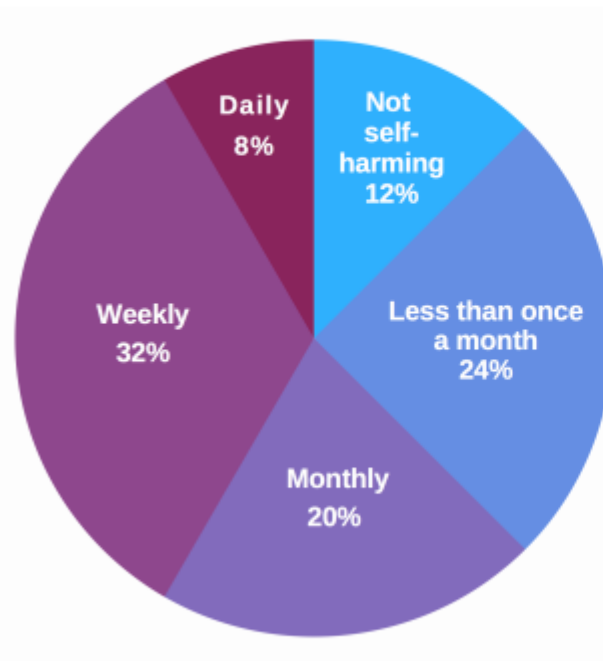
**Figure 6.3 AMHS Participants: Frequency of
Self-harm 6 months pre-intervention**
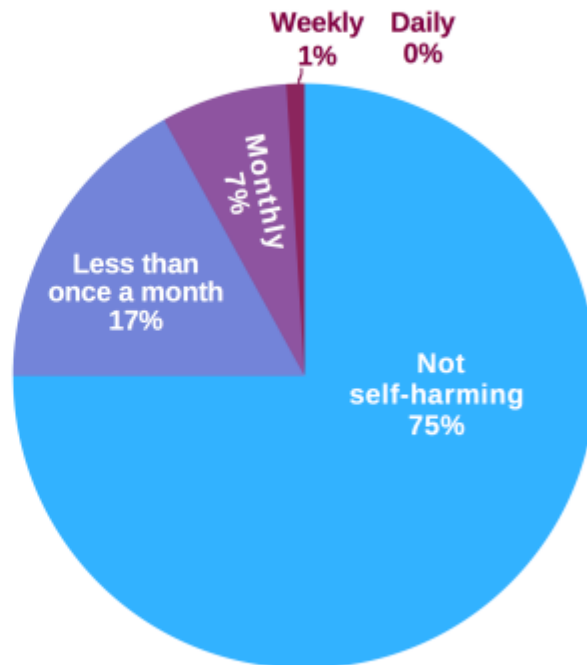
**Figure 6.4 AMHS Participants: Frequency
of Self-harm 6 months post-intervention**

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**National Dialectical Behaviour Therapy Project
(Flynn et al, 2018)**
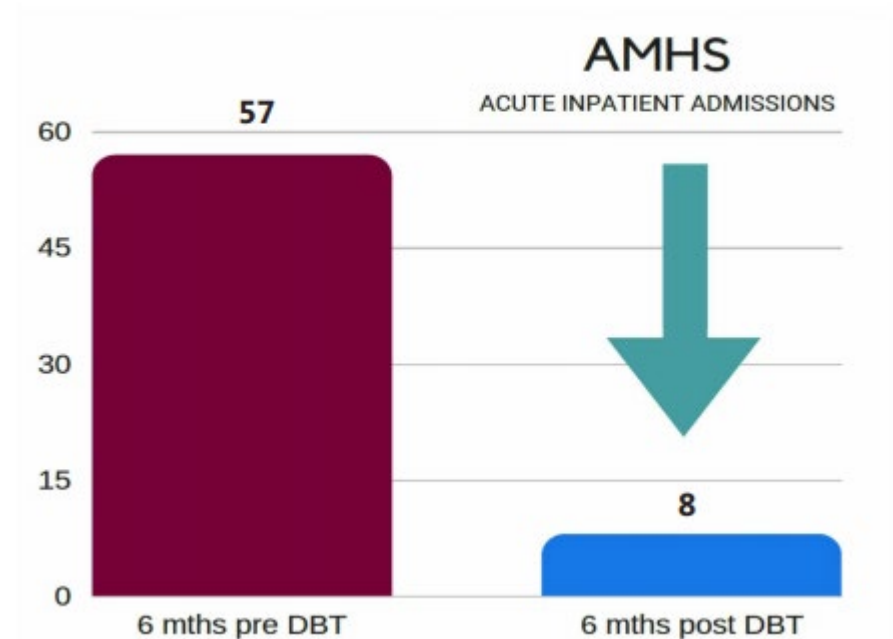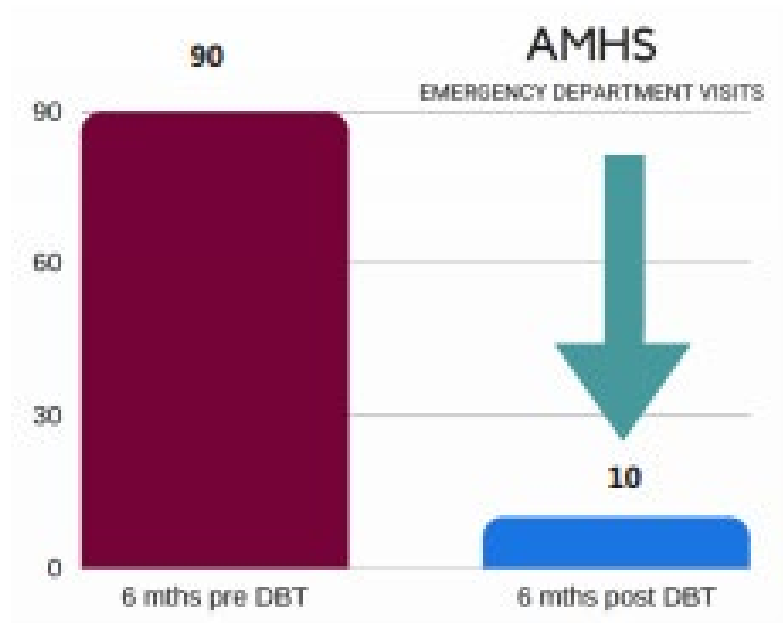
Opportunity to reduce incidence of self-harm:

Population-based approaches

Original article

Impact of the economic recession and subsequent austerity on suicide and self-harm in Ireland: An interrupted time series analysis

Paul Corcoran,[1,2]* Eve Griffin,[1] Ella Arensman,[1,2] Anthony P Fitzgerald,[2] and Ivan J Perry[2]

Scenario		Rate by end 2012				Cumulative excess over 2008–12
		Without recession	With recession	Difference (95% CI)	% difference	Number
A. If pre-recession trends continued	Suicide					Deaths
	Male	15.2	23.8	8.7*** (4.8 to 12.5)	57%	476*** (274, 678)
	Female	4.5	4.8	0.3 (−1.1 to 1.8)	7%	85 (−9, 180)
	Self-harm					Hospital presentations
	Male	241.9	316.0	74.1 (−6.3 to 154.6)	31%	5029* (626, 9432)
	Female	293.3	356.5	63.2* (4.1 to 122.2)	22%	3833* (321, 7345)

Area-level self-harm and deprivation, Dublin 2015-2017
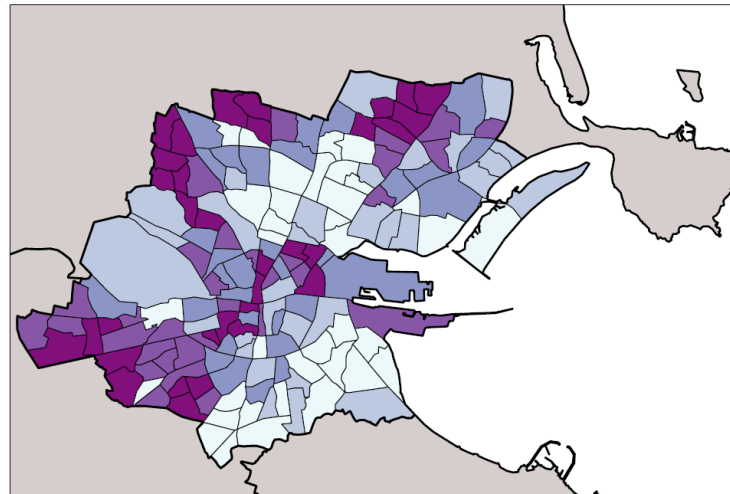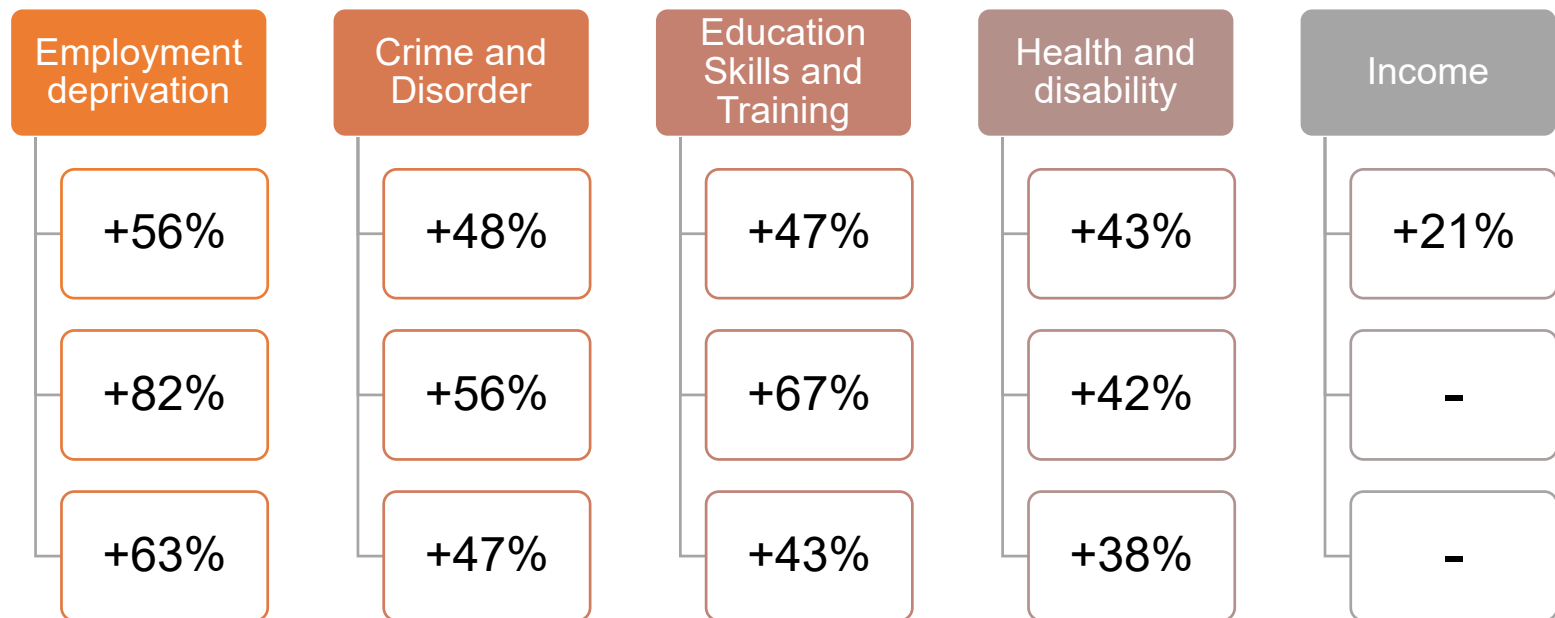

Rate of self-harm (per 100,000)
- Self-harm rate greater than 250
- Self-harm rate between 247 and 350
- Self-harm rate between 169 and 246
- Self-harm rate between 118 and 168
- Self-harm rate less than 118
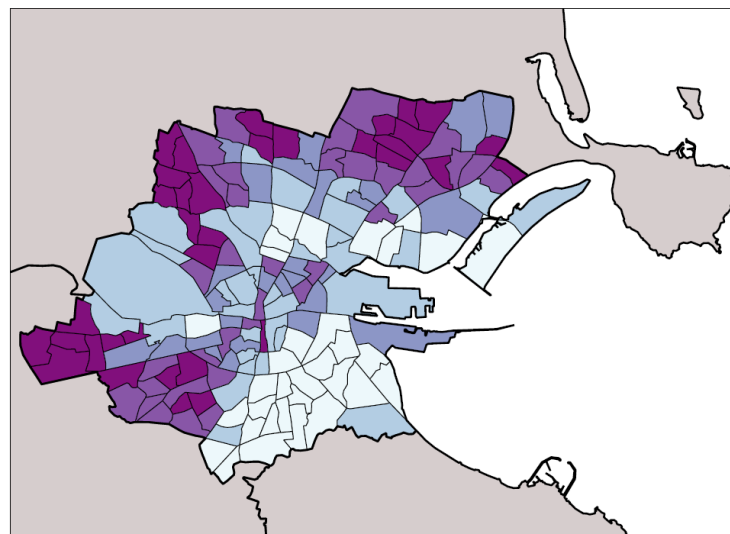
Extent of deprivation
- Most deprived
- Least deprived

Self-harm in Northern Ireland: Aspects of deprivation

National Suicide Research Foundation

Employment deprivation	Crime and Disorder	Education Skills and Training	Health and disability	Income
+56%	+48%	+47%	+43%	+21%
+82%	+56%	+67%	+42%	-
+63%	+47%	+43%	+38%	-

Griffin et al. European Journal of Public Health (in press).

Importance of high-quality, national data on mental health

Clinical care

Further integration of mental health services in acute settings

Routine management of self-harm and evidence-based interventions

Reducing self-harm at a population level

Self-harm is an important clinical issue but also a public health concern

More research needed on population approaches to reduce incidence of self-harm

Thank You!

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