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Deliberate self-harm in adolescents in Oxford, 1985–1995

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Deliberate self-harm (DSH) has been one of the major health problems of adolescents in the U.K. for many years. Any changes in rates of DSH or the demographic characteristics of the patient population are likely to have important implications for clinical services and for future suicidal behaviour. Following a decline in rates in the late 1970s and mid 1980s, there were signs in the late 1980s that rates were beginning to increase again. We have used data collected by the Oxford Monitoring System for Attempted Suicide on the basis of patients presenting to the general hospital in Oxford to review trends in DSH in under 20-year-olds between 1985 and 1995. There was a substantial increase in the numbers of teenage DSH patients during the 11-year study period, with an increase between 1985–1986 and 1994–1995 of 27·7% in males, 28·3% in females, and 28·1% overall. There were no demographic changes within the catchment area to explain a change of this size. As rates of repetition of DSH also increased in both sexes during the study period the overall number of episodes of DSH rose even more between 1985–1986 and 1994–1995 (+56·9% in males, +46·3% in females, and +49·4% overall). As in previous studies the majority of adolescents had interpersonal problems and/or difficulties with studying or employment. Self-poisoning with paracetamol and paracetamol compounds became increasingly common such that by 1995 these were used in almost two-thirds of overdoses. The recent increase in DSH in adolescents has important implications for general hospital and adolescent psychiatric services. The greater frequency of repetition of DSH may herald increased future suicide rates. The case for restricting the amount of paracetamol available is overwhelming. Evaluative trials of specific interventions following adolescent DSH are urgently required.

Introduction

Ever since rates of deliberate self-harm (DSH; self-poisoning and self-injury) in the U.K. escalated during the late 1960s and early 1970s to such an extent that it became a major health concern (Bancroft *et al.*, 1975; Holding *et al.*, 1977), this problem has been particularly common in adolescents (Krietman and Schreiber, 1979; Hawton and Goldacre, 1982). Following a decline in rates during the late 1970s and early 1980s, notably in older teenage girls (Sellar *et al.*, 1990*a*; Platt *et al.*, 1988), we subsequently reported that rates in Oxford had begun to rise again in the late 1980s in older adolescent females (Hawton and Fagg, 1992*a*).

A collaborative study of self-harm in 15 European centres (the WHO/EURO Multicentre Study on Parasuicide) has indicated that rates of DSH in 15–24-year-olds in the U.K. in 1989–1992 were among the highest in Europe, with Oxford rates for males being second only to those in Helsinki and female rates being second only to those of Cergy-Pointoise in France

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Some of the data in this paper concerning deliberate self-harm in older adolescents were included in a broader age-group in Hawton, K., Fagg, J., Simkin, S., Bale, E. and Bond, A. (1997). Trends in deliberate self-harm in Oxford, 1985–1995. British Journal of Psychiatry, 171, 556–560.

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(Schmidtke *et al.*, 1996). We have demonstrated elsewhere that rates of DSH in 15–24-year-olds are closely related to those for suicide, both across Europe (Hawton *et al.*, 1998) and in the U.K. (Hawton *et al.*, 1997). Furthermore, the risk of suicide following DSH in teenagers is considerable (Otto, 1972; Goldacre and Hawton, 1985; Sellar *et al.*, 1990*a*). Therefore any changes in the pattern of DSH can have significant implications for future suicide rates.

We have studied trends in DSH in under 20-year-olds in Oxford during the 11 years 1985–1995, utilizing data collected through the Oxford Monitoring System for Attempted Suicide, by means of which information on all self-harm referrals to the general hospital in Oxford has been collected systematically and continuously since 1976 (Hawton and Fagg, 1992*b*). We have previously demonstrated the reliability of our method of data collection (Sellar *et al.*, 1990*b*). We have also shown that changes in the pattern of self-harm in Oxford correlate highly with those in Edinburgh (Platt *et al.*, 1988), and comparison of the recent trends in Oxford (Hawton *et al.*, 1997) with those reported from elsewhere (e.g. Bialas *et al.*, 1996; McLoone and Crombie, 1996) indicates that those in Oxford are representative of general trends in this phenomenon in the U.K.

The aims of the study were to review trends in DSH in adolescents, to determine whether the pattern of repetition of self-harm has changed, to examine trends in substances used in self-poisoning, and to investigate other characteristics of adolescent self-harm patients which are relevant to the prevention of self-harm and service provision for this population.

Method

Subjects

The study population consisted of all individuals aged 19 years and under who were referred to the general hospital in Oxford between 1985 and 1995 following self-poisoning or self-injury. The general hospital receives all hospital-referred cases from Oxford City and the surrounding area. Patients referred to the hospital following self-poisoning or self-injury are identified by the Monitoring System for Attempted Suicide maintained by the University Department of Psychiatry (Hawton and Fagg, 1992*b*). Most deliberate self-harm patients are routinely referred to the emergency psychiatric service in the hospital. All patients referred to the service receive a detailed psychosocial assessment by a specially trained psychiatrist, psychiatric nurse, or social worker. Those aged 13 years and under are assessed by members of the child psychiatry service. Most assessments are discussed in detail with a senior psychiatrist. A range of patient characteristics and clinical items are recorded by the assessors on data sheets which are then coded and the data entered into a computerized data file. Through scrutiny of the records of the Accident and Emergency department a limited amount of information is also available on patients presenting to the hospital but not seen by the psychiatric service.

Self-poisoning is defined as the intentional self-administration of more than the prescribed dose of any drug whether or not there is evidence that the act was intended to cause self-harm. This category also includes overdoses of "drugs for kicks" and poisoning by non-ingestible substances and gas, provided the hospital staff consider that these are cases of deliberate self-harm. Alcohol intoxication is not included unless accompanied by other types of self-poisoning or self-injury. *Self-injury* is defined as any injury recognized by hospital staff as having been deliberately self-inflicted.