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Summary

Background Little is known about the relative incidence of fatal and non-fatal self-harm in young people. We estimated the incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England.

Methods We used national mortality statistics (Jan 1, 2011, to Dec 31, 2013), hospital monitoring data for five hospitals derived from the Multicentre Study of Self-Harm in England (Jan 1, 2011, to Dec 31, 2013), and data from a schools survey (2015) to estimate the incidence of fatal and non-fatal self-harm per 100,000 person-years in adolescents aged 12–17 years in England. We described these incidences in terms of an iceberg model of self-harm.

Findings During 2011–13, 171 adolescents aged 12–17 years died by suicide in England (119 [70%] male and 133 [78%] aged 15–17 years) and 1320 adolescents presented to the study hospitals following non-fatal self-harm (1028 [78%] female and 977 [74%] aged 15–17 years). In 2015, 322 (6%) of 5506 adolescents surveyed reported self-harm in the community; whereas for every female suicide, 919 females presented to hospital for self-harm and 213 self-harm occurred in the community. In 15–17 year olds, for every male suicide, 1255 attended hospital for self-harm and 21995 reported self-harm in the community, whereas for every girl who died by suicide, 1255 attended hospital for self-harm and 21995 reported self-harm in the community, whereas for every male suicide, 1255 attended hospital for self-harm and 21995 reported self-harm in the community, whereas for every female suicide, 919 females presented to hospital for self-harm and 6460 self-harmed in the community. Hanging or asphyxiation was the most common method of suicide (125 [73%] of 171), self-poisoning was the main reason for presenting to hospital after self-harm (849 [71%] of 1195), and self-cutting was the main method of self-harm used in the community (286 [89%] of 322).

Interpretation Ratios of fatal to non-fatal rates of self-harm differed between males and females and between adolescents aged 12–14 years and 15–17 years, with a particularly large number of females reporting self-harm in the community. Our findings emphasise the need for well resourced community and hospital-based mental health services for adolescents, with greater investment in school-based prevention.

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Evidence before this study
In adolescents, non-fatal self-harm is a common reason for hospital presentation and also occurs frequently in the community without coming to clinical attention. Suicide is a leading cause of death in adolescents and is often preceded by self-harm. However, little is known about the relative sizes of the populations of adolescents involved in these three levels of self-harm, despite the major implications such information could have for prevention and clinical management. We searched PubMed up to June 30, 2017, with the terms “suicide”, “self-harm”, “self-injury”, “self-poisoning”, “suicide attempt”, “attempted suicide”, “iceberg”, “relative”, “incidence”, “rates”, “adolescents”, “adolescence”, and “young”. We did not apply any language restrictions. Although several studies have addressed the incidence of each type of self-harm (suicide, hospital-presentation self-harm, and community-occurring self-harm), to our knowledge only one study has addressed the relative incidence of all three forms of self-harm. In a study published in 2014, McMahon and colleagues estimated the relative incidence of fatal and non-fatal self-harm in older adolescents (15–17 years) in Ireland and described these in terms of the three levels of an iceberg model. Their study showed that for every adolescent who died by suicide, 34 adolescents presented to the hospital for non-fatal self-harm and 555 adolescents reported self-harm in the community. The differences between incidences of fatal and non-fatal self-harm were particularly marked in females.

Added value of this study
We used national data on suicide, together with data on hospital-presenting self-harm from five hospitals from three research centres and data on self-harm in the community from a large-scale schools survey to calculate the relative incidence of fatal and non-fatal self-harm in adolescents aged 12–17 years in England. Estimated rates of fatal and non-fatal self-harm show that for every adolescent suicide, there are approximately 370 adolescents who present to hospital for self-harm and 3900 adolescents who report self-harm in the community. Consistent with previous research, our results show substantially higher incidences of both hospital-presenting and community-occurring non-fatal self-harm (which mostly does not come to the attention of clinical services) in females than in males. Our findings also show substantial differences in methods of self-harm between the three levels of the iceberg model, with hanging or asphyxiation the most common method of suicide, self-poisoning the main method used in hospital-presenting self-harm, and self-cutting the most common method of self-harm in the community.

Implications of all the available evidence
Taken together, our results and previous findings show the extent of fatal and non-fatal self-harm in adolescents, highlighting the sizeable problem of community-occurring self-harm, especially in females, but also that most self-harm, especially in young adolescents, does not come to the attention of clinical services. These data emphasise the need for preventive measures at the community level, especially through school-based programmes, and for well developed treatment services to meet the needs of those presenting to clinical services following self-harm.

Methods
Study design and population
For this retrospective analysis, we analysed mortality statistics, hospital monitoring data, and schools survey data for adolescents aged 12–17 years in England. Information about deaths by suicide in England was obtained from the Office for National Statistics (ONS) by year of registration, single year of age, and sex. All deaths with a coroner’s verdict of suicide (ICD-10 codes X60–X84) or undetermined intent (ICD-10 codes Y10–Y34) registered between Jan 1, 2011, and Dec 31, 2013, were included. These deaths are henceforth referred to as suicides, as per national policy.17–19 Mid-year population estimates for England were provided by ONS by sex, calendar year, and single year of age.20 Data on hospital-presenting self-harm were derived from the Multicentre Study of Self-Harm in England; in this ongoing study, data are collected on all presentations following self-harm to the emergency department in five general hospitals in Manchester (three hospitals), Derby (one hospital), and Oxford (one hospital).21–23 Demographic and clinical data, including method of self-harm, are collected through completion of psychosocial assessments by liaison psychiatry services in the general hospital (also by emergency department staff in Manchester). People who present to hospital but do not receive a psychosocial assessment are identified through scrutiny of emergency department electronic databases by trained staff, who extract less complete data from case records.

Self-harm is defined as any act of intentional self-poisoning or self-injury irrespective of the degree of suicidal intent or other motivation.24 In this analysis, we included the first presentation by each individual per year between Jan 1, 2011, and Dec 31, 2013. We included adolescents who resided in the catchment area of the city of Manchester, Derby unitary area, or Oxford extended area (Oxford city and an additional 64 statistical wards
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