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Background
Self-harm is a common reason for presentation to a general hospital, with a strong association with suicide. Trends in self-harm are an important indicator of community psychopathology, with resource implications for health services and relevance to suicide prevention policy. Previous reports in the UK have come largely from single centres.

Aims
To investigate trends in non-fatal self-harm in six general hospitals in three centres from the Multicentre Study of Self-harm in England, and to relate these to trends in suicide.

Method
Data on self-harm presentations to general hospital emergency departments in Oxford (one), Manchester (three) and Derby (two) were analysed over the 8-year period 1 January 2000 to 31 December 2007.

Results
Rates of self-harm declined significantly over 8 years for males in three centres (Oxford: –14%; Manchester: –25%; Derby: –18%) and females in two centres (Oxford: –2% (not significant); Manchester: –13%; Derby: –17%), in keeping with national trends in suicide. A decreasing proportion and number of episodes involved self-poisoning alone, and an increasing proportion and number involved other self-injury (e.g. hanging, jumping, traffic related). Episodes involving self-cutting alone showed a slight decrease in numbers over time. Trends in alcohol use at the time of self-harm and repetition within 1 year were stable.

Conclusions
There were decreasing rates of non-fatal self-harm over the study period that paralleled trends in suicide in England. This was reflected mainly in a decline in emergency department presentations for self-poisoning.

Declaration of interest
None.

Non-fatal self-harm is an important public health problem in England. In 2000–2001 there were an estimated 220 000 presentations to general hospital emergency departments involving 150 000 people.1 Self-harm is the main risk factor for completed suicide2,3 and is associated with increased all-cause mortality.4 In England, the National Suicide Prevention Strategy5 has a target of a 20% reduction in rates of suicide (including open verdicts) by 2010.6 One of the high-risk groups targeted in the strategy is people who self-harm. There is no national register of self-harm, and reported trends in self-harm to date have been from periods before the strategy was introduced in 2002.7–13 During 1990 to 1997, rates of self-harm increased in some centres in England,8–10 as well as rates of repetition and alcohol involvement,11,12 implying increasing pressure on emergency and hospital services. Health service planning requires up-to-date information on trends in self-harm to maintain an optimal provision of services, and to assess the effectiveness of management and preventive policies. Most reports of trends in self-harm in the UK have come from single centres. We know of one study relating rates of self-harm to suicide in the USA.14

The aim of this study was to investigate trends in non-fatal self-harm in multiple centres between 2000 and 2007, and to relate these to trends in suicide. During this period a national suicide prevention strategy was introduced for England. Specifically, we looked at trends in rates of self-harm, methods of self-harm, alcohol involvement and repetition of self-harm in six hospitals in three centres in England.

Method

Setting and sample
The study was undertaken in three centres currently involved in the Multicentre Study of Self-harm in England (for further details see Hawton et al1 and Bergen et al15). Data were collected on all individuals who presented with self-harm to general hospital emergency departments in Oxford (one), Manchester (three) and Derby (two) for the 8-year period 1 January 2000 to 31 December 2007. Self-harm was defined as intentional self-poisoning or self-injury, irrespective of motivation.9

Data collection
Following self-harm, most individuals received a psychosocial assessment (of mental state, risks and needs) by specialist psychiatric clinicians (and in Manchester also by emergency department staff),16 in line with clinical guidance.17,18 Demographic, clinical and hospital management data on each episode were collected by clinicians using forms, in Oxford and Manchester. In Derby, data were entered directly into a computerised system by clinicians. Individuals not receiving an assessment were identified through scrutiny of emergency department and medical records (computerised records in Derby), from which more limited data were extracted by research clerks. In all centres, individuals not assessed may have taken early discharge, refused the offer or not been offered an assessment for clinical reasons or unavailability of staff.

In Manchester, for the period 1 January 2000 to 31 August 2002, information was collected only on assessed episodes. Information was not collected on episodes that were not assessed (including those episodes in which individuals did not wait for treatment). The proportion of the total number of episodes that were found to have been assessed in a subsequent period (1 September 2002 to 31 August 2003) was 70%. Rates of self-harm for this centre for the earlier period were therefore adjusted upwards by a factor of 1.42 to take account of the 30% of non-assessed individuals. Rates of assessment were similar by...
age and gender and the adjustment was applied across all age and gender groups.

Data for this study included gender, age, date of self-harm, method of self-harm (including drugs used in self-poisoning and details of self-injury), alcohol involvement and psychosocial assessment.

Ethical approval

The monitoring systems in Oxford and Derby have approval from local health/psychiatric research ethics committees to collect data on self-harm for local and multicentre projects. Self-harm monitoring in Manchester is part of a clinical audit system, and has been ratified by the local research ethics committee. All three monitoring systems are fully compliant with the Data Protection Act of 1998. All centres have approval under Section 251 of the National Health Service (NHS) Act 2006 (formerly Section 60, Health and Social Care Act 2001) to collect patient-identifiable information without patient consent.

Rates of self-harm

Rates of self-harm were calculated for defined population areas within centre catchments (Oxford City, City of Manchester and Derby Unitary Area) for which centres had near to complete identification of self-harm presentations to hospital. Mid-year population estimates were obtained from the Office for National Statistics. Rates were calculated as the number of people (aged 15+) per 100 000 population for each centre, for each year, age standardised to the European population, with 95% confidence intervals based on a Poisson distribution. The 95% confidence intervals for average rates (2000–2007) were estimated using an approximation of the standard error (rate divided by the square root of the number of people) multiplied by 1.96.

Rates of suicide

Rates of suicide in England (age standardised to the European population) were obtained from the NHS Information Centre for Health and Social Care. Data for individuals of all ages included deaths where the coroner had given a suicide or open verdict.

Table 1: Number of episodes of self-harm and individuals involved, by centre, 2000 to 2007

<table>
<thead>
<tr>
<th></th>
<th>Oxford</th>
<th>Manchester</th>
<th>Derby</th>
<th>Total</th>
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<tr>
<td><strong>Episodes</strong></td>
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<td></td>
<td>13 102</td>
<td>22 985</td>
<td>15 119a</td>
<td>51 185a</td>
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<td></td>
<td>4889 (37.3)</td>
<td>9481 (41.2)</td>
<td>6113 (40.5)</td>
<td>20 483 (40.0)</td>
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<td></td>
<td>8213 (62.7)</td>
<td>13 504 (58.8)</td>
<td>8 985 (59.5)</td>
<td>30 702 (60.0)</td>
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<tr>
<td><strong>Individuals</strong></td>
<td></td>
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<td></td>
<td>7 394</td>
<td>15 293</td>
<td>8 591a</td>
<td>31 260a</td>
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<td></td>
<td>2 973 (40.2)</td>
<td>6 459 (42.2)</td>
<td>3 599 (42.0)</td>
<td>13 031 (41.7)</td>
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<td></td>
<td>4 421 (59.8)</td>
<td>8 834 (57.8)</td>
<td>4 974 (58.0)</td>
<td>18 229 (58.3)</td>
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<tr>
<td><strong>Males by age group, years</strong></td>
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<tr>
<td></td>
<td>2 968</td>
<td>6 402</td>
<td>3 593</td>
<td>12 965</td>
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<td></td>
<td>43 (1.4)</td>
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<td>970 (32.7)</td>
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<td>1 058 (29.4)</td>
<td>3 919 (30.2)</td>
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<td>18 03 (28.2)</td>
<td>9 06 (26.9)</td>
<td>3 558 (27.4)</td>
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<td>1 234 (34.3)</td>
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<td><strong>Females by age group, years</strong></td>
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<td></td>
<td>4 149</td>
<td>8 790</td>
<td>4 969</td>
<td>18 178</td>
</tr>
<tr>
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<td>243 (4.9)</td>
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<td></td>
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<td>1 868 (37.6)</td>
<td>7 262 (39.9)</td>
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<td></td>
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<td>444 (5.1)</td>
<td>332 (6.7)</td>
<td>1 058 (5.8)</td>
</tr>
</tbody>
</table>

a. Plus 21 episodes where gender was not known; thus total number of episodes 51 206.
b. Plus 18 persons whose gender was not known; thus total number of individuals 31 278.
c. Plus 68 males whose age was not known (total number males 13 031).
d. Plus 41 females whose age was not known (total number females 18 229).

Socioeconomic indicators

Socioeconomic conditions of the areas covered by the three centres were compared using Multiple Indices of Deprivation 2004 in England, which ranks areas from 1 (most deprived) to 32 482 (least deprived) over 7 domains (income, employment, health deprivation and disability, education skills and training, barriers to housing and services, crime, living environment). The mean rank over all domains for the City of Manchester was 4 268 (within the 15% most deprived areas), compared with Derby Unitary Area 13 329 (within the 40% most deprived), and Oxford City 15 953 (approximately midway). On the income and employment domains, Manchester was within the 20% most deprived, compared with Derby (within the 40% most deprived) and Oxford (within the 45%–35% least deprived).

Statistical analyses

Rates of self-harm and trends in rates were calculated separately for each centre. Rates for Manchester were adjusted for the period with missing data (1 January 2000 to 31 August 2002). Also, because of these missing data, trends in method of self-harm and repetition were analysed using data from two centres only (Oxford and Derby) for the years 2000–2002, and from the three centres for 2003–2007, because these variables were, to a certain extent, related to assessment status.

The χ²-test for trend (linear by linear association, two-sided) was used to test the significance of changes over the period 2000–2007. There was no significant autocorrelation in data tested for trend. Best-fit values from linear regression models were used to calculate percentage changes over time. Analyses and calculations were performed with Microsoft Office Excel 2003, SPSS version 15.0, Stata version 10.0 and Epi Info 2002 on Windows XP.

Results

Study sample

During the 8-year study period, 1 January 2000 to 31 December 2007, there were 51 206 episodes of self-harm by 31 278 individuals aged 7+ years across the three centres (Table 1).
Age and gender were known for 31,141 individuals (0.4%, n = 137 were missing) (Table 1). The median age for males was 31 years (interquartile range, IQR 22–41), and for females was 27 years (IQR 19–39). Nearly two-thirds of individuals (n = 19,646, 63.1%) were under 35 years. When examined by 5-year age groups, the largest number of females was in the 15–19 age group (n = 4,042, 22.2%), and the largest number of males was in the 20–24 age group (n = 2,279, 17.6%).

Rates of self-harm
Age-standardised rates per 100,000 (95% CI) for individuals aged 15+, averaged over the years 2000–2007, were: Oxford, males 310 (95% CI 294–325), females 412 (95% CI 395–429); Manchester, males 371 (95% CI 361–381), females 544 (95% CI 533–556); Derby, males 373 (95% CI 359–387), females, 510 (95% CI 494–527) (online Table DS1). Rates for both males and females were significantly lower in Oxford than the other centres, whose rates were similar. The female to male ratio of the mean annual rate of self-harm were found in two centres only. In Manchester, the decrease from 2000 to 2007 was approximately 18% (χ² for trend: 15.5, P < 0.001). In Oxford, the decrease was 8% (χ² for trend: 2.9, P = 0.088). Overall (three centres), the percentage decrease was 18% (χ² for trend: 21.4, P < 0.001). The decrease in the suicide rate in England during this period was approximately 19%.20

For males, significant decreasing trends in rates of self-harm were found in all centres. In Oxford, the decrease from 2000 to 2007 was 21% (χ² for trend: 33.0, P < 0.001) and in Derby it was 15% (χ² for trend: 15.5, P < 0.001). In Oxford, the decrease was 8% (χ² for trend: 2.9, P = 0.088). Overall (three centres), the percentage decrease was 18% (χ² for trend: 21.4, P < 0.001). The decrease in the suicide rate in England during this period was approximately 19%.20

For all individuals, significant decreasing trends in rates of self-harm were found in two centres only. In Manchester, the decrease from 2000 to 2007 was 21% (χ² for trend: 33.0, P < 0.001) and in Derby it was 15% (χ² for trend: 15.5, P < 0.001). Overall (three centres), the percentage decrease was 18% (χ² for trend: 21.4, P < 0.001). The decrease in the suicide rate in England during this period was approximately 19%.20

For females, significant decreasing trends in rates of self-harm were found in two centres only. In Manchester, the decrease from 2000 to 2007 was 17% (χ² for trend: 12.8, P < 0.001) and Derby 13% (χ² for trend: 6.4, P = 0.011). In Oxford, the decrease was 2% (χ² for trend: 0.1, P = 0.722). Overall (all three centres), the percentage decrease was 14% (χ² for trend: 7.7, P = 0.005). The decrease in the suicide rate in England for females during this period was approximately 25%.20

In Manchester, decreasing trends in rates of self-harm remained significant when calculated over the 5-year period 2003–2007 (i.e. excluding the period with adjusted data) in males (χ² for trend: 8.7, P = 0.003), females (χ² for trend: 4.9, P = 0.027) and all individuals (χ² for trend: 13.8, P < 0.001).

Methods of self-harm
There were 44,495 episodes of self-harm during 2000 to 2007 (two centres, Oxford and Derby, for 2000–2002; all three centres for 2003–2007), including 165 (0.4%) where the method was not recorded. Of the 44,330 episodes with a known method, 34,695 episodes (78.3%) involved ‘self-poisoning only’ (Oxford: 77.3%; Manchester: 78.4%; Derby: 78.9%), 6503 episodes (14.7%) involved ‘cutting only’ (Oxford: 12.8%; Manchester: 16.0%; Derby: 14.9%), 1309 episodes (2.9%) involved ‘other self-injury not cutting’ (Oxford: 3.6%; Manchester: 2.3%; Derby: 3.1%) and 1818 episodes (4.1%) involved ‘both self-poisoning and self-injury’ (Oxford: 6.7%; Manchester: 3.2%; Derby: 3.1%).

Trends in methods of self-harm
Trends in methods of self-harm are presented in Fig. 2. Figure 2a shows each method as a proportion of all self-harm for 2000–2007 and Fig. 2b shows the number of episodes by method of self-harm for 2003–2007.

‘Self-poisoning only’ as a proportion of all self-harm showed a decreasing trend during 2000 to 2007 (χ² for trend: 27.8, P < 0.001) (Fig. 2a) and the number of episodes of self-poisoning also decreased during 2003 to 2007 by approximately 15% (Fig. 2b).

‘Cutting only’ as a proportion of all self-harm during 2000 to 2007 showed a small increasing trend of 8% (χ² for trend: 8.9, P = 0.003) (Fig. 2a). However, the number of episodes of cutting decreased by approximately 10% during 2003 to 2007 (Fig. 2b).
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They were offered a psychosocial assessment by specialist psychiatric staff, although this differed by centre due to the nature of clinical services (Oxford: 72.1%; Manchester: 41.3%; Derby: 59.2%; \( \chi^2 = 2858.2, \text{d.f.} = 2, P < 0.001 \)). In Manchester, a further 26.4% of individuals were assessed by emergency department staff. Thus between two-thirds and three-quarters of individuals who presented with self-harm in all centres had some assessment.

**Alcohol involvement**

Alcohol use in the 6 h before, or as part of the act of self-harm, could only be determined for people who were assessed. Of the 35 843 assessed episodes from 2000 to 2007, 2990 (8.3%) had missing information on alcohol use, thus data were available for 32 853 episodes. Overall, alcohol involvement was similar in the centres (Oxford: 54.1%; Manchester: 55.4%; Derby: 57.4%; \( \chi^2 = 18.9, \text{d.f.} = 2, P < 0.001 \)). Alcohol involvement was greater in males (62.5%) than females (50.8%) (\( \chi^2 = 437.6, P < 0.001 \)).

There were no significant trends in alcohol involvement over the study period in males (\( \chi^2 \) for trend: 1.1, \( P = 0.286 \)) or females (\( \chi^2 \) for trend: 0.6, \( P = 0.439 \)).

**Repetition of self-harm**

We used re-presentation for self-harm within 1 year of an index episode as a measure of repetition. We took individuals at their first episode in each year 2000–2006, and calculated the percentage who repeated within 1 year (two centres for 2000–2002; all three centres for 2003–2007) (\( n = 44 495 \)). Overall, 20.7% of people in each year repeated self-harm within a year (Oxford: 22.6%; Manchester: 18.0%; Derby: 21.9%; \( \chi^2 = 71.3, \text{d.f.} = 2, P < 0.001 \)). There were no significant trends in repetition over the study period: Oxford, \( \chi^2 \) for trend: 2.37, \( P = 0.1 \); Manchester, \( \chi^2 \) for trend: 1.1, \( P = 0.298 \); Derby, \( \chi^2 \) for trend: 1.4, \( P = 0.239 \).

**Discussion**

In this study we investigated trends in non-fatal self-harm in six general hospitals in three centres in England during 2000 to 2007. Our main finding was that rates of self-harm declined (although less in Oxford than the other centres), in line with suicide rates in England, during a period when the national suicide prevention strategy was introduced.

**Rates of self-harm**

Overall rates of self-harm were higher in Manchester and Derby than Oxford, as expected based on greater socioeconomic deprivation in the first two areas.\(^{21,22}\) The decline in rates over the 8-year period was also greater in Manchester (21%) and Derby (15%) than Oxford (8%). Across the three centres, rates for females were approximately 40% higher than for males, consistent with findings elsewhere.\(^{9,10,23}\) The decline in rates over the 8-year period, however, was greater in males (14 to 25%) than females (2 to 17%).

The trends found in this study are in contrast to the steady increase in rates of self-harm found a decade earlier.\(^{9,10,22}\) Non-fatal self-harm leading to hospital attendance is the strongest risk factor for completed suicide,\(^2\) and these decreasing trends are consistent with the current downward trend in suicide rates in England over this period, most of which coincided with the national suicide prevention strategy.\(^{6,24}\) Suicide rates in local authority areas\(^{20}\) for study centres showed a consistent decline over the study period for Manchester, whereas rates in Derby and Oxford fluctuated at lower levels. This may indicate that...
the reduction in suicide and self-harm has been greater in areas of
greater socioeconomic deprivation.21 The suicide prevention
strategy targeted high-risk groups such as individuals who self-
harm and young men. The decline in rates of self-harm in males
in our study is consistent with this. Other targets of the strategy
such as improved media reporting of suicide and improved
clinical risk management, may also have contributed to the
decline; however, they were outside the scope of our study.
Another target was reduced access to lethal means, which
embraces safer prescribing of drugs. We discuss this below.

There may have been other reasons for the declining rates of
suicide and self-harm that were not related to the strategy. Stable
economic growth and decreasing rates of unemployment during
this period25 may have contributed, as well as changes in help-
seeking behaviour such as increased use of counselling services
and internet websites for self-help and support.26,27

Methods of self-harm
There were significant changes in methods of self-harm in the
three centres during 2000 to 2007. First, a decreasing proportion
and number of episodes involved self-poisoning alone. This is
consistent with one of the prevention strategy’s targets, and the
decreasing trend in suicide deaths by poisoning in England over a
similar period.28 We found no significant change in use of
particularly drugs for self-poisoning. Overall, nearly half of all
episodes involved paracetamol or salicylate and their compounds,
most readily available over the counter.

Second, as might be expected since self-poisoning decreased,
cutting alone increased as a proportion of all self-harm during
2000 to 2007. However, as with self-poisoning, the number of
episodes decreased over time.

Third, in contrast to self-poisoning and cutting, the proportion
and number of episodes involving other methods of
self-injury (such as hanging, jumping from a height, traffic-related
and drowning) increased significantly over time. These trends in
non-fatal self-injury are possibly related to changing trends in
suicide death by injury. For example, recent increases in suicide
deaths by hanging29 and jumping28 may reflect an increase in
attempts involving these methods, and an increase in non-fatal
attempts might therefore be expected.

Involvement of alcohol
The finding that alcohol involvement in episodes of self-harm
remained stable for males and females during the study period
is somewhat surprising, as hazardous drinking in the general
population, especially in women,30 and hospital admissions for
alcohol-related conditions and deaths from alcohol-related
causes31 both increased during this time. Further, alcohol
involvement in self-harm increased in line with general population
trends during an earlier period.32 One explanation may be that
our analysis was limited to assessed episodes (and assessment is
less likely for individuals under the influence of alcohol).33

Repetition of self-harm
The proportion of people re-presenting with a repeat episode of
self-harm within 1 year was unchanged. Thus although the total
number of episodes and individuals involved decreased over time,
those individuals who self-harmed continued to re-present with
approximately the same frequency. Assessment and referral for
further care can reduce repetition rates.34,35 However, since the
National Institute for Health and Clinical Excellence guidance
on the management of self-harm17 was introduced midway
through the study period, its impact may have been limited as
the centre hospitals already had dedicated clinical services for
self-harm in place throughout the study period and had high
assessment rates compared with other hospitals.36

Strengths and limitations
A strength of the study was the involvement of three centres
covering six general hospitals that enabled comparison of findings
between centres (e.g. rates), as well as analysis of pooled data (over
50,000 episodes), with sufficient statistical power to detect trends
not normally possible in single-centre analyses. Although the
centres may not be representative of England as a whole, their
catchment populations were varied and included individuals from
a wide range of sociodemographic backgrounds. Trends in the
three centres were remarkably similar, as were the characteristics
of the individuals who presented such as preference for method,
alcohol involvement and rate of repetition. This suggests that these
findings may have broad generalisability. Differences between
centres were largely in clinical management (e.g. rates of
assessment and referral for psychiatric aftercare), and these will
be explored in a future study.

A limitation of the study was use of the smaller sample (two
trends where data were related to assessment status, e.g. method
of self-harm. During 2003 to 2007, only half of all self-cutting
episodes were assessed compared with two-thirds to three-quarters
of other methods, so inclusion of 2000–2002 data (available for
assessed episodes only) would have influenced trend analyses by
incorrectly inflating proportions of other methods in those years.

A further limitation is that there were no major changes in
services or prevention activities related to the strategy targeting
individuals who self-harm in the study centres, so it is difficult
to attribute a direct causal link between them and reduced
rates of self-harm. Likewise, although adverse socioeconomic
conditions are known to be strongly associated with self-harm,
and some local studies have been done in the past,37,38 we have
not been able to analyse socioeconomic changes in study centres
over the study period.

Implications
Our findings provide important information on community
psychosocial health, with implications for acute and mental health
service management and suicide prevention policy.5 The decline
in rates of self-harm implies a lessening burden on hospital
emergency services during the study period. Decreasing trends
in the number of individuals who presented with self-poisoning
and self-cutting, and increasing trends for those who presented
with other more serious injury, such as hanging, may be related
to changing individual characteristics, and may also have
reflected changes in preferred methods of suicide at a national
level.

Self-harm leading to hospital attendance is the strongest risk
factor for death by suicide. Rates of self-harm can serve as a
measure of effectiveness of suicide prevention strategies since
the larger numbers involved imply a greater sensitivity to detect
change. Our findings suggest that prevention initiatives under-
taken in England since the introduction of the national strategy
in 2002,5 probably together with favourable societal factors, may
have had a positive impact in reducing both self-harm and suicide.
However, socioeconomic conditions in the UK have since
deteriorated. Assessment of the impact of the recent recession
and the associated rise in unemployment, both of which are
known risk factors for self-harm and suicide, are important topics
for future research.
Funding

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