NATIONAL REGISTRY OF DELIBERATE SELF HARM IRELAND

ANNUAL REPORT 2013

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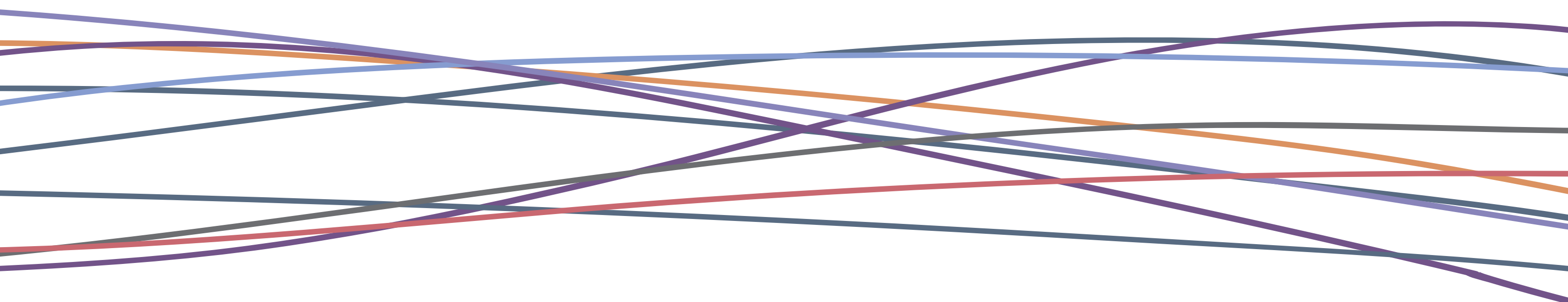

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FOREWORDS

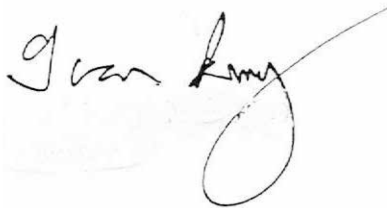
Over twelve years ago, we established in Ireland the world's first national registry of cases of intentional self-harm presenting to hospital emergency departments. The Registry was established at the request of the Department of Health and Children by the National Suicide Research Foundation working in collaboration with the Department of Epidemiology & Public Health, University College Cork. It is funded by the Health Service Executive's National Office for Suicide Prevention.

The Registry provides a unique opportunity to determine and monitor the incidence and repetition of self-harm presentations to hospital emergency departments in Ireland with the aim of identifying high-incidence groups and areas, and informing services and practitioners concerned with the prevention of suicidal behaviour.

One of the benefits of such a monitoring system is in examining trends of self-harm rates over time. Ireland was profoundly affected by the global financial crisis, and experienced five years of economic recession. Data collected by the Registry during this time reflected the impact of the recession on suicidal behaviour in Ireland, and we saw a 12% increase in rates of self-harm during the period 2007-2012.

This availability of reliable national-level data has given rise to a number of in-depth studies and analyses of suicidal behaviour in Ireland, leading to international dissemination of work and knowledge. It has also formed the basis of the development of the Northern Ireland Registry of Deliberate Self Harm by the Northern Ireland Public Health Agency.

As Director of the Registry, I would like to acknowledge the work of the data registration officers who maintain the high standards of the Registry. I would also like to commend the hospital staff for their diligence and dedication in meeting the needs of individuals who present to hospital as a result of self-harm. This is particularly pertinent in these times of constrained healthcare resources, and we are grateful for their facilitation and support of the on-going operation of the Registry.



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The National Registry of Deliberate Self Harm was established at the request of the Department of Health and Children by the National Suicide Research Foundation in collaboration with the Department of Epidemiology & Public Health, University College Cork. Since 2006 it has been funded by the Health Service Executive's National Office for Suicide Prevention.

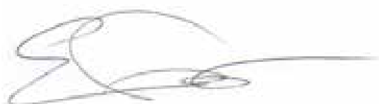
The Registry can be considered a unique health information system for multiple reasons. Internationally, it is currently the only registry with national coverage of self-harm presentations to hospital emergency departments. It provides real-time data on hospital treated self-harm, which contributes to early identification of specific patterns of self-harm, such as emerging high-risk groups and self-harm clusters in certain areas and the use of 'new' methods of self-harm.

Information obtained by the Registry also contributes to service planning. For example, information on geographic variation in the incidence of self-harm and extent of repeated self-harm has been used to inform the national implementation and evaluation of Dialectical Behaviour Therapy. The benefits of the Registry are further demonstrated by the on-going use of the Registry data as indicators for the evaluation of the effectiveness of self-harm and suicide prevention programmes, such as restricting access to highly lethal medication, such as distalgesic, and enhanced monitoring of prescribing patterns of benzodiazepines.

In recent months, the Registry outcomes have informed priorities for the new National Strategic Framework for Suicide Prevention in Ireland, 2015-2019, which will be completed by the end of the year.

Internationally, the Registry and related research into self-harm and suicide conducted by the NSRF has guided key priorities and recommendations in the recently published WHO global report on suicide: *Preventing Suicide: a Global Imperative,* such as the requirement of on-going surveillance systems of self-harm and suicide, and including the Irish National Registry of Deliberate Self Harm as an example.

I would like to acknowledge the on-going commitment and dedication of the data registration officers in ensuring the high quality operation of the Registry. I also would like to express my great appreciation to the hospital staff in terms of engaging with individuals following self-harm to provide the care they require, and for supporting the work of the Registry.



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The 2013 Annual Report shows a decrease in the national rate of self-harm for the third subsequent year

EXECUTIVE SUMMARY

THIS IS THE TWELFTH ANNUAL REPORT FROM THE NATIONAL REGISTRY OF DELIBERATE SELF HARM. IT IS BASED ON DATA COLLECTED ON PERSONS PRESENTING TO HOSPITAL EMERGENCY DEPARTMENTS AS A RESULT OF DELIBERATE SELF-HARM IN 2013 IN THE REPUBLIC OF IRELAND. THE REGISTRY HAD NEAR COMPLETE COVERAGE OF THE COUNTRY'S HOSPITALS FOR THE PERIOD 2002-2005 AND, SINCE 2006, ALL GENERAL HOSPITAL AND PAEDIATRIC HOSPITAL EMERGENCY DEPARTMENTS IN THE REPUBLIC OF IRELAND HAVE CONTRIBUTED DATA TO THE REGISTRY.

In 2013, the Registry recorded 11,061 presentations to hospital due to deliberate self-harm nationally, involving 8,772 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital following self-harm in 2013 was 199 per 100,000, a 6% decrease on the rate in 2012. This decrease follows successive decreases of 4% and 2% in the rate of self-harm in Ireland in 2011 and 2012, respectively. However, the rate in 2013 was still 6% higher than the pre-recession rate in 2007 (188 per 100,000).

In 2013, the national male rate of self-harm was 182 per 100,000, 7% lower than in 2012. The female rate of self-harm in 2013 was 217 per 100,000, 5% lower than in 2012. Despite the overall decrease in 2013, the male rate has increased by 12% since 2007 whereas the female rate is just 1% higher than in 2007.

In 2013, the only significant changes in the rate of hospital-treated self-harm by age were among males and females aged 40-44 and males aged 50-54 years. The male rate for those aged 40-44 years fell by 14% from 2012, from 263 to 226 per 100,000. The male rate for those aged 50-54 years fell by 17%, from 200 to 165 per 100,000. The female rate for those aged 40-44 years fell by 21%, from 303 to 238 per 100,000. Rates of self-harm for other age groups remained similar to 2012.

As in previous years, the female rate was higher than the male rate but the gender difference has narrowed from 37% in 2004-2005 to 19% in 2013. The peak rate for women was in the 15-19 years age group, at 619 per 100,000, whereas the peak rate among men was in 20-24 year-olds at 510 per 100,000. These rates imply that one in every 162 girls in the age group 15-19 and one in every 196 men in the age group 20-24 presented to hospital in 2013 as a consequence of self-harm.

There was widespread variation in the male and female self-harm rate when examined by city/county of residence. The male rate varied from 93 per 100,000 for Roscommon to 406 per 100,000 for Limerick City. The lowest female rate was recorded for counties Sligo and Offaly (130 per 100,000) with the highest rates recorded for Limerick City residents at 570 per 100,000. Relative to the national rate, a high rate of self-harm was recorded for male and female city residents and for men living in Louth, Carlow, South Dublin and Kerry and for women living in South Dublin, Carlow, Longford and Tipperary North. In 2013 the highest rates for both men and women were seen in Limerick City, where both rates were more than twice the national rate. In Cork City the male rate was 77% higher than the national average and the female rate was 29% higher.

Between 2012 and 2013, the national rate of hospital-treated self-harm decreased by 7% for men and 5% for women. The only significant decrease among men was observed in Meath (-23%). The most notable decreases for women included Waterford City (-34%), Offaly (-31%), Wexford (-21%) and Meath (-20%). A significant increase in the female rate of self-harm was observed in Dun-Laoghaire Rathdown (+25%).

Despite a decrease in the number of presentations in 2013 from 2012, the proportion of acts accounted for by repetition in 2013 (21.0%) was similar to 2012, but higher than that in 2010 or 2011 (19.9% and 19.5%, respectively). Therefore, repetition continues to pose a major challenge to hospital staff and family members involved. The rate of repetition was broadly similar in men and women (14.5% vs. 13.3%). Repetition varied significantly by age. Approximately 14% of self-harm patients aged less than 15 years re-presented with self-harm in 2013. The proportion who repeated was highest, at 16%, for 25-54 year-olds.

At least five self-harm presentations were made by 127 individuals in 2013, accounting for just 1% of all self-harm patients in the year but representing 9% of all self-harm presentations recorded. As in previous years, self-cutting was associated with an increased level of repetition. Almost one in five (18%) of those who used cutting as their main method of self-harm in their index act made at least one subsequent self-harm presentation in the calendar year compared to over one in ten (13%) of those who took an intentional drug overdose. Risk of repetition was greatest in the days and weeks following a self-harm presentation to hospital and the risk increased markedly with each subsequent presentation.

While overall the rate of repetition in one year was similar for men and women, repetition rates by gender did vary by Local Health Office (LHO) area. The largest gender differences in the rate of repetition were observed in those LHO areas with the highest repetition rates. Repetition of self-harm is a strong predictor of future suicide, and so the correlation between rates of repetition and suicide rates by region warrants further investigation.

Intentional drug overdose was the most common method of self-harm, involved in 67% of all acts registered in 2013. Minor tranquillisers, paracetamol-containing medicines and anti-depressants/mood stabilisers were involved in 39%, 29% and 21% of drug overdose acts, respectively. The number of self-harm presentations to hospital involving drug overdose in 2013 (7,457) represented a significant 10% decrease on the numbers recorded in 2012. This was also true when examined by type of drug. This was

mainly due to a significant reduction in the number of self-harm presentations involving minor tranquillisers, which reduced by 13% from 2012. The decrease was more prominent in women compared to men (-16% and -9% respectively). Further decreases were observed in the use of paracetamol-compound medication (-13%), SSRI's (-17%) and tricyclic anti-depressants (TCADs) (-30%).

Attempted hanging was involved in 7% of all self-harm presentations (10% for men and 4% for women). At 732, the number of presentations involving attempted hanging has decreased by 6% from 2012. However, the number of self-harm acts involving attempted hanging among of women has increased by 13% from 2012. Overall, the proportion of self-harm presentations involving hanging increased by 7% between 2007 and 2012. Increasing trends in highly lethal self-harm methods are associated with higher suicidal intent (Bergen et al, 2012; Beautrais et al, 2001) and can therefore be considered a true increase in self-harm that occurred during the recessionary period in Ireland. Whilst during 2007-2010 in particular there was a steep increase in self-harm involving highly lethal methods among both men and women, the proportion of cases involving highly lethal methods among men has again decreased in recent years. However, this decrease and a decline in methods of self-harm with low lethality since 2011 should be interpreted with caution.

Cutting was the only other common method of self-harm, involved in 24% of all episodes and was significantly more common in men (26%) than women (23%). In line with 2012, the treatment following self-cutting was similar for both women and men. 33% of presentations involving self-cutting required no treatment, 30% required sterstrips, 22% received sutures, while 5% were referred for plastic surgery.

Similar to 2012, alcohol was involved in just over one third of all cases (37%). While overall alcohol involvement decreased slightly from 2012, alcohol was significantly more involved in male episodes of self-harm than female episodes (40% versus 34%, respectively). Alcohol may be one of the factors underlying the pattern of presentations with deliberate self-harm by time of day and day of week. Presentations peaked in the hours around midnight and almost one-third of all presentations occurred on Sundays and Mondays. Consistent with previous years, the Registry identified an increased number of self-harm presentations to hospital associated with public holidays.

In 2013, 61% (n=6,766) of patients were assessed by a member of the mental health team in the hospital. Assessment was most common following attempted hanging (76%) and attempted drowning (69%). 70% of those not admitted to the presenting hospital received a psychiatric assessment prior to discharge. However, only 16% of patients who left before recommendation/medical advice received an assessment.

Next care varied significantly by HSE hospitals group. The proportion of self-harm patients that left before a recommendation was made varied from 10% in the Dublin/ Midlands Hospitals Group to 19% in the Dublin North East and North Eastern Hospital Groups. Inpatient care (irrespective of type and whether the patient refused) varied from 19% of the patients treated in Mid-Western Hospitals Group to 45% in the Dublin/ Midlands Hospitals Group. In addition, general and psychiatric admissions following treatment in the emergency department also varied significantly by hospitals group. The variation in recommended next care is likely to be due to variation in the availability of resources and services but it also suggests that assessment and management procedures with respect to deliberate self-harm patients is likely to be variable and inconsistent across the country.

For the first time in 2013 referrals for patients discharged from the emergency department following self-harm were recorded by the Registry. 70% of patients discharged from the presenting emergency department were provided with a referral. In 29% of episodes, an out-patient appointment was recommended as a next care step for the patient. 17% of patients were discharged with a recommendation to attend their GP for a follow-up appointment. 12% of those not admitted to the presenting hospital were transferred to another hospital for treatment. Other services (e.g. psychological services, community-based mental health teams and addiction services) were recommended in 10% of episodes.

National guidelines for the assessment and management of patients presenting to Irish EDs should be implemented as a matter of priority

RECOMMENDATIONS

FOLLOWING SUCCESSIVE INCREASES IN DELIBERATE SELF-HARM IN IRELAND DURING THE PERIOD 2007-2010, THE 2013 ANNUAL REPORT OF THE NATIONAL REGISTRY OF DELIBERATE SELF HARM SHOWS A THIRD SUBSEQUENT ANNUAL DECREASE, WHICH REPRESENTS A 11% DECREASE SINCE 2010. HOWEVER, THE 2013 NATIONAL SELF-HARM RATE IS STILL 6% HIGHER THAN THE NATIONAL RATE IN 2007, AND THE NATIONAL MALE SELF-HARM RATE IS STILL 12% HIGHER THAN THE EQUIVALENT RATE IN 2007. THE 2013 REGISTRY OUTCOMES UNDERLINE AN ON-GOING NEED FOR PREVENTION AND INTERVENTION PROGRAMMES TO BE IMPLEMENTED AT NATIONAL LEVEL. INCREASED AND CONTINUED SUPPORT SHOULD BE PROVIDED FOR EVIDENCE-BASED AND BEST PRACTICE PREVENTION AND MENTAL HEALTH PROMOTION PROGRAMMES IN LINE WITH PRIORITIES IN *REACH OUT,* NATIONAL STRATEGY FOR ACTION ON SUICIDE PREVENTION (2005-2014) AND *VISION FOR CHANGE*, THE REPORT OF THE EXPERT GROUP ON MENTAL HEALTH POLICY. A NUMBER OF THE RECOMMENDATIONS FOLLOWING FROM THE 2013 REPORT FINDINGS ARE CONSISTENT WITH THOSE PROPOSED IN RECENT YEARS, AND A NUMBER OF KEY OUTCOMES INDICATE ON-GOING PRIORITIES.

Considering that the rate of self-harm in 2013 was still 6% higher than in 2007, before the economic recession, this underlines the need for continued implementation and evaluation of programmes to increase awareness of mental health issues among the general public and professionals involved in supporting people who are unemployed and those experiencing financial difficulties.

There is growing evidence for the effectiveness of multi-level community based self-harm and suicide prevention programmes in addressing self-harm risk among people who face socio-economic challenges and who are vulnerable in terms of varying mental health issues *(Hegerl et al, 2013; Szekely et al, 2013; Mann et al, 2005)*. With regard to further research into the interaction between mental health difficulties and work related risk factors associated with self-harm and suicide, in 2014, the NSRF has started a three-year study (SSIS-ACE), which will be conducted in collaboration with the UCC Department of Epidemiology and Public Health, and the Department of General Practice. The SSIS-ACE study is funded by the Irish Health Research Board.

The Registry consistently provides evidence for different types of self-harm patients presenting to Emergency Departments (EDs), such as those engaging in highly lethal acts of self-harm with high risk of subsequent suicide and those using methods with low lethality but who may be at risk of non-fatal repetition. While it is strongly recommended that all self-harm patients presenting to the ED should receive a comprehensive risk and psychosocial-psychiatric assessment, recommended treatment should be tailored according to the patient's needs and risk of subsequent suicidal behaviour *(MacHale et al, 2013; Knesper, 2011; NICE, 2011)*. In this context, it is encouraging that as part of the National Mental Health Programme, 25 self-harm specialist nurses have taken up their position in different hospitals in the country since the start of 2014 and 12 more nurses have been allocated until the end of this year. In relation to the data on patients receiving a mental health assessment, it is noteworthy and encouraging that of those cases where this information was available (88% of the total), 61% of patients were assessed in the ED following a presentation of self-harm. Enhancing assessment and management of self-harm in hospital EDs should be an on-going priority of the National Mental Health Programme and the new National Strategic Framework for Suicide Prevention, 2015-2019.

A positive outcome is the significant reduction in the use of minor tranquillisers (benzodiazepines) and SSRIs among self-harm patients in 2013, which may be related to pro-active monitoring of prescribing patterns in primary care services since 2012. Even though the use of paracetamol-containing medicines also decreased in 2013, the relatively frequent use of these medicines underline the need for a review of the implementation of the paracetamol legislation.

The significant increase in female self-harm acts involving attempted hanging in 2013 and the on-going frequent engagement in this method by males underline the importance of suicide risk assessment combined with psychiatric and psychosocial assessment considering the high risk of subsequent suicide. In line with previous research *(Baker et al, 2012; Gunnell et al, 2005)*, more innovative and intensified efforts should be made to reduce self-harm and suicide by hanging. Further research into risk factors associated with highly lethal self-harm acts will be undertaken by the SSIS-ACE study.

In line with previous years, misuse or abuse of alcohol is one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underline the need for continued efforts to:

- Enhance health service capacity at specific times and to increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control *(NICE, 2011)*.
- Intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age and intensify national strategies to reduce access to alcohol and drugs *(CDC, 2010)*.
- Educate self-harm patients and their families about the importance of reduced use of and access to alcohol *(CDC, 2010)*.
- Arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse) *(NICE, 2011)*.

Based on recommendations of the Steering Group Report on the National Substance Misuse Strategy, in October 2013 a number of measures were proposed for inclusion in a Public Health Bill to target alcohol misuse and to reduce alcohol consumption (including minimum pricing, regulation of marketing and advertising, and health labelling) *(Department of Health, 2013)*.

The current report shows ongoing evidence that self-cutting is the method most strongly associated with high-risk of repeated self-harm following a presentation to an ED *(Arensman et al, 2013; Larkin et al, 2013)*. The Registry further illustrates the 'dose-response relationship' between the number of self-harm presentations and risk of repetition *(Perry et al, 2012)*. There is need for continued efforts to prioritise national implementation of evidence-based treatments shown to reduce risk of repetition, such as cognitive behavioural and dialectical

behavioural interventions *(Daigle et al, 2011; Binks et al, 2006)*. The NOSP has funded the national implementation of dialectical behaviour therapy for people diagnosed with Borderline Personality Disorder.

In line with previous years, there was considerable variation in the next care recommended to deliberate self-harm patients, and the proportion of patients who left hospital before a recommendation, from 10% in the Dublin/ Midlands Hospitals Group to 19% in the Dublin North East and North Eastern Hospitals Groups. While the Registry recorded that in 2013 near three-quarters of patients discharged from the ED following a self-harm presentation were provided with a referral, variations in the referral pathway for patients was seen according to HSE hospitals group. A subgroup of the National Mental Health Clinical Programme Steering Group produced National Guidelines for the Assessment and Management of Patients presenting to Irish Emergency Departments following self-harm *(MacHale et al, 2013)*. It is recommended that these guidelines be implemented nationally as a matter of priority. In addition, the NOSP has funded a pilot project to implement and evaluate suicide and self-harm awareness training for all ED staff and improving assessment procedures for self-harm patients in Cork and Kerry, which is a collaborative initiative between Cork University Hospital and the NSRF.

On-going work is being undertaken by the NSRF to link the Registry data with suicide mortality data obtained through the Suicide Support and Information System in Cork and the Central Statistics Office data. Linking the Registry self-harm data with the SSIS suicide mortality data revealed that self-harm patients were over 42 times more likely to die by suicide than persons in the general population. Evidence of the association between self-harm and suicide is further supported by recent UK based research showing a significant association between self-harm involving self-cutting and suicide among both adults and young people *(Bergen et al, 2012; Hawton et al, 2012)*. In addition, there are indications that increasing rates of self-harm in men are likely to be followed or paralleled by increasing suicide rates among men. It is therefore recommended that deliberate self-harm data be linked with suicide mortality data at a national level in order to enhance insight into predictors of suicide risk.

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CONTRIBUTION OF

Contribution of the Registry to implementation and evaluation of self-harm intervention and prevention programmes in Ireland

Information from the Registry on self-harm trends and demographic and clinical characteristics, has guided the development and implementation of recommendations and specific interventions, such as:

1. The implementation of self-harm specialist nurses in hospital emergency departments in Ireland as part of the National Mental Health Programme (2013-2014) - The implementation will take place in 2014 according to a stepped approach and prioritising hospitals according to the number of self-harm presentations. Currently, 25 of the allocated 37 self-harm specialist nurses have taken up their position in different hospitals across the country.

2. The implementation of Dialectical Behaviour Therapy (DBT) at national level (2013-2015) - Following successful implementation of DBT for patients with Borderline Personality Disorder and frequent self-harm repetition in Cork, DBT will be implemented nationally according to a stepped approach and prioritising areas with high levels of repeated self-harm. Currently eight teams have received DBT training and have subsequently started implementing DBT, with a further nine teams to receive training in September 2014.

3. Implementation of guidelines for assessment and management of self-harm patients presenting to Irish Emergency Departments (2014 - 2015) – The Registry data underlined the need to implement uniform evidence-based guidelines for the assessment and management of self-harm patients presenting to EDs.

4. The NOSP working group on restricting access to benzodiazepines (2012-2014) – The Registry consistently shows that intentional drug overdose involving benzodiazepines is high in Ireland. This information contributed to establishing a working group on restricting access to benzodiazepines by the NOSP.

THE REGISTRY

5

Limerick working group on reducing suicide and self-harm by drowning (2012-2014) – In recent years, the Registry identified a significant increase in attempted suicidal drownings in Limerick, which was paralleled by an increase in fatal suicidal drownings. This information contributed to establishing a working group in reducing suicide and self-harm by drowning by the local Suicide Resource Officer and other stakeholders.

6

Guiding and informing priorities for self-harm intervention and prevention programmes as well as the evaluation plan for the purpose of the new National Strategic Framework for Suicide Prevention in Ireland, 2015-2019

7

Guiding and informing the development of self-harm information systems internationally in the context of the first global report on suicide by the World Health Organisation: *Preventing Suicide: a Global Imperative*, which was launched on 5th September 2014. The report underlines the importance of self-harm surveillance as a core component of national suicide prevention programmes and it highlights exemplars of best practice in different countries, including the National Registry of Deliberate Self Harm in Ireland.

Since 2006, the Registry has complete coverage of all acute hospitals in Ireland

METHODS

BACKGROUND

THE NATIONAL REGISTRY OF DELIBERATE SELF HARM IS A NATIONAL SYSTEM OF POPULATION MONITORING FOR THE OCCURRENCE OF DELIBERATE SELF-HARM. IT WAS ESTABLISHED, AT THE REQUEST OF THE DEPARTMENT OF HEALTH AND CHILDREN, BY THE NATIONAL SUICIDE RESEARCH FOUNDATION AND IS FUNDED BY THE HEALTH SERVICE EXECUTIVE'S NATIONAL OFFICE FOR SUICIDE PREVENTION.

THE NATIONAL SUICIDE RESEARCH FOUNDATION WAS FOUNDED IN JANUARY 1995 BY THE LATE DR MICHAEL J. KELLEHER AND CURRENTLY OPERATES UNDER THE MEDICAL DIRECTORSHIP OF DR MARGARET KELLEHER, THE RESEARCH DIRECTORSHIP OF PROFESSOR ELLA ARENSMAN AND PROFESSOR IVAN J. PERRY AS DIRECTOR OF THE NATIONAL REGISTRY OF DELIBERATE SELF HARM. MS EILEEN WILLIAMSON IS THE EXECUTIVE DIRECTOR.

DEFINITION AND TERMINOLOGY

The Registry uses the following as its definition of deliberate 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'. This definition was developed by the WHO/Euro Multicentre Study Working Group and was associated with the term 'parasuicide'. Internationally, the term parasuicide has been superseded by the term 'deliberate self-harm' and consequently, the Registry has adopted the term 'deliberate self-harm'. The definition includes acts involving varying levels of suicidal intent and various underlying motives such as loss of control, cry for help or self-punishment.

INCLUSION CRITERIA

- All methods of self-harm are included i.e., drug overdoses, alcohol overdoses, lacerations, attempted drownings, attempted hangings, gunshot wounds, etc. where it is clear that the self-harm was intentionally inflicted.
- All individuals who are alive on admission to hospital following a deliberate self-harm act are included.

EXCLUSION CRITERIA

The following cases are NOT considered to be deliberate self-harm:

- Accidental overdoses e.g., an individual who takes additional medication in the case of illness, without any intention to self-harm.
- Alcohol overdoses alone where the intention was not to self-harm.
- Accidental overdoses of street drugs i.e., drugs used for recreational purposes, without the intention to self-harm.
- Individuals who are dead on arrival at hospital as a result of suicide.

QUALITY CONTROL

The validity of the Registry findings is dependent on the standardised application of the case-definition and inclusion/exclusion criteria. The Registry has undertaken a cross-checking exercise in which pairs of data registration officers independently collected data from two hospitals for the same consecutive series of attendances to the emergency department. Results indicated that there is a very high level of agreement between the data registration officers. Furthermore, the data are continuously checked for consistency and accuracy.

DATA RECORDING

Since 2006, the Registry has recorded its data onto laptop computers and transferred the data electronically to the offices of the National Suicide Research Foundation. Data for all deliberate self-harm presentations made in 2013 were recorded using this electronic system.

DATA ITEMS

A minimal dataset has been developed to determine the extent of deliberate self-harm, the circumstances relating to both the act and the individual and to examine trends by area. While the data items below will enable the system to avoid duplicate recording and to recognise repeat acts of deliberate self-harm by the same individual, they ensure that it is impossible to identify an individual on the basis of the data recorded.

INITIALS: Initial letters from an individual deliberate self-harm patient's name are recorded in an encrypted form by the Registry data entry system for the purposes of avoiding duplication, ensuring that repeat episodes are recognised and calculating incidence rates based on persons rather than events.

GENDER: Male or female gender is recorded when known.

DATE OF BIRTH: Date of birth is recorded in an encoded format to further protect the identity of the individual. As well as being used to identify repeat deliberate self-harm presentations by the same individual, date of birth is used to calculate age.

AREA OF RESIDENCE: Patient addresses are coded to the appropriate electoral division and small area code where applicable.

DATE AND HOUR OF ATTENDANCE AT HOSPITAL

BROUGHT TO HOSPITAL BY AMBULANCE

METHOD(S) OF SELF-HARM: The method(s) of self-harm are recorded according to the Tenth Revision of the WHO's International Classification of Diseases codes for intentional injury (X60-X84). The main methods are overdose of drugs and medicaments (X60-X64), self-poisonings by alcohol (X65), poisonings which involve the ingestion of chemicals, noxious substances, gases

and vapours (X66-X69) and self-harm by hanging (X70), by drowning (X71) and by sharp object (X78). Some individuals may use a combination of methods e.g., overdose of medications and self-cutting. In this report, results generally relate to the 'main method' of self-harm. In keeping with standards recommended by the WHO/ Euro Study on Suicidal Behaviour, this is taken as the most lethal method employed. For acts involving self-cutting, the treatment received was recorded when known.

DRUGS TAKEN: Where applicable, the name and quantity of the drugs taken are recorded.

MEDICAL CARD STATUS: Whether the individual presenting has a medical card or not is recorded.

MENTAL HEALTH ASSESSMENT: Whether the individual presenting had a review or assessment by the psychiatric team in the presenting hospital emergency department is recorded.

RECOMMENDED NEXT CARE: Recommended next care following treatment in the hospital emergency department is recorded.

CONFIDENTIALITY

Confidentiality is strictly maintained. The National Suicide Research Foundation is registered with the Data Protection Agency and complies with the Irish Data Protection Act of 1988 and the Irish Data Protection (Amendment) Act of 2003. Only anonymised data are released in aggregate form in reports. The names and addresses of patients are not recorded.

ETHICAL APPROVAL

Ethical approval has been granted by the National Research Ethics Committee of the Faculty of Public Health Medicine. The Registry has also received ethical approval from the relevant hospitals and Health Service Executive (HSE) ethics committees.

REGISTRY COVERAGE

In 2013, deliberate self-harm data were collected from each HSE region in the Republic of Ireland (pop: 4,593,300).

There was complete coverage of all acute hospitals in the HSE Dublin/ Mid-Leinster Region (pop: 1,327,844) which comprises two HSE National Hospitals Groups. Dublin/ Midlands Hospitals Group includes Adelaide & Meath incorporating the National Children's Hospital Tallaght, the Midland Regional Hospitals at Mullingar, Portlaoise and Tullamore, Naas General Hospital and Our Lady's Children's Hospital Crumlin. The Dublin South Hospitals Group includes St Columcille's Hospital Loughlinstown, St James's Hospital, St Michael's Hospital Dun Laoghaire and another hospital whose ethics committee stipulated that it should not be named in Registry reports.

There was complete coverage of all acute hospitals in the HSE Dublin/ North East Region (pop: 1,018,132). The region comprises the Dublin North East Hospitals Group and the North Eastern Hospitals Group. The Dublin North East Hospitals Group includes Beaumont Hospital, Children's University Hospital Temple Street, James Connolly Hospital Blanchardstown and Mater Misericordiae University Hospital. The North Eastern Hospitals Group includes Cavan General Hospital, Our Lady of Lourdes Hospital Drogheda and Our Lady's Hospital Navan.

There was complete coverage of all acute hospitals in the HSE South Region (pop: 1,175,700) which comprises the South Eastern and the Southern Hospitals Groups. The South Eastern Hospitals Group includes St Luke's Hospital Kilkenny, South Tipperary General Hospital, Waterford Regional Hospital and Wexford General Hospital. The Southern Hospitals Group includes Bantry General Hospital, Cork University Hospital, Kerry General Hospital, Mallow General Hospital and Mercy University Hospital Cork.

There was complete coverage of the acute hospitals in the HSE West Region (pop: 1,071,624) which comprises the Mid-Western and the West/ North Western Hospitals Groups. The Mid-Western Hospitals Group includes the Mid-Western Regional Hospitals at Ennis, Limerick and Nenagh and St John's Hospital Limerick. The West/ North Western Hospitals Group includes Letterkenny General Hospital, Mayo General Hospital, Portiuncula Hospital Ballinasloe, Sligo General Hospital and University College Hospital Galway.

In total, deliberate self-harm data were collected for the full calendar year of 2013 for all 35 acute hospitals that operated in Ireland during this year. As mentioned previously, since 2006 the Registry has had complete coverage of all acute hospitals in Ireland.

In 2013, a number of hospital emergency departments were re-designated as Model 2 status hospitals as part of the HSE's *Securing the Future of Smaller Hospitals*

framework, with some of these hospitals closing their emergency department and others operating on reduced hours. The hospitals which continue to have emergency departments on reduced hours include: St. Columcille's Hospital Loughlinstown, Bantry General Hospital, Mallow General Hospital, St. John's Hospital Limerick and the Mid-Western Regional Hospitals at Ennis and Nenagh. Data from these hospitals are recorded by the Registry for 2013.

POPULATION DATA

For 2013, the Central Statistics Office population estimates were utilised. These estimates provide age-sex-specific population data for the country and its constituent regional authority areas. Proportional differences between the 2013 regional authority population estimates and the equivalent National Census 2011 figures were calculated and applied to the National Census 2011 population figures for Irish cities, counties and HSE region figures in order to derive population estimates for 2013. For urban and rural district populations and HSE Local Health Office areas, National Census 2011 population data were utilised.

CALCULATION OF RATES

Deliberate self-harm rates were calculated based on the number of persons resident in the relevant area who engaged in deliberate self-harm irrespective of whether they were treated in that area or elsewhere. Crude and age-specific rates per 100,000 population were calculated by dividing the number of persons who engaged in deliberate self-harm (n) by the relevant population figure (p) and multiplying the result by 100,000, i.e. (n / p) * 100,000.

European age-standardised rates (EASRs) are the incidence rates that would be observed if the population under study had the same age composition as a theoretical European population. Adjusting for the age composition of the population under study ensures that differences observed by gender or by area are due to differences in the incidence of deliberate self-harm rather than differences in the composition of the populations. EASRs were calculated as follows: For each five-year age group, the number of persons who engaged in deliberate self-harm was divided by the population at risk and then multiplied by the number in the European standard population. The EASR is the sum of these age-specific figures.

A NOTE ON SMALL NUMBERS

Calculated rates that are based on less than 20 events may be an unreliable measure of the underlying rate. In addition, deliberate self-harm events may not be independent of one another, although these assumptions are used in the calculation of confidence intervals, in the absence of any clear knowledge of the relationship between these events.

The Registry recorded 3 cases of deliberate self-harm for which patient initials, gender or date of birth were unknown. These 3 cases have been excluded from the findings reported here. In addition, a small number of deliberate self-harm patients presented to hospital more than once on the same calendar day. This happened for a variety of reasons including being transferred to another hospital, absconding and returning, etc. These patients were considered as receiving one episode of care and were recorded once in the finalised Registry database for 2013.

A NOTE ON CONFIDENCE INTERVALS

Confidence intervals provide us with a margin of error within which underlying rates may be presumed to fall on the basis of observed data. Confidence intervals assume that the event rate (n / p) is small and that the events are independent of one another. A 95% confidence interval for the number of events (n), is n +/- 2√n. For example, if 25 deliberate self-harm presentations are observed in a specific region in one year, then the 95% confidence interval will be 25 +/- 2√25 or 15 to 35. Thus, the 95% confidence interval around a rate ranges from (n - 2√n) / p to (n + 2√n) / p, where p is the population at risk. If the rate is expressed per 100,000 population, then these quantities must be multiplied by 100,000.

A 95% confidence interval may be calculated to establish whether the two rates differ statistically significantly. The difference between the rates is calculated. The 95% confidence interval for this rate difference (rd) ranges from rd - 2√(n1 / p12 + n2 / p22) to rd + 2√(n1 / p12 + n2 / p22). If the rates were expressed per 100,000 population, then 2√(n1 / p12 + n2 / p22) must be multiplied by 100,000 before being added to and subtracted from the rate difference. If zero is outside of the range of the 95% confidence interval, then the difference between the rates is statistically significant.

The following is the team of people who collected the data that formed the basis of this Annual Report

ACKNOWLEDGEMENTS

The following is the team of people who collected the data that formed the basis of this Annual Report. Their efforts are greatly appreciated.

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James Buckley
Lisa Byrne
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Mary Nix
Eileen Quinn

Ms Amanda Wall: Data Management

Ms Eszter Vargyas: Assistance with statistical analysis

Mr Sean Cronin, Millenium Software: Software Engineer

We would like to acknowledge the assistance of staff of the Department of Health, the HSE National Office for Suicide Prevention, the respective HSE regions and the individual hospitals that have facilitated the work of the Registry.

We would also like to acknowledge receipt of a grant from ESB ElectricAID in December 2010 which enabled the upgrading of the IT equipment used for the operation of the Registry.

In 2013, 11,061 deliberate
self-harm presentations
to hospital were made
by 8,772 individuals

SECTION I.
HOSPITAL PRESENTATIONS

FOR THE PERIOD FROM 1 JANUARY TO 31 DECEMBER 2013, THE REGISTRY RECORDED 11,061 DELIBERATE SELF-HARM PRESENTATIONS TO HOSPITAL THAT WERE MADE BY 8,772 INDIVIDUALS. THUS, THE NUMBER OF SELF-HARM PRESENTATIONS WAS 8% LOWER THAN THAT IN 2012 AND THE NUMBER OF PERSONS INVOLVED ALSO DECREASED BY 8%. TABLE 1 SUMMARISES THE CHANGES IN THE NUMBER OF PRESENTATIONS AND PERSONS SINCE THE REGISTRY REACHED NEAR NATIONAL COVERAGE IN 2002.

Year	PRESENTATIONS Number	% diff	PERSONS Number	% diff
2002	10,537	-	8,421	-
2003	11,204	+6%	8,805	+5%
2004	11,092	-1%	8,610	-2%
2005	10,789	-3%	8,594	-<1%
2006	10,688	-1%	8,218	-4%
2007	11,084	+4%	8,598	+5%
2008	11,700	+6%	9,218	+7%
2009	11,966	+2%	9,493	+3%
2010	12,337	+3%	9,887	+4%
2011	12,216	-1%	9,834	-<1%
2012	12,010	-2%	9,483	-4%
2013	11,061	-8%	8,772	-8%

Table 1: Number of self-harm presentations and persons who presented in the Republic of Ireland in 2002-2013 (2002-2005 figures extrapolated to adjust for hospitals not contributing data).

The age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm in 2013 was 199 (95% Confidence Interval (CI): 195 to 203) per 100,000. This rate, which accounts for the changing age distribution of the population, represents a decrease of 6% on the equivalent rate of 211 (95% CI: 207 to 216) per 100,000 in 2012. This decrease follows decreases in 2011 and 2012. The incidence of self-harm in Ireland is examined in detail in Part II of this section of the Annual Report.

The numbers of self-harm episodes treated in the Republic of Ireland by HSE region, hospitals group, age and gender are given in Appendix 1. Of the recorded presentations in 2013, 46% were made by men and 54% were made by women. Self-harm episodes were generally confined to the younger age groups. Just over half of all presentations (53%) were by people under 30 years of age and 85% of presentations were by people aged less than 50 years.

In most age groups the number of self-harm acts by women exceeded the number by men. This was most pronounced in the 10-14 year age group where there were 4.1 times as many female presentations. The number of self-harm presentations made by men was slightly higher than the number made by women (1.0%) in the 25-34 year age group.

In line with 2012, 516 (5%) of all self-harm presentations were by residents of homeless hostels and people of no fixed abode and 69 (0.6%) were made by hospital inpatients.

SELF-HARM BY HSE HOSPITALS GROUP

Based on provisional figures acquired from the HSE Business Intelligence Unit, self-harm accounted for 0.91% of total attendances to general emergency departments in the country. This percentage of attendances accounted for by self-harm varied by HSE hospitals group from 0.70%, 0.72%, 0.78% and 0.79% in the Dublin/ Midlands, North Eastern, West/ North Western and South Eastern, to 0.99% in the Mid-Western, 1.00% in the Dublin North East, 1.02% in the Southern, and 1.33% in the Dublin South.

The proportion of self-harm presentations treated in each hospitals group in 2013 ranged from 7% and 8% in the North Eastern and the Mid-Western, to 11% in the South Eastern, 13% in the West/ North Western, 14% and 15% in the Southern and Dublin South, 16% in the Dublin/ Midlands and 17% in the Dublin/ North East.

The gender balance of recorded episodes in 2013 (at 46% men to 54% women) varied by hospitals group (Figure 1). Self-harm presentations by women outnumbered those by men in all but one of the eight hospitals groups. There were equal numbers of self-harm presentations by men and women in the North Eastern Hospitals Group.

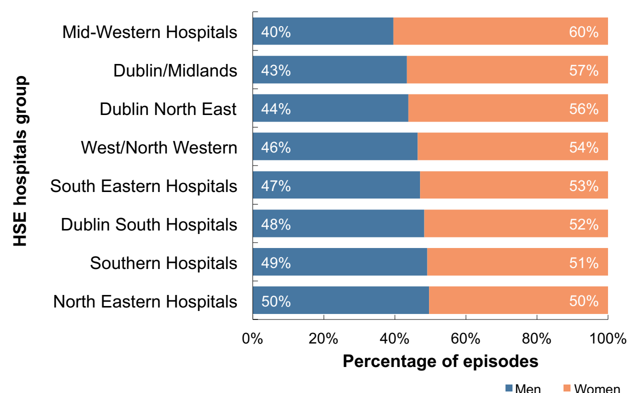


Figure 1: Gender balance of deliberate self-harm presentations by HSE hospitals group.

ANNUAL CHANGE IN SELF-HARM PRESENTATIONS TO HOSPITAL

While the national number of self-harm presentations to hospital in 2013 was 8% lower to that in 2012, there were some relatively large changes in the number of presentations at the level of the individual hospitals (Figures 2a and 2b). Only 7 general hospitals saw an increase in self-harm presentations between 2012 and 2013, while 28 general hospitals saw a decrease during the same period. Overall, the most pronounced changes were in small hospitals, where four hospitals saw decreases of more than 45%. This change in self-harm presentations is thought to reflect the re-designation of a number of hospitals as Model 2 status hospitals, with emergency departments closing or working on reduced hours for some of 2013. The increase in St. Michael's Hospital, Dun Laoghaire is a consequence of the correction of under-reporting of self-harm presentations in 2012 which were due to changes in their emergency department IT system. It should be noted that in small hospitals, large percentage changes are based on relatively small numbers.

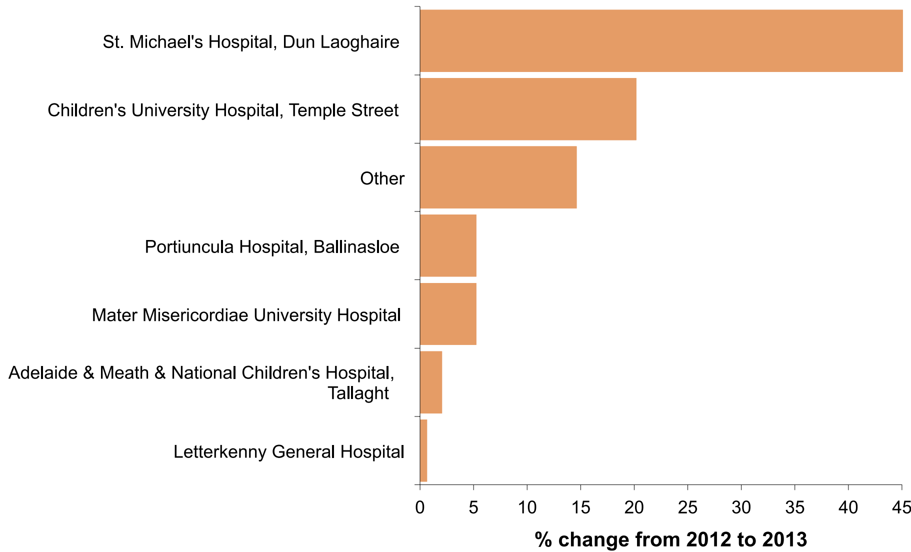


Figure 2a: Hospitals receiving more deliberate self-harm presentations in 2013.

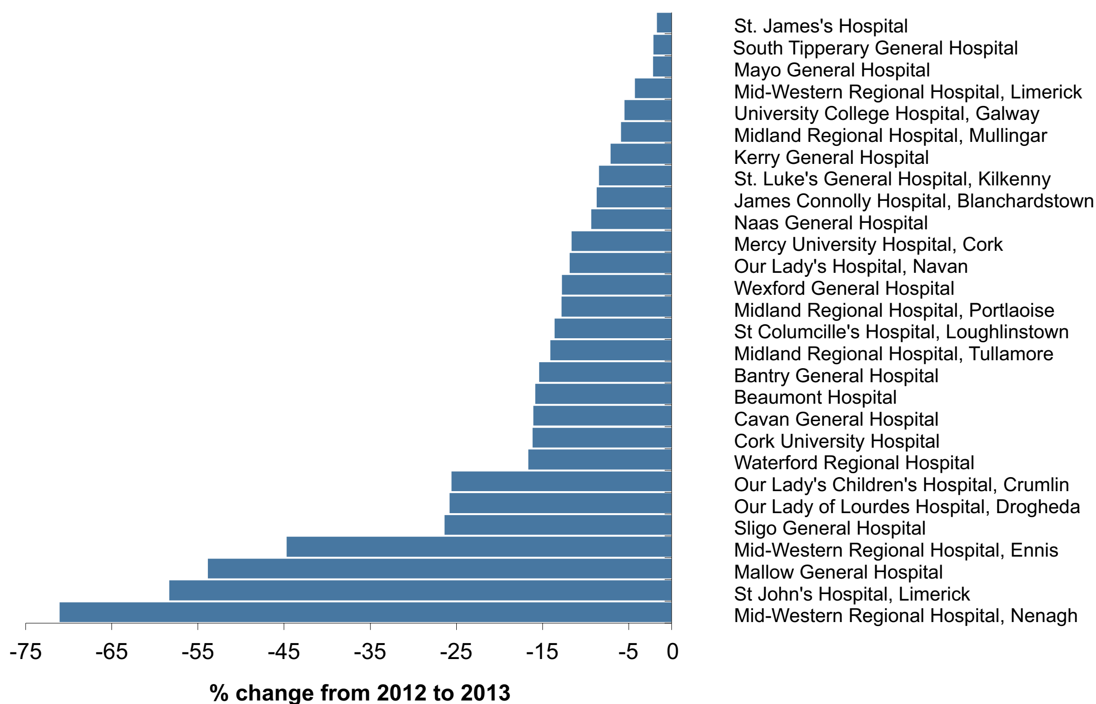


Figure 2b: Hospitals receiving fewer deliberate self-harm presentations in 2013.

VARIATION BY MONTH

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Men	426	373	430	389	426	477	449	472	382	482	398	369	5073
Women	500	420	519	505	507	522	565	523	500	511	476	440	5988
Total	926	793	949	894	933	999	1014	995	882	993	874	809	11061

Table 2: Number of self-harm presentations in 2013 by month for men and women.

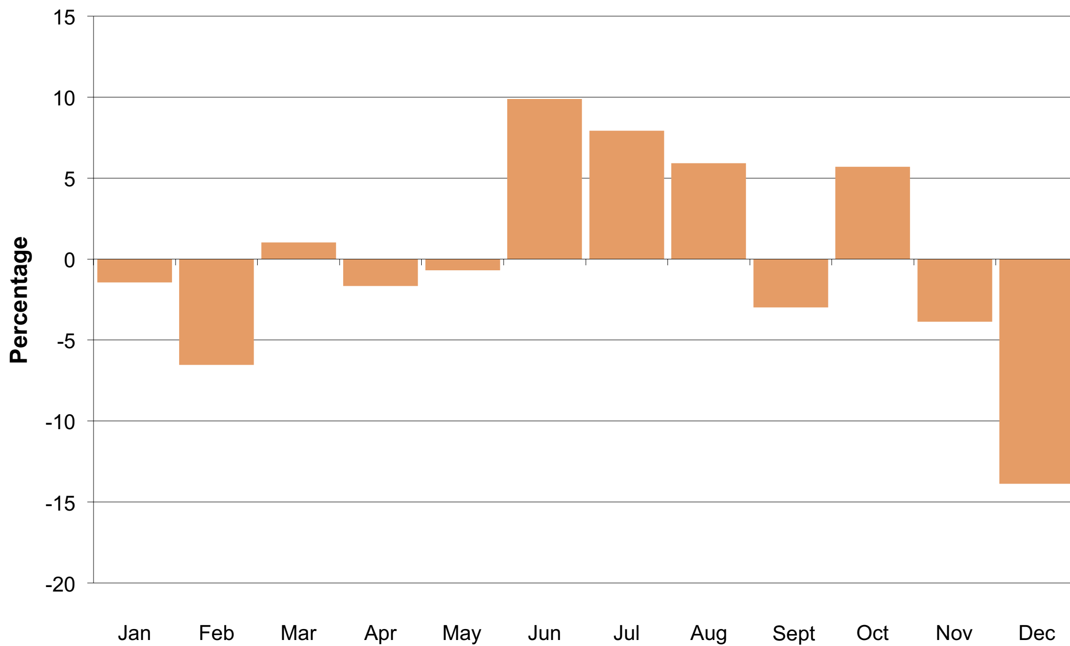


Figure 3: Percentage difference between the observed and expected number of self-harm presentations by month in 2013.

The monthly average number of self-harm presentations to hospitals in 2013 was 922. Figure 3 illustrates the percentage difference between observed and expected number of presentations, accounting for the number of days in each calendar month. In 2013, most months saw fewer self-harm presentations than might be expected. However June, July and August saw more self-harm presentations than might be expected (10%, 8% and 6%, respectively). The end of year fall in presentations was similar to that observed in previous years, with fewer presentations that might be expected, in particular for December (-14%).

VARIATION BY DAY

	MON	TUE	WED	THU	FRI	SAT	SUN	TOTAL
MEN	777	698	722	736	736	690	714	5073
	(15.3%)	(13.8%)	(14.2%)	(14.5%)	(14.5%)	(13.6%)	(14.1%)	(100%)
WOMEN	1002	839	787	763	785	873	939	5988
	(16.7%)	(14%)	(13.1%)	(12.7%)	(13.1%)	(14.6%)	(15.7%)	(100%)
TOTAL	1779	1537	1509	1499	1521	1563	1653	11061
	(16.1%)	(13.9%)	(13.6%)	(13.6%)	(13.8%)	(14.1%)	(14.9%)	(100%)

Table 3: Self-harm presentations in 2013 by weekday.
Note: On average, each day would be expected to account for 14.3% of presentations.

As in previous years, the number of self-harm presentations was highest on Mondays and Sundays. These days accounted for 31% of all presentations. Numbers fell after Monday to a level that was similar from Tuesday to Friday before rising again on Saturday. This pattern of the number of presentations by day of the week was more pronounced in women than in men.

During 2013, there was an average of 30 self-harm presentations to hospital each day. There were four dates in the year on which 50 or more self-harm presentations were made, including: January 1st, New Year's Day (n=51) and August 5th, the August Bank Holiday (n=50). The association between self-harm increases and public holidays has been a consistent pattern over many years.

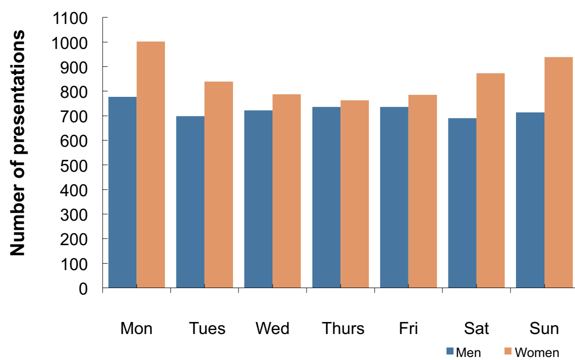


Figure 4: Number of presentations by weekday, 2013.

VARIATION BY THE HOUR

As in previous years, there was a striking pattern in the number of self-harm presentations seen over the course of the day. The numbers for both men and women gradually increased during the day. The peak for both women and men was 11pm. Almost half (46%) of the total number of presentations were made during the eight-hour period 7pm-3am. This contrasts with the quietest eight-hour period of the day, from 5am-1pm, which accounted for just 18% of all presentations.

The majority of patients (54%) were brought to hospital by ambulance and a further 3% were brought by other emergency services such as An Garda Siochana. The proportion brought by ambulance or other emergency services varied over the course of the day from 48% for presentations between noon and 4pm to 71% for those who presented between midnight and 8am.

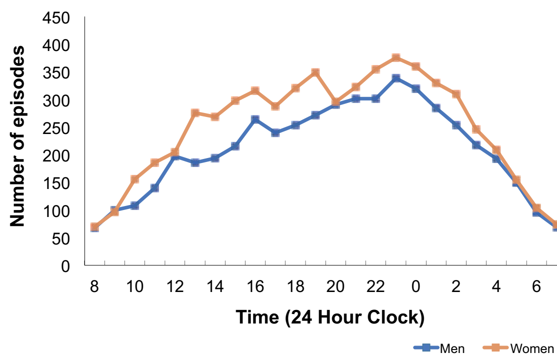


Figure 5: Number of presentations by time of attendance.

METHOD OF SELF-HARM

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	Total
Men	3148 (62.1%)	2018 (39.8%)	115 (2.3%)	503 (9.9%)	181 (3.6%)	1308 (25.8%)	313 (6.2%)	5073 (100%)
Women	4309 (72%)	2019 (33.7%)	94 (1.6%)	229 (3.8%)	146 (2.4%)	1369 (22.9%)	244 (4.1%)	5988 (100%)
Total	7457 (67.4%)	4037 (36.5%)	209 (1.9%)	732 (6.6%)	327 (3%)	2677 (24.2%)	557 (5%)	11061 (100%)

Table 4: Methods of self-harm involved in presentations to hospital in 2013.

Almost three quarters (67%) of all self-harm presentations involved an overdose of medication. Drug overdose was more commonly used as a method of self-harm by women than by men. It was involved in 62% of male and 72% of female episodes. Alcohol was involved in 37% of all cases. Alcohol was significantly more often involved in male episodes of self-harm than female episodes (40% and 34%, respectively).

Cutting was the only other common method of self-harm, involved in 24% of all episodes. Cutting was significantly more common in men (26%) than in women (23%). In 89% of all cases involving self-cutting, the treatment received was recorded. 30% received steristrips or steribonds, 33% did not require any, 22% required sutures while 5% were referred for plastic surgery. The treatment following self-cutting was similar for both men and women.

Attempted hanging was involved in 7% of all self-harm presentations (10% for men and 4% for women). At 732, the number of presentations involving attempted hanging has decreased by 6% from 2012. This decrease has been wholly due to a reduction in cases by men (-12%), while the number of attempted hangings by women has increased by 13% since 2012. Overall, the proportion of self-harm presentations involving hanging increased by 7% between 2007 and 2012.

The greater involvement of drug overdose as a female method of self-harm is illustrated in Figure 6. Drug overdose also accounted for a higher proportion of self-harm presentations in the older age groups, in particular for women, whereas self-cutting was less common. Self-cutting was most common among young people – in 33% of presentations by girls under 15 years and 22% of presentations by men aged under 25 years.

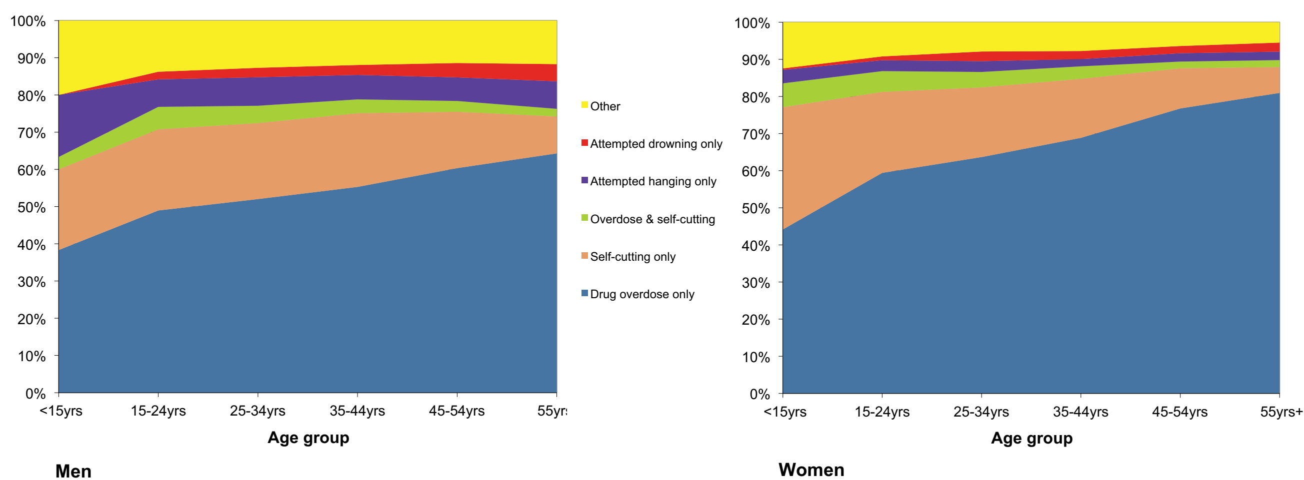


Figure 6. Method of self-harm used by gender and age group, 2013.

DRUGS USED IN OVERDOSE

The total number of tablets taken was known in 72% of all cases of drug overdose. On average, 30 tablets were taken in the episodes of self-harm that involved drug overdose. Three-quarters of drug overdose acts involved less than 38 tablets, half involved less than 21 tablets and one quarter involved less than 12 tablets. On average, the number of tablets taken in overdose acts was fairly similar for both men and women (mean: 33 vs. 28). Figure 7 illustrates the pattern of the number of tablets taken in drug overdose episodes for both genders. 43% of female episodes and 37% of the male episodes of overdose involved fewer than ten tablets.

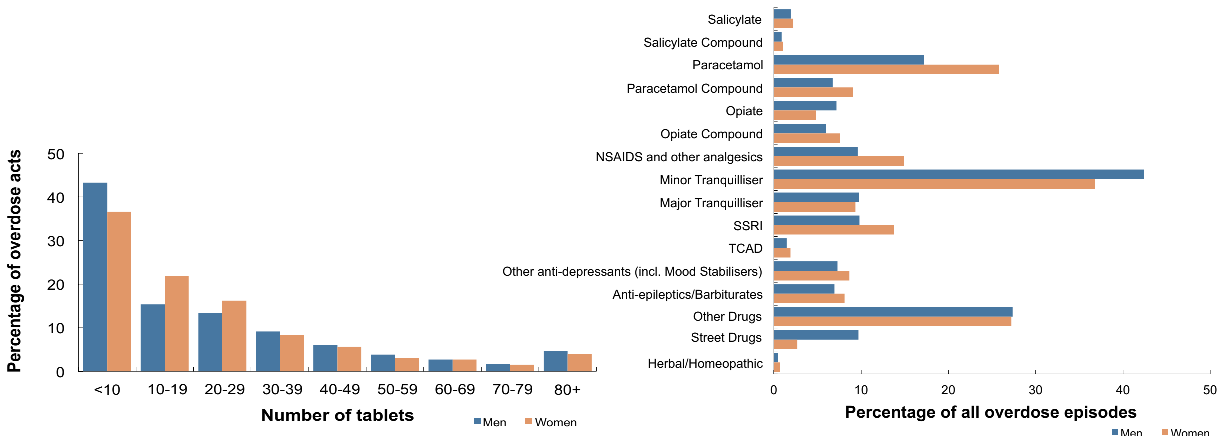


Figure 7: The pattern of the number of tablets taken in male and female acts of drug overdose.

Figure 8: The variation in the type of drugs used.
Note: Some drugs (e.g. compounds containing paracetamol and an opiate) are counted in two categories.

Figure 8 illustrates the frequency with which the most common types of drugs were used in overdose. 39% of all overdoses involved a minor tranquilliser and such a drug was used significantly more often by men than by women (42% and 37%, respectively) with (see contribution no. 3, page 11). A major tranquilliser was involved in 10% of overdoses. 46% of all female overdose acts and 36% of all male acts involved an analgesic drug. Paracetamol was the most common analgesic drug taken, being involved in some form in 29% of drug overdose acts. Paracetamol was used significantly more often by women (33%) than by men (23%). More than one in five acts (21%) of deliberate overdose involved an anti-depressant/ mood stabiliser. The group of anti-depressant drugs known as Selective Serotonin Reuptake Inhibitors (SSRIs) were present in 12% of overdose cases. Street drugs were involved in 10% of male and 3% of female intentional drug overdose acts. 'Other prescribed drugs' were taken in more than one in four (27%) of all overdoses which reflects the wide range of drugs taken deliberately in acts of drug overdose.

The number of self-harm presentations to hospital involving drug overdose in 2013 (7,457) was a decrease on the number recorded in 2012 (-10%). This was also true when the number of presentations involving each of the drug types described here were examined. Most notably, there was a reduction in the number of self-harm presentations involving minor tranquillisers by 13% from 2012. This reduction was more prominent among cases of self-harm by women compared to men (-16% and -9%, respectively). Further decreases were observed in the use of paracetamol-compound medication (-13%), SSRI's (-17%) and tricyclic anti-depressants (TCADs) (-30%).

The number of self-harm presentations to hospital involving street drugs fell a further 3% from 2012 (following a 10% decrease in 2012 from 2011) to 420, which is similar to the level recorded in 2007 (n=434).

RECOMMENDED NEXT CARE

Overall, in 15% of 2013 cases, the patient left the emergency department before a next care recommendation could be made. Following their treatment in the emergency department, inpatient admission was the next stage of care recommended for 33% of cases, irrespective of whether general or psychiatric admission was intended and whether the patient refused or not. Of all self-harm cases, 23% resulted in admission to a ward of the treating hospital whereas 9% were admitted for psychiatric inpatient treatment from the emergency department. It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, direct psychiatric admission figures provided here may be underestimates. In addition, some of the patients admitted to a general hospital ward will subsequently be admitted as psychiatric inpatients. In 1% of cases, the patient refused to allow him/herself to be admitted whether for general or psychiatric care. Most commonly, 53% of cases were discharged following treatment in the emergency department (see contribution no. 3, page 11).

Next care recommendations in 2013 were broadly similar for men and women. Men more often left the emergency room before a recommendation was made (17% vs. 12%). Women were more often admitted to a ward of the treating hospital than men (25% vs. 21%).

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	All
	(N=7457)	(N=4037)	(N=209)	(N=732)	(N=327)	(N=2677)	(N=656)	(N=11061)
General admission	28.9%	21.5%	25.4%	12.8%	10.7%	11%	15.7%	23%
Psychiatric admission	6.6%	5.8%	9.1%	21.7%	19%	9%	17.7%	8.7%
Patient would not allow admission	0.9%	1.2%	1%	1.2%	1.8%	0.7%	0.8%	0.9%
Left before recommendation	14.3%	18%	11%	10%	16.2%	17.1%	11.7%	14.5%
Not admitted	49.2%	53.5%	53.6%	54.2%	52.3%	62.2%	54.1%	52.8%

Table 5: Recommended next care in 2013 by methods of self-harm.

Recommended next care varied according to the method of self-harm (Table 5). General inpatient care was most common following cases of drug overdose and self-poisoning, less common after attempted hanging and least common after attempted drowning and self-cutting. The latter finding may be a reflection of the superficial nature of the injuries sustained in some cases of self-cutting. Of those cases where the patient used cutting as a method of self-harm, 62% were discharged after receiving treatment in the emergency department. The greater the potential lethality of the method of self-harm involved, the higher the proportion of cases admitted for psychiatric inpatient care directly from the emergency department.

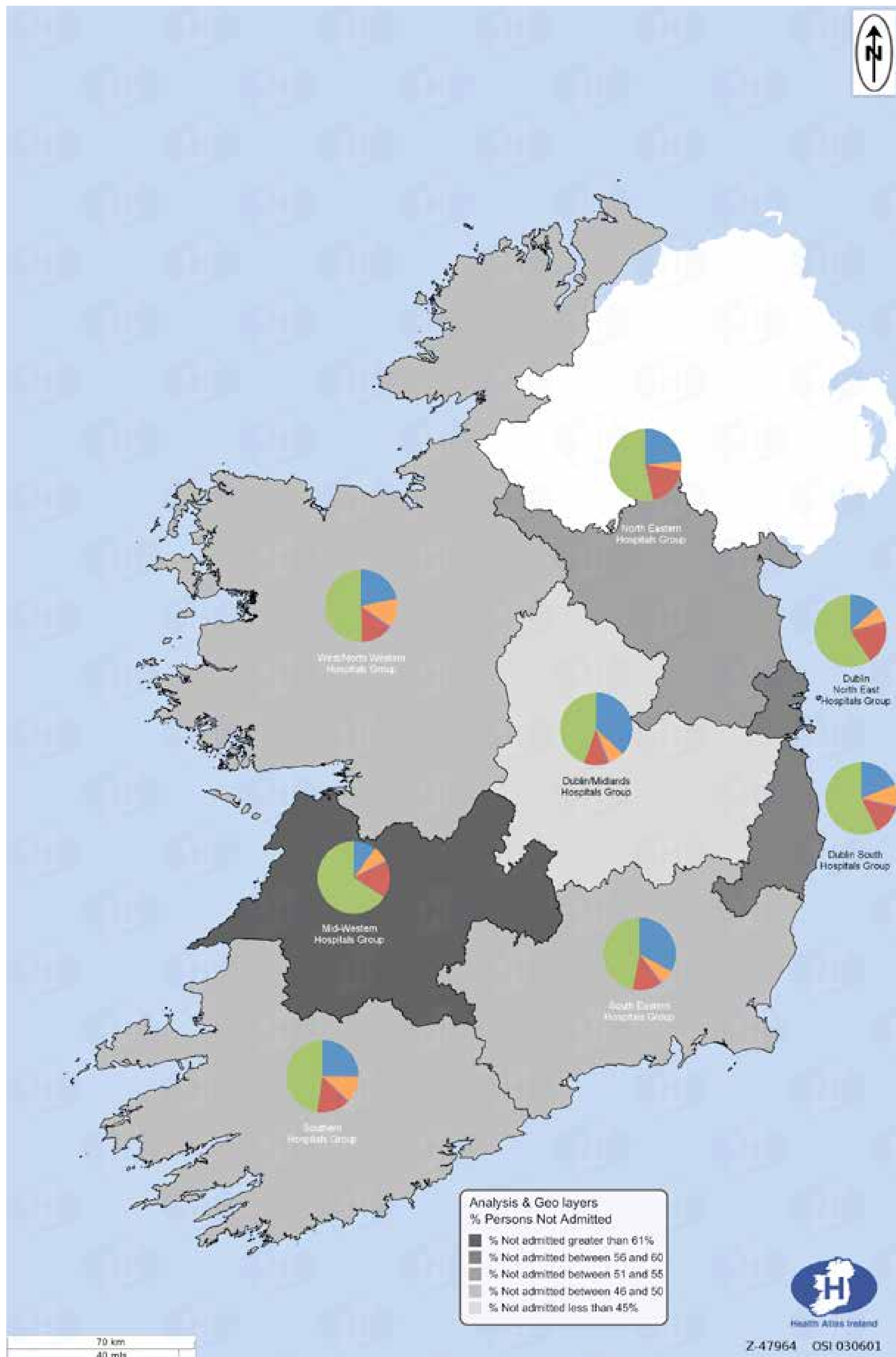
Next care varied significantly by HSE hospitals group (Table 6). A thematic map is also provided to illustrate this regional variation in next care in 2013. The proportion of self-harm patients who left before a recommendation was made varied from 10% in the Dublin/ Midlands Hospitals Group to 19% in the Dublin North East and North Eastern Hospitals Groups. Across the hospitals groups, inpatient care (irrespective of type and whether patient refused) was recommended for 19% of the patients treated in the Mid-Western, 21% in the Dublin North East, 28% in the North Eastern, 30% in the Dublin South, 36% in the West/ North Western, 38% in the Southern, 40% in the South Eastern and 45% in the Dublin/ Midlands Hospitals Group. As a corollary to this, the proportion of cases discharged following emergency treatment ranged from a low of 45% in the Dublin/ Midlands Group to a high of 66% in the Mid-Western Hospitals Group. The balance of general and psychiatric admissions directly after treatment in the emergency department differed significantly by hospitals group. Overall, direct general admissions were more common than direct psychiatric admissions in all but the Mid-Eastern Hospitals Group where there was little difference.

Appendix 2 details the recommended next care for self-harm patients treated at every hospital. For each hospitals group, there were significant differences between the hospitals in their pattern of next care recommendations.

	HSE Dublin / Mid-Leinster		HSE Dublin / North East		HSE South		HSE West		Republic of Ireland
	Dublin/ Midlands (n=1716)	Dublin South (n=1631)	Dublin North East (n=1960)	North Eastern (n=749)	South Eastern (n=1156)	Southern (n=1492)	Mid-Western (n=894)	West/North Western (n=1463)	(n=11061)
General admission	36.9%	18.8%	13.6%	23.5%	32.9%	25.1%	10%	21.8%	23%
Psychiatric admission	7.2%	9.7%	7.1%	4.1%	6.6%	11.9%	7.5%	13%	8.7%
Patient would not allow admission	1.3%	1%	0.7%	0%	1%	0.7%	1%	1.4%	0.9%
Left before recommendation	10.1%	13.2%	19.2%	19%	12.5%	14.6%	15.7%	13.5%	14.5%
Not admitted	44.6%	57.3%	59.3%	53.4%	47%	47.7%	65.9%	50.4%	52.8%

Note: On average, each day would be expected to account for 14.3% of presentations.

Table 6: Recommended next care in 2013 by HSE hospitals group.
Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in this table may be underestimates.



Map 1: Recommended next care for self-harm patients in the Republic of Ireland 2013 by HSE Hospital Groups area

Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission may be underestimates. Note: When a decision of 'not admitted' is recorded, this does not imply that a recommendation for other types of aftercare were not provided at the time of discharge.

SELF-HARM CASES DISCHARGED FROM EMERGENCY DEPARTMENT

For the first time in 2013 referrals for patients discharged from the emergency department following self-harm were recorded by the Registry (Figure 9).

Referrals following discharge included the following:

- In 29% of episodes, an out-patient appointment was recommended as a next care step for the patient.
- 17% of patients were discharged with a recommendation to attend their GP for a follow-up appointment.
- 12% of those not admitted to the presenting hospital were transferred to another hospital for treatment (9% for psychiatric treatment and 3% for medical treatment).
- Other services (e.g. psychological services, community-based mental health teams and addiction services) were recommended in 10% of episodes.
- 30% of patients discharged from the emergency department were discharged home without a referral.

There was variation in referrals offered to self-harm patients according to HSE hospitals group. 76% of patients in the Mid-Western Hospitals Group were referred for an out-patient appointment compared with just 14% in Northern Eastern Hospitals Group. Referrals to community-based mental health teams was highest in Dublin North East Hospitals Group (25%).

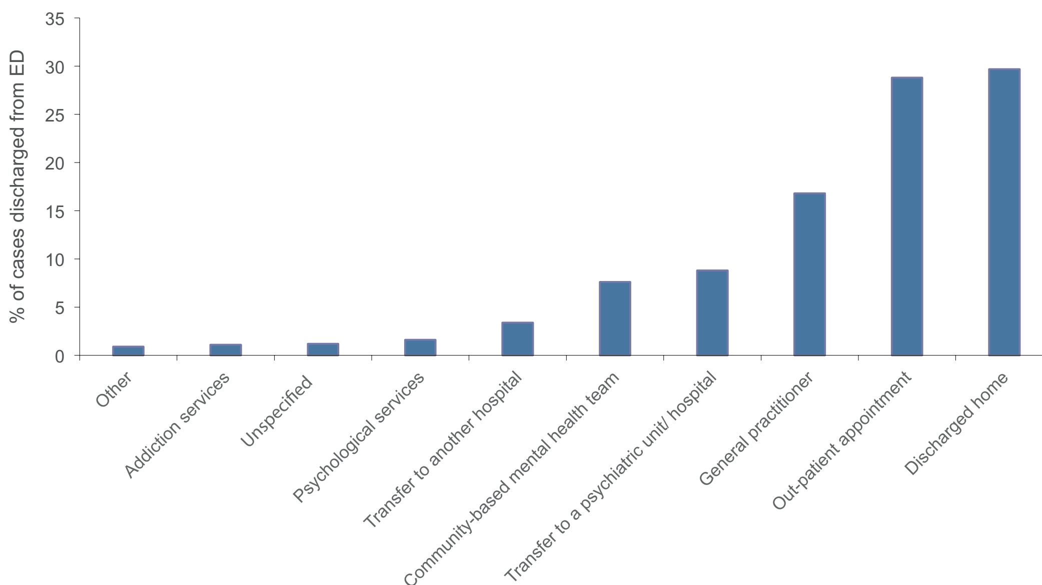


Figure 9: Referral of self-harm patients following discharge from the emergency department, 2013

MENTAL HEALTH ASSESSMENT

Whether the patient had a mental health assessment in the presenting hospital was known in 88% of all cases. In 2013, 61% (n=6,766) of patients were assessed by a member of the mental health team in the hospital (64% for women, 58% for men). 78% of under 15 year-olds received a psychiatric assessment. Assessment was most common following attempted hanging (76%) and attempted drowning (69%).

70% of those not admitted to the presenting hospital received a psychiatric assessment prior to discharge. However only 16% of patients who left before recommendation / medical advice received an assessment.

Psychiatric assessment varied according to time of the day in which the attendance occurred. 66% of presentations between 8am and 3pm received assessments.

Psychiatric assessment varied according to whether a patient was a repeat or not. 61% of those with an index episode of self-harm were assessed, compared with 55% of those with 5 or more presentations in 2013.

REPETITION OF SELF-HARM

There were 8,772 individuals treated for 11,061 self-harm episodes in 2013. This implies that more than one in five (2,289, 21.0%) of the presentations in 2013 were due to repeat acts, which is higher than the proportion of acts accounted for by repetition in 2010 and 2011 (19.9% and 19.5%, respectively) and similar to the years 2003-2009 (20.5-23.1%) and 2012 (21%). Of the 8,772 self-harm patients treated in 2013, 1,211 (13.8%) made at least one repeat presentation to hospital during the calendar year. This proportion is within the range reported for the years 2003-2011 (13.8-16.4%) and lower than the proportion recorded in 2012 (14.5%). At least five self-harm presentations were made by 127 individuals in 2013. They accounted for just 1.4% of all self-harm patients in the year but their presentations represented 8.8% of all self-harm presentations recorded.

The rate of repetition varied highly significantly with the method of self-harm involved in the self-harm act (Table 7). Of the commonly used methods of self-harm, self-cutting was associated with an increased level of repetition. Almost one in five (18.0%) who used cutting as a method of self-harm in their index act made at least one subsequent self-harm presentation in the calendar year.

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	All
Number of individuals treated	6098	3276	165	579	253	1921	464	8772
Number who repeated	792	432	17	82	35	345	74	1211
Percentage who repeated	13.0%	13.2%	10.3%	14.2%	13.8%	18.0%	15.9%	13.8%

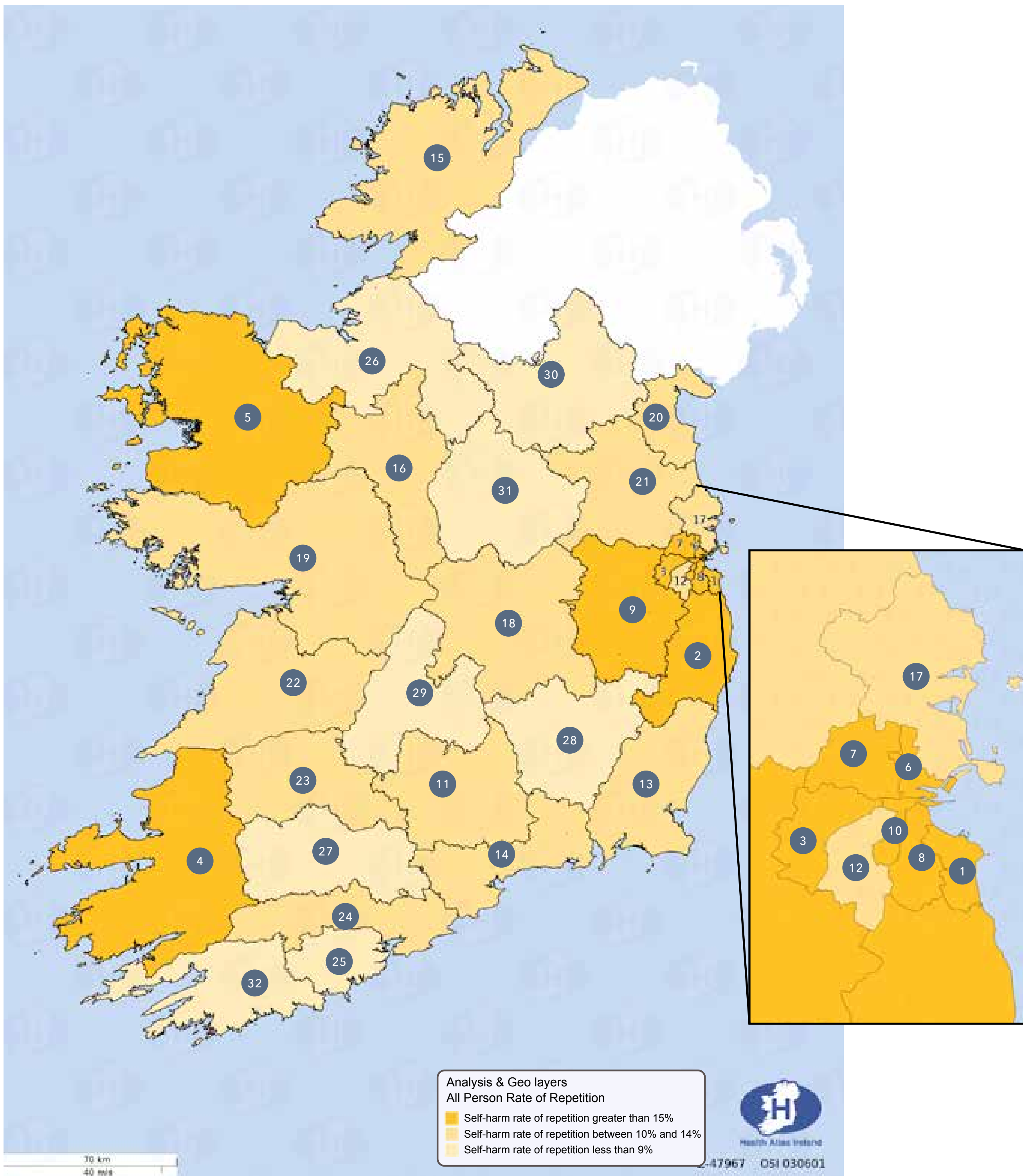
Table 7: Repeat presentation after index self-harm presentation in 2013 by methods of self-harm.

The rate of repetition was similar in men and women (14.3% vs. 14.6%). Repetition varied significantly by age. Approximately 14% of deliberate self-harm patients aged less than 15 years re-presented with self-harm in 2012. The proportion who repeated was highest, at 16%, for 25-54 year-olds.

There was variation in repetition rates when examined by HSE hospitals group (Table 8). The lowest rate was among deliberate self-harm patients treated in the North Eastern and Dublin/ Midlands Hospitals Group (12.8% and 13.1%, respectively) and the highest repetition rate, at 17.2% and 17.4%, was for patients treated in the Mid-Western and Dublin South Hospitals Groups.

		HSE Dublin / Mid-Leinster		HSE Dublin / North East		HSE South		HSE West		Republic Of Ireland
		Dublin/ Midlands	Dublin South	Dublin North East	North Eastern	South Eastern	Southern	Mid-Western	West/ North Western	
Number of individuals treated	Men	634	592	679	311	463	628	306	540	4033
	Women	806	652	853	329	503	624	431	637	4739
	Total	1440	1244	1532	640	966	1252	737	1177	8772
Number who repeated	Men	102	120	115	45	63	71	39	80	583
	Women	113	127	139	29	58	79	51	77	628
	Total	215	247	254	74	121	150	90	157	12114
Percentage who repeated	Men	16.1%	20.3%	16.9%	14.5%	13.6%	11.3%	12.7%	14.8%	14.5%
	Women	14%	19.5%	16.3%	8.8%	11.5%	12.7%	11.8%	12.1%	13.3%
	Total	14.9%	19.9%	16.6%	11.6%	12.5%	12%	12.2%	13.3%	13.8%

Table 8: Repetition in 2013 by gender and HSE hospitals group



Map 2: Rate of repetition (within 1 year) in the Republic of Ireland 2013 by HSE Local Health Office area for all presentations (Numbers indicate rank from 1 for highest to 32 for lowest)

The country's 32 HSE Local Health Offices (LHOs) have been the central focus of all HSE primary, community and continuing care services.

For 2013, the thematic map provided illustrates the variation in the overall rate of repetition within one year by LHO area. Rates of repetition varied significantly by LHO area. Dublin South, Wicklow and Dublin West had the highest rates of repetition (21.2%, 18.9% and 18.5%, respectively). The lowest rates of repetition were seen in West Cork, Longford/Westmeath and Cavan/Monaghan (3.7%, 7.1% and 8.2%, respectively).

While overall the rate of repetition in one year was broadly similar for men and women (14.5% vs. 13.3%), repetition rates by gender did vary by LHO area. The largest differences in the rate of repetition by gender were generally observed in those LHO areas with the highest repetition rates. The female rate of repetition was higher in LHO areas Wicklow (22% vs. 16%) and Dublin West (26% vs. 13%, respectively). Caution should be taken in interpreting the repetition rates associated with the smaller hospitals as the calculations may be based on small numbers of patients.

Appendix 3 details the repetition rate for male, female and all patients treated following self-harm in 2013. Caution should be taken in interpreting the repetition rates associated with the smaller hospitals as the calculations may be based on small numbers of patients.

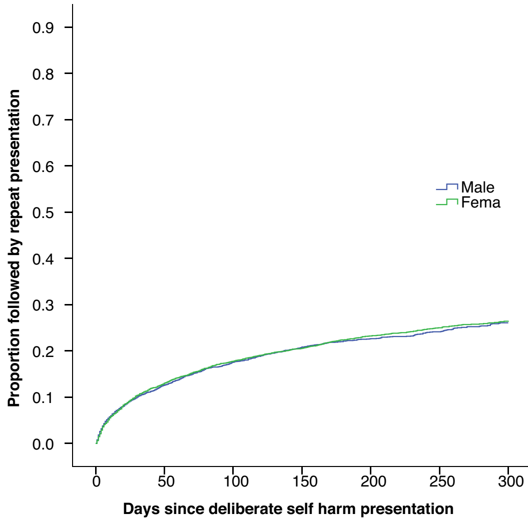
RISK OF REPETITION

Risk of repetition was greatest in the days and weeks following a deliberate self-harm presentation. A total of 8,385 self-harm presentations were made to hospital emergency departments in the first nine months of 2013. For 17.4% of these (n=1,460) there was a repeat self-harm presentation made within three months (91 days). This proportion varied significantly by HSE Hospitals Group: North Eastern (13.2%), Southern (13.4%), South Eastern (15.9%), Dublin/ Midlands (16.1%), West/ North Western (16.8%), Mid-Western (16.9%), Dublin North East (20.4%) and Dublin South (22.5%).

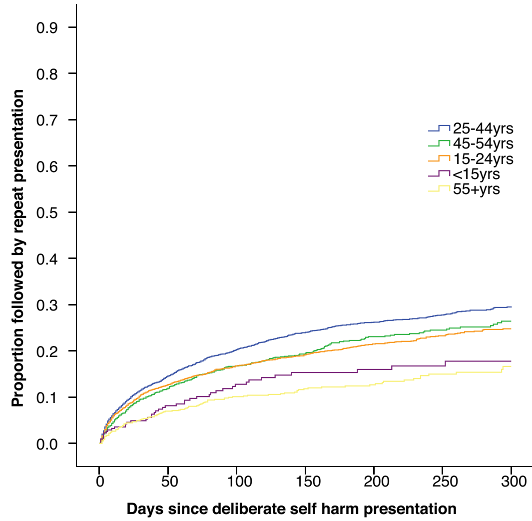
This proportion of self-harm presentations followed by a repeat presentation within three months was almost identical for men (17.0%) and women (17.7%) but did vary by age group. The proportion was lowest among those aged under 15 years (13.1%) and over 55 years (10.4%), compared with 16.1% among 15-24 year-olds, 19.7% among 25-44 year-olds and 17.6% among those aged 45-54 years. The proportion of self-harm presentations followed by a repeat presentation within three months also varied according to method of self-harm (12.9% following an attempted drowning, 14.5% following a drug overdose, 14.7% following an attempted hanging, 24% after an act involving drug overdose and self-cutting and 25.3% after an act of self-cutting only).

Variation in the proportion of self-harm presentations followed by a repeat presentation within three months was also observed based on recommended next care following the initial act. The proportion was lowest for those who were admitted to a general ward (13.1%), compared to 17.1% of those who were not admitted, 19.2% who were admitted to a psychiatric ward and 24.2% who left before a recommendation.

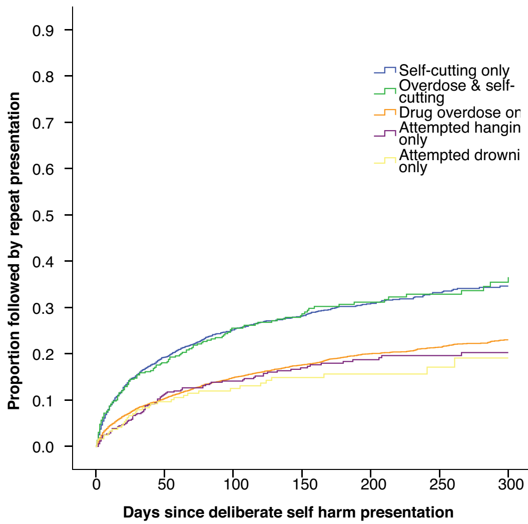
However, the factor having by far the strongest influence on likelihood of repetition was the number of self-harm presentations made to hospital. Just one in ten (10.7%) first presentations in January-September 2013 was followed by a repeat presentation in the next three months. This proportion was 32.8% following second presentations, 46.5% following third presentations, 62.8% following fourth presentations and 81.8% following fifth or subsequent presentations. The full pattern of repetition in 2013 is illustrated in Figure 9 by gender, age group, method of self-harm, recommended next care and number of self-harm presentations.



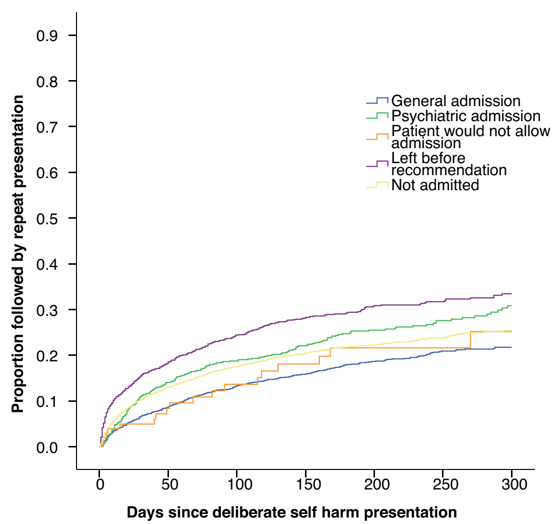
(a) Gender



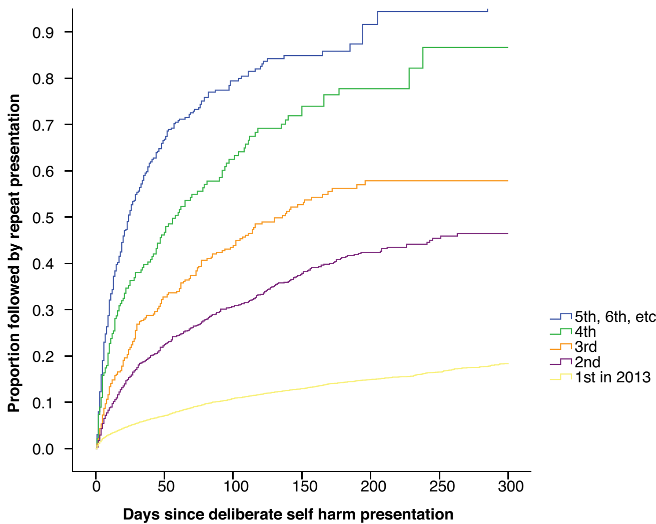
(b) Age group



(c) Method of self-harm



(d) Recommended next care



(e) Number of self-harm presentation

Figure 10: Rate of repeated presentation to hospital following a self-harm presentation in 2013 by gender, age group, method of self-harm, recommended next care and by the number of the self-harm presentation.

The rate in 2013 was still 6% higher than in 2007, the year before the economic recession

SECTION II.
INCIDENCE RATES

FOR THE PERIOD FROM 1 JANUARY TO 31 DECEMBER 2013, THE REGISTRY RECORDED 11,061 SELF-HARM PRESENTATIONS TO HOSPITAL THAT WERE MADE BY 8,772 INDIVIDUALS. BASED ON THESE DATA, THE IRISH PERSON-BASED CRUDE AND AGE-STANDARDISED RATE OF SELF-HARM IN 2013 WAS 191 (95% CI: 187 TO 195) AND 199 (95% CI: 195 TO 203) PER 100,000, RESPECTIVELY. THUS, THE AGE-STANDARDISED RATE IN 2013, WHICH ACCOUNTS FOR THE CHANGING AGE DISTRIBUTION OF THE POPULATION, WAS 6% LOWER THAN THE EQUIVALENT RATE IN 2012 (211 PER 100,000). THIS DECREASE FOLLOWS TWO SUCCESSIVE DECREASES IN THE ANNUAL IRISH RATE OF PERSONS PRESENTING TO HOSPITAL AS A RESULT OF SELF-HARM IN 2011 AND 2012. HOWEVER DESPITE THIS, THE RATE IN 2013 WAS STILL 6% HIGHER THAN IN 2007, THE YEAR BEFORE THE ECONOMIC RECESSION.

	MEN		WOMEN		ALL	
Year	Rate	% diff	Rate	% diff	Rate	% dif
2002	167	-	237	-	202	-
2003	177	+7%	241	+2%	209	+4%
2004	170	-4%	233	-4%	201	-4%
2005	167	-2%	229	-1%	198	-2%
2006	160	-4%	210	-9%	184	-7%
2007	162	+2%	215	+3%	188	+2%
2008	180	+11%	223	+4%	200	+6%
2009	197	+10%	222	-<1%	209	+5%
2010	211	+7%	236	+6%	223	+7%
2011	205	-3%	226	-4%	215	-4%
2012	195	-5%	228	+1%	211	-2%
2013	182	-7%	217	-5%	199	-6%

Table 9: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2002-2013 (extrapolated data used for 2002-2005 to adjust for non-participating hospitals).

Population figures and the number and rate of persons treated in hospital following self-harm in 2013 are given in Appendix 4 by age and gender for persons residing in the Republic of Ireland and for the residents of each of the four HSE regions.

VARIATION BY GENDER AND AGE

The person-based age-standardised rate of self-harm for men and women in 2013 was 182 (95% CI: 177-188) and 217 (95% CI: 211-222) per 100,000, respectively. Thus, there was a significant 7% decrease in the male rate of self-harm, while the female rate also decreased by 5% from 2012 to 2013. Taking recent years into account, the male self-harm rate in 2013 was 12% higher than in 2007 whereas the female rate was just 1% higher.

The female rate of self-harm in 2013 was 19% higher than the male rate. This gender difference has been decreasing in recent years. The female rate was 37% higher in 2004-2005, 32-33% higher in 2006-2007, 24% higher in 2008, and 10-17% higher in 2009-2012.

There was a striking pattern in the incidence of self-harm when examined by age. The rate was highest among the young. At 619 per 100,000, the peak rate for women was among 15-19 year-olds. This rate implies that one in every 162 girls in this age group presented to hospital in 2013 as a consequence of self-harm. The peak rate for men was 510 per 100,000 among 20-24 year-olds or one in every 196 men. The incidence of self-harm gradually decreased with increasing age in men. This was the case to a lesser extent in women as their rate remained relatively stable, at about 250 per 100,000, across the 30 to 49 year age range.

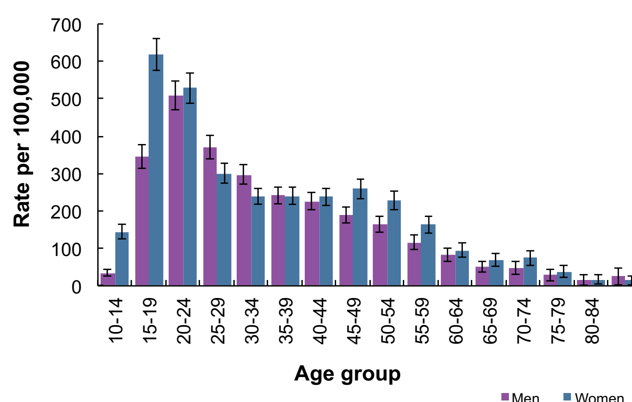
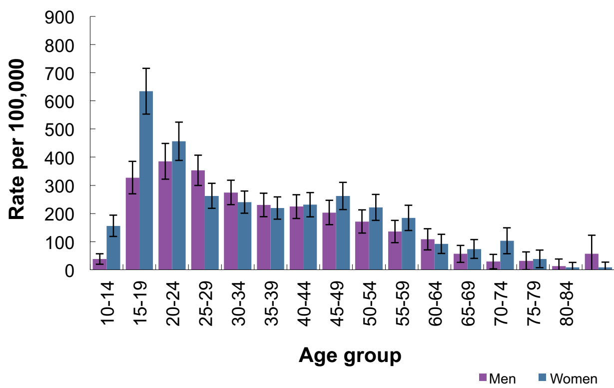


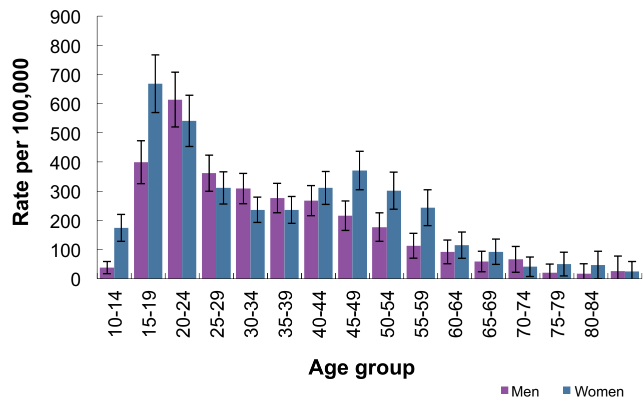
Figure 11: Person-based rate of self-harm in the Republic of Ireland in 2013 by age and gender.

Gender differences in the incidence of self-harm varied with age. The female rate was three times greater than the male rate in 10-14 year-olds and 79% higher than the male rate in 15-19 year-olds. The female rate of self-harm was again higher than the male rate across the 45-59 year age range. However, in 25-34 year-olds, the male rate was 23% higher than the female rate. Since 2009, the Registry has recorded a significantly higher rate of self-harm in men in this age group compared to women.

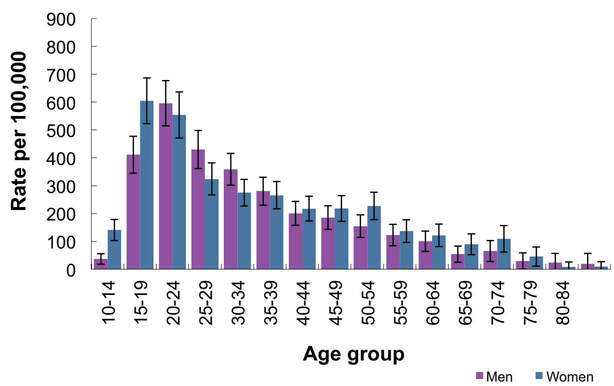
In 2013, the only significant changes in the rate of hospital-treated self-harm by age were among males and females aged 40-44 and males aged 50-54 years. The male rate for those aged 40-44 years fell by 14% from 2012, from 263 to 226 per 100,000. The male rate for those aged 50-54 years fell by 17%, from 200 to 165 per 100,000. The female rate for those aged 40-44 years fell by 21%, from 303 to 238 per 100,000. Rates of self-harm for other age groups remained similar to 2012.



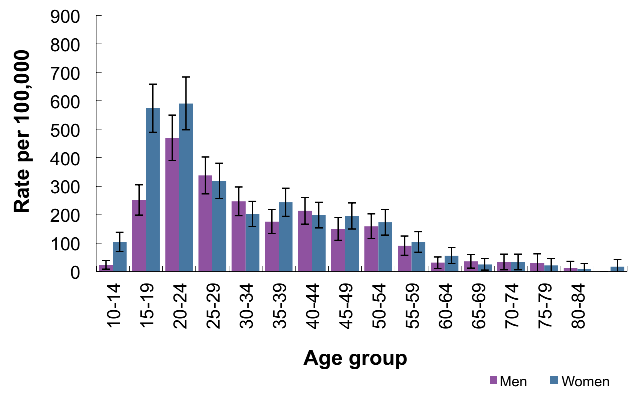
(a) HSE Dublin/ Mid-Leinster



(b) HSE Dublin/ North East



(c) HSE South



(d) HSE West

Figure 12: Person-based rate of self-harm in 2013 by residents of the four HSE regions by age and gender.

Figure 12 shows the incidence of self-harm by age and gender for the residents of each of the country's four HSE regions. The pattern was broadly similar to that at national level. The self-harm rate was highest among the young – among 15-24 year-olds for women and among 20-24 year-olds for men. Gender differences varied by HSE region. The male self-harm rate exceeded the female rate in the age group 20-24 years in HSE regions Dublin/ North East and South. In almost all regions the peak self-harm rate was among women aged 15-19 years, except for HSE West where the female self-harm rate among those aged 20-24 years was marginally higher.

Self-harm was rare in 10-14 year-olds, particularly for boys. However, the incidence of self-harm increased rapidly over a short age range. This is illustrated in greater detail in Figure 13. In 13-18 year-olds, the female rate of self-harm was significantly higher than the male rate. The increases in the female rate in early teenage years were particularly striking. The peak rates among younger people were in 22-year old men and 15 year-old women, with rates of 546 and 697 per 100,000, respectively.

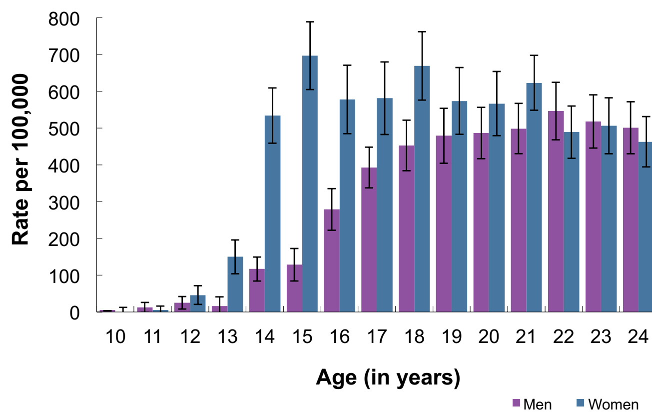


Figure 13: Person-based rate of self-harm in the Republic of Ireland in 2013 by single year of age for 10-24 year-olds.

VARIATION BY HSE REGION

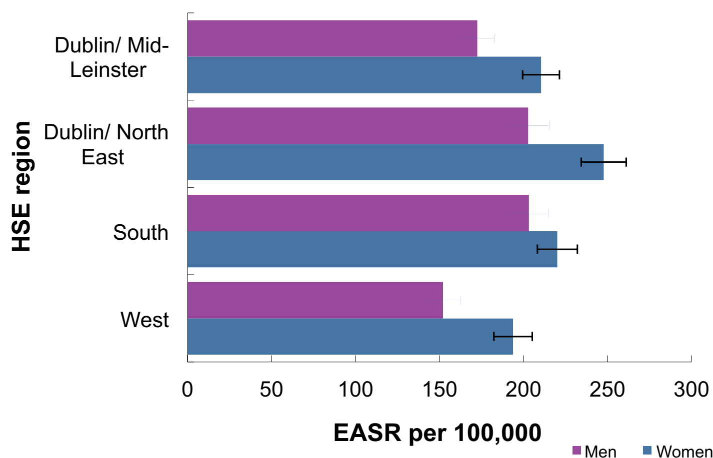


Figure 14: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by HSE region of residence and gender.

The 19% higher incidence of self-harm for women compared to men varied by HSE region. The female rate of self-harm was significantly higher than the male rate in all HSE regions – by 8% in HSE South, 22% in Dublin/ North East and Dublin/ Mid-Leinster and 27% in HSE West.

In 2013, the incidence of male and female self-harm was significantly higher than the national rate in the HSE Dublin/ North East region (+11% for men and +14% for women) and in the HSE South region for men (+12%; Table 10). The rate was significantly lower in the HSE West region for both genders (-17% for men, -11% for women).

The observed 7% decrease in the national male rate of self-harm was primarily due to decreases of 7% and 11% in the HSE regions South and Dublin/ North East. The 5% decrease in the national female rate of self-harm was also due to decreases due to decreases in the HSE regions South (-9%) and Dublin/ North East (-7%) (Table 11).

While the national rate of hospital-treated self-harm in men aged 50-54 years decreased by 17% in those aged 50-54 years, this pattern was due to a reduction in rates in HSE Dublin/ North East (-39%). The decrease observed in males and females aged 40-44 years was primarily due to decreases in the HSE South region (-32% and -26%, respectively).

HSE REGION	MEN					WOMEN				
	Rate	95% CI*	Rate difference**	95% CI***	% difference	Rate	95% CI*	Rate difference**	95% CI***	% difference
Dublin/ Mid-Leinster	172.5	(+/-13)	-10	(+/-12)	-5.3	210.5	(+/-13)	-6	(+/-12)	-2.8
Dublin/ North East	202.7	(+/-12)	21	(+/-14)	11.3	247.7	(+/-12)	31	(+/-15)	14.4
South	203.3	(+/-10)	21	(+/-13)	11.6	220.2	(+/-11)	4	(+/-13)	1.7
West	152.1	(+/-10)	-30	(+/-12)	-16.5	193.7	(+/-11)	-23	(+/-13)	-10.5
Ireland	182.1	(+/-6)	-	-	-	216.5	(+/-6)	-	-	-

** 95% Confidence Interval for the HSE region self-harm rate.*
*** Rate difference = HSE region rate – national rate for men and women.*
**** 95% Confidence Interval for self-harm rate difference.*
Table 10: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by HSE region of residence and gender with comparison to the national rate.

HSE REGION	MEN					WOMEN				
	2013	2014	Rate difference	95% CI***	% difference	2013	2014	Rate difference	95% CI***	% difference
Dublin/ Mid-Leinster	172.5	177.0	-5	(+/-18)	-2.5	210.5	212.5	-2	(+/-19)	-1.0
Dublin/ North East	202.7	228.8	-26	(+/-17)	-11.4	247.7	266.2	-18	(+/-17)	-6.9
South	203.3	219.5	-16	(+/-15)	-7.4	220.2	241.3	-21	(+/-16)	-8.7
West	152.1	159.2	-7	(+/-15)	-4.5	193.7	201.1	-7	(+/-16)	-3.6
Ireland	182.1	195.1	-13	(+/-8)	-6.7	216.5	228.4	-12	(+/-9)	-5.2

** 95% Confidence Interval for self-harm rate difference.*
Table 11: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 and 2012 by HSE region of residence and gender.

URBAN AND RURAL DISTRICT COMPARISON BY HSE REGION

Figure 15 illustrates the self-harm rate for residents of urban districts and rural districts in each of the four HSE regions. Nationally, the incidence of persons presenting to hospital with self-harm was 373 per 100,000 for residents of urban districts which was more than twice (127%) the incidence rate of 164 per 100,000 among residents of rural districts. In each HSE region, the incidence of self-harm was significantly higher in the urban district population. Compared to rural district populations, the self-harm rate was 86%, 125% and 308% higher in the urban district populations of the HSE regions of Dublin/ Mid-Leinster, South and West, respectively. The difference was far less pronounced in the HSE Dublin/ North East where the urban district population had a 42% higher rate.

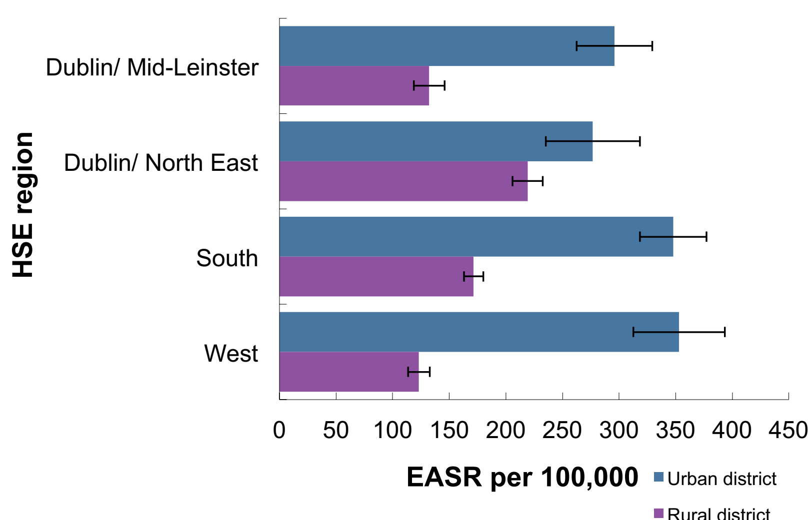
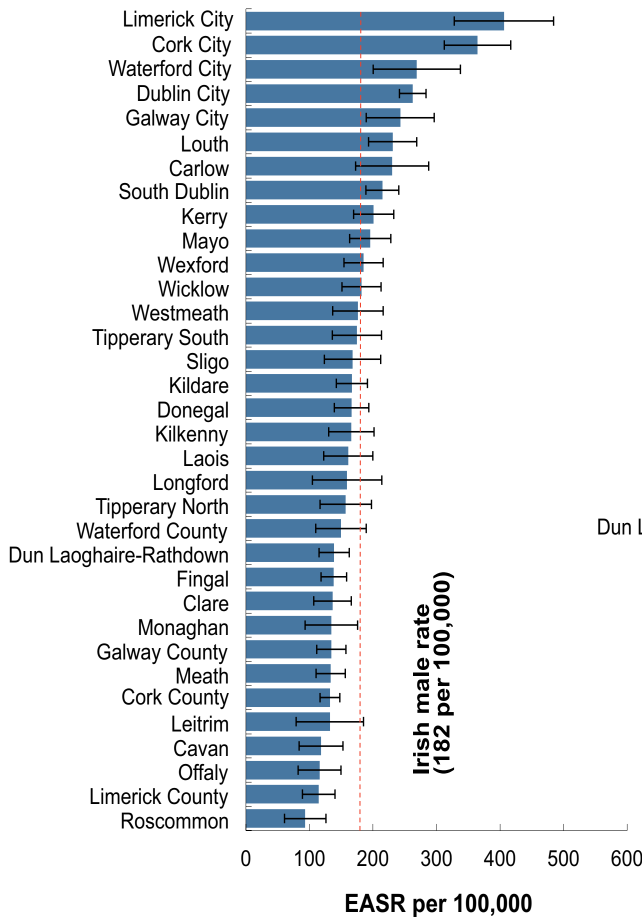


Figure 15: Person-based European age-standardised rate (EASR) of self-harm in 2013 for urban and rural district residents by HSE region.

RATE BY CITY AND COUNTY



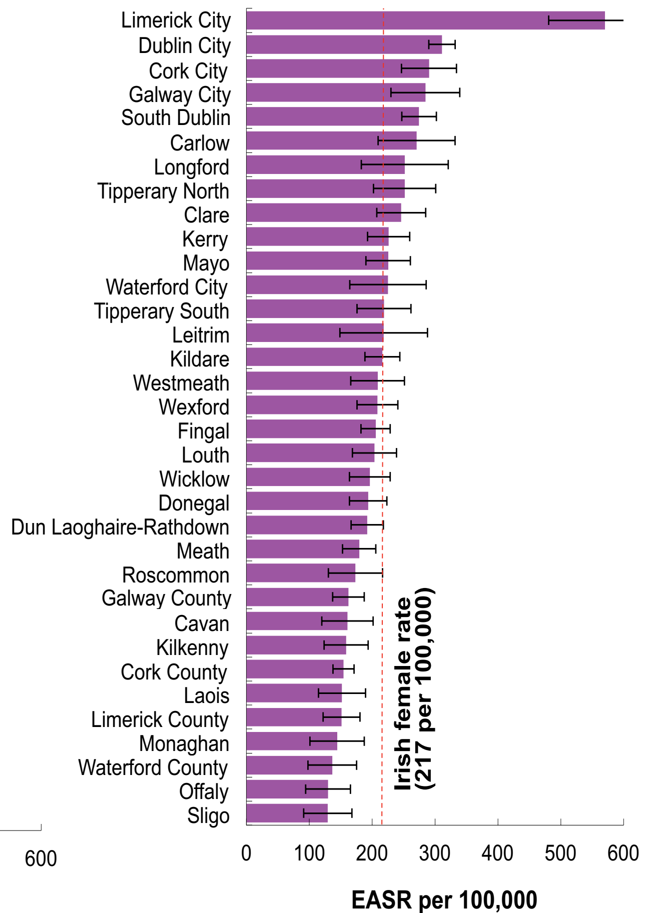


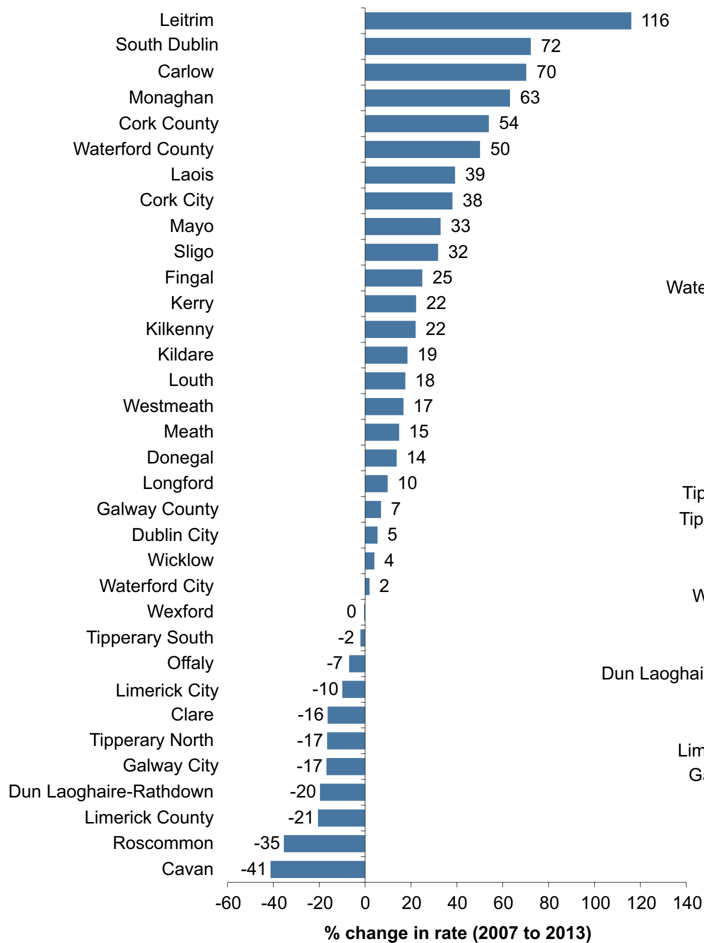
Figure 15a: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by city/county of residence for men.

Figure 15b: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by city/county of residence for women.

There was widespread variation in the male and female self-harm rate when examined by city/county of residence. The male rate varied from 93 per 100,000 for Roscommon to 406 per 100,000 for Limerick City. The lowest female rates was recorded for counties Sligo and Offaly (130 per 100,000) with the highest rates recorded for Limerick City residents at 570 per 100,000. Relative to the national rate, a high rate of self-harm was recorded for male and female city residents and for men living in Louth, Carlow, South Dublin and Kerry and for women living in South Dublin, Carlow, Longford and Tipperary North. In 2013 the highest rates for both men and women were seen in Limerick City, where both rates were more than twice the national rate. In Cork City the male rate was 77% higher than the national average and the female rate was 29% higher.

At a national level, the female self-harm rate exceeded the male rate by 19%. The magnitude of this gender difference varied by city/county. The female rate far exceeded the male rate in Roscommon (+86%), Clare (+80%), Leitrim (+65%), Tipperary North (+60%) and Longford (+58%). The opposite pattern of a significantly higher male rate was observed in Sligo (-23%), Waterford City (-16%) and Cork City (-20%).

Between 2012 and 2013, the national rate of hospital-treated self-harm decreased by 7% for men and 5% for women. The only significant decrease for men were observed in Meath (-23%). The most notable decreases for women included Waterford City (-34%), Offaly (-31%), Wexford (-21%) and Meath (-20%). A significant increase in the female rate of self-harm was observed in Dun-Laoghaire Rathdown (+25%).



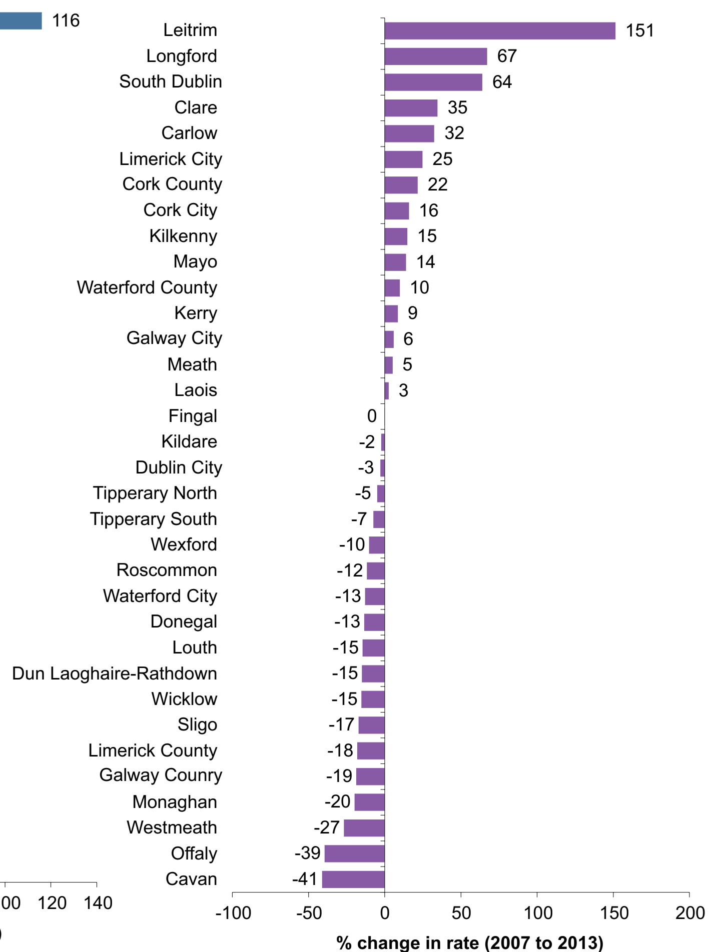


Figure 16a: Percentage change from 2007 to 2013 in the person-based European age-standardised rate of self-harm in the Republic of Ireland by city/county of residence for men.

Figure 16b: Percentage change from 2007 to 2013 in the person-based European age-standardised rate of self-harm in the Republic of Ireland by city/county of residence for women.

There were significant year-to-year increases in the rate of hospital-treated self in Ireland since the advent of the economic recession in 2008. Despite the decrease in 2013, the overall rate has increased by 6% since 2007, from 188 to 199 per 100,000. The male rate has increased by 12% from 162 to 182 per 100,000 and the female rate has increased by 1% from 215 to 217 per 100,000. Figures 16a and 16b illustrate, for each county and city, the percentage change in the rate of hospital-treated self-harm from 2007 to 2013.

There have been notable increases in the male rate of self-harm in Leitrim, South Dublin and Carlow. While a number of cities and counties have also seen an increase in the female rate of self-harm, these increases have been less pronounced.

RATE BY HSE LOCAL HEALTH OFFICE

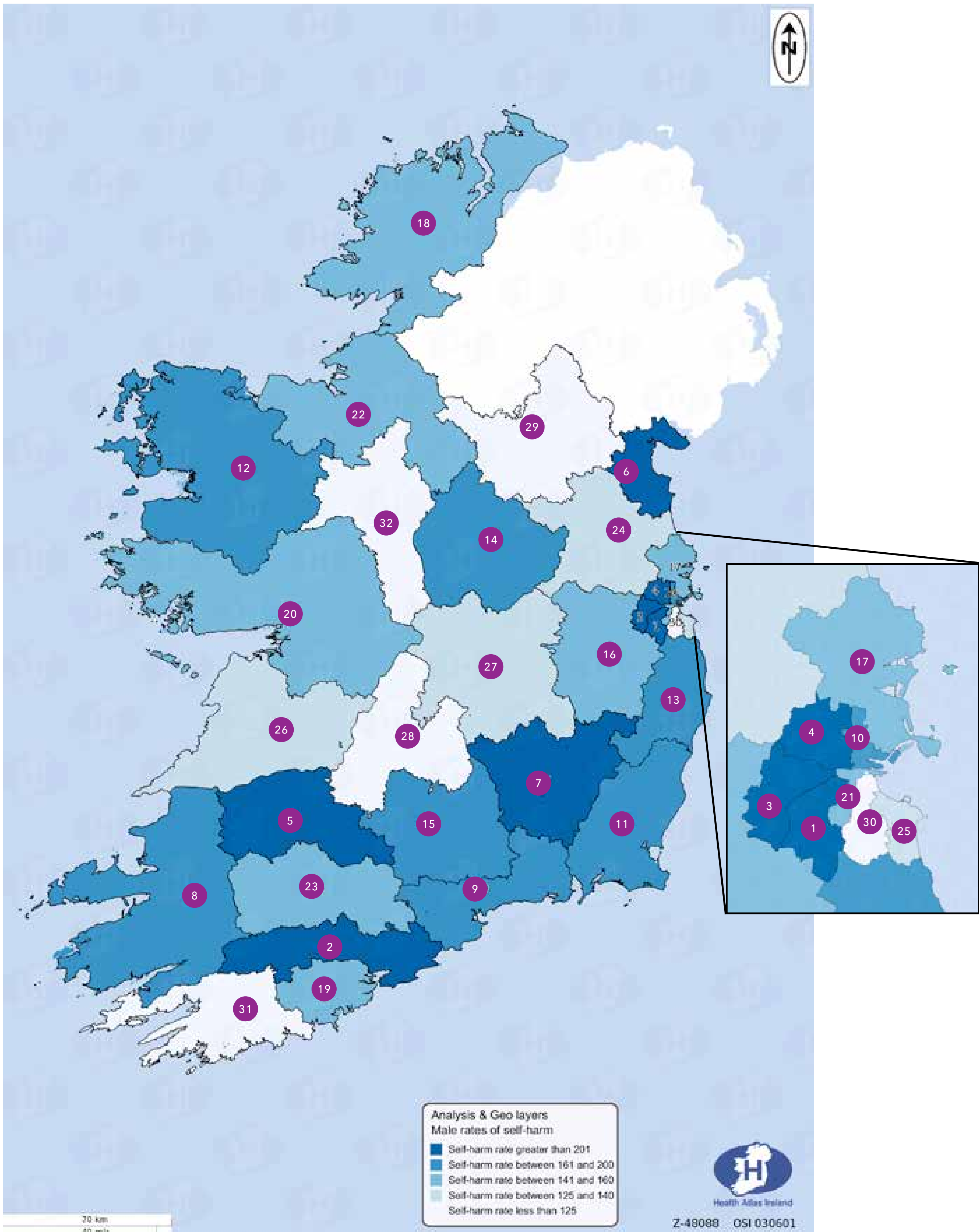
For 2013, Table 12 details the population (derived by the National Census 2011), number of men and women who presented to hospital as a result of self-harm and the incidence rate (age-adjusted to the European standard population) for each LHO area. Thematic maps are also provided to illustrate the variation in the male and female incidence of hospital-treated self-harm by LHO area.

There was approximately a twofold difference in the rate of self-harm when examined by LHO area. The rate for men ranged from 77 per 100,000 in Roscommon to 243 per 100,000 in Dublin South West and for women ranged from 100 per 100,000 in West Cork to 309 per 100,000 in Dublin South West. The female rate exceeded 240 per 100,000 for Dublin South West, Limerick, Dublin West and Dublin North West and in Cork North Lee and Dublin South West for the male rate.

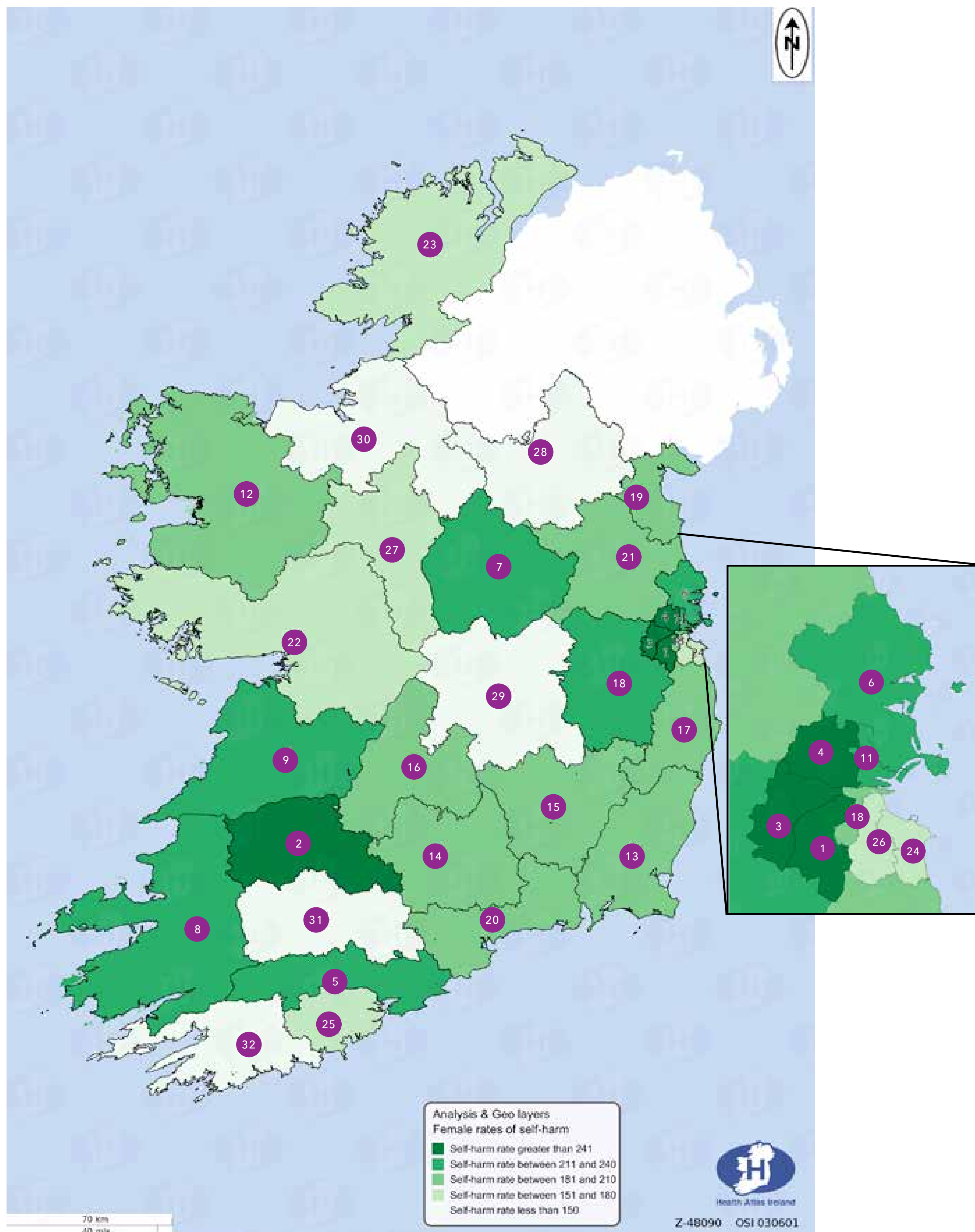
Table 12: Self-harm in 2013 by HSE Local Health Office (LHO) area of residence and gender

HSE REGION AND LHO		MEN				WOMEN			
		Population*	Self-harm			Population*	Self-harm		
			Persons	Rate**	Rank		Persons	Rate**	Rank
DUBLIN MID LEINSTER	Dublin South City	69042	110	141	21	71143	143	190	18
	Dublin South East	57530	67	110	30	62502	96	157	26
	Dublin South West	75078	188	243	1	79393	240	309	1
	Dublin West	72067	177	231	3	74265	196	268	3
	Kildare/West Wicklow	113750	176	156	16	114660	246	219	10
	Laois/Offaly	79017	97	125	27	78229	105	141	29
	Longford/Westmeath	62432	104	169	14	62732	135	223	7
	Dun Laoghaire	62008	79	128	25	68555	114	171	24
	Wicklow	58450	96	172	13	60092	110	193	17
DUBLIN NORTH EAST	Cavan/Monaghan	66734	76	116	29	65639	94	150	28
	Dublin North	119057	182	151	17	125305	275	230	6
	Dublin North Central	66320	136	185	10	69059	151	218	11
	Dublin North West	98800	227	218	4	102945	261	255	4
	Louth	60763	125	206	6	62134	110	184	19
	Meath	91910	115	129	24	92225	155	181	21
SOUTH	Carlow/Kilkenny	65251	128	203	7	65064	125	202	15
	Cork North	44889	58	141	23	44642	55	129	31
	Cork North Lee	90708	219	241	2	91094	213	238	5
	Cork South Lee	93436	146	147	19	97733	166	166	25
	Cork West	28437	28	107	31	28093	26	100	32
	Kerry	72629	133	198	8	72873	152	222	8
	Tipperary South	47156	77	168	15	46980	91	205	14
	Waterford	63520	117	190	9	64287	113	181	20
	Wexford	71909	125	183	11	73411	144	206	13
WEST	Clare	58298	71	127	26	58898	122	221	9
	Donegal	80523	113	150	18	80614	134	177	23
	Galway	124758	185	146	20	125895	221	179	22
	Limerick	76749	162	209	5	77638	212	274	2
	Mayo	65420	108	180	12	65218	127	210	12
	Tipperary North/East Limerick	54406	66	119	28	53338	102	194	16
	Roscommon	32353	24	77	32	31712	44	155	27
	Sligo/Leitrim/West Cavan	49299	67	141	22	49185	63	137	30

** Population derived by the National Census 2011*
*** Person-based European age-standardised rate per 100,000 population*



Map 4: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by HSE Local Health Office area for men (Numbers indicate rank of rate from 1 for highest to 32 for lowest)



Map 3: Person-based European age-standardised rate (EASR) of self-harm in the Republic of Ireland in 2013 by HSE Local Health Office area for men (Numbers indicate rank of rate from 1 for highest to 32 for lowest)

APPENDICES

HSE REGION	Dublin/ Mid-Leinster				Dublin/ North East				South				West				Republic of Ireland	
Hospital Group	Dublin/ Midlands		Dublin South		Dublin North East		North Eastern		South Eastern		Southern		Mid-Western		West/ N.Western			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-4YRS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-9YRS	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	<5
10-14YRS	19	77	<5	<5	10	55	<5	5	<5	21	12	30	<5	27	9	29	60	247
15-19YRS	101	180	61	138	80	192	52	44	82	110	79	112	43	74	79	174	5771024	
20-24YRS	87	119	121	141	166	143	54	46	102	77	153	120	63	96	107	109	853	851
25-29YRS	103	78	109	81	126	132	49	43	72	69	105	91	53	72	109	89	726	655
30-34YRS	106	86	129	107	133	132	48	34	68	79	116	77	55	64	82	71	737	650
35-39YRS	83	92	90	84	91	77	58	36	55	54	77	78	33	77	74	83	561	581
40-44YRS	76	86	93	76	94	93	41	49	51	46	52	62	30	35	82	67	519	514
45-49YRS	58	84	72	67	64	112	26	44	34	57	41	51	20	32	49	64	364	511
50-54YRS	45	77	56	65	47	67	9	41	23	47	39	51	19	19	46	56	284	423
55-59YRS	23	44	25	40	23	48	13	17	21	16	21	35	10	17	24	26	160	243
60-64YRS	22	22	19	12	11	22	9	6	21	13	17	23	8	18	<5	6	110	122
65-69YRS	16	9	<5	11	7	15	5	6	<5	11	10	12	5	<5	7	<5	56	71
70-74YRS	<5	12	<5	13	3	3	<5	<5	5	10	8	10	10	<5	5	<5	41	58
75-79YRS	<5	<5	<5	<5	1	6	<5	0	<5	<5	<5	5	<5	0	<5	<5	14	23
80-84YRS	<5	<5	0	0	1	2	0	<5	<5	0	<5	<5	<5	<5	0	0	5	7
85YRS+	<5	0	<5	<5	1	1	0	<5	<5	0	0	<5	0	0	0	<5	6	6
TOTAL	**745**	**971**	**788**	**843**	**858**	**1102**	**372**	**377**	**544**	**612**	**733**	**759**	**354**	**540**	**679**	**784**	**5073**	**5988**

APPENDIX 1: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE REPUBLIC OF IRELAND BY HSE REGION AND HOSPITALS GROUP, 2013

APPENDIX 1: DELIBERATE SELF-HARM BY HSE HOSPITALS GROUP AND HOSPITAL

	Adelaide & Meath & National Children's Hospital, Tallaght		Midland Regional Hospital, Mullingar		Midland Regional Hospital, Portlaoise		Midland Regional Hospital, Tullamore		Naas General Hospital		Our Lady's Children's Hospital, Crumlin	
	M	F	M	F	M	F	M	F	M	F	M	F
<15YRS	12	49	0	8	<5	<5	0	<5	0	0	6	14
15-19YRS	43	85	15	18	5	18	6	13	30	36	<5	10
20-24YRS	34	39	12	11	6	11	5	15	30	43	0	0
25-34YRS	99	75	13	25	30	16	12	14	55	34	0	0
35-44YRS	58	76	32	26	15	16	12	10	42	50	0	0
45-54YRS	45	55	13	25	11	18	9	8	25	55	0	0
55-64YRS	18	32	5	15	<5	<5	9	6	10	9	0	0
65YRS+	9	18	5	<5	0	<5	<5	<5	<5	<5	0	0
TOTAL	**318**	**429**	**95**	**130**	**71**	**86**	**57**	**71**	**196**	**231**	**8**	**24**

APPENDIX 1A: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN/MIDLANDS HOSPITALS GROUP, 2013

	St. Columcille's Hospital, Loughlinstown		St James's Hospital		St Michael's Hospital, Dun Laoghaire		Other	
	M	F	M	F	M	F	M	F
<15YRS	0	<5	0	<5	0	0	<5	<5
15-19YRS	16	36	27	53	0	<5	18	45
20-24YRS	41	21	50	78	<5	<5	28	39
25-34YRS	43	26	135	118	<5	<5	56	43
35-44YRS	32	35	102	66	<5	<5	46	57
45-54YRS	26	29	63	60	<5	11	37	32
55-64YRS	6	16	23	19	<5	<5	13	15
65YRS+	<5	6	<5	11	0	<5	5	11
TOTAL	**167**	**170**	**404**	**406**	**13**	**24**	**204**	**243**

APPENDIX 1B: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2013

	Beaumont Hospital		Children's University Hospital, Temple Street		James Connolly Hospital, Blanchardstown		Mater Misericordiae University Hospital	
	M	F	M	F	M	F	M	F
<15YRS	0	<5	10	53	0	<5	0	0
15-19YRS	11	60	<5	49	34	44	31	39
20-24YRS	24	31	0	0	47	56	95	56
25-34YRS	63	51	<5	<5	76	98	119	114
35-44YRS	65	43	0	0	40	56	80	71
45-54YRS	33	79	0	0	22	35	56	65
55-64YRS	12	23	0	0	10	18	12	29
65YRS+	8	10	0	<5	<5	5	<5	11
TOTAL	**216**	**299**	**15**	**104**	**230**	**314**	**397**	**385**

APPENDIX 1C: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2013

	Cavan General Hospital		Our Lady of Lourdes Hospital, Drogheda		Our Lady's Hospital, Navan	
	M	F	M	F	M	F
<15YRS	<5	<5	<5	0	0	<5
15-19YRS	5	11	35	19	12	14
20-24YRS	10	8	33	21	11	17
25-34YRS	20	18	59	38	18	21
35-44YRS	20	20	55	38	24	27
45-54YRS	8	23	15	41	12	21
55-64YRS	7	<5	8	14	7	7
65YRS+	<5	<5	<5	5	<5	5
TOTAL	**75**	**87**	**210**	**176**	**87**	**114**

APPENDIX 1D: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2013

	St Luke's General Hospital, Kilkenny		South Tipperary General Hospital		Waterford Regional Hospital		Wexford General Hospital	
	M	F	M	F	M	F	M	F
<15YRS	0	<5	<5	<5	0	12	<5	5
15-19YRS	20	31	14	22	30	37	18	20
20-24YRS	38	22	12	18	26	18	26	19
25-34YRS	30	21	35	39	38	31	37	57
35-44YRS	23	25	20	23	33	23	30	29
45-54YRS	17	29	5	24	18	28	17	23
55-64YRS	13	8	<5	6	15	6	10	9
65YRS+	0	<5	<5	<5	<5	8	6	7
TOTAL	**141**	**142**	**94**	**138**	**163**	**163**	**146**	**169**

APPENDIX 1E: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2013

	Bantry General Hospital		Cork University Hospital		Kerry General Hospital		Mallow General Hospital		Mercy University Hospital, Cork	
	M	F	M	F	M	F	M	F	M	F
<15YRS	0	0	8	12	<5	9	0	0	<5	9
15-19YRS	<5	<5	34	45	19	29	<5	<5	24	35
20-24YRS	<5	7	46	39	34	24	<5	0	67	50
25-34YRS	<5	<5	73	54	63	22	<5	<5	80	88
35-44YRS	6	6	44	43	29	39	<5	<5	48	51
45-54YRS	<5	<5	31	25	17	43	<5	<5	28	30
55-64YRS	<5	<5	10	19	13	10	<5	<5	11	25
65YRS+	0	<5	5	10	6	9	<5	<5	8	8
TOTAL	**19**	**25**	**251**	**247**	**183**	**185**	**12**	**6**	**268**	**296**

APPENDIX 1F: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE SOUTHERN HOSPITALS GROUP, 2013

	Mid-Western Regional Hospital, Ennis		Mid-Western Regional Hospital, Limerick		Mid-Western Regional Hospital, Nenagh		St John's Hospital, Limerick	
	M	F	M	F	M	F	M	F
<15YRS	0	<5	<5	25	0	0	0	0
15-19YRS	<5	7	42	65	0	<5	0	<5
20-24YRS	<5	<5	61	87	0	8	<5	0
25-34YRS	<5	8	105	127	0	0	<5	<5
35-44YRS	<5	12	61	99	<5	0	0	<5
45-54YRS	<5	<5	37	47	<5	0	0	0
55-64YRS	<5	<5	17	33	0	0	0	0
65YRS+	<5	0	13	9	0	0	0	0
TOTAL	**11**	**36**	**339**	**492**	**<5**	**9**	**<5**	**<5**

APPENDIX 1G: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE REPUBLIC OF IRELAND BY HSE REGION AND HOSPITALS GROUP, 2013

	Letterkenny General Hospital		Mayo General Hospital		Portiuncula Hospital, Ballinasloe		Sligo General Hospital		University College Hospital, Galway	
	M	F	M	F	M	F	M	F	M	F
<15YRS	5	<5	<5	9	0	<5	<5	5	0	7
15-19YRS	19	50	22	27	9	26	7	22	22	49
20-24YRS	19	16	25	17	20	16	12	16	31	44
25-34YRS	41	40	25	38	24	15	39	10	62	57
35-44YRS	26	27	43	45	8	21	26	23	53	34
45-54YRS	17	24	18	23	10	18	17	23	33	32
55-64YRS	5	9	7	5	<5	5	7	<5	5	10
65YRS+	0	0	6	5	0	<5	<5	<5	6	<5
TOTAL	**132**	**170**	**149**	**169**	**74**	**106**	**112**	**103**	**212**	**236**

APPENDIX 1H: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE WEST/NORTH WESTERN HOSPITALS GROUP, 2013

APPENDIX 2 - RECOMMENDED NEXT CARE BY HOSPITAL

	Adelaide & Meath & National Children's Hospital, Tallaght (n=747)	Midland Regional Hospital, Mullingar (n=225)	Midland Regional Hospital, Portlaoise (n=157)	Midland Regional Hospital, Tullamore (n=128)	Naas General Hospital (n=427)	Our Lady's Children's Hospital, Crumlin (n=32)
GENERAL AND PSYCHIATRIC ADMISSION	42.8%	55.1%	59.9%	50%	30.7%	71.9%
PATIENT WOULD NOT ALLOW ADMISSION	0.5%	0%	0.6%	0.8%	3.5%	3.1%
LEFT BEFORE RECOMMENDATION	6.8%	10.2%	11.5%	11.7%	15.5%	0%
NOT ADMITTED	49.8%	34.7%	28%	37.5%	50.4%	25%

APPENDIX 2A: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN/ MIDLANDS HOSPITALS GROUP, 2013

	St Columcille's Hospital, Loughlinstown (n=337)	St James's Hospital (n=810)	St Michael's Hospital, Dun Laoghaire (n=37)	Other (n=447)
GENERAL AND PSYCHIATRIC ADMISSION	21.7%	31.9%	59.5%	25.3%
PATIENT WOULD NOT ALLOW ADMISSION	0.9%	1.5%	0%	0.2%
LEFT BEFORE RECOMMENDATION	14.2%	16.3%	2.7%	7.6%
NOT ADMITTED	63.2%	50.4%	37.8%	66.9%

APPENDIX 2B: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2013

Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in Appendices 2A-2I may be underestimates.

	Beaumont Hospital (n=515)	Children's University Hospital, Temple Street (n=119)	James Connolly Hospital, Blanchardstown (n=544)	Mater Misericordiae University Hospital (n=782)
GENERAL AND PSYCHIATRIC ADMISSION	13.8%	42%	29.6%	15.9%
PATIENT WOULD NOT ALLOW ADMISSION	0%	0%	0.7%	1.3%
LEFT BEFORE RECOMMENDATION	15.7%	0.8%	20.6%	23.4%
NOT ADMITTED	70.5%	57.1%	49.1%	59.5%

APPENDIX 2C: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2013

	Cavan General Hospital (n=162)	Our Lady of Lourdes Hospital, Drogheda (n=386)	Our Lady's Hospital, Navan (n=201)
GENERAL AND PSYCHIATRIC ADMISSION	53.1%	13%	35.3%
PATIENT WOULD NOT ALLOW ADMISSION	0%	0%	0%
LEFT BEFORE RECOMMENDATION	17.3%	21%	16.4%
NOT ADMITTED	29.6%	66.1%	48.3%

APPENDIX 2D: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2013

Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in Appendices 2A-2I may be underestimates.

	St Luke's General Hospital, Kilkenny (n=283)	South Tipperary General Hospital (n=232)	Waterford Regional Hospital (n=326)	Wexford General Hospital (n=315)
GENERAL AND PSYCHIATRIC ADMISSION	48.8%	39.2%	30.1%	41%
PATIENT WOULD NOT ALLOW ADMISSION	1.8%	0%	0.9%	1.3%
LEFT BEFORE RECOMMENDATION	14.1%	9.1%	11.7%	14.6%
NOT ADMITTED	35.3%	51.7%	57.4%	43.2%

APPENDIX 2E: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2013

	Bantry General Hospital (n=44)	Cork University Hospital (n=498)	Kerry General Hospital (n=368)	Mallow General Hospital (n=18)	Mercy University Hospital, Cork (n=564)
GENERAL AND PSYCHIATRIC ADMISSION	52.3%	51.2%	44.8%	11.1%	19%
PATIENT WOULD NOT ALLOW ADMISSION	0%	0%	2.2%	0%	0.4%
LEFT BEFORE RECOMMENDATION	2.3%	6.8%	17.1%	0%	21.3%
NOT ADMITTED	45.5%	42%	35.9%	88.9%	59.4%

APPENDIX 2F: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE SOUTHERN HOSPITALS GROUP, 2013

Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in Appendices 2A-2I may be underestimates.

	Mid-Western Regional Hospital, Ennis (n=47)	Mid-Western Regional Hospital, Limerick (n=831)	Mid-Western Regional Hospital, Nenagh (n=11)	St John's Hospital, Limerick (n=5)
GENERAL AND PSYCHIATRIC ADMISSION	55.3%	15.5%	0%	20%
PATIENT WOULD NOT ALLOW ADMISSION	0%	1.1%	0%	0%
LEFT BEFORE RECOMMENDATION	10.6%	16.2%	0%	0%
NOT ADMITTED	34%	67.1%	100%	80%

APPENDIX 2G: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE MID-WESTERN HOSPITALS GROUP, 2013

	Letterkenny General Hospital (n=302)	Mayo General Hospital (n=318)	Portiuncula Hospital, Ballinasloe (n=180)	Sligo General Hospital (n=215)	University College Hospital, Galway (n=448)
GENERAL AND PSYCHIATRIC ADMISSION	51.3%	33%	40%	28.4%	25.9%
PATIENT WOULD NOT ALLOW ADMISSION	1.3%	1.6%	0.6%	2.8%	0.9%
LEFT BEFORE RECOMMENDATION	9.6%	12.6%	11.1%	11.2%	18.8%
NOT ADMITTED	37.7%	52.8%	48.3%	57.7%	54.5%

APPENDIX 2H: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE WEST/ NORTH WESTERN HOSPITALS GROUP, 2013

Note: It may not always be recorded in the emergency department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in Appendices 2A-2I may be underestimates.

APPENDIX 3 - REPETITION BY HOSPITAL

		Adelaide & Meath & National Children's Hospital, Tallaght	Midland Regional Hospital, Mullingar	Midland Regional Hospital, Portlaoise	Midland Regional Hospital, Tullamore	Naas General Hospital	Our Lady's Children's Hospital, Crumlin
NUMBER OF INDIVIDUALS TREATED	Men	270	87	63	55	159	8
	Women	357	120	76	58	184	22
	Total	627	207	139	113	343	30
NUMBER WHO REPEATED	Men	58	8	8	4	25	1
	Women	53	9	11	10	30	3
	Total	111	17	19	14	55	4
PERCENTAGE WHO REPEATED	Men	21.5%	9.2%	12.7%	7.3%	15.7%	12.5%
	Women	14.8%	7.5%	14.5%	17.2%	16.3%	13.6%
	Total	17.7%	8.2%	13.7%	12.4%	16%	13.3%

APPENDIX 3A: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN/MIDLANDS HOSPITALS GROUP, 2013

		St Columcille's Hospital, Loughlinstown	St James's Hospital	St Michael's Hospital, Dun Laoghaire	Other
NUMBER OF INDIVIDUALS TREATED	Men	126	315	13	165
	Women	139	314	17	209
	Total	265	629	30	374
NUMBER WHO REPEATED	Men	27	72	1	33
	Women	29	67	8	31
	Total	56	139	9	64
PERCENTAGE WHO REPEATED	Men	21.4%	22.9%	7.7%	20%
	Women	20.9%	21.3%	47.1%	14.8%
	Total	21.1%	22.1%	30%	17.1%

APPENDIX 3B: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2013

		Beaumont Hospital	Children's University Hospital, Temple Street	James Connolly Hospital, Blanchardstown	Mater Misericordiae University Hospital
NUMBER OF INDIVIDUALS TREATED	Men	192	13	194	298
	Women	251	81	254	287
	Total	443	94	448	585
NUMBER WHO REPEATED	Men	23	1	32	62
	Women	32	13	37	67
	Total	55	14	69	129
PERCENTAGE WHO REPEATED	Men	12%	7.7%	16.5%	20.8%
	Women	12.7%	16%	14.6%	23.3%
	Total	12.4%	14.9%	15.4%	22.1%

APPENDIX 3C: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2013

		Cavan General Hospital	Our Lady of Lourdes Hospital, Drogheda	Our Lady's Hospital, Navan
NUMBER OF INDIVIDUALS TREATED	Men	65	179	73
	Women	79	155	98
	Total	144	334	171
NUMBER WHO REPEATED	Men	9	24	12
	Women	6	15	10
	Total	15	39	22
PERCENTAGE WHO REPEATED	Men	13.8%	13.4%	16.4%
	Women	7.6%	9.7%	10.2%
	Total	10.4%	11.7%	12.9%

APPENDIX 3D: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2013

		St Luke's General Hospital, Kilkenny	South Tipperary General Hospital	Waterford Regional Hospital	Wexford General Hospital
NUMBER OF INDIVIDUALS TREATED	Men	128	78	142	122
	Women	128	105	142	136
	Total	256	183	284	258
NUMBER WHO REPEATED	Men	16	14	22	14
	Women	9	14	19	17
	Total	25	28	41	31
PERCENTAGE WHO REPEATED	Men	12.5%	17.9%	15.5%	11.5%
	Women	7%	13.3%	13.4%	12.5%
	Total	9.8%	15.3%	14.4%	12%

APPENDIX 3E: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2013

		Bantry General Hospital	Cork University Hospital	Kerry General Hospital	Mallow General Hospital	Mercy University Hospital, Cork
NUMBER OF INDIVIDUALS TREATED	Men	19	240	133	11	237
	Women	22	229	150	6	232
	Total	41	469	283	17	469
NUMBER WHO REPEATED	Men	0	15	27	1	31
	Women	2	24	24	0	37
	Total	2	39	51	1	68
PERCENTAGE WHO REPEATED	Men	0%	6.3%	20.3%	9.1%	13.1%
	Women	9.1%	10.5%	16%	0%	15.9%
	Total	4.9%	8.3%	18%	5.9%	14.5%

APPENDIX 3F: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE SOUTHERN HOSPITALS GROUP, 2013

		Mid-Western Regional Hospital, Ennis	Mid-Western Regional Hospital, Limerick	Mid-Western Regional Hospital, Nenagh	St John's Hospital, Limerick
NUMBER OF INDIVIDUALS TREATED	Men	8	296	2	2
	Women	29	404	3	3
	Total	37	700	5	5
NUMBER WHO REPEATED	Men	1	39	0	0
	Women	5	48	2	0
	Total	6	87	2	0
PERCENTAGE WHO REPEATED	Men	12.5%	13.2%	0%	0%
	Women	17.2%	11.9%	66.7%	0%
	Total	16.2%	12.4%	40%	0%

APPENDIX 3G: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE MID-WESTERN HOSPITALS GROUP, 2013

		Letterkenny General Hospital	Mayo General Hospital	Portiuncula Hospital, Ballinasloe	Sligo General Hospital	University College Hospital, Galway
NUMBER OF INDIVIDUALS TREATED	Men	109	112	56	94	178
	Women	128	136	89	93	202
	Total	237	248	145	187	380
NUMBER WHO REPEATED	Men	11	23	13	12	25
	Women	18	18	10	9	25
	Total	29	41	23	21	50
PERCENTAGE WHO REPEATED	Men	10.1%	20.5%	23.2%	12.8%	14%
	Women	14.1%	13.2%	11.2%	9.7%	12.4%
	Total	12.2%	16.5%	15.9%	11.2%	13.2%

APPENDIX 3H: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE WEST/ NORTH WESTERN HOSPITALS GROUP, 2013

APPENDIX 4 - DELIBERATE SELF-HARM BY RESIDENTS OF HSE REGIONS

Age group	Population	MEN			Population	WOMEN		
		Deliberate self-harm				Deliberate self-harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	186300	0	0	(+/-0)	179400	0	0	(+/-0)
5-9yrs	169900	0	0	(+/-0)	163200	1	1	(+/-1)
10-14yrs	157800	54	34	(+/-9)	151200	217	144	(+/-19)
15-19yrs	141300	488	345	(+/-31)	133300	825	619	(+/-43)
20-24yrs	131800	672	510	(+/-39)	126900	671	529	(+/-41)
25-29yrs	154200	571	370	(+/-31)	165900	498	300	(+/-27)
30-34yrs	187100	556	297	(+/-25)	200300	481	240	(+/-22)
35-39yrs	180300	437	242	(+/-23)	183400	440	240	(+/-23)
40-44yrs	171800	389	226	(+/-23)	171100	408	238	(+/-24)
45-49yrs	155400	293	189	(+/-22)	156600	405	259	(+/-26)
50-54yrs	140500	232	165	(+/-22)	142400	325	228	(+/-25)
55-59yrs	124800	145	116	(+/-19)	126400	207	164	(+/-23)
60-64yrs	111300	92	83	(+/-17)	112400	107	95	(+/-18)
65-69yrs	94600	48	51	(+/-15)	94900	66	70	(+/-17)
70-74yrs	67200	32	48	(+/-17)	71000	53	75	(+/-21)
75-79yrs	48800	14	29	(+/-15)	57200	22	38	(+/-16)
80-84yrs	30600	5	16	(+/-15)	42100	7	17	(+/-13)
85yrs+	20100	5	25	(+/-22)	41900	6	14	(+/-12)
Total**	**2273800**	**4033**	**182**	**(+/-6)**	**2319600**	**4739**	**216.5**	**(+/-6)**

APPENDIX 4: DELIBERATE SELF-HARM BY RESIDENTS OF THE REPUBLIC OF IRELAND, 2013

** 95% Confidence Interval.*
*** The total rates are European age-standardised rates per 100,000.*

Age group	Population	MEN			Population	WOMEN		
		Deliberate self-harm				Deliberate self-harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	54103	0	0	(+/-0)	52376	0	0	(+/-0)
5-9yrs	48253	0	0	(+/-0)	46300	0	0	(+/-0)
10-14yrs	44931	17	38	(+/-18)	42951	67	156	(+/-38)
15-19yrs	39413	129	327	(+/-58)	38143	242	634	(+/-82)
20-24yrs	38423	148	385	(+/-63)	39237	179	456	(+/-68)
25-29yrs	48135	170	353	(+/-54)	52978	139	262	(+/-45)
30-34yrs	57929	159	274	(+/-44)	62022	149	240	(+/-39)
35-39yrs	53065	122	230	(+/-42)	54729	120	219	(+/-40)
40-44yrs	49881	112	225	(+/-42)	49783	115	231	(+/-43)
45-49yrs	43788	89	203	(+/-43)	45032	118	262	(+/-48)
50-54yrs	39679	68	171	(+/-42)	41064	91	222	(+/-46)
55-59yrs	34614	47	136	(+/-40)	36316	67	184	(+/-45)
60-64yrs	30534	33	108	(+/-38)	31597	29	92	(+/-34)
65-69yrs	24914	14	56	(+/-30)	25826	19	74	(+/-34)
70-74yrs	17406	5	29	(+/-26)	19419	20	103	(+/-46)
75-79yrs	12728	4	31	(+/-31)	15699	6	38	(+/-31)
80-84yrs	7929	1	13	(+/-25)	11540	1	9	(+/-17)
85yrs+	5267	3	57	(+/-66)	11311	1	9	(+/-18)
Total**	**650991**	**1121**	**172.5**	**(+/-10)**	**676323**	**1363**	**210.5**	**(+/-11)**

APPENDIX 4A: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE DUBLIN/ MID-LEINSTER REGION, 2013

** 95% Confidence Interval.*
*** The total rates are European age-standardised rates per 100,000.*

Age group	Population	MEN			Population	WOMEN		
		Deliberate self-harm				Deliberate self-harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	44373	0	0	(+/-0)	43216	0	0	(+/-0)
5-9yrs	38621	0	0	(+/-0)	36618	1	3	(+/-5)
10-14yrs	34057	13	38	(+/-21)	32783	57	174	(+/-46)
15-19yrs	29282	117	400	(+/-74)	27385	183	668	(+/-99)
20-24yrs	27686	170	614	(+/-94)	27918	151	541	(+/-88)
25-29yrs	37593	136	362	(+/-62)	40452	126	311	(+/-55)
30-34yrs	45974	142	309	(+/-52)	49975	118	236	(+/-43)
35-39yrs	43389	120	277	(+/-50)	44048	104	236	(+/-46)
40-44yrs	39630	106	267	(+/-52)	39223	122	311	(+/-56)
45-49yrs	33825	73	216	(+/-51)	33963	126	371	(+/-66)
50-54yrs	29383	52	177	(+/-49)	29820	90	302	(+/-64)
55-59yrs	24766	28	113	(+/-43)	25471	62	243	(+/-62)
60-64yrs	21762	20	92	(+/-41)	22637	26	115	(+/-45)
65-69yrs	18767	11	59	(+/-35)	19566	18	92	(+/-43)
70-74yrs	13601	9	66	(+/-44)	14601	6	41	(+/-34)
75-79yrs	9622	2	21	(+/-29)	12003	6	50	(+/-41)
80-84yrs	5846	1	17	(+/-34)	8499	4	47	(+/-47)
85yrs+	3888	1	26	(+/-51)	8196	2	24	(+/-35)
Total**	**502064**	**1001**	**203**	**(+/-13)**	**516373**	**1202**	**248**	**(+/-13)**

APPENDIX 4B: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE DUBLIN/ NORTH EAST REGION, 2013

** 95% Confidence Interval.*
*** The total rates are European age-standardised rates per 100,000.*

Age group	Population	MEN			Population	WOMEN		
		Deliberate self-harm				Deliberate self-harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	45700	0	0(+/-0)	43800	0	0	(+/-0)	
5-9yrs	42800	0	0(+/-0)	41900	0	0	(+/-0)	
10-14yrs	40800	15	37	(+/-19)	39000	55	141	(+/-38)
15-19yrs	37200	153	411	(+/-67)	35700	216	605	(+/-82)
20-24yrs	36100	215	596	(+/-81)	32500	180	554	(+/-83)
25-29yrs	36500	157	430	(+/-69)	39500	128	324	(+/-57)
30-34yrs	44300	159	359	(+/-57)	47300	130	275	(+/-48)
35-39yrs	44600	125	280	(+/-50)	44800	119	266	(+/-49)
40-44yrs	43400	87	200	(+/-43)	43200	94	218	(+/-45)
45-49yrs	40400	75	186	(+/-43)	40800	89	218	(+/-46)
50-54yrs	37500	58	155	(+/-41)	37400	85	227	(+/-49)
55-59yrs	33500	41	122	(+/-38)	32900	45	137	(+/-41)
60-64yrs	29900	30	100	(+/-37)	29600	36	122	(+/-41)
65-69yrs	25900	14	54	(+/-29)	25600	23	90	(+/-37)
70-74yrs	18400	12	65	(+/-38)	19200	21	109	(+/-48)
75-79yrs	13500	4	30	(+/-30)	15400	7	45	(+/-34)
80-84yrs	8500	2	24	(+/-33)	11400	1	9	(+/-18)
85yrs+	5300	1	19	(+/-38)	11100	1	9	(+/-18)
Total**	**584300**	**1148**	**203**	**(+/-12)**	**591100**	**1230**	**220**	**(+/-12)**

APPENDIX 4C: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE SOUTH REGION, 2013

** 95% Confidence Interval.*
*** The total rates are European age-standardised rates per 100,000.*

Age group	Population	MEN			Population	WOMEN		
		Deliberate self-harm				Deliberate self-harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	42124	0	0	(+/-0)	40008	0	0	(+/-0)
5-9yrs	40225	0	0	(+/-0)	38382	0	0	(+/-0)
10-14yrs	38013	9	24	(+/-16)	36466	38	104	(+/-34)
15-19yrs	35404	89	251	(+/-53)	32072	184	574	(+/-85)
20-24yrs	29592	139	470	(+/-80)	27245	161	591	(+/-93)
25-29yrs	31972	108	338	(+/-65)	32970	105	318	(+/-62)
30-34yrs	38897	96	247	(+/-50)	41003	83	202	(+/-44)
35-39yrs	39246	69	176	(+/-42)	39823	97	244	(+/-49)
40-44yrs	38889	83	213	(+/-47)	38894	77	198	(+/-45)
45-49yrs	37387	56	150	(+/-40)	36806	72	196	(+/-46)
50-54yrs	33939	54	159	(+/-43)	34116	59	173	(+/-45)
55-59yrs	31920	29	91	(+/-34)	31713	33	104	(+/-36)
60-64yrs	29104	9	31	(+/-21)	28566	16	56	(+/-28)
65-69yrs	25019	9	36	(+/-24)	23908	6	25	(+/-20)
70-74yrs	17793	6	34	(+/-28)	17780	6	34	(+/-28)
75-79yrs	12951	4	31	(+/-31)	14099	3	21	(+/-25)
80-84yrs	8326	1	12	(+/-24)	10661	1	9	(+/-19)
85yrs+	5644	0	0	(+/-0)	11293	2	18	(+/-25)
Total**	**536445**	**761**	**152**	**(+/-10)**	**535804**	**943**	**194**	**(+/-11)**

APPENDIX 4D: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE WEST REGION, 2013

** 95% Confidence Interval.*
*** The total rates are European age-standardised rates per 100,000.*

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