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Trends in Emergency Department Visits for Non-Suicidal Self-Injury among Italian Youth: An 11-Year Retrospective Analysis

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Abstract

Non-suicidal self-injury (NSSI) represents a serious concern during developmental years, yet research on NSSI patterns remains limited, particularly regarding presentations in emergency departments (ED). This cross-sectional study examined trends in ED visits for NSSI among individuals aged 5 to 19 years in Piedmont, Italy, from 2011 to 2021. All NSSI cases were extracted from the national ministerial ED discharge database using medical records and/or ICD9CM codes. Results were expressed both as population-based rates and as proportions relative to total ED visits.

Overall ED attendance stayed relatively constant at approximately 210,000 visits per year (55% males) throughout 2011–2019, before dropping by half in 2020 and 2021. NSSI population and visit rates began rising from 2013, reaching a peak in 2019, with roughly 25 and 23 NSSI visits per 100,000 ED visits among girls and 76 and 69 among boys. During 2020 and 2021, NSSI visit rates continued to climb, especially among girls and older adolescents. The steady rise in NSSI over the past decade constitutes an escalating public health challenge that requires greater awareness to support timely identification and preventive efforts.

Keywords: Emergency Department, Self-injury, Italian youth, Public health

Introduction

Non-suicidal self-injury (NSSI) is defined as the intentional and deliberate damage to one's own body tissue without any suicidal purpose. For an act to qualify as NSSI, it must not involve repetitive stereotypic movements and must not be better accounted for by another medical or psychiatric condition [1–3]. Along with suicidal ideation — which spans from fleeting thoughts of death to actual suicide attempts [3] — NSSI belongs to the broader category of self-harm thoughts and behaviors [3, 4].

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NSSI leads to significant emotional distress or functional impairment and is linked to both internalizing and externalizing psychiatric conditions [5]. Furthermore, because it shares many risk factors with suicidal ideation, NSSI can serve as an important warning sign for future suicidal actions [6–9].

NSSI often functions as a maladaptive coping mechanism used to relieve intense negative emotions or cognitive states (such as anxiety or overwhelming tension), to manage interpersonal conflicts, or to generate a sense of relief or control [1, 10, 11]. Repeated NSSI tends to occur more frequently than isolated episodes and can resemble an addictive pattern. It ranges from relatively mild expressions, such as pulling out hair or deliberately interfering with wound healing, to more serious acts like burning or cutting the skin [1, 11].

The prevalence of NSSI during adolescence is estimated at 18%–22% [12], although figures vary somewhat across different samples and countries [10, 12–15]. Systematic reviews indicate that NSSI reaches its highest

frequency around ages 15–16 years and then gradually decreases into late adolescence [10, 16]. Despite this relatively high prevalence, the percentage of adolescents who meet full DSM-5 diagnostic criteria for NSSI is considerably lower, ranging from 1.5% to 6.7% [17]. According to the Global Burden of Disease (GBD, 2020) study coordinated by the Institute for Health Metrics and Evaluation (IHME), NSSI showed an overall decline of about 12.6% in prevalence and 3.8% in incidence since 2010. Nevertheless, with nearly 13.2 million cases globally, NSSI remains the third leading contributor to Disability-adjusted life years (DALYs) among adolescents.

Although still relatively few in number, recent Italian studies have produced mixed findings, with reported NSSI prevalence ranging from 12% [18, 19] to over 40% [20] depending on the sample. Consistent with international data, girls were more frequently affected than boys, while results regarding age, ethnicity, and parental education levels were less uniform [19]. Additionally, a cross-sectional analysis conducted in one of Italy's largest pediatric hospitals found a clear upward trend in ED admissions for NSSI among young people receiving child psychiatry consultations between 2011 and 2016 [21].

The COVID-19 pandemic raised widespread concerns about its potential effects on adolescent mental health, including specific issues such as eating disorders and NSSI [16, 22]. Lockdowns and social restrictions may have disrupted emotional regulation skills and intensified maladaptive responses to stress [22, 23], potentially contributing to the emergence or worsening of NSSI [23–25], particularly among those with prior vulnerabilities [26].

Given the scarcity of large-scale epidemiological research on ED presentations for NSSI among Italian youth, this study sought to outline the 10-year trend in ED visits for NSSI from 2011 to 2021 in the pediatric and adolescent population and to explore possible differences by age and gender.

Materials and Methods

Study population and design

A retrospective cross-sectional review was conducted of all emergency department (ED) attendances for individuals aged 5–19 years between January 2011 and October 2021 in Piedmont, Italy. Piedmont is Italy's second-largest region by area, spanning roughly 25,400 square kilometers. Positioned in the north-western corner of the country, it has a resident population of approximately 4.3 million, with nearly 15% aged 5–19 years, according to 2021 census figures. The average population density across the region is estimated at 168 people per square kilometer.

ED visit records were extracted from the National Discharge Information System (NDIS). This database holds mandatory details on hospital stays and patient profiles, covering demographic information, the reason for the ED visit, date and method of arrival and discharge, location and circumstances of the incident, severity grading, and the final clinical diagnosis recorded using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD9-CM). All documented ED attendances from January 2011 through October 2021—the latest period with officially available administrative data—were retrieved and incorporated into the analysis.

NSSI episodes were detected by tracing specific coded entries within the NDIS. Cases were included when the attending physician recorded the event via a primary or secondary diagnostic code indicating suspected intentional injury (codes E980–E989), late effects of self-inflicted harm (code E959), or when the discharge summary explicitly marked the injury as intentional and non-accidental in the designated field.

Ethics

The study used data accessed through the NDIS via the universal patient identification number (ID). This ID is a centrally generated, certified, anonymous, and non-reversible individual code assigned before any data storage. National regulations governing health information ethics permit accredited institutions to access such records for administrative, healthcare planning, or epidemiological objectives once official institutional clearance has been granted. Therefore, no separate Ethics Committee approval was necessary.

Statistical analyses

Descriptive statistics were applied to all ED attendances involving people aged 5–19 years from 2011 to 2021. NSSI cases were categorized by gender and divided into three age brackets: 5–9 years, 10–14 years, and 15–19 years. For every year of the study, findings were presented both as NSSI visit rates and as NSSI population rates. Annual NSSI visit rates together with their 95% confidence intervals (CIs) were calculated relative to the total volume of ED attendances and expressed as cases

per 100,000 visits. Annual NSSI population rates excluded duplicate visits by the same person and were computed using age- and gender-specific population counts, reported as cases per 100,000 inhabitants.

To adjust for variations in age structure and enable fair comparisons across years and genders, both NSSI visit rates and population rates were standardized using the 2018 population distribution and ED attendance patterns. Standardized (STD) figures were then shown as NSSI events per 100,000 inhabitants and as STD events per 100,000 ED visits.

Statistical significance of differences across age group, gender, and year was examined using the McNemar test to account for repeated observations and potential clustering. Temporal trends throughout the study period were evaluated using the Cochran-Armitage test, with the significance threshold set at $\alpha < 0.05$.

Lastly, to generate an overall summary of NSSI risk according to gender, age, and calendar year, logistic regression models were fitted separately for each study year and for the complete dataset. Outcomes were expressed as Odds Ratios (ORs) accompanied by 95% confidence intervals. All data processing and statistical computations were carried out with SAS version 9.4 (SAS Institute Inc., Cary, NC, United States) and STATA version 17 (© Copyright StataCorp LLC 1996–2023).

Results and Discussion

NSSI admissions were calculated as proportions per 100,000 total ED visits within the 5–19-year-old population, stratified by age groups [5–19] and gender. Rates were monitored over the full 11-year span, encompassing the primary COVID-19 pandemic years, as presented in **Figure 1**.

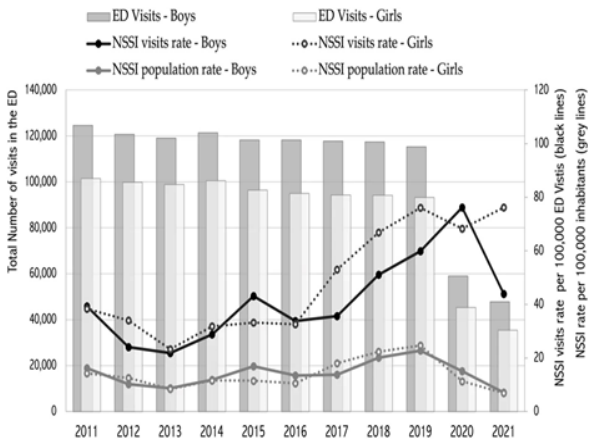

Figure 1. Total number of emergency department (ED) visits, and age-adjusted gender-specific (dotted line for girls) non-suicidal self-injury (NSSI) visits rate trend* per 100,000 ED visits (black lines), and NSSI rate trend per 100,000 inhabitants (grey lines) (Piedmont region, Italy, 2011–2021). NSSI, Non-Suicidal Self-Injury; ED, emergency department; * 2011–2021 Ed visits trend was significant ($P < 0.05$) over the whole period (Piedmont, Italy, 2011-2021).

Analyses revealed that ED attendances stayed fairly steady until 2019, averaging around 120,000 visits for boys and 100,000 for girls annually, as illustrated in **Figure 1**. Once the pandemic began and continued through October 2021, the total number of visits declined by more than 50% (from 93,249 in 2019 to 35,451 for girls, and from 115,306 to 47,789 for boys).

The standardized NSSI population rate displayed a mild early decline that bottomed out in 2013 (8.7; 95% CI = 5.3–12.1 for boys and 8.4; 95% CI = 4.9–11.8 for girls). From that point, the rate climbed steadily, attaining its highest level in 2019 (22.8; 95% CI = 17.3–28.3 for boys and 24.7; 95% CI = 18.9–30.6 for girls). This upward movement reversed in 2020 and persisted into 2021, producing a two-fold drop in 2020 and a three-fold drop in 2021.

Throughout the pandemic and the first 10 months of 2021, total ED attendances fell by more than half compared with earlier years. This marked decrease directly affected the standardized population rate and reversed the pre-2019 upward trend.

Likewise, the standardized NSSI visit rate showed an initial modest dip until 2013, recording its lowest figures for both genders (STD rate of 21.8; 95% CI = 14.9–32.1 for boys and 23.3; 95% CI = 15.5–35.0 for girls per 100,000 visits). The rate then rose progressively and at a comparable pace in boys and girls alike, reaching its maximum in boys during 2020 (STD ratio of 76.2; 95% CI = 56.9–102.0) and in girls during 2021 (STD ratio of 76.2; 95% CI = 52.2–111.0). Over the entire study span, a statistically significant increasing trend ($P < 0.05$) in NSSI-related ED visits was evident for both genders **(Figure 1)**.

As shown in **Tables 1 and 2**, NSSI visit rates, broken down by age category, revealed contrasting patterns between boys and girls and across age bands. The 15–19 years group had the highest NSSI rates in both genders across all years examined. In girls, the rate first declined by roughly two-thirds from 2011 to 2013 (from 61.6;

95% CI = 40.9–92.7 down to 19.5; 95% CI = 9.3–41.0 per 100,000 ED visits). It then surged more than fivefold in 2020 to reach 112.9 (95% CI = 72.0–177.0), before easing back to 104.6 (95% CI = 62.0–176.5) in 2021.

Table 1. NSSI visit rates, broken down by age category (girls).

Girls	15–19 years of age			10–14 years of age			5–9 years of age		
Year	Visits	NSSI	Rate (95% CI)	Visits	NSSI	Rate (95% CI)	Visits	NSSI	Rate (95% CI)
2011	37,334	23	61.61 (40.9–92.7)	30,988	8	25.82 (12.9–51.6)	33,158	8	24.13 (12.1–48.2)
2012	35,963	21	58.39 (38.1–89.5)	30,855	5	16.20 (6.8–38.9)	33,055	8	24.20 (12.1–48.4)
2013	35,803	7	19.55 (9.3–41.0)	30,976	7	22.60 (10.8–47.4)	32,085	9	28.05 (14.6–53.9)
2014	35,850	15	41.84 (25.2–69.4)	31,910	8	25.07 (12.5–50.1)	32,814	9	27.43 (14.3–52.7)
2015	34,034	11	32.32 (17.9–58.4)	30,192	10	33.12 (17.8–61.6)	32,162	11	34.20 (18.9–61.8)
2016	32,947	15	45.53 (27.5–75.5)	29,305	11	37.54 (20.8–67.8)	32,797	5	15.25 (6.4–36.6)
2017	32,971	19	57.63 (36.8–90.3)	29,797	20	67.12 (43.3–104.0)	31,591	11	34.82 (19.3–62.9)
2018	32,826	26	79.21 (53.9–116.3)	30,256	20	66.10 (42.7–102.4)	31,165	17	51.34 (33.9–87.7)
2019	32,450	33	101.69 (72.3–143.0)	30,404	19	62.49 (39.9–98.0)	30,395	19	62.51 (39.9–98.0)
2020	16,825	19	112.93 (72.0–177.0)	14,524	9	61.97 (32.3–119.1)	14,072	3	21.32 (6.9–66.1)
2021	13,387	14	104.58 (62.0–176.5)	11,928	11	92.22 (51.1–166.4)	10,136	2	19.73 (4.9–78.9)

Number of overall emergency department (ED) visits and of non-suicidal self-injuries (NSSI), and age category-specific NSSI rate, per 100,000 ED visits, with 95% Confidence Interval (95% CI) per year in Girls (Piedmont, Italy, 2011–2021).

Table 2. NSSI visit rates, broken down by age category (boys)

Boys	15–19 years of age			10–14 years of age			5–9 years of age		
Year	Visits	NSSI	Rate (95% CI)	Visits	NSSI	Rate (95% CI)	Visits	NSSI	Rate (95% CI)
2011	39,484	19	48.12 (30.7–75.4)	42,488	14	32.95 (19.5–55.6)	42,635	16	37.53 (23.0–61.3)
2012	36,822	16	43.45 (26.6–70.9)	41,637	5	12.01 (5.0–28.9)	42,263	8	18.93 (9.5–37.9)
2013	35,883	11	30.66 (17.0–55.4)	41,798	9	21.53 (11.2–41.4)	41,381	6	14.5 (6.5–32.3)
2014	36,311	17	46.82 (29.1–75.3)	42,780	6	14.03 (6.3–31.2)	42,344	12	28.34 (16.1–49.9)
2015	35,436	21	59.26 (38.6–90.9)	40,711	13	31.93 (18.5–55.0)	42,060	17	40.42 (25.1–65.0)
2016	35,807	16	44.68 (27.4–72.9)	40,463	13	32.13 (18.7–55.3)	41,963	11	26.21 (14.5–47.3)
2017	36,132	16	44.28 (27.1–72.3)	41,401	14	33.82 (20.0–57.1)	40,217	12	29.84 (17.0–52.5)
2018	35,681	20	56.05 (36.2–86.9)	41,343	17	41.12 (25.6–66.1)	40,334	23	57.02 (37.9–85.8)
2019	35,356	30	84.85 (59.3–121.3)	41,719	23	55.13 (36.6–83.0)	38,231	16	41.85 (25.6–68.3)
2020	19,798	18	90.92 (57.3–144.3)	20,755	18	86.73 (54.7–137.6)	18,511	9	48.62 (25.3–93.4)
2021	16,770	5	29.82 (12.4–71.6)	17,707	9	50.83 (26.5–97.7)	13,312	7	52.58 (25.1–110.3)

Number of overall emergency department (ED) visits and of non-suicidal self-injuries (NSSI), and age category-specific NSSI rate, per 100,000 ED visits, with 95% Confidence Interval (95% CI) per year in Boys (Piedmont, Italy, 2011–2021).

Boys experienced a parallel early reduction in NSSI rate, falling from 48.1 (95% CI = 30.7–75.4) in 2011 to 30.7 (95% CI = 17.0–55.4) in 2013. The rate later climbed to 90.9 (95% CI = 57.3–144.3) in 2020, before sharply declining to its lowest recorded level of 29.8 (95% CI = 12.4–71.6) per 100,000 ED visits.

Within the 10–14 years age bracket, NSSI rates exhibited a consistent upward trajectory in both genders from 2012 through 2020 (increasing from 12.0 to 86.7 per 100,000 visits; 95% CI = 5.0–28.9 and 54.7–137.6, respectively, for boys, and from 16.2 to 22.2 in 2021 for girls; 95% CI = 6.8–38.9 and 51.1–166.4).

The 5–9 years age group maintained the lowest rates throughout the entire observation period. For girls, the rate peaked in 2019 at 62.5 (95% CI = 39.9–98.0), then decreased in 2020 and remained nearly unchanged in 2021. For boys, the peak occurred in 2018 at 57.0 (95% CI = 37.9–85.8), followed by a modest decline in 2019 and a subsequent rebound to approximately 52.6 (95% CI = 25.1–110.3) in 2021.

Table 3 summarizes the annual and overall odds ratios (with 95% confidence intervals) of NSSI visits for girls relative to boys, and for the 10–14 and 15–19 years age groups relative to the youngest age group.

Table 3. The annual and overall odds ratios (with 95% confidence intervals) of NSSI visits for girls relative to boys, and for the 10–14 and 15–19 years age groups relative to the youngest age group.

Year	Girls	15–19 years of age	10–14 years of age
	OR (95% CI)	OR (95% CI)	OR (95% CI)
2011	0.95 (0.6–1.4)	**1.73 (1.1–2.9)**	0.94 (0.5–1.7)
2012	1.32 (0.8–2.2)	**2.36 (1.3–4.2)**	0.65 (0.3–1.4)
2013	1.05 (0.6–1.9)	1.23 (0.6–2.4)	1.08 (0.5–2.2)
2014	1.05 (0.7–1.7)	1.58 (0.9–2.7)	0.67 (0.3–1.3)
2015	0.76 (0.5–1.2)	1.24 (0.7–2.1)	0.86 (0.5–1.5)
2016	0.95 (0.6–1.5)	**2.11 (1.2–3.9)**	1.61 (0.9–3.0)
2017	1.47 (1.0–2.2)	1.56 (0.9–2.6)	1.50 (0.9–2.6)
2018	1.29 (0.9–1.8)	1.19 (0.8–1.8)	0.93 (0.6–1.4)
2019	1.20 (0.9–1.7)	**1.81 (1.2–2.7)**	1.15 (0.7–1.8)
2020	0.88 (0.6–1.4)	**2.75 (1.4–5.3)**	**2.07 (1.1–4.1)**
2021	1.74 (1.0–3.1)	1.63 (0.7–3.6)	1.79 (0.8–3.9)
Overall	1.13 (1.0–1.3)	**1.65 (1.4–1.9)**	1.12 (0.9–1.3)

Odds ratios (OR) and 95% Confidence interval (95% CI) of non-suicidal self-injuries (NSSI) by gender and age category per year and overall (Piedmont, Italy, 2011–2021). a) Reference categories for gender: boys, and "5–9 years of age" for the age category. Yearly OR are adjusted for age category and gender, and overall OR are adjusted for age category, gender, and year.

Statistically significant values are in bold.

Independent of age, the results indicated a small but non-significant elevated risk of NSSI among girls, with an overall OR close to 1.13 (95% CI 1.0–1.3). Significant differences appeared when age groups were considered separately, most notably in the 15–19 years category, where girls carried consistently higher odds of NSSI across the 11 years, ranging from 1.2 to 2.8, and an overall significant OR of 1.65 (95% CI 1.4–1.9). In 2020, young people aged 10–14 and 15–19 years displayed markedly increased odds of presenting to the ED for NSSI, with ORs of 2.07 (95% CI 1.1–4.1) and 2.75 (95% CI 1.4–5.3), respectively, while the odds for girls were slightly reduced and not statistically significant (OR 0.88; 95% CI 0.6–1.4).

This research examined the pattern of emergency department (ED) attendances across 11 years, with particular focus on the frequency and evolution of visits related to non-suicidal self-injury (NSSI) and the possible influence of the COVID-19 era on these trends. Our findings revealed that, following many years of fairly steady overall ED activity, a dramatic reduction exceeding 50% occurred from 2020 onward. This observation aligns with earlier reports from various countries, including Italy, where both routine and urgent care services experienced significant reductions due to the pandemic [22, 27].

In addition to the broad drop in ED usage, the pandemic altered the profile of presenting complaints by decreasing those considered postponable or of lower urgency [22]. Consequently, certain specific requests that normally accounted for only a small fraction of total attendance became relatively more prominent amid the overall decline in 2020 and 2021. The contrasting movements seen in NSSI population rates versus NSSI visit rates clearly illustrate the complexity of the situation. While the pandemic-driven decline in total ED visits artificially lowered the population-based NSSI rate, healthcare staff simultaneously faced a higher proportion of NSSI cases among the smaller number of patients who did attend.

In keeping with several recent publications, our data confirmed a relative rise in NSSI episodes during the pandemic [17]. However, unlike the GBD study, which documented a modest decline in self-harm between 2010 and 2019 (GBD, 2020), we found that NSSI visit rates had already been climbing since 2013 at both the population level and within ED attendances, particularly among children and adolescents.

Concentrating on the COVID-19 timeframe, a recent systematic review noted that although the absolute number of events fell, the proportion of ED visits attributed to NSSI increased, accompanied by greater injury severity. This suggests the pandemic may have catalyzed worsening youth mental health. The same review highlighted increased healthcare utilization after self-harm acts, especially among adolescents and notably among girls [25]. Other contemporary studies have similarly concluded that the pandemic disproportionately affected adolescents who were already vulnerable due to personal or social circumstances. For these young people, heightened challenges in managing new stressors — such as isolation, diminished social networks, fewer opportunities for group activities, or even everyday personal pursuits — likely raised the chance of turning to NSSI [24, 26, 28–30].

Regarding gender patterns, our analysis detected only a small, non-significant overall difference in NSSI occurrence across the study period. Nevertheless, clear

distinctions emerged when examining gender-specific trajectories and age categories. NSSI visit rates reached their highest point among boys during the early pandemic years before declining, whereas rates among girls continued to rise, suggesting differing responses to the same stressors. Although statistically notable, this divergence warrants closer scrutiny. It may stem from the different pace of emotional and social development between adolescent boys and girls, with girls often manifesting the effects of stress at an earlier stage than their male peers [31]. Furthermore, boys tend to conceal signs of self-injury more often (for instance, by linking them to sports-related incidents) and are less inclined to seek professional help than girls of similar age [12]. The suspension of sporting activities and the increased presence of family members at home during lockdowns may have partially contributed to the observed gender differences during the pandemic.

With respect to age, the pronounced variation in NSSI visit rates among older adolescents — clearly reflected in the elevated risk figures — aligns with existing evidence showing higher rates of NSSI among high school students compared with younger pupils [15, 32]. This pattern likely relates to ongoing brain maturation, particularly the still-developing prefrontal cortex during adolescence, which remains highly plastic and offers less effective regulation of emotional responses to stress. As noted by Wilkinson, NSSI occurrence is typically elevated during adolescence and early adulthood relative to both younger children and older adults. Since NSSI frequently forms part of wider ineffective coping mechanisms, this finding also matches the general rise in psychological distress documented in these age groups [8]. Research further indicates that traits commonly linked to NSSI include difficulties with emotion regulation, lower academic achievement, challenges in interpersonal relationships (such as heightened sensitivity to rejection), and a tendency toward negative interpretations of events [33, 34].

Given the consistent upward trend in self-harm over the past decade and the fact that ED presentations capture only the most visible portion of all NSSI episodes, there is an urgent need to strengthen public health initiatives aimed at earlier identification and more effective prevention. The wide variation in findings across the literature — arising from differing methodologies for measuring NSSI — underscores the necessity for greater focus on these behaviors.

According to WHO figures, NSSI itself constitutes a significant risk factor for suicide among young people, a leading cause of death in this age group [35]. Consequently, NSSI can exert a substantial influence on healthy adolescent development. As personal identity takes shape during these years, it lays the foundation for long-term mental well-being [36]. Behaviors such as NSSI that can emerge early and intensify over time, therefore, demand prompt attention [37]. It is essential to enhance and harmonize existing data sources to quickly identify at-risk youth and offer interventions tailored to their gender and age. At the same time, these information systems should be leveraged more effectively to deepen understanding of the individual, environmental, and social factors surrounding NSSI.

Although the present study adopted a relatively straightforward descriptive design and relied on readily accessible official data sources — which, overall, represent a strength — its findings should still be interpreted with awareness of certain constraints.

Since the analysis draws exclusively from national ministerial administrative records, which are generally robust and comprehensive, they remain vulnerable to inaccuracies stemming from operator-dependent data entry. Moreover, the determination of whether an injury was intentional can be influenced by multiple variables, including the clinician's personal judgment, level of attentiveness, interviewing skills, and time constraints during assessment. Another constraint concerns the 2021 dataset, which, due to administrative and legal processes, was available only through October. As a result, the true number of NSSI cases identified may be somewhat underestimated.

Lastly, for the objectives of this investigation, all ED attendances were included in the analysis, regardless of whether they represented initial or repeat NSSI episodes (which, in any case, accounted for less than 3% of total visits). This approach was chosen because it better reflects the overall workload imposed on hospitals by the phenomenon being examined.

Conclusion

The observed rise in NSSI episodes over time, set against a backdrop of steadily declining overall ED attendances, underscores the need for more detailed examination of these patterns to uncover the less visible dimensions of the NSSI issue. Across the past decade, both population-based rates and ED visit rates for NSSI showed clear

increases well before the onset of the COVID-19 pandemic. While the pandemic artificially lowered the population rate due to reduced healthcare utilization, it simultaneously intensified the underlying phenomenon. NSSI among young people constitutes a non-postponable emergency and a major public health challenge. It is therefore essential to strengthen early intervention and preventive measures within primary care settings so that at-risk individuals can be identified quickly and more severe consequences avoided. To date, NSSI may represent only one visible manifestation of the broader decline in mental health among children and adolescents. These trends warrant continued longitudinal investigation and ongoing surveillance to support improved health outcomes for adolescents and the population as a whole.

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